

A Comprehensive Interaction between Illness and Culture:
Recognition and Treatment of Evil Eye
in rural San Marcos, Guatemala

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DISSERTATION

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**A Comprehensive Interaction
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Contents

Prologue: The Ominous Threat of Dying of Communicable Diseases	13
The extent of a cultural illness: Evil Eye in Guatemala	19
1 ASSESSING ‘EVIL EYE’ AS AN ILLNESS CATEGORY TO UNDERSTAND HEALTH-SEEKING BEHAVIOURS AND PREDICAMENTS	21
1.1 Introduction	23
1.2 An instrumental concept of illness	27
1.3 The conceptualisation of Evil Eye	28
1.4 Research Questions	37
1.5 Outline of the Research Objectives	43
1.6 Background and Theoretical Foundations	44
1.7 Biomedicine as the predominant expectation of health-seeking behaviours	46
1.8 Global policies and approaches to local realities: Health-related studies in the Guatemalan context	68
1.9 Conclusions	76
2 RESEARCH DESIGN	81
2.1 Reflecting on concepts and meanings	81
2.2 Understanding Evil Eye within a phenomenological approach	82
2.3 Setting	86
2.4 San Marcos	88
2.5 Methodology	89
2.6 Methods	103
Judgement under (un)certainty among healthcare systems in Guatemala	111
3 MEDICAL PLURALISM IN GUATEMALA	117
3.1 Introduction	117
3.2 The Recognition of Medical Pluralism	121
3.3 Contemporary Models of Traditional Care	124
3.4 Folk illnesses within pluralistic medical models	126

3.5	'Origins' of a Mayan Traditional Medical System	134
3.6	Traditional health system within a globalised world	143
3.7	The production of health: Evil Eye within a pluralistic model of healthcare	169
3.8	Conclusions	174
Health as Social Change		177
4	GUATEMALAN NATIONAL HEALTH SYSTEM AND REFORMS	181
4.1	Introduction	184
4.2	History of the Institutionalisation of Guatemala's Health System . .	187
4.3	Current Guatemala Health System	193
4.4	Internationalisation of Health Policies	203
4.5	Democratic Transition	206
4.6	Current National Health Priorities	217
4.7	Conclusions	221
A Case of Several Encounters		227
5	SITUATING EVIL EYE AMONGAETIOLOGIES	233
5.1	Introduction	233
5.2	The Nature of the Illness Category	236
5.3	Understanding Evil Eye as an <i>Ambiguous Illness</i>	259
5.4	Evil Eye as Social Behaviour	270
5.5	Conclusions	279
Healing and Relief		285
6	HEALING (COLLECTIVE) BODIES	289
6.1	Introduction	289
6.2	Interpreting Signs and Symptoms	291
6.3	Diagnostic Criteria of Evil Eye's Symptomatology	295
6.4	The Knowledge Domain and the Healing Process of Evil Eye	306
6.5	The Role of Divination in the Healing of Evil Eye	318
6.6	Evil Eye's Social Conception	325
6.7	Conclusions	330
Structural Factors and Political Economy of Healthcare Interactions		335
7	THE CONFLICT BETWEEN INDIGENOUS AND BIOMEDICAL CONCEPTIONS OF ILLNESS	345
7.1	Introduction	345

7.2	The impact of Illness Beliefs	346
7.3	A Cultural Understanding of the Evil Eye's Nosology	350
7.4	Evil Eye as a Melting Category	356
7.5	Caretakers within Healthscapes	370
7.6	Evil Eye's ethnophysiology. The intentionality of including diverse meanings	373
7.7	Articulating Experiences of Illness	378
7.8	Conclusions	388
	Stumbling on (Mis)diagnosis	393
8	SIMPLE TERMS, DIFFERENT UNDERSTANDINGS AND THE TRANSLATION OF MEDICAL CONCEPTS INTO CULTURAL PRACTICES	399
8.1	Introduction	401
8.2	Junction between Illnesses	405
8.3	Development of ARI Control Programmes	411
8.4	Development of ADD Control Programmes	425
8.5	The Effects of Drug Acquisition	438
8.6	The Implications of Cultural Coding in Health	442
8.7	Conclusions	448
9	Conclusions: Fighting Death in Rural San Marcos	451
9.1	Behaviour as a prominent factor in health	451
9.2	Healthscapes in rural San Marcos	453
9.3	The powerful impact of Evil Eye	454
9.4	Negotiating healthcare practices among systems of care	457
9.5	Intentional behaviour	460
9.6	Implications of this study	462
	Bibliography	465
	Zusammenfassung	559
	Eidesstattliche Erklärung	563
	Curriculum Vitae	565

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Prologue: The Ominous Threat of Dying of Communicable Diseases

At the end of August 2016, an event made front-page news in the Guatemalan press: the newly installed Minister of Health of Guatemala, Lucrecia Hernández Mack, officially announced that “supernatural and traditional” illnesses associated with under-five child mortality should be included as priorities in the primary health care system in order to strengthen the provision of healthcare within indigenous communities in rural areas. The minister explained how the understanding of such illnesses is important for effective treatment of preventable and communicable diseases. When the minister made this announcement, she mentioned *Evil Eye* as an example. Evil Eye is an illness-experience found in various places and regions, where the phenomenon is permeated by ideas of sorcery, witchcraft, humours, and psychobiological factors. Under this ideology, Evil Eye works on the basis that a person can cause someone or something harm, causing him/her/it to fall ill or become otherwise damaged, producing specific symptoms as the illness progresses.

Yet, after the Minister made this announcement, her proposal was received with indignation and many negative comments from some in the civil and political sector: a wave of articles and pronouncements appeared opposing her initiative. These negative articles or comments illustrate persistent racist perceptions and cultural insensitivity within the general population which negatively affect the implementation of strategies that seek to include illnesses -like Evil Eye- into the agenda for the provision of primary-health care. The inclusion of Evil Eye, even though its definition is non-biomedical, derives from the fact that many of its symptoms are similar to those of important infectious and parasitic diseases. Until the recent effort by the new Minister of Health, there has been an absence of strategies to provide culturally appropriate treatment for Evil Eye and other traditional illnesses within a ‘collaborative model of health’. The implementation of this strategy would involve the inclusion of traditional midwives and Mayan therapists or healers, working altogether with medical staff, to provide attention

and treatment at primary care centres.

The study and use of behavioural models have influenced the understanding of factors that function as determinants of healthcare, especially within pluralistic medical settings where the allopathic model is considered more effective and less risky in terms of predictable impacts. Behavioural models intertwine with politics, public healthcare, psychology and anthropology, among other areas of studies. While some of these frameworks seek to provide a broader understanding of how such macro-structural factors drive the distribution of healthcare, an examination of behavioural responses to illnesses show that they are strongly linked to cultural norms that both trigger and justify specific practices that embrace complex dynamics. Because of this complexity and variability, behavioural changes are difficult to assess and even more difficult to accomplish. Factors that are perceived as detrimental to health, however, have often contributed to policy changes by acting on the assumption that some traditional practices are based on a lack of understanding or acceptance of biomedical approaches. This work brings together a detailed review of some of the aforementioned aspects, but more importantly, it examines the way in which a particular illness, Evil Eye, considered relevant under a behavioral change needs to be deeply examined and appropriately evaluated. Evil Eye, like any other illness, implies a damaged state of health. Yet it also expands into other areas of human life that do not necessarily represent a threat. In my dissertation, I expand on the socio-political framework to explain the phenomenon of Evil Eye and emphasise the importance of socio-political and historical issues that arise when addressing questions of the health-care systems and practices.

Experiences of illness, pain, distress and suffering are concepts used by lay and professional individuals, yet the understanding of and responses to each of these are not self-evident and homogeneous but deeply involved with personal and social perceptions and strategies for explaining, making sense of, and overcoming these experiences. Concepts of illness and health, as well as health-seeking practices and strategies used by health practitioners (as well as researchers) within behavioral healthcare models are normally filled with scientific explanations and therefore reduced to something tangible and logical, disrupting these multifarious experiences in favor of generic concepts that are manifested in ‘predictable’, ‘observable’ and ‘expected’ behaviours. Yet illnesses are influenced by, and negotiate among, idiosyncrasy, religious ideology, and political, social and cultural settings, all of which claim the power to decide on a particular healthcare model and practices. Behaviours with regard to healthcare and therapies, which deal with the most

vital aspects of a person's life and well-being, therefore develop differently among individuals and groups. Hence, any study of illness and health is only a partial representation of a social and individual frame.

Scholars in this field have offered significant insights and explanations about the importance of understanding culturally defined illness and how this concept can be correlated or juxtaposed to standardized biomedical concepts. Thus, points of encounter and conflicts in the realm of illnesses have occupied the interest of anthropologists, eventually becoming issues of interest to international public health institutions, NGOs and governmental facilities that deal with the provision of medical care. However, some illnesses have been unable to win long-standing interest for public health initiatives.

Evil Eye filters through the interstices of anthropology and medical perspectives, standing between traditional and biomedical healthcare systems, therapies and understandings. From a traditional perspective, Evil Eye is an illness experience found in various places and regions, where the phenomenon is permeated by ideas of sorcery, witchcraft, humors, and psychobiological factors. Under this ideology, Evil Eye works on the basis that a person can cause someone or something harm, causing him/her/it to fall ill or become otherwise damaged, producing specific symptoms as the illness progresses. From a biomedical perspective, this belief is one of several 'cultural barriers' to full acceptance of the available biomedical services and therapies. Evil Eye attributes comprise a domain of biological and social relations of diverse interpretative possibilities. It presents a variety of symptoms, including headaches, diarrhoea, fever, vomiting, shortness of breath, wheezing, and persistent cough, among other symptoms. These symptoms are also indicators of acute respiratory infections (ARIs) and acute diarrhoeal diseases (ADDs), the leading causes of childhood deaths worldwide. The condition of Evil Eye can be perceived as mild or severe. Diagnosis of these symptoms as ARI or ADD infections creates a paradox, because the improvement of health services has increased the use of drugs as a primary therapy, creating expectations about the efficacy of allopathic treatments that are not always met. Furthermore, the variety and complexity of pathogens, exposure routes, and illness outcomes lead to diagnoses that are often inaccurate or vague, and thence to extensive reliance on broad-spectrum antibiotics. The expense and the uncertain outcome of biomedical treatment threaten people's economic and emotional security, and thus lead to a 'traumatic' experience.

Evil Eye therefore has a strong effect on the diagnosis and treatment of ARIs and ADDs, two of the main priorities of international and national childhood health-

care policies. Biomedicine has influenced the illness management of Evil Eye, not in terms of how it is explained, but in terms of how it is treated. Although lack of resources and inaccessibility of health facilities have deeply influenced the treatment of Evil Eye, this illness continues to be an important factor in social ideas and relations concerning practices, values, morality, and affliction, not only on an embodied self but also extending to the caretaker's children. An ongoing debate concerning compliance with therapies to prevent and treat these communicable illnesses has created a space to examine the role and impact of Evil Eye with the aim of increasing the use of primary and secondary healthcare facilities, under the assumption that Evil Eye is only a superstition that can be overcome through behavioural change and educational campaigns. Evil Eye does not completely reject biomedical therapies, but makes selective use of them. Patients and their families rely primarily on traditional and folk treatments, since the symptoms are not necessarily perceived as having a biomedical cause. Specific biomedical treatments, such as oral rehydration therapies to treat diarrhoeas, are seen as highly important to prevent aggravated cases of diarrhoea. The traditional approach to Evil Eye, however, has favoured the use of therapies that are concerned primarily with restoring the body's balance—that is, the treatment is based on the aetiology of the illness and not solely on symptoms, which might or might not entail treatments considered necessary in biomedical terms. Because of these perceptions and practices, Evil Eye raises many concerns and conflicts within the biomedical frame.

By focusing on behavioral models, public health initiatives have constantly stressed the role and impact of caretakers in children's health. Mothers are expected to care for their children, beginning with such 'natural' practices as breastfeeding or even where and how to give birth. Mothers are assumed to behave in certain ways, and their behaviours are understood as having a direct impact on the well-being and health status of their children. If ARIs and ADDs have been targeted as priorities and many treatment initiatives have been and are still applied, why do people still make use of the concept of Evil Eye? Healing begins when the 'perpetrator acknowledges its own wrongdoing'. This also applies to invisible pathogens or threats. If we do not know what is making us ill, we are confronted not only with an illness but also with anxiety and insecurity. More importantly, we lose control of our own self (or the possibility to care or provide for our loved ones). Evil Eye, however, is a means of entitlement. Even if the healing and treatment can develop into something unexpected, Evil Eye allows negotiation and the possibility of navigating through healthcare systems.

San Marcos reports not only high rates of Evil Eye but also the largest number of deaths due to diarrhoea and pneumonia in the country of Guatemala. This

shows that, despite the significance of Evil Eye for people who believe in it, this phenomenon remains poorly understood, resulting in an inaccurate understanding of the medical implications of an Evil Eye diagnosis. Although a few studies do reveal the local importance of Evil Eye—its meaning and role as a social process—they fall short of recognizing how the illness is constituted and the importance of events or implications associated with it. Because there is no universal definition of what constitutes (emotional) well-being, Evil Eye walks among contradictions. The explanation I like to use to define Evil Eye is that it is a concept that adjusts and deals with uncertainty, provides emotional connection to one degree or another, and helps caretakers to gain different types of support. It is not limited to these aspects, yet these do define and structure the illness.

This study relies on a series of ethnographical data from caretakers and health-care providers that are significant in understanding the notion of Evil Eye in the context of medical pluralism. It seeks to provide a better understanding of this illness concept and its relationship with diarrhoeal diseases and respiratory infections from the perspective of people who believe in or are confronted with the phenomenon in the Department of San Marcos, Guatemala.

The extent of a cultural illness: Evil Eye in Guatemala

‘The distinction between studying quality of care and studying barriers or access is not always clear in outcomes research.’

— Kasper (2000:332)

Melvin was two and a half years old when we met him and his mother Gloria in 2009 at the health center of Comitancillo, San Marcos, Guatemala, where he was diagnosed with severe pneumonia. Gloria was holding him in her arms; he was almost motionless and breathing rapidly, probably suffering from tachypnea. He had also candidiasis¹, diarrhoea and high fever. Gloria’s perception was that Melvin was ill with Evil Eye. Prior to attending the health center, the SIAS² personnel from Xequiac, where they lived, recommended that he be referred to the National Hospital in San Marcos, with which the health center concurred. One day after this encounter, she came to the ACCESS’s office project in San Lorenzo to seek help, where I was working as part of the research team (around 15 kilometers from Comitancillo). Gloria was reluctant to go to the hospital and was hoping we could supply her with some medicine; however, Melvin’s state was precarious. The medical doctor of the program confirmed the diagnosis and reaffirmed the advice to take him to the hospital. A few minutes later Gloria, her husband, and Melvin were taken to the National Hospital at San Marcos by a fieldworker of the team. We met Gloria twice, once on the day Marvin was referred to the hospital and then two weeks later on a follow-up visit.

Gloria: “In the beginning I cured Melvin for two weeks with plants we use for Evil Eye. I gave him infusions of mint, wormseed and ruta. He gets the Eye

¹“*Candidiasis* is a fungal infection caused by yeasts that belong to the genus *Candida*. There are over 20 species of *Candida* yeasts that can cause infection in humans, the most common of which is *Candida albicans*. *Candida* yeasts normally live on the skin and mucous membranes without causing infection; however, overgrowth of these organisms can cause symptoms to develop. Symptoms of candidiasis vary depending on the area of the body that is infected. Candidiasis that develops in the mouth or throat is called “thrush” or oropharyngeal candidiasis” (Center of Disease Center and Prevention CDC, <http://www.cdc.gov/fungal/candidiasis/>, accessed on 13.05.2009).

²Sistema Integral de Atención en Salud en Guatemala. See Chapter VII.

quite often but he normally gets better after the treatment, so we took him to the healer to see why he wasn't recovering. The healer said that the Eye was too strong, probably caught it from a drunken man. Melvin had fever on his back and on his head, and also was coughing. The fever didn't decrease for a couple of days so I went to see the people of the SIAS where they gave me some pills. . . At night Melvin was worse! I think it might have been the pills, so the next day were people coming for the vaccines so I took Melvin to the SIAS again but instead of giving me something, they just referred Melvin to the health center, who then referred him to the hospital. I spent almost 15 days there! It was really awful. . . the first week Melvin was in intensive care. The second week Melvin was put in another section. During all that time I only had a chair close to his sickbed. I couldn't leave the hospital. . . I couldn't stand it after two weeks and decide to leave the hospital. I felt like I was inside of a prison I couldn't leave. . . you lose control of everything. The doctors told me, 'You cannot leave now, Melvin is not completely healed,' so I talked to my husband and he agreed, so I left. He knew how desperate I was feeling; besides I also have more children that needed me and my husband couldn't take care of them and you can't just ask other people to do it. Then we went to the pharmacy in San Pedro and bought medicines in case Melvin started with some of the symptoms again, which appeared three days after he left the hospital. [At the pharmacy we bought] Enteroguanil®³, metronidazole, ferrous sulfate. . . and I cannot remember the rest of the names. I have these empty bottles here in case he gets sick again. I don't want to end up at the hospital one more time! But you have to be careful when a child gets sick with Eye and then with other diseases.³ You can't mix treatments up. Children can die if they get injections and the Eye hasn't been removed. It explodes in their body. But doctors don't know. They just tell us, "Don't be silly, the Eye doesn't exist".

³The use of the terms *disease* and *illness* in this work is based on the differences between using public health data or more general concepts to illustrate aspects of pathologies and morbidity. The distinction between these two concepts is of particular importance, especially in the field of medical anthropology. They refer to specific understandings, perceptions and dynamics of healthcare, reflecting the fact that pain, distress, affliction, symptoms, etc., in the realm of ailments are personal and socio-cultural experiences, rather than specific pathologies in terms of biomedical definitions of dysfunctions even though these concepts are often used interchangeably by laypersons (cf. Vivien et al. 2013). The use of the concepts *disease* and *illness* by the informants in this research, however, is my own interpretation in order to stress a particular perception, since there is no adequate translation in Spanish of these two definitions. I use the concept *disease* when referring to biomedically defined pathologies or dimensions of pathologies, and *illness* when referring to a broader definition of ailments, pain, distress, and subjective experiences when interpreting the significance of ailments in a manner not limited to the biomedical focus. For a theoretical discussion of the concepts *disease*, *illness*, *sickness*, see works such as Nordenfelt 1994; Kleinman 1980, 1986; Kleinman & Seeman 2000; Kleinman et al. 2006; Twaddle 1994; Young 1982; and Wikman et al. 2005.

1 ASSESSING ‘EVIL EYE’ AS AN ILLNESS CATEGORY TO UNDERSTAND HEALTH-SEEKING BEHAVIOURS AND PREDICAMENTS

‘It is the irreducible ‘sociosomatic’ quality of illness experience, rooted in the infrapolitics of everyday life as well as the more encompassing political, economic, and cultural realities of the societies we live in, which should be of deep concern to both social scientists and medical professionals.’

— Kleinman & Seeman (2000:231)

The professionalisation of healthcare, a range of global and local practices and ideologies described/perceived as “dominative” or paradigmatic, locates Evil Eye as a target (among other practices, i.e., *beliefs*) of interventions, with the aim being to deplore local practices as negligent behaviours¹ or *cultural barriers*.² However, such “supernatural paradigms”³ are not always applied, since people tend to consider multiple concepts and models of disease causation to understand their world,

¹ *Illness behaviour* “describes the manner in which persons monitor their bodies, define and interpret their symptoms, take remedial actions, and utilize the healthcare system. People differentially perceive, evaluate, and respond to illness, and such behaviours have enormous influence on the extent to which illness interferes with usual life routines, the chronicity of the condition, the attainment of appropriate care, and the co-operation of the patient in the treatment condition” (Mechanic 1982:1).

² *Barriers* to health refer to all possible factors that limit or decrease the use of specific health services or treatments which reduce or increase the likelihood of suffering certain diseases (cf. Gill et al. 2013; Kasper 2000).

³ A “supernatural paradigm” presupposes that illnesses relate to the influence of a powerful source such as spirits, ancestors, environment, etc. Within this framework, illness occurs when social balance or the environment is disturbed or damaged. As a result, a person falls

including biomedical conceptions and methods (cf. Joel et al. 2003; Luby 2013:44). Moreover, understandings of disease causation may not assume that one can be cured or healed solely by one medical model. While a physician relies on various medical tests and examinations to establish a nosological profile, patients attribute different causes for the origin and symptoms of their illness, resulting in pluralistic explanations and practices (Choi & Nisbett 2000; Whitaker 2003). Illnesses are also strongly influenced by culture,⁴ which defines behaviours attached to the illness and ideas regarding care and treatment. The probability of misdiagnosis or failure to diagnose an illness is therefore higher when a physician is not aware of a patient's understanding of their illness, as well as when a patient or caretaker understands, considers and expresses symptoms differently from the biomedical model (cf. Arcury et al. 2004; Cabassa et al. 2008; Kleinman 1980; Weller et al. 1997). Hence, culturally specific beliefs play an imperative role that dictates the cause and outcomes of an illness, influencing the use of healthcare services and practices of care, which are confronted by different kinds of dynamics, including personal encounters as well as non-governmental and governmental frameworks.

The first chapter will explain the importance of studying Evil Eye as an illness category. Previously, the study of Evil Eye has taken place largely around the domain of culture and outside the influence of the multiple and overlapping institutional health interventions and financial support. A historical review will provide clarity regarding how Evil Eye overlaps (1) healthcare, (2) cultural aspects, and (3) normative discourses of health, thereby becoming a peripheral concern within (global) medical endeavors to overcome diseases, being relegated to merely cultural features. Despite the contributions of theoretical perspectives within medical anthropological studies, a classificatory scheme for Evil Eye has not achieved a theoretical recognition that explains many of the health-seeking behaviour predicaments.

ill because s/he has broken a taboo, has been cursed, has been affected by harmful spirits, has not shown respect to ancestors, etc. Good examples of such cases can be found in the book *Morality, Hope and Grief: Anthropologies of AIDS in Africa*, edited by Dilger & Luig, which is a collection of papers on topics related to AIDS/HIV, including beliefs about causation.

⁴I regard the concept of *culture* as a process of social relations that is shared within a group where dynamics have reached a consensus and its characteristics are meaningful; hence these dynamics are constantly regenerated, since its socialisation is what shapes and controls it. From this perspective, culture is not a generic concept, but a notion that encloses specific features within a specific context, in this case those related to the process of health/illness/health-seeking patterns, including diagnostic, treatment, and attention, i.e., patterns of healthcare (see Chapter VII).

1.1 Introduction

With an estimated population of 15.44 million,⁵ Guatemala is marked by high levels of poverty,⁶ inequity,⁷ and low levels of human development. It is also one of the most stratified countries in the world, where ethnicity plays a main role in the distribution of resources. Indigenous⁸ women, who do not speak Spanish, are more likely to face poor health outcomes and rely on traditional forms of healthcare (Glei & Goldman 2000:6-8). Guatemala is one of the most impoverished countries in Latin America, with the highest maternal and infant mortality rates in the region (CEPAL 2005; Glei & Goldman 2000; Gragnolati & Marini 2003; Bruce et al. 2014; Steele 1994), especially among the indigenous population, who primarily live in isolated rural areas. In 2011⁹ the mortality rate of children under five was 30 per 1,000 live births and the maternal mortality in 2009¹⁰ was 134 per 100,000. In Guatemala, the estimated under-5 mortality rate in 2000 was 51 deaths per 1,000 live births; in 2012, this estimate had decreased to 32 deaths per 1,000

⁵ World Population Statistics <http://www.worldpopulationstatistics.com/guatemala-population-2013/>

⁶In 2007, 56.2% of the population were living under the poverty line, 50.9% lived on less than USD 2.00 per day, and 15.2% lived on less than USD 1.25 (VARITE 2010:7) The minimum monthly wage for agricultural and non-agricultural activities is GTQ 2,280.34 monthly (Q.74.97 per day), while for the textile and export sector it is GTQ 2,096.06 (Q.68.91 per day) (Acuerdo Gubernativo No.537-2013). The minimum salary required to purchase a *canasta básica* (CBA) (basic basket) of food is GTQ 2,172.60, while the minimum to cover the price of the *canasta básica vital* (CBV) (basic vital basket), which includes services such as education, health, housing, transport, and recreation, is GTQ 3,964.60 (<http://www.ine.gob.gt/np/CBA/>).^[200E?] In 2011, 38% of Guatemalans were economically active. The majority of the people (38%) are employed in the agricultural sector, followed by services with 26%, 14% in industry, and 18% in commerce. Agricultural workers are primarily indigenous men; women are normally employed in the industry sector (LO/FTF 2013:13-14).

⁷Using the Gini coefficient, a measurement of the level of equality (with a score of 0 meaning complete equality and 100 meaning total inequality), Guatemala was ranked 131 in 2011, one of the most the most unequal countries in the world out of a total of 187 (World Food Programme, <http://wfp.org/countries/guatemala/overview>) (accessed on 14.12.2013)

⁸The international discourse defines *indigenous* as “communities, peoples and nations . . . which, having a historical continuity with pre-invasion and pre-colonial societies that developed on their territories, consider themselves distinct from other sectors of the societies now prevailing on those territories, or parts of them. They form at present non-dominant sectors of society and are determined to preserve, develop and transmit to future generations their ancestral territories, and their ethnic identity, as the basis of their continued existence as peoples, in accordance with their own cultural patterns, social institutions and legal system. . . . On an individual basis, an indigenous person is one who belongs to these indigenous populations through self-identification as indigenous (group consciousness) and is recognised and accepted by these populations as one of its members (acceptance by the group)” (United Nations (2004) document PFII72004/WS.1/3).

⁹ UNICEF/WHO (2013): “Immunisation Summary: A Statistical Reference Containing Data through 2011,” p. 69.

¹⁰Although Guatemala’s under-five mortality rate has decreased from 85.0 to 42.0 per thousand, the target for 2015 is to reduce it to a third of its 1990 value, or 28.3 per thousand (CEPAL 2005: The Millennium Development Goals: A Latin American and Caribbean Perspective, Chapter VIII).

live births, a decrease of 63%—nearly achieving the MDG target of 27 by 2015 (UNICEF 2013b). However, despite being on the positive track, Guatemala had a higher mortality rate in 2012 for children under 5 years of age than all other Central American countries. In fact, the under-5 mortality rate in Guatemala was 70% higher than the mortality rate in the Latin America and Caribbean region, which averaged 19 deaths per 1,000 live births in 2012 (*idem*). In Guatemala in 2010, 14% of all deaths in children under 5 years of age were attributable to pneumonia and 7% were attributable to diarrhoea (UNICEF 2010). Pneumonia and diarrhoea are the leading infectious causes of death outside the neonatal period, both in Guatemala and globally (UNICEF 2012b).

Guatemala is ranked as the last country in Latin America and the Caribbean with respect to health statistics, and 81st out of 226 countries globally in terms of gross domestic product (GDP).¹¹ Its population has an average of 4.1 years of formal education, it ranks third in life expectancy at birth (70.8), and it had a Human Development Index (HDI)¹² value of 0.581 for 2012, positioning the country at 133 out of 187 countries (UNICEF 2010; 2013a). Illiteracy is around 18.5% among the population age 15 and over and 37.5% among the indigenous population, as opposed to 15.3% for the non-indigenous population¹³ (PAHO 2012). Although some improvement has been made in health and economic indicators (MSPAS 2011; Murray et al. 2013), inequality continues to be a compelling problem, since 25.9% of the population live in Multidimensional Poverty¹⁴ and another 9.8% are vulnerable to multiple limitations (UNICEF 2013a:5).

Approximately 7.2 million of Guatemala's population are under 5 years of age, roughly half of the entire population.¹⁵ Many of these children suffer from chronic malnutrition.¹⁶ The rate of malnutrition¹⁷ is higher among rural-indigenous com-

¹¹GDP is the broadest and most widely used monetary calculation of national income. It includes the value of goods and services produced by domestic factors or production (labour, capital, materials) during a fiscal year or in a given period of time (World Trade Organisation, www.wto.org/english/res_e/download_e/inbr_e.pdf).

¹²The Human Development Index (HDI) is a summary measure for estimating long-term progress in three basic areas of human development: health, education, and income (UNDP 2013: Human Development Report. The Rise of the South: Human Progress in a Diverse World. Guatemala).

¹³www.ine.gob.gt

¹⁴The Multidimensional Poverty Index (MPI), introduced in 2010 in the Human Development Report (HDR), identifies multiple deprivations in the same household in education, health and standard of living (UNDP 2013: Human Development Report. The Rise of the South: Human Progress in a Diverse World. Guatemala).

¹⁵Encuesta Nacional de Condiciones de Vida, ENCOVI 2011, <http://www.ine.gob.gt/index.php/encuestas-dehogares-ypersonas/condiciones-de-vida>

¹⁶World Food Program, <http://www.wfp.org/countries/guatemala/overview> (accessed on 26.01.2013).

¹⁷*Malnutrition* refers to all deviations from adequate and optimal nutritional status, including energy undernutrition and over-nutrition. It may arise from deficiencies of specific nutrients or

munities, and the magnitude of this disparity may be increasing (Gragnotati & Marini 2003; MSPAS et al. 2009; MSPAS et al. 2012). The chronic malnutrition rate of the country is 49.8%, the highest in Latin America and the Caribbean and the fourth highest in the world (ibid., p.12); the rate is 69.5% among children in indigenous communities; the overall malnutrition rate of children under five is 19.3% (UNICEF 2010:4). Fifty-nine percent of all children and adolescents live in poverty, and 19.2% are considered extremely poor. Of the approximately 1,200 children born daily, one dies every thirty minutes as a consequence of malnutrition and other preventable diseases (UNICEF 2013c).

National health programmes and some scholars have identified cultural factors, particularly ethnic-related beliefs, together with poverty, as determinant causes for inappropriate health practices and/or not seeking biomedical care (Aguirre 1994; Boyle et al. 1989; Hendricson et al. 1996; Robledo et al. 1999; Westberg 1989). One such example has been research on pulmonary infections and acute diarrhoeas, which has drawn attention to health-seeking practices, highlighting how the combination of poor living conditions and low rates of utilisation of public health facilities has a negative impact on health indicators (cf. Bruce et al. 2013; Curtis et al. 2000; Gragnolati & Marini 2003; Leininger 1996; Luby 2013; Malik et al. 1992; Nichter 1988, 2002; Nielsen et al. 2001).

Pneumonia, “the forgotten killer of children”, the leading global cause of death among children under five (Smith et al. 2011; Wardlaw et al. 2006), together with deaths from diarrhoeal disease, claim the lives of more young children than malaria, measles and AIDS combined (UNICEF 2012a; Wardlaw et al. 2006; WHO 2009). Consequently, significant effort has gone into the implementation of improved healthcare practices, focused specifically on both midwifery and child care. The underlying premise of these initiatives is that much child and maternal mortality can be prevented through timely and appropriate treatment-seeking behaviours and improved knowledge to identify risk factors (cf. Gleit & Goldman 2000; Colvin et al. 2013). Hence, most of the ‘child’ and ‘global healthcare’ models and epidemiological studies tend to focus on the micro-context, which McMichael calls “prisoners of the proximate”¹⁸ (1999:890). Special attention has been given to

from diets based on inappropriate combinations or proportions of foods caused by inadequate iodine, vitamin C, iron or vitamin A. It can also result from excess nutrient losses or utilisation (Shetty 2003:18).

¹⁸ According to McMichael, the epidemiological approach to studying the determinants of populations’ health have been limited, over the years, to: 1) a concern with proximate risk factors; 2) a focus on individual-level versus population-level influences on health; 3) a typically modular (time-windowed) view of how individuals undergo changes in risk status; and 4) the confrontation with unseen or unexpected large-scale social and environmental changes (1999:887).

attitudes,¹⁹ which are stressed as individual-level high risk-behaviours, i.e., proxy causes, rather than taking into account the multiplicity of underlying political, economical, environmental forces or power structures. It also ignores social dynamics amidst families and communities, which are also part of the illness's process with regard to the provision of care giving and of financial and emotional support. However, through an anthropological approach other considerations in healthcare decisions have been identified. Foster and Anderson (1980), for example, observed that under-utilisation of modern health services is closely associated with accessibility and service costs, as opposed to being solely influenced by local beliefs or rejection of hegemonic biomedicine. Illnesses are placed not only in a 'biological body' but displayed in a wide variety of conditions and factors that interact with families, communities, and other stakeholders, challenging understandings and modes of action and intervention.

A 'global healthcare model' approach depends on a series of systematic responses that begins with the recognition by mothers or caregivers of the symptoms and severity of children's diseases. This results in standardised patterns of seeking-behaviour, including the time of response from the onset of the symptoms to the actual seeking of help from community health workers and medical professionals. Yet, standardised approaches cannot always be applied, since the wide range of healthcare models co-exist in parallel with other factors: competing health-illness theories; causal models; acceptance or rejection of therapies; decisions within family dynamics; personal/community resources; perceptions of the biomedical interventions; and the household mechanisms of treatment options (cf. Scott et al.2014). Currently, most experts would agree with Nichter that "health behaviour is complex and based on contingencies of social and economic as well as cultural significance" (Nichter 1989:83). Discussion of particular illnesses is helpful because it focuses our attention on how culture shapes health-seeking patterns. Thus, to understand decisions and behaviours related to illness, we must reflect on disease categories and their implications outside the biomedical scope, since health and diseases are defined within the context of culture (cf. Adams & Hawkings 2007; Luby2013; Nichter 2008). This study addresses the question of how people interpret and deal with cases of acute diarrhoeal and respiratory infections in young children, and the role of the concept of Evil Eye, as it influences caretakers' treatment-seeking behaviours for these two diseases.

¹⁹ *Attitude* is defined as "a relatively enduring organisation of beliefs, feelings, and behavioural tendencies towards socially significant objects, groups, events or symbols" (Hogg et al. 2005:150). Attitudes sustain appropriate or inappropriate behaviour, and are thus seen as a decisive key to control and anticipate some behavioural actions or relations, since *attitudinal outcomes* in a patterned behaviour are the result of practices to achieve or reach specific purposes (cf. Fessler 1999).

1.2 An instrumental concept of illness

During the late 19th century, anthropological theory interpreted health and illness as part of an animist religious model, where magic and witchcraft were presented as a direct consequence of religious and superstitious beliefs (cf. Rivers 1924; Roberts 1976). In his book *The Golden Bough* (1890), Frazer points out the transition from a magic state (Age of Magic), where people defend themselves against evil and hostile environments through magical practices, towards a state connected to religion, where there is a belief in a direct intervention of benevolent or malevolent agents (gods), who determine the course of people's lives and who directly influence their welfare and well-being. Science appears as a final development stage in this evolutionary scheme.

Many aspects of health and illness have been analysed within this framework of magical and religious systems, where Evil Eye (*mal de ojo*, *daño de ojo*, *ojo amargo* in Spanish), Fright (*susto*), and Fontanel Fall (*caída de mollera*), among other folk illnesses and their healing practices, are seen as a result of some external coexisting force, and are forms of traditional or ancient beliefs. This 'Darwinistic model' also implies a natural order of logical thinking, in which actions that are regarded as non-scientific are part of a system of beliefs which function to recognize or avoid situations that are unsafe or lack good judgment. *Beliefs* are complex cognitive and social expressions of interactions and symbols rooted within deeper structures that affect people's perceptions and choices, which make an act or a choice significant. Thus, beliefs are fused expressions and attitudes which result from cognitive process and subjective emotions/perceptions (cf. Good 1994:1-24). Yet practices driven by *beliefs*, rather than by scientific arguments, give the impression that people unconsciously make wrong choices due to their lack of awareness of their own biases and because people do not question their own ideas. Beliefs call attention to what appears to be a cognitive illusion of 'wrong' and 'right'. This is important to emphasize because beliefs are active systems of behaviours and explanations, not merely descriptions of options and decisions. Beliefs are an important cultural script that expands and adds reflections of (dis)order into the social order.

Some of the earliest works in medical anthropology focused on indigenous healing systems (ethnomedical systems) and how these differ cross-culturally (cf. Foster & Anderson 1980). According to Fabrega, these studies share certain aspects, putting emphasis on 'theories of etiology (disease causation), diagnostic criteria, therapeutic measures, formalised interaction between patients and healers, and mechanisms for training healers' (1974:27-28). Over the years, medical anthropologists have focused on the importance of the cultural domain in understanding perceptions

of illness and treatment decisions, especially studies within pluralistic societies, such as studies of biomedical versus folk-defined illness. Many ailments that are considered to be of a supernatural nature, caused by “forces” and treated mainly by healers, generally using natural or herbal remedies, are referred to as ‘folk illnesses’ (cf. Boyle & Andrews 1989; Holliday 2008; Keegan 1996; Leininger 1996; Solis et al. 1990; Rubel 1964; Westberg 1989). The deployment and transformation of some folk illnesses is, however, in different ways, a product of allopathic medicine or other healthcare models which have amplified and even changed processes of diagnostic, treatment and perceptions.

In his extended analysis of *beliefs*, Good (1994) points out that popular health beliefs are normally understood in biomedical terms as erroneous and non-valid, i.e., *false beliefs*, as opposed to biomedical knowledge and practice. Popular beliefs can have a great impact on clinical care, since these beliefs are poorly understood or not taken into account when treating a patient. In this context, Rapp notes, ‘the language of biomedical science is powerful. Its neutralising vocabulary, explanatory syntax, and distancing pragmatics provide universal descriptions of human bodies and their life process that appear to be pre-cultural or non-cultural’ (Rapp 1990:29). Further ‘the appropriation of biomedical language and the diagnosis of disorders using biomedical terminology ... leave traditional healers [and their patients] vulnerable to scrutiny by biomedical practitioners’ (Meier zu Biesen et al. 2012:8). The concept of Evil Eye presents the difficulty of semiotics noted by Good, where the illness is formulated in terms of beliefs and behaviours and thus, within the biomedical model, constitutes a demonstration of “irrationality of culture” (Sperber 1985) and a barrier to effective care. In this sense, in the classic volume edited by Benjamin Paul, *Health, Culture and Community* (1955), *culture* was defined as a barrier to effective health practices or ‘good health’, a formulation that strongly prevailed during the latter half of the 20th century and powerfully influenced subsequently works. There is not only a linguistic challenge but also a phenomenological frame that needs to be taken into account to demonstrate that Evil Eye, as a belief concept, becomes visible in daily practices and bodily expressions (symptoms), permeating and engaging differently with “rational explanations”.

1.3 The conceptualisation of Evil Eye

Evil Eye expresses the idea that a person, animal or object could become ill or be harmed when they have been looked upon by individuals who possess a special force or faculty to injure or even cause death, with or without intention (Dionisopoulos-

Mass 1976:51-52; Dundes 1992; Harris 1996; Leyn 1999; Lykiaropoulos 1981; Maloney 1976; Migliore 1997, 1981; Moss et. al 1972; Nicholson 1999; Seligman 1910; Spooner 1976; van Gennep 1981; Yukes 1997). This phenomenon has been explored at length by scholars from different disciplinary frameworks. In mythology, this faculty was also attributed to the deities, demons and supernatural forces (cf. Seligman 1910). Evil Eye, also known as ‘the eye of envy’, ‘the empty or salty eye’, ‘the eye that wounds’, ‘the narrow or envious eye’ (cf. Gravel 1995:7), is not a unique or isolated phenomenon. Its existence is widespread and also can be found among Indo-European and Semitic cultures. It dates back to the Stone Age and has been traced to several regions and ethnic groups (Apostolides & Dreyer 2007; Hand 1981; Seligman 1910; van Gennep 1981:3). This idea of universality is critically reviewed by Roberts (1976), who, in his statistical cross-cultural study, remarks that the phenomenon involves trans-cultural diffusion, a point of view also shared by other scholars (cf. McCartney 1992; Weller et al. 2014).

Evil Eye refers to a relatively consistent condition with striking similarities worldwide. Despite ethnic boundaries, different societies broadly share similar concepts of Evil Eye, interlinking social relationships, ideologies, and practices in which children are regarded as particularly susceptible or vulnerable to this illness (Baer & Bustillo 1993; Harris 1996; Migliore 1981; Robledo et al. 1999; Sachs 1983; D’Andrade et al. 1972). In this regard Rivera and Wanderer note that ‘Evil Eye... represents a new and separate category, in contrast to ethnographic reports on adult illnesses, in which evil eye is typically classified as either a magical, supernatural, or emotional illness. While evil eye is often classified in broad categories for adults, it seems clear that beliefs about the evil eye in children are more narrowly defined’ (Rivera & Wanderer 1986:368). The folk interpretation is a disruption of body balance caused by someone by looking directly at another (deliberately or not). It can also be a result of environmental conditions, linked with physical or emotional symptoms. As Lock and Scheper-Hughes point out ‘whereas biomedicine... presupposes a universal, a historical subject, critical medical anthropologists are confronted with rebellious and “anarchic bodies”—bodies that refuse to conform (or submit) to presumably universal categories and concepts of diseases, distress, and medical efficacy’ (Lock & Scheper-Hughes 1996:43). Although interpretations of Evil Eye might differ, one of its particularities is that the symptoms and malfunctions attributed to it are similar and generally of a sudden manifestation (cf. Apostolides 200:11; Baer & Bustillo 1993; Galt 1982). Hence, Evil Eye is used as an *emic* illness category and an explanation for sickness across many cultures in order to account for somatic symptoms, ranging from headaches to dizziness, diarrhoea, fever, and cough, which can be seen as lethal if they are

not treated properly and immediately (Baer et al. 1993; Rubel 1960; Sachs 1983). As a result, people who perceive and explain the appearance of the symptoms as caused by Evil Eye frequently do not seek help within the biomedical system, relying primarily on traditional or home-care treatments (cf. Adams & Hawkings 2007; Garro 2000; Luby 2013).

A generally accepted historical theory that explained the phenomenon was called *the Glance theory*, an Aristotelian explanation of how sight possesses an intrinsic force that can settle on someone or something. Gravel states that this idea has been maintained for many centuries as an explanatory model which deduced that ‘there is some substance or some power that emanates from the eye that settles on the object seen. This substance or power, when projected by some people, is believed to cause harm’ (Gravel 1995:5). One scholar who was devoted to this approach was folklorist Alan Dundes, who defined Evil Eye as “a fairly consistent and uniform folk belief complex based upon the idea that an individual, male or female, has the power voluntarily or involuntarily, to cause harm to another individual or his property merely by looking at or praising that person or property” (Dundes 1992:258). Yet, the phenomenon of Evil Eye has been transformed on the basis that its presence responds to contemporary conflicts that are explained through it, as has been the case of other folk illnesses such as *fright*²⁰ (cf. Rubel 1984; Uzzell 1974). In this sense Galt asserts that the presence of Evil Eye is broad and has endured because of its ‘flexibility and significance’, i.e., its cultural, situational and individual value (1982:664).

Moss & Cappannari (1976) explain the occurrence and similarities of Evil Eye in different geographical areas as due to *diffusion* as a result of religiosity and doctrines. Christian, Muslim and Jewish communities all explicitly presuppose the attributions of good and evil. Hence, in the Mediterranean region and in Near Eastern cultures the concept of Evil Eye has a strong connection with religious constructs and provides ‘an informal mechanism for regulating behaviour and social interaction’ (Elliot 1992:147). In some regions of modern Greece Evil Eye is considered a severe threat (cf. Apostolides et al. 2008:1032). Similar to Galt’s proposition, Migliore suggests that, parallel to this visible dichotomy that characterises religious belief, the two attributions of ‘good’ and ‘evil’ also emphasize ritualised interpersonal relations of ‘correct’ and ‘incorrect’ behaviours (1983:4).

²⁰Found in Latin America, the Philippines and New Guinea, *fright* or *susto* refers to a situation in which either an abrupt disturbance, such as being shocked, or an emotional trauma, or a series of dreadful experiences or a frightening encounter with a ghost have damaged a person, often by startling their soul out of their body. The person afflicted has trouble sleeping or sleeps too much, lacks energy or strength, may stop eating, and is afflicted by headaches, diarrhoea, and diverse aches and pains, similar to depression or post-traumatic stress disorder (Rebhun 2004:322-323).

Since Evil Eye is found in many cultures, even when these cultures differ greatly (Elliot 1992; Dionisopoulous-Mass 1976; Gravel 1995; Hardie 1981), the phenomenon tends to be explained in similar ways. In this regard, Galt's analysis of Evil Eye notes that 'we are dealing not with an *etic* concept invented by anthropologists but rather with an image of great historical depth, wide diffusion, and a quality of persistence' (1982:668). Consequently many cultures make use of protective prayers, herbs, amulets or isomorphic figures as prophylactic measures or apotropaic methods to avoid harm, like the well-known *nazarboncuğu* symbol found frequently around the Mediterranean, or the Dulya or Fig sign found in Turkish, Slavic, North African, and South and Central American cultures (Dundes 1981; Gravel 1995; Migliore 1997; Papanikolas 2002; Seligmann 1910; Weller et al. 2014). They include the North African open-hand symbolism and the use of the number five (Westermarck 1926:445-453), among others.

The majority of the studies of Evil Eye however, derive from a classic folklore perspective (Dundes 1992; Hand 1992; Lykiaropoulos 1981; McCartney 1992; van Gennep 1992) and its historical context (Bernidaki-Aldous 1988). A few scholars have reviewed aspects of Evil Eye in terms of its psychological (McCartney 1943), pathological and psychological perspectives (Erkoreka 2005; Stein 1974); in terms of patron-client relations within a model of social exchange (Garrison & Arensberg 1976); and under its religious aspects, approaching it as a belief or superstition concept (Buonanno 1989; Carroll 1984; Dundes 1992; Elliot 1990, 1991, 1992; Elworthy 2004; Foster 1972; Gravel 1995; Sault 1990; Stein 1974). Some scholars emphasize that Evil Eye is also associated with social manifestations such as misfortune (Spooner 1976), envy, jealousy or a profound unrestrained feeling of admiration or desire that are not necessarily expressed through the eye, but through sorcery or witchcraft (Adams & Hawkings 2007; Baer & Bustillo 1993; Chevalier et al. 2003; Evans-Pritchard 1951; Harris 1996; Madsen 1964; Reminick 1974; Spiro 2005; Trotter 1982).

It should be noted that the notion of *envy* is inextricably linked to scarcity, i.e., limited assets or features that promote feelings of desire, uncertainty, and a fear that the owner of these assets cannot or will not share them. This idea of wealth and possession prevails as a part of symbolic constructions where the social-structural stratification imaginary—even among 'well-educated and sophisticated' individuals—evokes a differentiated (economic) social system that responds to the 'gazer identity' (Galt 1982:677). Gravel's proposition is that Evil Eye originated in a pre-feudal egalitarian community in which collaboration was essential, where contest was counter-productive, making sharing crucial in order to survive (cf. Gravel 1995:8-9). Thus Evil Eye suggests an extension of the "limited good" (Stein

1974:251), an economical morality, based on the principle of reciprocity and cooperation of goods, relationships, and services (cf. Albrecht & Verbrugge 2000:299).

In this regard, some scholars have used the term ‘Evil Eye’ as a synonym for envy (Garrison & Arensberg 1976; Lison 1979; Shoeck 1969; Van Wyk 2004:1215-1216), or moral medium (Elliot 1991, 1992; Galt 1982; Herzfeld 1981). Within a highly differentiated social system, ‘envy’ and ‘resentment’ were particularly suspected by acquaintances, kin and individuals with peculiar features and physical disabilities, people excluded from particular social relational conventions, outsiders and enemies (Elliot 1992:53). However, the interpersonal dynamic of Evil Eye as an effect of envy, or its manifestation as a result of witchcraft, differs from the concept of a ‘vicious and covetous envy’ described by Evans-Pritchard (1951), since the context where Evil Eye and envy are ascribed has more to do with the intrinsic ambiguity of an involuntary threat than with representations of personal confrontations. The conceptualisation of Evil Eye as an effect of envy is also displayed in ethical terms within the Bible in order to normalize relationships, as Elliot explains: ‘The malignant Evil Eye and the social destructive force of its envy source serves here as a negative foil for affirming the unlimited nature of divine compassion, Jesus’ solidarity with the poor and undeserving, the importance of *communal sharing and social cohesion*, and a calculus according to which the last shall be first and the first last’ (Elliott 1992:62; emphasis is mine). In addition to being in the Bible, Evil Eye can also be found in the Talmudic writings and later on in the Koran (Hand 1981:170).

Based on ethnographic data obtained on the island of Pantelleria, Italy, Galt adopts Needham’s (1978) concept of *synthetic image* to explain the presence of this phenomenon. Evil Eye provides an explanation to understand how and why dissimilar events (*disparate phenomena*) frequently conjoin under an empirical representation, resulting in ‘primary factors’ of ‘vehicles for significance’ which do not convey explicit ‘universal meanings’ (Needham 1978:11). The explicit meanings have the characteristics of unambiguity and proximity when representing certain experiences. This allows the creation, adoption and transformation—over the years and among diverse communities—of a significant ‘synthetic image’ that accounts for the ideas of gazing, magical harm, envy, protective and healing measures (Galt 1982) attributed to Evil Eye. Therefore, ‘meanings of illness at the microsocial level are also conditioned by, and impact upon the more general macrobelief systems that surround health and illness concepts. At this general level, concepts of health and well-being become inextricably connected to fundamental notions of self-identity’ (Herzlich & Pierret in Turner 2000:21).

The adaptive concept of Evil Eye has come to constitute what Spiro referred to as a ‘cognitive affirmation of experience’ (Spiro 1967:248), in which cultural understandings, beliefs, values, and relationships are established and endorsed through meaningful experiences. *Meaning* can only be derived in allusion to feelings, ideas, symbols, practices, knowledge, etc., when specific situations or goods depict a unique connotation that cannot be reproduced or communicated by another expression or channel in a particular time or context and are therefore contingent. Thus, meaning ‘is not something attached to and fixed by a particular referent, contained in a particular word or concept, but rather something people creatively construct through their ‘use’ of language in specific circumstances’ (Mignolo 2000:9). Conceptions regarding diseases are in permanent flux since these emerge from social exchange, i.e., becoming socially constructed through values, fashion, and particular circumstances—some more than others (Turner 1996:106), even when the clinical descriptions are more or less fixed (Turner 2000:21). Therefore, the common meaning attached to Evil Eye makes it possible to generate broader, consistent practices or behaviours regarding health-seeking strategies, as long as the illness itself can accommodate the different needs of the various factors. In other words, Evil Eye is not only concerned with its intrinsic illness category, but also with the access to appropriate healthcare options, since the strategies and practices attached to it are largely embedded in meaningful experiences.

I depart from the hypothesis that Evil Eye is a meaningful notion tied to practical cultural behaviours that provide viable tools and concrete forms of response to confront specific illnesses, which constitute an economic and social hazard, enhancing social ties and responsibilities, and transforming vulnerability²¹ into a capacity to act (cf. Ahearn 2001:112). In this sense the phenomenon of Evil Eye creates a cultural matrix which allows people to organise illness experiences within their cultural and social structure. Hence, Evil Eye as a *state* of illness provides a fundamental social relational context, apart from the biomedical diagnostic system by which the symptoms of Evil Eye are classified.

Evil Eye in the Guatemalan Context

Beliefs about Evil Eye were probably brought to Latin America during the colonisation, having been disseminated by Arabs in Spain during the 16th century (de Castaneda 1946 in Weller et al. 2014). In a cross-cultural review of the literature on Evil Eye among four different population groups (Puerto Ricans in Con-

²¹ *Vulnerability* comes from the Latin *vulnus* (‘a wound’) or *vulnare* (‘to wound’). It is defined as “to be able to be physically or emotionally hurt and liable to damage or harm, especially from aggression or attack” (Rogers 1997:65).

necticut, Mexican Americans in South Texas, Mexicans in Guadalajara, and rural Guatemalans), Weller et al. researched how the diffusion of beliefs and particular ideas have endured overtime. Following early studies focused on *culture*, Weller et al. (2014) discussed Wissler's theoretical contribution of the concepts of 'culture area' and 'age area'. The age-area concept, Wissler's most criticised notion, is the process of making historical deductions in which new traits that constantly originate at the 'culture center' diffuse outwards in terms of both time and space. The concept of 'culture area' shifts the focus of 'groups' onto their special features that go beyond a geographical grouping of social units. A culture area starts to take form after preliminary favorable adjustments to social and environmental conditions take place. This adaptation then starts to diffuse once these adjustments have become a 'social habit' which resists change. Taking this theory of cultural change and making use of an explanatory model (Kleinman 1978, 1986), Weller et al. demonstrate that contemporary beliefs of Evil Eye remain present in Latin America or Latino communities (as well as in other geographical areas) to a large degree, and have been maintained for over 500 years. They show how some of the ideas that make up this phenomenon have been 'preserved' while others have been adapted or modified into 'cultural values'. Across several significant 'themes', their research depicts the intra- and inter-cultural differentiations between cultures that redirect the notion of Evil Eye that is still prevalent among these communities (Weller et al. 2014).

Evil Eye nosology has therefore emerged and become entwined with Mayan cosmological notions (a fusion of pre- and post-Conquest elements) in which people associate their cultural knowledge, perceptions of the diseases and its treatment with their ancestors, a process referred to as *curanderismo* by some scholars (cf. Adams & Hawkings 2007; Rivera 1985; Sáenz & Foster 2001). Health status and healing among the Mayans is considered inextricably linked to syncretic religious practices (Maya/Catholic) and secular (biomedicine) measures (cf. Metzger & Williams 1963; Teruel 2008; Trotter 1998, 1982). In the Mayan tradition, health is based on the perception that everything exists as a part of a continuum of interconnections that allows individuals to maintain their physical and spiritual balance. A study carried out in Santa Catarina, Ixtahuacán, reports that, despite the fact that people have converted to Protestantism, individuals do not label Evil Eye as a superstition but as a legitimate illness category to be treated by traditional healers, including prayers to God (Harris 1996). This is similar to the practice found among Sicilian Canadians (Migliore 1997). In the published literature on Evil Eye from Latin America this condition is frequently associated with fallen fontanel (*mollera caída*), blocked intestine (*empacho* or *púj*), fright (*susto*), soul

loss (*espanto*), bad air (*mal aire*) and nervousness or anxiety (*nervios*) (Adams 1955; Berke 1989; Cáceres 2008; Gillin 1959; Holliday 2008; Villatoro 1982).

Rubel's systematic analysis of *susto* (1964) draws attention to culture-specific aetiologies to identify and effectively treat symptoms associated with Evil Eye. Other investigators have identified folk theories of illness which incorporate diagnosis, aetiology and treatment (cf. Finerman 1989; Foster & Anderson 1980; Helman 1990; Jenkins & Karno 1992; Landrine & Klonoff 1994). Because the incidence of some ailments is high, and powerfully affect daily lives, many studies that have explored the relationship between folk illnesses and medical outcomes (Holliday 2008; Rubel 1993; Rubel & Moore 2001) have concluded that, from an epidemiological perspective, these 'folk beliefs' or 'traditional values' need to be modified in order to improve treatment outcomes (cf. Gagnolati et al. 2003:12; Kamat 2006; Makundi et al. 2006). However, some of these illnesses have been incorporated into people's daily lives to such an extent that perceptions and treatments are socially integrated and are reflected in societal norms (Kleinman & Seeman 2000; Lock & Kaufert 1998; Lock & Scheper 1996).

Symptoms of Evil Eye appear when an imbalance develops in the body, i.e., one of the humoral states in the body is disturbed (Harris 1996; Leyn 1999; Logan 1973; Tedlock 1987). This is treated almost exclusively within the framework of traditional medicine, such as has been described in some cases in African communities²² (cf. Lugo, Cooperman, et al. 2012:67-69; Maboea 1994). Adams & Hawkings (2007) refer to this condition as a disgrace (misfortune), and find that for the region of Sololá (K'iche' area), in Guatemala, Evil Eye (*uwa winaq*) has no order or ranking, and is not a disease caused by natural agents or spiritual agents; rather it is a spiritual disease *per se* lacking the character of intentionality that other spiritual diseases (*k'oqob'al*) have. However, in Santa María de Jesús, a Cakchiquel-speaking area, Evil Eye (*cha 'coaj* or *cha'ako wi ta'a*) is defined as a 'hot' illness that can be caused by natural or supernatural sources (cf. Burleigh et al. 1989; Weller 1984; Weller et al. 2014).

The significance of Evil Eye has been marginalised not solely by physicians, but also by some anthropologists, who consider it an erroneous cultural health attribution in which 'parental perceptions and contributions to care, as well as cultural factors that influenced treatment, are magnified when combined with other family issues and general life stressors' (Dziegielewski 2010:140). Or, as Adams puts it, 'a critical weakness of some of the older Latin American health projects lay

²²Such as in the Middle East and North Africa (Tunisia, Morocco, Iraq, Jordan, Egypt and Lebanon) and sub-Saharan Africa (Tanzania, Cameroon, Democratic Republic of Congo, Mali, Senegal, Chad, Niger, Djibouti, Guinea-Bissau, Mozambique, Liberia, Ghana, Uganda, Nigeria, Ethiopia, Kenya).

in their failure to recognize the relevance of local social and cultural conditions. Many programs had been carried out in communities whose way of life was very different from that of the professional people who staffed the projects, people who frequently lacked the insight into local culture necessary for effective work in these communities' (Adams1955:436). Consequently, the clinical manifestations of an illness attributed to Evil Eye are often diagnosed and treated by biomedical practitioners under biomedical parameters, while the Evil Eye paradigm is considered to be concerned with beliefs, not medicine. Yet the attempt to distinguish between biomedical concepts and 'folk illnesses' normally relies on the presumed universality of biomedical terminology, which fails to provide an equivalent concept for the symptoms. Thus, the personal and social aspects of the illness that are embedded outside the medical realm are neglected, leading to a sort of medical control that may contradict, clash or even become counter-productive with the ways people perceive, understand, approach and treat them.²³

The literature on Evil Eye depicts a good example of this kind of illness, especially because some of its attributes are related to health outcomes that overlap with symptoms of respiratory infections and acute diarrhoea (vomiting, fever, cough, constant weeping, loss of appetite, etc.), which are subject to a variety of interpretations and therefore a variety of help-seeking behaviours. Because the association of respiratory illnesses and acute diarrhoea with Evil Eye is viewed as plausible by caretakers, modern medical treatment may be sought only when the condition of the child is perceived as extremely serious and Evil Eye has been discarded as the illness' source. Furthermore, for the majority of underprivileged natives in rural Guatemala, seeking accurate diagnoses and effective therapies frequently implies getting in touch with several health providers (Rohloff et al. 2011:429), including traditional healers and pharmacy employees, bringing together different understandings and approaches to healthcare. Nevertheless, the Evil Eye concept has been underexplored or underestimated in communities where its significance represents a daily challenge to overcoming illness, distress, and suffering, but is regarded by the representatives of modern medicine as a misconception.

²³As Lock observed, 'medicalisation inevitably entails a missed identification between the individual and the social bodies and the tendency to transform the social into the biological' (Lock 1996:48). This approach establishes and encourages biomedical healing practices and outweighs any possible benefits and significance that lay or alternative practices may have, especially in cases where some symptoms are explained by or attributed to social relations and the efficacy of the treatment is dependent on these relations.

1.4 Research Questions

When is Evil Eye a disease?

There is without doubt an international and national awareness of the importance of health inequities as a determinant of health outcomes. A general literature review confirms that most studies focus on the question of the underutilisation of (including barriers to) healthcare facilities rather than on the social dynamics and cultural concepts that shape healthcare decisions.²⁴ Despite the existence of several studies which refer to the importance of increased understanding of the role of folk-illnesses as determinates of healthcare seeking decisions, the case of Evil Eye, and its importance in childhood illnesses that are biomedically defined, remains underexplored (cf. Baer & Bustillo 1993; Rivera & Wanderer 1986). Medical personnel consistently consider folk-health practices and the concomitant decision-making processes for treatment of diarrhoeal disease and respiratory infections as risk factors, especially when related to Evil Eye (cf. Baer & Bustillo 1993).

Children diagnosed with Evil Eye frequently manifest a set of symptoms and behavioural patterns that overlap with other diagnostic categories such as acute respiratory infections (ARIs) and acute diarrhoeal diseases (ADDs), whose aetiological explanations frequently adhere to the hot-cold dichotomy framework (cf. Escobar et al. 1983; Foster & Anderson 1980). Frequently, however, respiratory infections and acute diarrhoeas can also be identified as conventional biomedical concepts for which standardised treatments are employed. To reflect more flexibly upon the concept of Evil Eye, we need to initially understand its local meaning before we explain people's behaviours concerning this phenomenon. Even when Evil Eye has a common aetiology and symptoms, its meaning, diagnosis, and treatment often differ across cultures, especially when related to black magic or witchcraft (cf. Madsen 1964; Saunders 1954; Westberg 1989; Young 1980). This lack of conceptual and response uniformity has contributed to the failure to understand alternative responses within indigenous or rural contexts (cf. Tedlock 1987; Sáenz de Tejada 1997). Consequently, within the biomedical framework, this phenomenon has been relegated to 'culture-bound' status,²⁵ unique to specific cultures, and considered a barrier to effective healthcare decisions.

Even when the concept of health used by the World Health Organisation (WHO) tries to cover different aspects of life—physical, social and mental—the concept entails an essentialism: health is a single unit and therefore can be treated only

²⁴'Access to care' and 'barriers to care' are closely related concepts, undifferentiated in some literature, yet differing in meaning and significance (cf. Peters et al. 2007; Savedoff 2007).

²⁵ See Chapter III.

under standardised models of care. This has been the focus of the global effort of many NGOs and health programmes. Such initiatives introduced references for the identification and treatment of diseases in terms of *cultural hegemony* (Gramsci 1971). Health and disease are normally conceptualised within a medical setting, in a peculiar way that places the *suffering* inside the biomedical formulation, a condition that is also culturally encoded. Thus, since the concepts of both states (health and disease) contain an intrinsic value, i.e., possession of peculiar characteristics and ongoing processes, this neutralizes the idea of health or disease as a definite category. In this sense, Comaroff points out that ‘there has been an awareness that ‘factual’ knowledge might imply social values, that medicine has bequeathed us powerful metaphors along with its ‘natural’ truths and that these might reinforce the deep-seated paradoxes raised by illness’ (Comaroff 1982:56). This problem addresses the question of conceptualisation and formulation in terms of beliefs and behaviours by which the experiences around a disease are built, generating a *syndrome of experience*, ‘a set of words, experiences, and feelings which typically ‘run together’ for members of a society’ (Good 1977:27), contrasted with a *real pathology* (Good 1994:10), which has an impact on the choice of therapies (cf. Janzen 1978a, 1978b; Young 1981). Good argues that the biomedical knowledge system reflects an apparently natural order or ‘absolute truth’, instead of reinterpreting medical knowledge as a descriptive, cultural, and classificatory system (Hahn & Kleinman 1983:313).

The widespread identification of childhood illnesses such as “acute diarrhoeal diseases” and “acute respiratory infections” within the international public health domain as central to the goal of death prevention among children under 5 years has resulted in the definition of folk-related health-seeking and treatment decisions as barriers and misled practices. This has contributed to the development of theoretical approaches to health promotion that tend to rely on models of behaviour change. Health professionals within the biomedical community, who argue for a universal approach to recognize and treat childhood illnesses, consider health behaviours²⁶ surrounding Evil Eye as inappropriate, since the mother’s or caretaker’s perceptions on ARIs and ADDs tend to differ significantly from biomedical positions. Furthermore, local perceptions are mixed with biomedical explanations, typologies, and pluralistic case management. A disease can therefore be the result of a supernatural source as the primary cause for such symptoms, and is not necessarily identified within the conceptual framework of the biomedical paradigm. Luby explains this phenomenon among Bangladeshi mothers who interpret symp-

²⁶ One widely used definition of *health behaviours*, which I use in this thesis, is “any activity undertaken for the purpose of preventing or detecting disease or for improving health and well-being” (Conner & Norman 2005:2).

toms of pneumonia as a result of exposure to cold, and make use of treatments such as massage oil and garlic instead of antibiotics, which has precipitated public health interventions, i.e., biomedically trained scientists attempting to change caretakers' behaviours and beliefs in order to pursue 'the cognitive pathway of their own intellectual journey' (2013:44). In this sense, Garro suggest that 'for contemporary research, an almost unavoidable complication in applying any of the [explanatory schemes] is the widespread acceptance of biomedical explanations, although the form they take may vary greatly. Further, many colonised peoples have experienced *new* forms of sickness and some explanations for these conditions pose a challenge to existing framework' (Garro 2000:309).

While the conceptualisation of acute diarrhoea and acute respiratory infections includes only signs and symptoms (which are not always easy to identify), Evil Eye also includes affective behaviours and makes use of available social resources. Accordantly, Garro (2000) points out that cultural understanding provides tools which, when called into play, help make sense of another's experiences. Experiences and social practices of mothers or caretakers are strongly shaped by cultural patterns and health-illness beliefs (i.e., explanations for disease causation) that have an effect on illness outcomes. Moreover, an illness does not only concern a physical disorder but includes a broader social order, producing or affecting family dynamics and relationships that transcend a biological order or status. Driven by people's understandings, knowledge, emotions, experiences, economic possibilities, and available health services, we can understand why specific patterns of care and treatments are selected. Additionally, these dynamics are engendered and influenced by the increasing access to modern health interventions, which national and international health policies have introduced in rural settings. Specifically, I pose the questions:

- (1) How does Evil Eye's aetiology and perceived degrees of severity, ascribed to its symptoms and signs, enhance particular health practices?
- (2) Why does Evil Eye work as a parameter when interpreting symptoms of acute diarrhoea and acute respiratory infections?
- (3) Does the framework of the healthcare system in Guatemala in the provision of healthcare for the rural population contribute to the promotion of an integrated system of health?

Currently, recommended treatments for ADDs and ARIs employ pharmaceuticals, principally antibiotics. In the opinion of Illich, 'overmedicalisation changes adaptive ability into passive medical consumer discipline' (1975:77). The health system

in Guatemala is almost exclusively dependent on a curative health model rather than preventive medicine. As a result, the utilisation of drugs plays a crucial role in the management of illnesses, albeit with a number of side effects.²⁷ Some of these are: (a) antibiotics are frequently taken at the appearance of initial symptoms that are considered dangerous, often causing a delay to present at the post or health center, because antibiotics ‘mask’ some symptoms of ADDs and ARIs; (b) people easily acquire medicines in pharmacies even when many should only be sold via prescription; (c) the expertise of pharmacists is perceived as qualified medical advice, even when a medical opinion or exam is reported as ‘better’, but the costs (including time, distance, and even fear) that are paid to see a medical doctor does not necessarily compensate the endeavour; and (d) treatments provided at the post- or health center are often perceived as ineffective, increasing the use of pharmacies for treatment access.



Figure 1.1: Pharmacy in Comitancillo

This crisis of confidence in public-health approaches challenges the provision of care and the role of the national healthcare systems and their interventions (cf. Illich 1975). In conjunction, the heavy workload of the public national health services decreases their capability to attend all of the patients, since medical staff and equipment and other resources are never sufficient. This leads to the problem of ‘recognition’ by nurses and doctors, who take patients who seem to ‘require more’ medical assistance, provoking frustration and mistrust among users, in addition to undermining the effectiveness of therapeutic goals. Parallel to this, affordable biomedical services and treatments, inadequate education, lack of sanitary facilities, dietary deficiencies, unhealthy environment conditions, and the like, are also part of the debate of *medicalisation* vs. *de-medicalisation* that shapes peo-

²⁷Further extending his view, Illnich wrote that “The proliferation of medical agents is health-denying not only or primarily because of the specific functional or organic lesions produced by doctors, but because they produce dependence. And this dependence on professional intervention tends to impoverish the non-medical health supporting and healing aspects of the social and physical environments, and tends to decrease the organic and psychological coping ability of ordinary people” (1975:77).

ple's practices and that enable patients to be less dependent on the biomedical healthcare model (Cant & Sharma 2000). In order to improve health among a population, health services must be capable of delivering effective healthcare not only by increasing their availability but also by making it acceptable within local beliefs and practices, allowing a healthcare system that is compatible with them and takes them into account (cf. Scott et al. 2014).

In order to achieve this goal, the implementation of culturally appropriate healthcare initiatives needs to include not only policy enforcement but deployment of multiple and innovative channels of communication and cooperation among health seekers and providers which are effective in reaching vulnerable populations. The main challenge is delivering interventions within the existing folk health-system and providing appropriate and affordable interventions. This holistic healthcare model could operate by integrating the participation of the different health providers and the civil population. At an empirical level, this 'custom law' is legitimised by the inclusion of several healthcare models. Yet authoritative allopathic practices, i.e., the 'objectification of the disease', deny the practicability of folk health models and placebo effects. In this sense, a holistic model should only operate within a provision of equality health-services where folk and complementary medicine are optional and not a 'first-line treatment for the poor and those who do not speak the language of the dominant society' (Bodeker & Gerard 2002:8).

The importance of the choice of treatment

Taking Charles Leslie's approach, Nichter stresses that the study of medical systems should be taken as *social systems*, 'not only systems of knowledge and treatment practices' (Nichter 2002:81-82), comprising all the 'work of culture' involved, including social and material resources, emotional support, etc. (cf. Obeyesekere 1985; 1990 in Nichter 2002:82). Accordingly, treatment(s) and health seeking for children with Evil Eye also need to be approached under the 'micropolitics of the social relations of therapy management' (Nichter 2002). This requires consideration of multidimensional fundamental factors, such as attribution of meaning, the dynamics by which the health-seeking process affects behaviour, social relationships within the household, recognition of illnesses or prior experience with the same or similar illnesses, perceived severity and perceived efficacy of available treatments and the exchange of information regarding diagnosis and therapy at public health facilities (cf. Kamat 2006:2956).

Although illness experiences are an individual event, therapeutic practices involve

a series of notions and perceptions that reference intercultural codes, which are essential for people to communicate crucial necessities and expected outcomes. Illnesses such as Evil Eye demonstrate how the border between illnesses and case management is a ‘coded model’, intertwined with social and cultural ideas of what (pathologically) an illness signifies and the implications of that condition. In this regard, according to Michael Taussig (1980), diseases are not only biological ‘things-in-themselves’ but also expressions of social relations.²⁸

My hypothesis is that Evil Eye is a prevailing source that exerts a powerful influence upon treatment decisions for illnesses displaying symptoms similar to ADDs/ARIs, since it works as a social force that produces meaning amidst misfortune, suffering and collective illness experiences, evoking practices of solidarity. Within the highly traditional Mam culture, where this research was conducted, individuals have a tendency to understand the symptoms of Evil Eye as a *logical effect* of human condition (vulnerability or disposition) amidst adversity, rather than merely a biological disruption. Prior experiences of pain, discomfort and distress associated with an illness affect time response in health-seeking, method or treatment choices, and the location and agent who will treat the ailment. This means not only treatment of the somatic symptoms, but an emphasis on social responses that frame a coherent meaning for the illness. Thus, understanding comorbidity between Evil Eye and diarrhoeas/acute respiratory infections helps to improve awareness of the limitations of ARI/ADD-prevention efforts and control programmes. Biomedicine also plays an important role in the treatment of similar symptoms of Evil Eye, and is generally assumed to efficiently treat many diseases. Yet, a general reluctance persists when it comes to treating symptoms from causes that are not considered biological. Evil Eye accounts for physical and social aspects that appear to be treated successfully if linked to traditional forms of healing, including the criteria to diagnosis the illness. Therefore, the fear of a misdiagnosis, subsequent therapy at a governmental health facility, and unaffordable treatments or therapy, among others, are some of the factors that are key to health-seeking decisions.

²⁸A study conducted by Hansjörg Dilger in Tanzania concerning HIV/AIDS found that ‘the dynamics of care and kinship in the context of AIDS cannot be adequately understood if they are analysed only with regard to the provision of financial and emotional resources for sick and dying relatives, or by describing the specific acts of nursing and care given by members of a household in a situation of need. . . Relationships of care are embedded in a tight web of kinship obligations and of meanings and processes, which have to be situated in the often complex biographies of lineages and families as well as in the context of rural-urban dynamics and the political economy of healthcare in Tanzania’ (Dilger 2010:119). Although it addresses the specific context of HIV/AIDS in Africa, Dilger’s research highlights the extent to which illnesses are shaped by different dynamics and understandings that take place within a broad range of representations and multi-layered frameworks in which families and communities channel family and community relations.

In examining the role culture plays in shaping health-seeking behaviours, I will address the following questions:

- (1) What are the underlying considerations that affect people's medical treatment decisions?
- (2) How does culture influence the prevalence of Evil Eye?
- (3) Does the belief in Evil Eye support or hinder the choice of standardised treatments for acute diarrhoeas and acute respiratory infections?

1.5 Outline of the Research Objectives

The aim of this research is to examine the phenomenon of Evil Eye by examining the health-seeking behaviours and the meanings attached to this illness.

The principal objective of the study is:

To understand the cultural beliefs influencing health behaviours, i.e., how people's experiences and practices can contribute to the understanding of health seeking in relation to Evil Eye.

Investigation of the role of Evil Eye in healthcare-seeking decisions requires examining the perceptions and knowledge of mothers, family members and others whose opinions are sought, as well as the medical personnel involved in cases of children with symptoms of acute diarrhoeas and respiratory infections where Evil Eye is explicitly involved. This will include a detailed examination of the decision-making process which culminates in the treatment of children; how consent for treatment is achieved; and the negotiations which take place prior to treatment, such as those concerning medical decisions of hospitalisation when children are dangerously ill with acute respiratory and diarrhoeal infections.

In order to investigate this, a series of **sub-objectives** will be applied to focus the research. These are:

- (1) Investigate the role of local traditional knowledge and practices that people use to cope with illnesses/diseases.
- (2) Explore the social dynamics of healthcare associated with Evil Eye as an explanatory approach towards access to health.
- (3) Map out how healthcare decisions regarding Evil Eye differ from healthcare decisions regarding diarrhoeal disease and acute respiratory infections.

- (4) Critically appraise the wider role of national and international public-health interventions that tend to underemphasize the cultural dimensions of health-seeking behaviours.

1.6 Background and Theoretical Foundations

The theoretical framework to analyse Evil Eye is based upon the system of *beliefs*. One of the purposes of this study is to explain that *illness beliefs*, as well as *illness knowledge*, derive from both experience and rationality. However, the term ‘knowledge’ in a biomedical framework is normally used as a proposition of universality or a level of generality and consensus concerning the rational basis of its elements (propositions, rules, concepts). ‘Beliefs’, on the other hand are perceived as lacking this kind of consensus and are seen as merely ‘representations’ or personal models of the world (or of a particular illness). From a theoretical point of view, these two concepts are essential to discuss illness categories that evaluate the ideas of ‘cultural barriers’, ‘risk’, and ‘expected’ behaviours. While *beliefs* lead to ideas of thinking, personal values, and acting that might not seem entirely ‘right’, *knowledge* produce claims of reliable and valuable information. People’s healthcare dynamics challenge this problematic dichotomy, conceptually and empirically, underpinning ideas and behaviours that can be a source of conflict between different models of healthcare and rationality.

This analytical model reflects on sociocultural and medical-health behaviour phenomena pointing at people’s reasoning and practices to use these concepts as references for healthcare practices. Health-seeking behaviours are recognised as intentional patterns employed in order to attain specific (health) outcomes. Yet, *beliefs* concerning illnesses are presumed to be unintentional, in terms of not being cognitive actions because of a lack of a normative and rational paradigm (cf. Good 1994; Pebley et al. 1999). As a result, illness concepts, outside the biomedical paradigm, are expressed as ‘local ideas’ of ailments. Additionally, within the larger framework of the Millennium Development Goals (CEPAL-NU 2005) concluding in 2015 and the fact that many countries have not met their targets of reducing infant mortality rates, there has been a renewed interest in healthcare models concerning children, and in mothers’ attitudes towards different healthcare models and preferences for treatments.

Making use of an interpretive (Heideggerian) phenomenology approach and based on a critical medical anthropological framework, I seek to reflect on the meaning of Evil Eye in the rural area of San Marcos. This interpretive framework enables us to examine the effect of the production of biomedical knowledge, the relationship

of models and institutions of healthcare and agreed-upon national/global health initiatives on the specific socio-cultural context of Evil Eye. It draws on a conceptual framework of social and behavioural theories that is relevant to public health interventions and medical anthropological debates by incorporating phenomenological perspectives on illness experiences. This framework spans a growing number of health-related issues that have an impact on perceptions and practices that are otherwise invisible. This theoretical orientation links different aspects of health and illness that develop among, contest, or support economical, political, social, religious and environmental factors, which create different ideas, perceptions, meanings and practices of healthcare.

Using the concepts of *knowledge* and *beliefs* in the realm of health and health promotion interventions, I discuss the inter-relationship between models of healthcare, concepts and perceptions of illness, and illness actions in response to cultural representations of Evil Eye, acute diarrhoea and respiratory infections as life-threatening, in order to improve our understanding of health-seeking behaviours and predicaments. Theories often used in public health interventions (e.g., health belief model, theory of reasoned action and planned behaviour, etc.) usually address particular health behaviours as problematic in particular populations or in particular health problems, yet the evidence of this research shows that public health discourses and interventions tend to blur and marginalise specific local understandings and practices that engage with social relations important in the provision of healthcare. Health and illness are shaped by broader and diverse factors, as well as social determinants of health and health inequality. Additionally, public health approaches are based on specific medical settings, health institutions and discourses. The ideas of illness, treatments, deviant behaviour and interactions between patients and their health care providers that these institutions and discourses support always influence the production of knowledge and beliefs, yet health behavioural theories tend to reduce the multiple determinants and levels of health to treatable ailments or follow a treatment regime valued as ‘adequate’ or ‘right’.

In order to analyse the effects of policy reforms, one must first identify the conceptual frameworks and categories that are applied to healthcare intervention programmes, especially those that address ‘barriers’ to health. Patterns of health-seeking behaviour are seen as an important key to determine the outcome of disease. The decision-making process to seek (medical) care at a given time and place, from an individual perspective, is influenced by community norms and expectations (McElroy & Jezewsky 2000). Accordingly, many studies focus on these influences, since some attitudes toward illnesses are seen as harmful and the re-

sult of *false beliefs when* confronted with the *rational knowledge* of science (cf. Baer 2003). It is important to examine the meaning of *belief* in anthropological and medical research, when juxtaposed with the term *knowledge*, to understand ethnographic and research findings (cf. Good 1994).

Making use of a phenomenological framework, *knowledge* is an intersubjective “possession” (Cairns 2013), which is temporally and spatially framed. *Knowledge* is not a natural thing given, but is mediated by object, subject and environment. Mohanty (1997) points out that the aim of scientific knowledge is to replace ordinary perceptions motivated by a practical control and domination of what are called facts (cf. Comaroff 2010:22-23). In this sense Husserl’s philosophy was a way to demonstrate a crisis in the positivist tradition of the European ‘objective sciences’, which tried to see the world as if it were a totality, therefore leaving out the specificity of experience. In Barret’s view “operationally, the Euro-American development enterprise is based on ‘scientific’ principles invented and/or discovered by reductionist science in the North and West. A near universal assumption holds that technological progress is a good thing. International health programs are one arm of this global octopus” (Barret 1997:581).

1.7 Biomedicine as the predominant expectation of health-seeking behaviours

A positivistic view of illnesses considers ‘scientific knowledge’ as free of subjectivity and as the only way to comprehension—a secular, Cartesian-legacy, dualist conception of mind-body that became a powerful characteristic of medical belief (Rhodes 1996:167). However, despite the way in which concepts are presented, scientific reductionism can also have medical implications, since illnesses are states of interpretation, negotiation and articulation of social practices that go beyond ‘signs’ and ‘symptoms’ enclosed by a biological explanation (i.e., factual scientific knowledge) (cf. Atkins 1995; Chen et al. 1992; Kleinman 1992). The complexities of healthcare behaviours and experiences draw attention to the questions posed by Mechanic: “Why [do] persons with similar complaints behave so differently and why [does] the same person with comparable symptoms at various times choose to seek medical care on one occasion but not another?” (Mechanic 1979:394). Although there is no a simple answer to this, I can venture to say that beliefs, knowledge, meaning and practices are not only produced within a specific time and space, but also have different (practical) implications when applied indifferent contexts. Thus, people negotiate between identities and behaviours consistent with their perceptions and experiences, which at different times can be apparently

contradictory or deviant.

In the 1960s, with the emergence of the interdisciplinary field ‘medical anthropology’, a resultant expansion of the biomedical-epistemic framework helped to overcome the form of knowledge imposed by the positivist scientific method (Good 1994; Young 1982; Lock & Scheper-Hughes 1996). This transcended the individualistic and naturalistic position, a reductionist view of health that does not conceive of health and disease status as relational processes but merely as a universal fact, i.e. a *category fallacy*²⁹ (Kleinman 1980). What is called a *natural history of disease*, the standard procedure by which the conventional epidemiology identifies clinical courses of pathologies and different types of disease prevention, must be understood within a cultural or collective reference. For a more effective approach to the treatment of disease, it is indispensable to observe disease within its wider connections and interactions, between supra- and infrastructures of society, in order to better understand the relevant cultural-specific aspects. Health-seeking behaviours are not just an individual process but active, shared, interactive interrelations which take place within families and community practices (cf. Dilger 2010). Accordingly, diseases are not only part of a rational medical model, but framed in particularities or *cultural idioms of distress*³⁰ (Nichter 2010). Janzen highlights the importance of the “therapy management group”, which consists of the social lay structure or system that cares for or makes decisions for the person who suffers (with or without his/her consent) (Janzen 1987:68). Illnesses (episodes) are therefore managed not only through one exclusive healthcare model or person (e.g., a medical doctor or healer), but are socially managed by family members, community, kin, and social or affiliation groups. Therefore, according to Janzen, the choice of therapy is group-dependent. As a result, aetiologies, symptoms and illnesses are acknowledged and experienced in different ways, which lead to different health-seeking behaviours, i.e., perceptions, understandings and practices.

However, while diseases are a health concern, specific healthcare needs have broader health and social impacts. In this sense, Garro points out that an explanatory framework that lacks a cognitive theory reduces the notion of cultural knowledge to a “cultural knowledge pool” (2000:283). A cognitive theoretical framework em-

²⁹ Kleinman defines *category fallacy* in relation to diseases categories as an ‘imposition of a classification scheme onto members of societies for whom it holds no validity’.

³⁰ *Idioms of distress* may be defined as the ways in which members of socio-cultural groups convey affliction. These idioms vary across cultures, depending on the salient metaphors and popular traditions that pattern the human biological capacity for experiencing distress, including conditions that are sufficiently severe to meet criteria for psychiatric disorder. Cultural groups, for example, may describe distress in more psychological or more somatic terms, or may cluster syndromes in different ways, connecting symptoms together that other cultures do not acknowledge as related. This leads to substantial diversity in culturally defined syndromes across groups’ (Good 1977:33-34).

phasizes not only behavioural patterns, but the ‘rules’ of such behaviours, defining what is socially and culturally expected or appropriate in particular situations and circumstances. The standardised (biomedical) approach regarding a particular illness disregards the cultural component.

Access to healthcare

Access to healthcare is a complex term that includes both demand- and supply-side factors (cf. Anderson et al. 2003; Bruce et al. 2014; Mooney 1983; Peterson 1996). Conventionally, access to healthcare is defined as the provision of total national coverage with an adequate *supply* and available services and resources in order to preserve or improve people’s health (cf. Agudelo-Suárez et al. 2012; Dauvrin 2012). Supply refers to service delivery, including human resources, and demand relates to behaviour towards those health services, which is also influenced by the supply of services. Thus, supply and demand overlap to a certain extent. The *degree* to which populations make use of the health services depends on financial, organisational, social and cultural factors, while the *utilisation* of such services is conditional on affordability, acceptability and physical accessibility of services (Gulliford et al. 2002:186).

Normally, the *utilisation* of healthcare services is employed as a measure of access, often disaggregated to reflect specific populations receiving particular health services (Savedoof 2007:2-3). Penchansky and Thomas (1981) defined *access* based on the factors influencing the level of use in relation to the healthcare that is required. According to these authors, *access* articulates the degree of “fit” between the particularities and expectations of the providers and patients, which are configured by availability, accommodation, accessibility, affordability and acceptability. Therefore *access to healthcare* is on one hand shaped by personal characteristics, and on the other on the services available that influence utilisation. Similarly to Penchansky and Thomas, Shengelia et al. (2003) define *access* as the probability of using the healthcare services by measuring insurance coverage or the possibility of obtaining expected health outcomes when needed or required. According to Shengelia et al., the gap between an *effective* coverage and total possible coverage can be divided into seven singular gap components: resource availability; physical availability; affordability; cultural acceptability; provider-related quality; adherence; and strategic choice. Effective coverage is directly influenced by the resources and proximity that can be provided at the health services.

While the term *access* has been conceptualised in different ways, research on *access* and *barriers* to healthcare, according to Kasper, has expanded only in two

directions: (1) theoretical models, which offer a frame of reference for understanding determinants of health behaviour in the use of particular health facilities, i.e., *demand*, and (2) a focus on population-based information, to explain disparities in access to health in order to conduct practical analyses to develop health policies (2000:324) to improve healthcare *supply*. However, although the delivery of healthcare is recognised as necessary to improve people's health, frequently a demand-side approach in terms of patients' barriers has been employed, when considering outcomes of health-service utilisation (cf. Peters 2007; Kasper 2000). A *barrier-patient-focus* framework centers on aspects that may appear to be 'resistance' or 'inadequate' behaviour regarding the use of specific health services. This is partly due to the fact that effective case management and risk behaviours tend to highlight individual factors that may impact healthcare utilisation, rather than the identification of unsuitable or inequitable health service access (cf. Stevens et al. 1992). Since health services are developed to meet the health needs of patients, it follows that the delivery of health services should also be designed to meet those needs. How well these needs are met will have an important effect on the decisions people make about how and when to use the services, about whether to use prescribed medication, the degree to which healthcare advice is followed and whether or not these services will be recommended to others (Bruce et al. 2010).

An extensive literature regarding *access* and *barriers* to care has included health outcomes, rather than the equitable provision of care, as a measure of whether access is appropriate or not. This is mainly because the *acceptability* of healthcare has been addressed before other barriers such as effectiveness, affordability, appropriateness and geographical access. For example, research from Africa, South Asia and Latin America on factors associated with decreased probability of seeking formal care for sick children has identified lower educational level, younger age of mothers or caregivers, lower occupational status, death of a previous child, lack of perception of the severity of the illness, and indigenous ethnicity (cf. Ensor & Cooper 2004; Scott et al. 2014). In addition, the child's age, nutritional status, and socio-economic factors have been seen as potentially explaining differences in mothers' or caretakers' care-seeking behaviour as categories of risk factors. Misperceptions or non-recognition of the benefits of biomedicine have also been implicated in the decrease in demand for formal healthcare. In summary, factors such as population characteristics (community, environmental and social resources), cultural acceptability and individual attributes (vulnerability, health status, needs, beliefs and preferences, socioeconomic status) have all been identified as determinants of the use of health services (Kasper 2000:328).

Although these factors are frequently the result of inequity and unequal opportunity (cf. Marrone 2007), several public-health studies have suggested that these characteristics could have an important impact on access to healthcare, and could thus become ‘targets’ of interventions to increase ‘acceptance’ (cf. Goldaman et al. 2002; Gagnolati 2003; LaVeist 1994). Similarly, Nichter and Lock point out that ‘since the birth of the discipline in the 1970s, medical anthropologists have been asked to investigate ‘cultural barriers’ to health programs that represent ‘progress and modernity’. Over the years, anthropologists have come to better appreciate how stakeholders use the language of ‘culture barriers’ to deflect attention from program failures or justify reasons for not investing in a particular program due to an assumption that they would not be culturally acceptable’ (2002:12). Structural factors such as poor-quality, inadequate or deficient health services frequently are not considered as determinants of health but merely as financial obstacles to the provision of national coverage. Concepts such as “cultural barriers” have been used to avoid addressing reforms in planning, development and implementation of more effective healthcare programmes, including identification of community health hazards and education of community residents in order to empower them to improve their health.

Early approaches to health and diseases in anthropology

Anthropological inquiry took an interest from the beginning in health issues related to religious aspects of culture, exploring practices around illness with a focus on the various rituals, and magical or supernatural events, initially described as *primitive*, and generally placed within a general *theodicy* (manifestation of God’s providence) (cf. Aguirre 1994; Singer et al. 2007:103-110), thus separating the study and praxis of biomedicine from indigenous or folk healthcare systems. This had the effect that, for decades, health and disease were studied in terms of marginal assumptions, i.e., as part of a cultural sub-category (e.g., religious beliefs), rather than a system itself. After World War II there emerged among anthropological associations, such as the American Anthropological Association (AAA) and the Society for Applied Anthropology (SMA), a growing interest in issues concerning international public health called ‘Applied Anthropology in Medicine’ (Caudill 1953; Pelto & Pelto 1997). First, through the formation of the Group for Medical Anthropology (GMA) in 1967 in the USA, and later, with the foundation of the Society for Medical Anthropology, concepts of health and illness were explored, based on their cultural and social construction, but without ignoring biological aspects. As a result, health and diseases were viewed as not only related to culture or biology but as the product of a bio-cultural construction, access to technologies,

social and political disparities, and power relationships, referred to by Lock as “macro-structural questions” (cf. Good 1994; Lock 1986; Trostle 2005).

Medical anthropology, unlike the epidemiological perspective, focuses not only on the distribution and determinants of diseases or disease agents, but also covers those aspects that influence or determine health conditions, including care-seeking patterns and access to services that determine patients’ recovery. Within this framework, the introduction of the distinction between *illness* and *disease* (Fabrega 1974), a fundamentally new approach to health-related issues, facilitated a better understanding of a pathological state (biomedical defined) and a person’s experiences and perceptions about it. This elucidated the importance of the cultural context for effective care and treatment outcome (Rhodes 1996:171; Rubel & Moore 2001) in terms of a *semantic illness network*, i.e., ‘the words, situations, symptoms and feelings which are associated with an illness and give it meaning for the suffer’ (Good 1977:39).

When faced with the problem of how to understand illness in non-Western cultures, some anthropologists attempted to identify typologies within a cross-cultural comparative framework. In this context, two systems were identified. The *personalistic system* explained diseases as the result of supernatural, non-human beings. Within this category, illness is understood as misfortune attributed to ‘the active, purposeful intervention of an agent, who may be human (witch or sorcerer), nonhuman (ghost, ancestor, evil spirit), or supernatural (a deity or other very powerful being)’ (Foster1976:775). The other system, called the *naturalistic system*, explained disease as a result of the disruption of the body’s balance, i.e., “impersonal, systemic terms”, by which disease results from ‘such natural forces or conditions as cold, heat, dampness, and, above all, by an upset in the balance of the basic body elements’ and can be restored by avoiding disease-producing situations and/or behaviour (Foster1976:775). However, these “non-Western medical systems” (idem,p.773) are not mutually exclusive (cf. Foster & Anderson 1980). Garro (2000) suggests that Foster’s naturalistic health system, based on Latin American humoral balance theory, incorrectly recognised emotional illnesses as naturalistic, when these are actually ‘non-personalistic’. As a result, this dual-disease aetiology lacks consistency for a comparative typology framework (cf. Garro 2000:307-308). Nevertheless, Foster’s typology recognises that illnesses are part of a larger explanatory framework for a diverse category of misfortunes (ibid., p.308). Similarly, Young’s approach classifies illnesses into *externalising* and *internalising* systems. Whereas the internalising system is based on a physiological notion and rationalisation of inner structure ‘which make it possible for people to order events within the sick person’s body from the onset of symptoms to the conclusion

of the sickness episode' (Young 1976:147), the externalising system relies on aetiological explanations for 'serious sickness [in] form of narratives in which at least some medically important events take place outside the sick person's body [where sickness] is a symptom of disrupted relations and pathogenic agencies are usually purposive and often human or anthropomorphised' (Young 1976: 147-149). Illnesses that are of a naturalistic order need to be cured through therapeutic practices that depend on the healer's capacity to re-establish the patient's physiological balance. Those of an externalising system, on the other hand, concentrate on the 'pathogenic agency' event that made a person ill, relating symptomatic and intrasomatic symptoms (Young 1976:148). The strength of Young's systems is that biomedicine is not placed as a paradigm model but as part of larger cultural frameworks (cf. Garro 2000).

Another model used to classify and explain illness is Murdock's framework, which divides illnesses between *natural* and *supernatural* causation. Illnesses belonging to the first category identify stress, organic deterioration, infections and accidents; it is defined as "any theory, scientific or popular, which accounts for the impairment of health as a consequence of some experience of the victim in a manner that would appear reasonable to modern medical science" (Murdock 1980:17). Supernatural premises of animistic, mystical and magical causation "fall into three readily distinguishable groups" but have "little in common, other than that they all rest on supernatural assumptions which modern medical science does not recognize as valid" (Murdock 1980:17). Until the 1970s, when illnesses and practices were deemed "irrational" or "magical" in biomedical terms, the investigators failed to consider naturalistic medical systems such as Ayurvedic, Unani, Chinese and Latin American humoral medical theories, which include the use of herbs, homeopathy, massages, bone-setters, amulets or talismans, divination, shamanism, etc. In this sense Lynn Payer, in her book *Medicine and Culture* (1996), asserts that biomedical systems are also shaped by their specific cultural context and therefore also belong to traditional medicine or ethnomedicine (cf. Singer 2004).

Ethnomedicine offers holistic care, which incorporates local natural and social resources and local health and healing epistemologies into the healing process. Anyinam defines ethnomedicine as 'the totality of health, knowledge, values, beliefs, skills, and practices of members of a society including all clinical and nonclinical activities that relate to their health needs' (1995:321). Ethnomedicine has been included in local and international policies, such as the WHO, which make explicit recommendations to include ethnomedical therapies to reach indigenous populations when biomedicine (regarded as the standard) is not available or is not fully accepted. Yet, the term ethnomedicine has been, and is still, used as a synonym for

practices of *false beliefs* among indigenous people around the world. Furthermore, a great range of methods and approaches exists in biomedicine as well, involving different practices and measures, such as the use of biomedical technologies, as well as different systems of relations with patients and other systems of healthcare. In this sense Ong & Colliert (2005) assert that, far from being a homogenising influence, the expansion of global science and technology connects different localities as one component of a global assemblage, with the result that local realities are transformed but also transform this global circulation.

Thus, according to Lock and Nguyen, biomedicine, ‘despite its grounding in science, is a site of struggle about control and interpretation of what will count as legitimate truth claims’ (2010:82)—a site where the normative biomedical language of the assumed universal individual/social body (p.83), and where ‘knowledge produced about the body and its management in health and illness was firmly situated in the domain of ‘objectified’ nature’ (p.32), is confronted by local ecologies in addition to the effects produced by history, politics, and economics (p.103). Similarly, Parkin et al. explain how the supposedly standardised and homogenous biomedicine is influenced by different medical practices, systems and *beliefs*, an interrelation that results in contests, or moves either towards or away from standard biomedicine. Then these practices, ‘resulting from the interplay between globally standardised biomedical policies and procedures and the various local communities who adjust their own medical traditions and interpretations to these overarching impositions, create further medical diversity’ (2010:118). Thus, the idea of a homogenous biomedicine is only ‘imagined’ since it is created from specific social locations—even when the claims made about its scientific foundation are based on normative knowledge.

Infectious diseases and the role of anthropological research

Since epidemiological research, in particular the programmes of WHO and the United States Agency for International Development (USAID), focuses on risk factors that are associated with the incidence and probabilities of a particular illness, the collaboration of disciplines, especially between medical anthropologists and epidemiologists, has increased (cf. Inhorn 1997a, 1997b; Sommerfeld 1998). Epistemological assumptions and notions of ‘risk’ have cited “cultural barriers” that seem to be related to misunderstandings and practices that become an impediment to understanding people’s practices and predicaments (Inhorn 1995). The involvement of anthropologists in international health campaigns, however, directed attention to how focusing on an illness to explore the perceptions, knowledge and practices related to that illness can provide the basis for a functional

analysis, i.e., the effect of illness, as an element of a social system, upon behaviours, as well as its effect on a society that follows structural forms of social relationships and organisations.

The epidemiological interest in infectious diseases arose during the 1970s and 1980s and focused primarily on the microbiology, diagnosis, treatment, and prevention of parasitic diseases. In contrast, bacterial and viral infections as the leading causes of infectious diseases (also referred as transmissible or communicable diseases) were not deeply investigated. The recognition of the importance of bacterial and viral infections, particularly with respect to childhood illnesses, had a significant impact, not only on the shift in global health interventions, fundamental to the improvement of environmental sanitation and water supply, but also in defining a new area of applied research. The 1980s initiative “Child Survival” launched by WHO/UNICEF in 1983 through the initiative “A Children’s Revolution”, targeted the reduction of child morbidity and mortality due to ARIs and ADDs, with a focus on vaccine-preventable childhood diseases, through the Expanded Programme on Immunisation (EPI). In Guatemala, this project led to the participation of anthropologists in the development and evaluation of health programmes, using a type of focused assessment called ‘ethno-classification’, in order to better understand health-related beliefs and practices (Scrimshaw 1992; Scrimshaw & Hurtado 1988). Prior to this, research on infectious diseases was principally focused on microbiological agents. However, this shift in focus highlighted the importance of cultural practices and the social environment in the transmission and treatment of such diseases (cf. Inhorn & Brown 1997a).

A series of projects were conducted by the International Centre for Diarrhoeal Disease Research in Dhaka, Bangladesh during the 1980s and 1990s. In the late 1970s and early 1980s, some publications looked at anthropological aspects of diarrhoeal diseases. As a result, the USAID created an entire project for diarrhoeal diseases under the direction of the prominent public health researcher Richard Cash from Harvard. One of the resulting papers stated that diarrhoeal diseases have important aspects of life and death. Indigenous terms or categories, previously overlooked, for severe diarrhoea cases became of special interest. An example is the Bangladeshi term ‘green diarrhoea’. If a child fell ill and was diagnosed under this category, people would immediately put him into a truck or car and take him into the hospital. If the child did not meet this category, people did not react so quickly (cf. Mushtaque et al. 1988). Anthropological research showed that this category corresponded to the biomedical definition of severe diarrhoea.

The American Anthropological Association’s Working Group on Anthropology and Infectious Diseases delineated this field as a ‘broad area which emphasizes the in-

teractions between socio-cultural, biological, and ecological variables relating to the etiology and prevalence of infectious disease' (Brown 1981:7). Of striking importance was the involvement of anthropologists within WHO programmes (cf. Gove & Pelto 1994; Vlassoff & Manderson 1994), which began in 1950 with the study of typhus control in Peru, led by Edward Welling, followed by Hsu's research of a cholera epidemic in southwestern China and Hank's study of diphtheria immunisation in a Thai community (Inhorn & Brown 1997a:12). However, public health initiatives focused on programmes that tackled primarily behavioural interventions connected to the target diseases. This was built on the premise that some behaviours are not appropriate but can be changed by reducing or eliminating inappropriate practices that jeopardize people's health. The concept of (false) *beliefs* among public health interventions therefore became a point of key importance to explain the possible failures of public health intervention programmes to anticipate outcomes when specific actions were the result of people acting according to their cultural beliefs and values. Thus, these research projects focused on practices that increased or maintained behaviours that were considered barriers to healthcare (cf. Good 1994). Anthropologists called attention to the consideration of local realities, which are essential to understanding social structural aspects that can aggravate a problem or become hindrances to interventions, and they also stressed the impact such plans may have when trying to execute global or national initiatives that are not adjusted to local particularities—the values or beliefs that underpin healthcare practices. According to Inhorn, however, the study of infectious diseases has always been 'compromised' by funding opportunities with international health agendas (1997a:17). This means that global intervention programmes have not been planned according to cultural specificities, but have been based upon general assumptions of awareness and acceptability.

In a rather pragmatic effort, the 'therapeutic modalities' and 'right therapy management' approaches were designed to facilitate access to effective interventions, especially through the use of antibiotics for bacterial infections (Manderson 1998). According to Manderson, the role of medical anthropologists resulted in an 'oversimplification of behavioural patterns', on one hand because their task as consultants in public health research only focused on 'relevant data' to help generate specific guidebooks rather than explaining causalities in a broader context, and on the other hand because exhaustive research methodologies, such as ethnographic studies, were replaced by pragmatic conceptual frameworks for rapid assessment of applied research. The study of diarrhoeal diseases and respiratory infections is a good example of this change through the development of programmes to improve health by identifying factors that increase people's risk (cf. Inhorn 1995).

In Pigg's debate regarding the medical anthropology arena and so-called 'global health' endeavors, she stresses the importance of "on sitting and doing" ethnography action methodology in global health. Pigg's critique reflects on policies and agendas concerning healthcare, advocating for a practice of patient ethnography, with "sitting" a method to understand and reflect more critically the decisions that patients make - according to their local reality - marginalised, unclear or ignored local logics or paths, in order to "do something" for "global health". This raises the question what are the problems and how to tackle these. Healthcare strategies and programmes could remain inconclusive if they fail to address the question of *what* matters, and *why*, for the patients and not only for the organisations (donors, NGOs, national ministries) that launch such efforts. This critical and applied approach questions the legitimisation of healthcare priorities, biomedical ideas and technologies that situates the production of knowledge at different levels, including ethnographic research (Pigg 2013).

According to Byron Good (1994), one of the problems in the field of medical anthropology is that 'scientific medical knowledge' presupposes that other curative knowledge and approaches, such as folk beliefs and practices, are primarily based on "false beliefs", thus creating a hierarchical relationship between modern and indigenous knowledge. As a result, public health interventions and programmes promote models of change in health behaviour as the conceptual framework that underpins the relationship between knowledge and behaviour. The goal of this postulation, 'as a major social science component of disease control has been to document knowledge, attitudes and beliefs, either through ethnographic interviews or surveys, with the aim to adapt national or multinational interventions to suit local interventions' (Manderson 1998:1020). As a result, medical anthropological research seeks to provide information, for example on beliefs, perceptions and practices that explains particular behaviours related to the causes and treatments of illnesses. With this information in hand, public health interventions are designed to attain 'good health' by employing 'right strategies' to prevent and control diseases. Anthropological research has thus contributed importantly to the design and implementation of public health interventions that have positive impacts on people's health by identifying the structural settings that describe the individual's cognition of illnesses. This research helps to explain why and how the varying local understandings and perceptions of diseases and particular interventions are dependent or independent variables of the political economy of disease control (e.g., implementation of disease-control policies; accessibility and quality of services; drug supply; endemicity of specific diseases; environmental and ecology factors; exposure to hazards, etc.)

As an example, global initiatives to prevent and eradicate vaccine-preventable diseases, such as polio and smallpox, have greatly reduced mortality rates among children worldwide. However, while the success of some public health interventions might support the notion that behavioural change can only improve people's health, it overlooks the fact that local solutions for overcoming diseases and other predicaments might also work. Elisha's (2010) work on polio eradication in northern Nigeria, which had the greatest number of confirmed cases of polio in the world and was the source of outbreaks in several West African countries, revealed that the campaign initiative was received with 'skepticism', 'subversion', and 'refusal' of some caretakers to immunize their children. The resistance was based on fears of ethnic-eradication campaigns, vaccine safety, the capacity of the government to provide basic healthcare, and the role of the international public-health community. Folk categories therefore not only describe specific aetiologies but can also account for social and cultural dynamics that explain or suggest why and how people's perceptions and behaviours (based on social values and cultural traditions) influence preventive practices, create drug resistance, cause poor adherence to medical advice, or reduce the effectiveness of treatment.

More recently, the anthropological approach to global health, produced by scholars writing in the field of critical medical anthropology (CMA), has brought an analytical perspective to the impact that structural adjustment programmes³¹ have had on national setting health services. It also addresses how cultural and social life influence public health and how increases in social inequality and population growth affect the process of policy development (cf. Comaroff & Comaroff 1992; Farmer 2005; Ferrera 1993). The application of CMA to health phenomena brought together the historical, economic and political contexts, plus the social and cultural forces, that shape and constrain individual agency programs (cf. Singer 2004). The analysis of structural violence³², for example, proposes a different focus in order to interpret disease and mortality among the poorest as a form of violence resulting from structural inequality (Farmer 2001; 2005; 2008).

³¹The origin of SAP as a process and policy is bound up with the global economic downturn of the 1970s, the ensuing international debt crisis, the shift among economic elites from Keynesianism to monetarism, and the political shift with the election of the Reagan and Thatcher administrations in the early 1980s. These factors created a type of credit package called "Enhanced Structural Adjustment Facility" that is offered to underdeveloped nations if certain macroeconomic conditions are met. SAPs refer to the country-specific agreements negotiated by international financial institutions with local ministries of finance (Harvey 2005). The work "Structural Adjustment Programs and the Delivery of Health Care in the Third World" analyses this global framework of SAP more explicitly (Brunelli 2007).

³²"The concept of structural violence is useful in that it draws attention to how social conditions can substantially limit opportunities and capabilities of individuals, particularly the less fortunate, explaining in broad terms why the world's poor are unfairly burdened by disease and the absence of wellbeing" (Napier et al. 2014:1622)

Health-Behaviour Models and Approaches in Public Health Studies

Predicting health behaviours has been an area of major interest of health-related studies, with the aim of contributing to the improvement of people's well-being and health by providing frameworks to identify the determinants of risk behaviours. One of the premises of this line of investigation is that specific morbidity and mortality causes are the results of particular behaviour patterns, and secondly, that these can be changed (cf. Conner & Norman 2005; Inhorn 1995). The study of health-seeking behaviours has a long history in the field of social psychology, but interest in it has increased since the mid-1980s, along with other areas of studies, especially epidemiological studies, that are also concerned with evaluating the predispositions of thought and behaviour that affect people's health (cf. Adler & Matthews 1994; Conner & Norman 2005). The dominant approaches have been the development of 'pathways models' of health-seeking behaviours, which focus on the actions of an individual, and research on 'determinants' of behaviour, which stresses the factors that influence people's choices (Michie et al. 2008).

In the context of globalised programmes and the idea of 'risk behaviours' regarding AIDS, Bujra argues that 'ministries of health, the media, and healthcare industry routinely alert the public to health risks in the course of promoting beneficial health behaviours and health related practices. The reality is, that many recommendable health practices are unfeasible or untenable to various sectors of the population given the availability of resources, their lifestyle, and the existing gender and power relations' (2000:13). Healthcare-seeking behaviour is normally defined as any endeavour (or decision-making process) that is carried out in order to obtain treatment and cure when people feel ill or sick (cf. Ward & Thomas 1997). These decisions rely on explanatory models that embody a cultural frame, such as norms and expectations that determine healthcare-seeking behaviours. Decision-making models are used to explain behavioural patterns in response to specific signs and symptoms, i.e., the perceived nature of illness and the treatment/therapy selected (Foster & Anderson 1980). Thus, health-seeking behaviours are frequently variable and often arbitrary, depending on analytical, emotional and contextual circumstances, including accessibility to health facilities, distance, cost, etc. (Woods & Graves 1973).

Models of health-seeking behaviour frequently take into account demographic features such as level of education, and the occupation and income of the head of household, which are decisive factors in developing countries (Ryan 1998). Normally healthcare-seeking models include multiple factors in order to elicit closer

insights into how people recognize an illness, how the process of identification of symptoms develops, how people perform case management, what patients' references and perceptions are, etc. For example, perceptions, experience, and satisfaction with the health treatment encounter, the patient-care/health provider relationship and treatment outcome all play a significant role in subsequent health-seeking behaviour. Yet, health-behaviours models also largely shape the immediate situations that are labeled as risks. Under this view, 'health beliefs' enhance risks when social or cultural features entail particular practices that significantly increase the probability of making an incorrect decision regarding the acquisition of healthcare, as well as of repeating 'reasoned thinking and acting' that can represent a life-threatening decision by an individual.

Conversely, some anthropological research has made use of emic-focused models of attitude and behaviours, for instance with respect to HIV/AIDS, in order to generate programmes or methods of behaviour change to prevent or reduce the transmission of the virus (Ashforth 2010). This research has contributed to the critical analysis of intervention programmes that specifically target people at risk (cf. Hausmann et al. 2003:5; Quaranta 2010). In order to measure the impact of attitudes on behaviour, an emic health model highlights the importance of considering individuals' beliefs and behaviours, correlated with perceptions, attitudes, self-efficacy, and (local) knowledge, that together affect health outcomes by determining the use of healthcare providers and institutions. The epistemological relevance of an emic model is that differentiated aspects and responses do not presume a universal frame of reference and meaning, but pursue an extensive understanding of the significance of specific behaviours, identifying what is at stake within a specific context. Different models of health-seeking behaviours have different impacts when the problems or aspects that are addressed take into account not only the disease-specific attributes but also the factors that significantly influence people's lives.

Knowledge, Attitude, and Practices (KAP) Surveys

KAP surveys were developed in the 1950s and at first were used primarily for family planning and population studies (Bulmer & Warwick 1993). They are currently used as a method to gain information regarding local practices for planning health programmes (Manderson & Aaby 1992a), and as a mechanism to provide a better understanding of communities' perspectives and behaviours with respect to specific issues. KAPs are frequently used by organisations such as USAID, UNICEF and WHO to assess diseases, and to develop promotion campaigns and targeted interventions. KAP studies have not only helped to understand what

people know about a particular disease (nosology, transmission, diagnosis, interventions) but also how people ‘feel’ about the disease (perception of infection) and their behaviours (measures of protection, management of diseases or outbreaks, risk practices). Normally KAP studies have three phases: 1) a pre-evaluation; 2) an intervention programme; and 3) a post-evaluation to measure impact. In the mid-1980s the ‘Global Programme on AIDS’, directed by the WHO, adopted this model to guide healthcare practices and prevention campaigns to modify ‘risk’ behaviours, using a view of the person as a rational being, acting according to a cost/benefit rationale in a social vacuum, as the sole person responsible for his/her behaviour. In this way, risk emerged as an individual matter related to personal choices, rather than a complex process that calls for an adequate understanding of economic, social and political dynamics within which personal action unfolds (Quaranta 2010:183-184).

The advantages of KAPs are that they are cost-effective and easy to design; it is reasonably easy to train interviewers; they provide statistical data that can be generalised from samples; and they produce data that is easily interpreted and that can be transformed into intervention projects. Some disadvantages of KAP studies include bias on the part of the interviewers due to interactions with the respondent (i.e., courtesy bias, recall bias, seasonal bias); reported bias (when the reported or normative behaviour differs from the real practices); and the problem of generalisation, which refers to the reporting of preconceived notions (Bhattacharyya 1997:212-216; Caldwell et. al 1994; Manderson & Aaby 1992a; Nichter 1993; Stone & Campbell 1984). With respect to generalisation, Bhattacharyya points out that ‘in research on ARIs it is almost impossible to determine the severity of the past episodes if the mother did not feel the episode was serious, she may be not able to remember whether the child had specific signs and symptoms’ (1997:215). In addition, Pelto and Pelto (1997) in a critical review stressed that public health professionals frequently interpret beliefs as the opposite of knowledge. Another challenge is the difficulty of assessing or measuring the importance of certain knowledge, attitudes, and perceptions derived from particular experiences that play out in specific contexts, as a result of false generalisations and formulations (cf. Hausmann-Muela et al. 2003). Also, ‘reported practices’ (as in the KAP surveys) may be very different from actual practices, as observed especially in ethnographic studies. Nevertheless, it has been precisely through KAP surveys that the role and relevance of Evil Eye in childhood illnesses has been documented in many geographical regions (cf. Cerón 2007; Kappor & Raiput 1993). Even though such a model of theory reduction remains controversial, it allows us to raise anew the question of meaning and its implications for different concrete

experiences of illness and health.

The Health Belief Model

Developed during the 1950s by a group of social scientists at the U.S. Public Health Service, the Health Belief Model (HBM) was formulated to explain health behaviours and to promote the use of health services by acutely or chronically ill patients, in response to the failure of a free tuberculosis (TB) health screening programme (Becker 1974; Hochbaum 1958; Rosenstock 1960, 1974). The HBM is based on the psychological theories of “decision making” and “value expectancy” (Clearly 1986; Mainman & Becker 1974), and is sustained by two aspects of health-related behaviour: (1) the intention of not becoming ill, or of getting well, if ill; and (2) the perception that certain action(s) will prevent or cure an illness. Decisions regarding health-seeking based on this model will therefore depend on the person’s perceptions of the benefits and barriers involved³³.

The HBM has been widely employed to obtain information concerning perceived barriers with regard to diarrhoeal and respiratory infections in order to explore caregivers’ ‘perceived susceptibility and severity’, which is considered crucial to predict and increase biomedical care, as well as to conduct experimental studies to assess the effectiveness of health education programmes (cf. Tanakamon 2008; Wongsrit 1999). Although the HBM has been helpful for prevention-focused programmes that aim to promote specific behaviours, this model stresses the role of a patient’s ‘personal responsibility’. It underlines an “appropriate fear-based” message, but does not account for more complex causation factors over which an individual has less personal control or which are influenced by social, economical, or environmental factors; it focuses largely on aspects that can be measured (cf. Tylor et al. 2007).

³³The first HBM, developed in the 1950s included (1) *Perceived susceptibility*: Subjective estimate of the risk of getting sick, including feelings of vulnerability, as well the probability of acceptance or denial of a diagnosis; (2) *Perceived severity*: Subjective perception of the severity of a disease or illness and its consequences (social consequences, disability, death, etc.), and motivation to seek healthcare; (3) *Perceived benefits*: Perception of the effectiveness of the treatments available, including estimation of both perceived effectiveness and perceived benefit, which might prompt or delay the decision to seek treatment (Rosenstock 1990); (4) *Perceived barriers*: Possible hindrances to taking specific health actions, which include a wide range of internal or external factors; and (5) *Self-efficacy*: Perception of one’s own potential to execute actions in order to succeed in a particular circumstance. Self-efficacy is a construct in many behavioural theories, as it directly relates to whether or not a person performs the desired behaviour. This aspect was added later, during the late 1980s, after adjustments were made to the model to include data gathered by the health community concerning the role that knowledge and perceptions play in health-seeking behaviours (Bandura 1977, 1986; Bandura et al. 1988). Since then, this model has been employed to predict more general health behaviours and has been adapted to explore a variety of long- and short-term health behaviours, including sexual risk behaviours and the transmission of HIV (Glanz et al. 2002:52).

The HBM has, in practice, focused mainly on the measurement and analysis of perceived vulnerability, severity, benefits and barriers (cf. Chen et al. 1992). It has been criticised for several limitations, such as not explaining the attitudes, beliefs, or other individual determinants that dictate a person's acceptance of a health behaviour; not considering habitual behaviours that may determine a decision to accept a recommended action; not considering non-health-related explanations that impact health-seeking decisions; and not taking into account external or internal factors, such as environmental or economic aspects, that prevent people from following recommended actions (Cochran & Mays 1993). Moreover, it supposes that all people have access to standardised information on diseases; it also supposes that the sole purpose of people's health-related behaviour is simply to 'get well' (cf. Davidhizar 1983; Clearly 1986).

The Theory of Reasoned Action (TRA) and Theory of Planned Behaviour (TPB)

The Theory of Reasoned Action (TRA), first proposed by Ajzen and Fishbein in the late 1960s, was designed to identify and change patterns of beliefs and attitudes that could help individuals respond more effectively to 'objective' situations. This model is based on the premise that the understanding of volitional behaviours could be predicted, thus allowing a level of generalisation (Ajzen 1998). The model combines multiple variables described as *beliefs* (in order to measure the likelihood that an action might promote or negate a given outcome, and evaluate outcomes accomplished or avoided, in terms of their sought and negative consequences in a specific time and place); *attitudes* (the addition of an individual's significant probability of responding in certain ways, i.e. personal beliefs about value of behaviour, measured on scales); *normative beliefs* (referent beliefs about what behaviours others expect, including the degree to which an individual wants to comply with others' expectations); *subjective norm* (defined as the sum of the normative beliefs, but independently assessed); and *behavioural intent* (resulting from the combination of the behavioural attitude and the subjective norm, which are considered as the central cognitive precursors to acting) (Tylor et al. 2007).

Since behavioural and normative beliefs are derived from individuals' perceptions of the social world, these are likely to reflect the ways in which economic or other external factors shape behavioural choices. Criticism of the TRA focuses on the fact that it does not take into account the social nature of human action, that is, social realities such as a comprehensive understanding of the social and economic determinants of health behaviours.

Like the HBM and the TRA, the Theory of Planned Behaviour (TPB) is also a value-expectancy theory based model. In the case of TPB, ‘behaviours’ and ‘behavioural intentions’ are also taken to be functions of: 1) *control beliefs*, significant to the individual’s perceptions of (a) the external factors that restrain or make possible an action and (b) self-efficacy (individual’s conviction of an outcome derived from a specific behaviour); and 2) *Perceived Behavioural Control* (PBC), described as the result of ‘perceived control’(what people consider as voluntary practices) and ‘perceived difficulty’ (the degree of difficulty of a specific behaviour). In other words, a person makes a decision according to his or her perceived capacity and autonomy to take control over a situation. Despite the applicability of the TRA & TPB models, they have been criticised for their central psychosocial elements, which fail to reflect how social contextual factors influence risk behaviours. According to Cochran and Mays (1993), many of these conceptual theories do not take into account cultural, social and ethical differences. They assume that people are motivated to act ‘rationally’ base on individualistic, ‘middle-class, European-American values and standards’, with certain general resources and skills available to help them make explicit decisions about their behaviours.

Explanatory Models

In his influential publication ‘Patients and Healers’, Kleinman proposed the ‘explanatory model’ (EM) to help practitioners and investigators understand better how patients make sense of their illness—their experience of it, including its meaning and their own expectations of their recovery process³⁴, and how cultural and societal contexts affect the ways people negotiate with such experiences. This model has been useful in understanding non-Western medical beliefs that tend to clash or interact negatively with clinical assessments (cf. Finkler 1985, 1994). The EM is defined as ‘the notions about an episode of sickness and its treatment that are employed by all those engaged in the clinical process’ (Kleinman 1980:105). EMs “contain explanations of any or all of five issues: aetiology, onset of symptoms, pathophysiology, course of sickness (severity and type of sick role) and treatment. EMs are tied to specific systems of knowledge and values centred in the different social sectors and sub-sectors of the healthcare system”(idem).

³⁴The EM consist of (1) presumed causes of the illness (*aetiology*); (2) *signs and symptoms* by which the illness is recognised; (3) how it affects the body (*pathophysiology* of the illness); (4) the prognosis (*course* of the illness); and (5) recommended therapies (*treatment*) (Kleinman 1980: 105-107). People apply content from their cultural reality to define these categories to help them to make sense of the dysfunction. Connections among these five concepts form a semantic network, guided by symbolic reality.

EMs are drawn out through a series of structured, qualitative, open-ended questions³⁵ eliciting multi-layered responses which provide information about forms of knowledge and illness narratives. The responses provide information about social rituals and conventions, symbols, forms of knowledge and illness narratives. Kleinman's EM attempted to distinguish between diseases and illnesses to overcome the gap between medical knowledge and specific cultural health behaviours (Kleinman 1988), in order to address 'intracultural and intracommunity' divergences in people's belief behaviours, expectations, social values, relationships and practices (Pelto & Pelto 1997). The closing of this gap constitutes 'a bridging reality that links the social and cultural world with psychobiological and biological reality' (Kleinman 1980:41), which works as a filter through which a person can perceive and interpret the social matrix in which they live. Thus, EM depends on contextual and cognitive analysis of care-seeking behaviours, and the economic and socio-cultural factors that influence people's choices in care-seeking.

The cognitive influences of the psychological sciences in medical anthropology have been labeled 'ethnosemantics' (or ethnolinguistic) and 'ethnoscience' (D'Andrade 1995; D'Andrade et al. 1972; Dressler 2007; Weller 2007). For Kleinman these aspects provide a theoretical basis for comparative studies to be carried out within different healthcare systems (the professional, popular, and folk sectors) as well across cultures. Later, Kleinman shifted his original conceptions of the EM to focus on the 'subjective experience' of illnesses, seeing illness narratives as strikingly important to the approach and understanding of particular experiences of illnesses.³⁶ Although EM was important in recognising biomedical practices as based on an ethnocentric cultural perspective, some of the critiques of the EM approach include: (1) it tends to overlook power relationships between groups and classes as a cause for illnesses; (2) it does not take into account the social process through which behavioural and biological signs are given a social meaning; (3) it overlooks how social relationships influence and allocate illnesses; and (4) it presupposes that patients' understanding of the illness is rather static (Young 1982:266-268). Scheper-Hughes addresses the concern that such an explanatory-model framework is motivated by the integration of epidemiological and anthropological research

³⁵ The primary questions are: What do you call the problem? What do you think the illness does? What do you think the natural course of the illness is? What do you fear? Why do you think this illness or problem has occurred? How do you think the sickness should be treated? How do you want medical personnel to help you? Whom do you turn to for help? Who should be involved in decision-making?

³⁶ Kleinman states, 'Today, I am uncomfortable with the style and even the preoccupation of 'models', ethnocultural or other, which imply too much formalism, specificity, and authorial certainty, but models were definitely in my mind in the 1970s, a residue of symbolic and structuralist readings... I, like many others...have become less impressed by systematic connections and more by differences, absences, gaps, contradictions, and uncertainties' (1995:7-8).

to identify causal relations between beliefs and risk behaviour in an operational formulation of an illness and individuals' experiences, in which biomedicine 'reduce[s] the complexity and richness of anthropological knowledge to a few reified and practical concepts' (1990:191).

Despite the critiques, the EM has been widely applied in anthropological research. A good example is Pool's study carried out in Cameroon on kwashiorkor among children in the mid-1990s.³⁷ More recently, studies have focused on mental health disorders, such as depression and somatic diseases, among ethnic minorities (cf. Arcury et al. 2004; Cabassa et al.2008), schizophrenia (cf. Charles et al. 2007; McCabe & Priebe 2004), and clinical research with the aim of addressing specific beliefs related to primary prevention programmes for disease or injury (e.g. education about nutrition, dangers of drug consumption such as tobacco and alcohol, immunisation against infectious diseases, regular exams and screening tests to monitor risk factors for illness). Another example of the use of EM to approach local perceptions and healthcare in anthropological and epidemiological research has been the study of diarrhoeal disease and the use of oral rehydration therapy (ORT)³⁸, which efficacy and low cost have made a primary and safe resource in developing countries since the 1980s. Although this intervention has become an essential part of the WHO/UNICEF programs to rehydrate children, it is still not well implemented in some areas. As a result several countries have used EM to measure diarrhoeal illness-related beliefs associated with different choices of therapies in order to improve acceptance of ORT and insure adequate treatment (cf. Bentley 1988; Blum & Nahar 2004; Hurtado 1989, Weiss 1988).

Explanatory Model Interview Catalogue (EMIC)

Stimulated by research experience in cultural psychiatry and tropical medicine, and promoted by international health policy and multicultural health programmes (Weiss 2001, 2008), *cultural epidemiology*, an integrated framework incorporating public health, epidemiology and anthropology, has become particularly important

³⁷ In his EM approach, Pool encounters at least four diverse explanations given to the illness. Although the child is diagnosed at the health center with severe protein-energy malnutrition caused by a poor diet, the interpretations of the mother and other health providers differ and overlap (Pool 1994). Instead of clear-cut curative measures, the result is a set of interrelated dynamics that determine how the illness should be properly treated.

³⁸ ORT was previously only used as an intravenous therapy for diarrhoeal dehydration. In 1971, during the Bangladesh liberation war, a cholera epidemic in the refugee camps of Bonga broke out after millions of people had crossed over the border into districts of Bengal. With intravenous fluid stocks running out, the state of the refugees became critical. Mahalanabis, who was treating the refugees, introduced ORT into the camps, reducing the mortality rate from 30% to 3.6% in adults and from 90% to less than 1% for infants (Mahalanabis et al. 1973; Ruxin 1994).

in addressing the influence of socio-cultural factors on the locally valid illness representations indifferent cultural settings (cf. Trostle & Sommerfeld 1996; Weiss 2008:837). In this context, EMIC was initially conceived as a mixed-research-method framework of locally adapted explanatory model interviews based on a common frame. It elicits experiences and meanings associated with individuals' behaviours in relation to a particular illness, and includes both quantitative variables of 'locally meaningful categories' and 'qualitative prose', which clarify the meaning behind particular behaviours, cross-referenced for analysis to provide "a descriptive account, facilitate comparisons, and clarify the cultural basis of risk, course, and outcomes of practical significance for clinical practice and public health" (Weiss 2008:837). In an initial study of leprosy in Mumbai, India, Weiss focused on perceptions, beliefs and practices related to this illness (Weiss et al. 1992), shifting later to the notions of 'experiences', 'meaning', and 'behaviour' as a conceptual framework and integrating 'patterns of distress (PD)', 'perceived causes (PC)' and 'help-seeking (HS)' as operational variables for a cultural epidemiology of illness representation (Weiss 2001).

EMIC integrates several sources and approaches, such as previous ethnographic data, to develop a baseline to address socio-cultural features with the aim of facilitating planning of healthcare services. It is composed of different sections which include open-ended questions that contain emic and etic units of analysis. The first phase focuses on basic questions that generate specific response categories, followed by alternative responses the person did not refer to in order to reduce the probability of leaving out responses that can be statistically measured. The priority in the interview is to obtain the ideas that the person provides spontaneously. This method is of particular importance for non-clinical community-based programmes when supported with ethnographic research. However, this method tends to make assumptions concerning cultural knowledge which may not accurately reflect a particular way of perceiving, understanding and behaving, meaning that the resulting public healthcare campaigns or interventions are regarded as morally neutral (cf. Pigg & Pike 2001:195). Certain responses are ignored or presupposed, whereas other concepts cannot be scaled or easily validated, such as aspects of fear, suffering, stigma, oppression, and values.

Focused ethnographic studies (FES) and Rapid Assessment Procedures (RAP)

The concept of focused ethnography was introduced by Otterbein (1977) as an approach that is 'problem-oriented, in the sense that the ethnographer desires to

explain the culture trait which he has focused upon. He solves his problem, so to speak, by including in his report topics which he believes, or other anthropologists believe, are causal factors. He will also usually include a description of the subsystem (economic, social, political, or belief system) in which the focus topic is embedded' (Otterbein 1977:10). The peculiarity of a FES approach is its rather short-term field research. Yet this limitation on research in situ is compensated with an intensive use of instruments such as photo and video cameras and voice recorders. Instead of social groups or fields, FES gathers data on experiences through diverse ways of communication. It focuses on local concepts or categories of illnesses, individual illness experiences, normative behaviour, decision-making processes, and macro-social aspects that have an effect on personal choices regarding illnesses. In the 1990s a FES research protocol was developed by the Acute Respiratory Infection Programme of the WHO (Gove & Peltó 1994) in order to "explore the systematic patterns of cultural knowledge concerning specific illness categories in relation to actual behaviours involving those illnesses and accompanying symptoms to obtain operationally important information and insights on specific health problems" (Peltó 1997:155). In this connection, Foster argued that a general predicament in behavioural research was the failure of the social scientist 'to keep research simple' (1987a:713), and he censured the propensity to be so 'keen on conveying an impression of research sophistication that they need to address the question of the ends for which the research is carried out' (p.714).

Similarly, rapid assessment studies were developed in order to generate highly focused information in a short period of time. Scrimshaw and Hurtado (1988) designed the *Rapid Assessment Procedures Manual* to explore the impact of primary healthcare on nutritional status. FES and RAP ethnographic protocols are both influenced by Kleinman's approach of *explanatory models*. Manderson and Aaby (1992a, 1992b) state that FES and RAP studies should also include distinctive, i.e., non-normative, behaviours, in order to account for the variability of practices. Additionally, the emphasis on folk illnesses or cultural concepts that do not correspond to biomedical nosology should accompany the aspects of the social and class context. Bhattacharyya states that although FES explores the conceptual models of illness, it fails to account for the social dynamics of illness management within and among families (1997:231). Nevertheless, both models of data collection have facilitated identifying aspects of delay in treatment-seeking, inappropriate health service provision at health facilities, gender dynamics and economic constraints, among other problems.

1.8 Global policies and approaches to local realities: Health-related studies in the Guatemalan context

Diseases and illnesses should be understood as a result of historical processes, rooted in experiential realities (cf. Brown et al. 1996:183-218). Thus, when unfamiliar primary healthcare services are introduced into an indigenous rural context, socio-cultural, economic and political references are of paramount importance. Different interpretations of these variables can result in different reactions to the new services. An anthropological focus on *culture change theory* has been used to explain why and how practices related to the relationship between allopathic and indigenous practices and beliefs continue to exist. In Guatemala, changes to healthcare models have been based on the *diffusion theory model*, which underlines the *adoption* of ‘innovations’; *contact* with different models of healthcare; and *interactions* between groups (cf. Adams 1955, 1960, 2005; Adams & Rubel 1967; Cosminsky 1975, 1983, 2001; Woods 1973). Ranging from diffusion to explanatory models, many studies have been formulated, not only to gain understanding, but most of all to integrate different values and behaviours into practices to promote and deliver healthcare within biomedical standards into a pluralistic medical system (Adams 1955; Cosminsky 1975; 1994; 2001).

Medical pluralism is generally present in societies with strongly divided social classes where there is not one exclusive medical system, but rather differentiated subsystems of healthcare that coexist or compete, and whose practices are based upon the predominant structure of class, caste, racial, ethnic, religious, or gender distinctions (Baer 2003; Frankenberg 1980:198; Leslie 1992; Singer 2004:29). Normally, biomedicine has a dominant epistemologically, politically, intuitively, and financially sanctioned status over ethnomedical or alternative practices. In this connection, Charles Leslie points out that ‘the triumph of modern medicine has been to improve care by applying scientific research and new forms of professional organisation to biomedical problems. . . This has led to effective knowledge for controlling and curing infectious diseases and to the complex technology that characterizes the modern hospital. Efforts to increase the scope and to improve the quality of health care have sought to eliminate or severely restrict ‘irregular practices’, so that ideally local medical systems will simply become extensions of a nationally and internationally standardized medical system’ (1980:191). In Latin America, medical pluralism is manifested largely in three forms: 1) biomedicine,

2) traditional³⁹ or folk medicine, and 3) shamanism.⁴⁰ Until recently, modern biomedicine was practiced principally in clinics and hospitals in urban areas (cf. Crandon-Malamud 1993; Ferzacca 2001:68; White 2001).

In his work in Tepoztlán, México, during the 1920s, Robert Redfield provided the first important contribution to studies of *folk-illnesses* for the Mesoamerican region. With a focus on the change of societies from so-called ‘primitive’ societies and peasant people, conceived as stagnant and therefore assumed to be different from Western civilisation, Redfield created the idea of a ‘folk-urban continuum’, suggesting that the influence of urban life on social attitudes and organisation on local villages takes place in an inevitable way and influences the development of a more complex society. There followed a general understanding of folk illnesses as a consequence of isolation.

During the 1930s and 1940s, North American (cf. Foster 1944; Gillin 1959) and German (cf. Stoll 1938) researchers conducted systematic anthropological studies in Guatemala on health and disease. Gillin’s book *El espanto mágico* was especially important in providing an awareness of folk-illnesses among the rural, indigenous population and the importance of the use of medicinal plants among healers. The focus was *traditional medicine*, i.e., healers, midwives, medicinal plants and folk illnesses (the product of the fusion of pre-conquest Mayan beliefs and Spanish culture). The traditional medical system is not only a practical solution to confront common ailments but also provides a fulfillment of cultural practices that respond to a wider social frame. Many of the ethnographies and studies produced during these decades provided information on perceptions and practices of the indigenous population and related the precarious health status of the population to cultural practices (cf. Montengro & Stephens 2006). The many illness beliefs were interpreted as the result of ignorance, superstition, esoteric/supernatural practices, and a strong belief in luck and destiny (cf. Barrett 1997).

³⁹The concept ‘traditional medicine’ does not imply a static conceptualisation of local healing practices, but rather a healing system that includes a wide variety of practices and (ceremonial) specialists that are not part of the Western biomedical model. The WHO defines it as the ‘health practices, approaches, knowledge and beliefs incorporating plant, animal and mineral based medicines, spiritual therapies, manual techniques and exercises, applied singularly or in combination to treat, diagnose and prevent illnesses or maintain well-being’ WHO (2003) Fact Sheet 134: Traditional Medicine, <http://www.who.int/mediacentre/factsheets/fs134/en/>.

⁴⁰The term *shaman* is an Evenk word, a Paleo-Siberian group. By the beginning of the 21st century the Evenk numbered about 70,000 living between Mongolia, Russia and China. The Evenk were traditionally organised along paternal line clans, each of which was led by a group of elders, including the clan shaman (Encyclopedia Britannica). By the beginning of the 20th century the term *shaman* was being used to refer to magic-religious healers, native healers, medicine men (or women) and the like, whose practices are closely related to the spiritual world and healing practices (Hughes 1996:145; Vitebsky 1995).

A decade later, the Institute for Nutrition of Central America and Panama (INCAP), a research institute which is part of the WHO and the Pan American Health Organisation (PAHO), brought together local and foreign scientists who focused on issues related to health/disease and public health concerns from several areas of study, including anthropology. Founded in the early 1950s, INCAP had a particular interest in applied medical anthropological research, specifically on issues related to health and nutrition (Baer et al. 2003; Burleigh et al. 1989; Pebley et al. 1999; Weller et al. 1997). During this period the studies produced by INCAP focused on the relationships between prevalent diseases, cultural practices and social behaviours. In the beginning of the 1950s the U.S. anthropologist Richard Adams, hired by Dr. Nevin Scrimshaw, the founder of INCAP, wrote several monographs about Mayan medical beliefs and practices and the clash between allopathic and traditional medicine. This work was continued by Nancie Solien et al. (1957), who focused on culturally influenced conflicts between traditional and modern behaviours that could help to clarify scientific investigations and public health interventions (Barret 1997:580). In his book *Un análisis de las creencias y prácticas médicas en un pueblo indígena de Guatemala*, Adams developed a model for understanding beliefs and healthcare practices when illnesses of *intern* and *extern* order appear; his system was circumscribed by cultural relativisms primarily based on Robert Redfield's premise of the existence of folk-medicine. This model was used in medical anthropological studies related to illnesses and healthcare practices until the 1980s. For Barrett, Adams' work on indigenous medical systems 'set the stage for four decades of applied anthropology in Guatemala and around the world when he diagnosed the problem as a *breakdown in communication caused by ignorance of local beliefs and practices*' (1997:580; the emphasis is mine). Important studies on bone setting were also conducted by Benjamin Paul (1955), Paul & Paul (1975) and Lois Paul (1978), who also researched Mayan midwifery, followed by studies by Sheila Cosminsky (1975, 1976, 1977a, 2001).

Many of these studies focused on health behaviours to help reduce infant mortality, documenting important practices in the traditional Mayan medical system. Yet, initially, the programmes the INCAP launched were not easily adopted within the communities in which traditional practices were systematically seen as part of the problem. In Adams' view, one of the efforts in a rural community showed that 'from the point of view of the anthropologist, the program in Magdalena was relegated as a meeting ground of two cultures. The personnel of INCAP came to Magdalena as Central and North Americans with goals characteristic of their occidental culture. Public health, nutrition, and scientific experiment are important concerns in this culture: they are not important in Guatemalan

Indian culture’ (Adams 1955:436). Adams recognised that part of the problem of acceptance was that members of the INCAP team were not mindful about the importance indigenous people placed on blood (blood samples were judged as necessary for diagnostic purposes). The indigenous population perceived blood as intrinsic and non-regenerative (Barret 1997:579-580). INCAP did not take local perceptions of the body and health into account due to a lack of recognition that indigenous people had a healthcare system and therapeutic models of their own. In this regard, Green contended that government health programmes were part of the pacification agenda implemented in order to appease demands for social change (Greenberg 1989). Barret noted that much of the resistance toward biomedical practitioners and practices was based on the observation that medical personnel did not understand how the traditional health system worked but instead ‘treated only mild illnesses, referring more difficult cases to a distant hospital, where the villagers knew very well that people only went to die’ (Barret 1997:580).

After working at INCAP, Richard Adams worked at the National Indigenous Institute (NII), a component of the inter-American indigenous movement in Latin America, where his research focused on traditional illnesses at a national level. The NII was founded by official decree on August 28, 1945 by the government of Guatemala, based on the resolution of the Congress of Patzcuaro, Michoacán in 1940. Its purpose was to ‘integrate’ the indigenous population and ‘ensure’ its participation with the rest of the population.⁴¹ Various studies and policies in the United States triggered interest in the inclusion of indigenous groups into the productive economy of the countries by legal policies through the creation of institutes dedicated to this purpose. The primary focus of the NII was the ‘problem’ of ethnicity in Guatemala. Adams’ approach and work at the NII was based on the premise that social integration theory intended to force assimilation of the indigenous population into a ‘national culture’. The NII was a government agency which worked under the auspices of the Ministry of Education. Its focus was what was referred to as the “Indian problem”—specifically, to help to improve indigenous life conditions through research studies and publication of the journal *Guatemala Indígena*, as well as brochures, booklets and other materials that could have practical application to those ‘problems’. It also provided advisory services to government agencies for the execution of rural development projects.

⁴¹Que Guatemala, en su constitución étnica confronta el problema de grupos indígenas con una cultura cuyos valores positivos deben protegerse, pero a los cuales es preciso estimular para que eleven su nivel cultural, social y económico y concurren en mejor forma a la integración de una fuerte nacionalidad y que la Constitución de la República, en el inciso 15 del artículo 137, dispone la creación y mantenimiento de instituciones que concentren su atención sobre los problemas indígenas y aseguren el concurso del Estado para la pronta resolución de dichos problemas’ (Informe del Segundo Congreso Lingüístico Nacional, Guatemala: Ministerio de Educación 1985, p.7).

Many of these surveys focused on indigenous languages, linguistic maps, and diverse cultural data regarding music and traditional indigenous clothing. Initially, in addition to research, NII's function was to act as a consultant and advisor on issues related to indigenous population. It also involved advocacy programmes to protect and/or legalise indigenous practices and provide support at different levels, such as scholarships for study outside the country. However, despite recognition at the judicial level the policies of 'ethnification' directed toward the indigenous population did not provide solutions for their needs in ways that responded to their own identities. As a result of the absence of a coherent plan and appropriate strategies, the inadequate definition of the "Indian Problem", and the absence of social scientists at the Institute, the work of NII was criticised for trying to force assimilation without taking into account the reasons why the indigenous population lacked social mobility. These included the absence of state benefits such as primary healthcare and education. In addition, as victims of discrimination and segregation, the indigenous population had no political presence in the government.

One of the most important works published by the INCAP during the 1970s was Hurtado's article, "Some Ideas for a Structural Model of Beliefs in Relation to the Illnesses in the Highlands of Guatemala". Based on Adams' work, Hurtado (1973) developed a classification based on Mayan cosmogony: (1) diseases caused by the mechanical disruption of the body's balance, (2) illnesses caused by the rupture of the emotional equilibrium, (3) diseases caused by the disruption of the hot-cold balance, (4) diseases caused by the influence of other beings, natural or supernatural, (5) diseases caused by intestinal parasites, (6) illnesses provoked by the loss of soul. This model was used widely during subsequent years by anthropologists and by medical personnel and nutritionists, among other professionals, in order to understand and classify illnesses. Parallel to this, another important contribution was Cosminsky's work during the 1970s at INCAP elaborating a theoretical perspective to understand health systems better, recognising medical pluralism in societies such as Guatemala. Her work *La atención del parto y la antropología médica* became a classic in medical anthropological research for people who work in maternal-child programmes in Latin America. Between the late 1970s and the late 1980s, Harrison and Cosminsky published several articles and books describing the 'culture of health in Guatemala' (Cosminsky & Harrison 1976; 1984).

During the 1960s, the initiative Alliance for Progress provided countries in Latin America with targeted support for community cooperatives and help to restructure projects through modernisation (Streeter 2006). Parallel to this, the Smithsonian Institution, contracted by the Institute of Inter-American Affairs, undertook a six-

month study of the first ten years of United States–assisted health programmes in Latin America. This study resulted in the creation of the Health Advisory Committee of the Foreign Operations Administration, the focus of which was to change or influence some aspects within ‘traditional societies’ to improve health services planning and operations⁴² (Foster 2010:394). Relevant works in the field of medical anthropology were primarily linked with religion, with which the conception of spiritual ailments, sorcery and witchcraft, rituals and symbolism were described as directly connected in the Mayan tradition. These practices were threatened by the introduction of Pentecostalism (Adams & Hawkins 2007:10-11) and by the social dislocation associated with economic deprivation and the political and military disruptions which occurred during the 1980s.

During the 1970s, international health promotion and aid programmes in developing countries were expanded (cf. Buckley 1989). In Guatemala, an event of immense importance was the devastating earthquake of 1976, which resulted in widespread destruction and approximately 250,000 deaths (WHO 1997). During reconstruction following the earthquake, ‘Western practices’ were introduced into the Guatemalan national healthcare system. The introduction of ‘Western practices’ and technologies in rural indigenous Guatemala constituted a non-natural transformation in people’s perceptions and practices, and many of the measures met with negative outcomes. The arrival of many international-aid NGOs, and the repressive and violent period of the civil war during the early 1980s, increased the presence of international institutions.

During this period, several NGOs and international agencies conducted studies and developed strategies to improve and assist maternal and child care services, particularly in rural areas. An example was the international ‘Safe Motherhood Initiative’⁴³ of the WHO, designed to reduce maternal mortality. However, by the beginning of the 1980s the national healthcare system of Guatemala began to restrain traditional healers, including midwives,⁴⁴ by banning them from practicing⁴⁵

⁴²Foster points out that ‘medical and health programs in developing countries’ supported by the U.S.–aided programs—but also other international or even national institutions—‘will be more successful if in design and operation they take into consideration the social, cultural, and psychological characteristics of the target group’ (ibid., p. 395).

⁴³The strategy included: (1) adequate primary healthcare and an adequate share of available food for females from infancy to adolescence, and universally available family planning; (2) good prenatal care, including nutrition, with early detection and referral of those at high risk; (3) the assistance of a trained person at all births; and (4) access to the essential elements of obstetric care for women at higher risk (Mahler 1987).

⁴⁴Since 1955 the Ministry of Public Health of Guatemala has had programs to train midwives, adopting the recommendations of the WHO towards a formal recognition of their practices in the national healthcare system. The policies of the training program, however, do not recognize practitioners who have not attended the courses, which renders their practices illegal. Instead of focusing on traditional birth practices, the premise is to refer the pregnant woman to a healthcare facility to avoid complications.

⁴⁵Periódico El Imparcial 11.06.1963; 10.04.1969; 13.02.1982.

(cf. Velimirovic & Velimirovic 1978).

The international studies were conducted to understand more clearly the effects of ethnomedical beliefs and practices as causal factors that underpinned the choice of healthcare and treatment, with the aim of facilitating medical research and public health interventions. However, according to Domínguez, ‘in this type of research there [was] no need to take into consideration either the welfare of the people or matters of adequacy and efficiency of the beliefs and practices studied’ (1983:268). Moreover, beliefs were oversimplified and detached from their cultural meaning. Until the middle of the 1980s, limited attention or consideration was given to the importance of cultural classification and meanings of illnesses. A major development in the health field and in the relationship between health and the socio-cultural frame was Villatoro’s book *Etnomedicina en Guatemala* (1984), which marked the beginning of the collaborative work on health-related studies (including professionals such as medical doctors, biologists, pharmacists, and historicists, among others) in the areas of public health, anthropology and pharmacy, setting a precedent in the development of medical anthropology studies (Mosquera 2007:235).

Of particular importance were the behavioural models that began to win acceptance among anthropologists with the use of KAP surveys to develop behavioural models of traditional healthcare. The 1980s also saw investigations of illnesses using health models and the publication of journals, bulletins, and magazines, such as *Tradiciones de Guatemala*, published by the ‘Centre of Folklore Studies’ at the Universidad de San Carlos de Guatemala (USAC). Additionally, institutions were created, such as the Center for Mesoamerican Studies on Appropriate Technology (*Estudios Mesoamericanos sobre Tecnología Apropiable*—CEMAT) and the Rural Enterprise Program on Medicinal Plants (*Programa de Empresa Rural de Plantas Medicinales*—ERPLAM). INCAP initiated an important movement in multidisciplinary research and provided a unique institutional base for social science research. Many investigators who started their work at INCAP continued their research at other institutions and produced important works focused on health systems, choice of treatments and therapies, ethnobotany, and many other areas.

After the militarisation of some health services during the civil war, and the constant presence of conflicts and violence in the country, the provision of healthcare and political/community participation changed.⁴⁶ The United States’ promotion of healthcare has resulted in short-term solutions that were supported by the temporary electoral success of particular political groups. However, the presence and

⁴⁶See Chapter IV.

interest of international agencies and other organisations created conditions for research related to the reduction of social disparities. These activities focused on ethnic and cultural diversity and exclusion, rural development, child survival programmes, and women's reproductive health. These actions reflect a framework in which health is supposed to be legitimised by a democratic system that focuses on and promotes community participation in health programmes, gender-focused research, understanding the variability in illness concepts, resource-poor healthcare management and the factors that influence the utilisation of healthcare services in a pluralistic medical setting (cf. Adams & Hawkins 2007).

With the aim of providing solutions to health problems, new anthropological and health-related research and published texts reflect at least three trends. One includes the state's functions and policies designed to comply with international health accords on the provision of primary healthcare and the impact of structural adjustment strategies on the provision of primary health programmes (e.g., NGOs supervised by the Ministry of Health and privatisation of health services) (cf. Badillo et al. 2009; Balsells 2003; Hurtado & Sáenz de Tejada 2001; Leatherman & Thomas 2009; Maupin 2008, 2009; Rohloff et al. 2011). These reforms are generally part of structural adjustment programmes introduced by international financial institutions to promote market-oriented practices. Low public expenditure on health, lack of transparency and corruption are all analysed in terms of their impact on healthcare. They are associated with the unsuccessful efforts of public health care that should be meeting the health needs of the population (cf. Danel & La Forgia 2005; La Forgia 2005; La Forgia et al. 2005).

A second group of studies is related to the impact of structural adjustment on health services delivery, such as immunisation programmes, improved sanitation and sanitary education, related to commitments contained in the Peace Accords signed in 1996 and in particular through the involvement of NGOs (cf. Becerill & López 2011; Arnold et al. 2009; Clifford 2009). A final group of studies focuses on health attention models and the specific needs of target populations. Here, diseases such as communicable, emergent (or resurgent), and neglected tropical diseases play an important role, where socio-cultural practices are likely to lead to acquiring infections. Some of these studies also address aspects of traditional medical healthcare related to curing practices (cf. Ángel 1993; Barillas 2005; Hinojosa 2004). In these studies, behavioural dimensions still focus primarily on cultural determinants of health-seeking models and disease-oriented aetiologies in order to reduce the incidence of preventable diseases as a part of the health or epidemiological transition (i.e., the shift in the major causes of death from infectious diseases such as diarrhoea and pneumonia to chronic and degenerative diseases).

The transformation that public health studies and programmes underwent in the 20th century has also captured the interest of the private sector in the form of partnerships with the government health sector, influencing not only methods of healthcare delivery and policies, but also high-priority health objectives.

1.9 Conclusions

Since the early 1980s, initiatives concerning maternal and child health have addressed the influence of the culture as factors that hinder the feasibility or acceptability of recommended projects. Consequently, programmes and interventions based on different behavioural theories have been put in place to bring about change in mothers' behaviours. Oral rehydration therapy (ORT) and the "Survival Programme" led by WHO/UNICEF to reduce the number of diarrhoea-related deaths among children under five, for example, had a major impact on the role of social and behavioural research in public health. Behavioural change models which targeted mothers or caretakers were therefore introduced to facilitate direct change. Whereas in the late 1970s and 1980s an implicit component of 'good practices' recognised biomedical models and standards as 'correct' behaviours under the umbrella of 'international health', during the early 1990s the orientation shifted to 'global public health' (cf. Adams et al. 2008; Biehl & Petryna 2013; Janes & Corbet 2009; Phillips & Verhasselt 1994). This led to continuous surveillance of infectious and emergent diseases to improve access to treatment, research that provided descriptive explanations about *beliefs* and practices to promote new behaviours.

There then followed the development of health-behaviour models and approaches that targeted the reduction of morbidity and mortality rates of preventable and neglected diseases, with special attention focused on pregnant women and children under five. The problematisation of prevalent illnesses, in the language of public health models, foregrounded some cultural behaviours, especially those based on *beliefs* and social dynamics, as negative influences on people's health and healthcare decisions. International and national programmes for disease control efforts have therefore advocated practices that are not always sustainable or suitable. The epistemological discourse of global health comprises a framework that expresses the purported benefits in terms of scientific understanding or knowledge (e.g., biomedical treatments, diagnosis, procedures, medical devices). This representation of healthcare seeks to transform certain local behaviours and case-management practices, considered to be high-risk, into 'targets', in order to provide 'optimal care' or expected outcomes based on 'required knowledge', instead of en-

couraging local beliefs that might influence patients to adhere to recommended biomedical healthcare paths and treatments. Health behaviour models and approaches in public health studies tend to characterize traditional illness beliefs as a ‘bad influence’ on healthcare behaviours.

Such models have been proposed and applied in health-related studies in Guatemala, explaining that the relationship between illness beliefs and healthcare related practices account for high cases of morbidity and mortality among children. Ethnographic data however, indicates that such beliefs take account of the ‘objective rational response’ to illnesses, which aim to maximize health outcomes. The insertion of ‘beliefs’ into questions of health is constantly viewed as an impediment in seeking biomedical care and as a source of medical complications. Since beliefs are cultural-based attitudes, illness behaviours rooted in a traditional or folk system are rejected as ‘limited-knowledge’. The questions of effective delivery of care and regulation of practices from a public health perspective have therefore only focused on the progression of the illness, without addressing the forms of ‘suffering’, local acceptance or resistance of treatments, social networks and values, and other social aspects that emerge from the interrelation between the illness and the social/cultural environment that houses these illness beliefs, which tend to override biomedical concepts of disease. Primary healthcare was used as a model for the changes required to implement a healthcare system based on standardised processes and goals. The perceived benefit was the creation of a healthcare organisation involving higher levels of community participation in its programmes in order to integrate ‘local perspectives’ and ‘empower local individuals’ into mainstreamed development discourses (Morgan 2006), to predict decision- and treatment-seeking behaviour, and to promote sustainable impacts.

Although public health policies and interventions have helped to make improvements, statistical evidence shows that many illnesses that were expected to be eradicated or controlled are still reported as endemic, including diarrhoeal diseases and respiratory infections. To facilitate planning and interventions in rural population, research design has tended to include and overuse different health-behaviour models to collect data on all the possible barriers to the success of such projects. One of the problems is that such models have minimised the importance of reflecting on cultural knowledge, the cognitive processes that affect individuals’ understandings and decisions about health, as well as the ways in which specific health behaviours are placed on other levels of life that are not an immediate part of the realm of health and illness. New interdisciplinary research trends based on interpretative frameworks have incorporated KAPs, EM or EMIC models, or have been influenced by these in their approaches and methods. They also address the

importance of socio-cultural structures that explain much of the contextual picture. While methods to analyse illnesses have been rapidly increasing, the elementary conception of culture and how it influences or shapes individual behaviour is built upon a rationality that tends to reduce individual acts to fixed practices, rather than fluid connections among groups and individuals. Moreover, the interpersonal relations that influence and enable decisions demonstrate that health behaviours are built upon ‘reflexive communities’ and rely on problem-solving strategies in everyday life. Yet the emphasis on beliefs has shifted the argumentation that folk-illnesses and illness beliefs follow a trajectory of unreasoned and risky arguments in decision-making.

Lash’s (2000) hermeneutical concept of ‘reflexive community’ reveals how individuals act towards specific decisions and actions and how and why they prefer some options over others within complex circumstances. It discloses particular ways of behaving, thinking and reaching decisions individually or among groups, suggesting micro-interactions conceived in a wider society at a particular place and time that is complex, social, practical and emotional (Lash & Urry 1994:316). Health-seeking behaviours should therefore be based on a similar reflexive approach. Within the realm of health care, Evil Eye’s uncertainty challenges reasoned arguments, reveals established practices, relates the reflexivity processes used in making decisions, and discloses relationships among patients and health providers that shape specific practices. This ‘reflexivity’ questions the assumptions of ‘ignorance’, ‘bad practices’ or beliefs, and enables us to open a discussion of how uncertainty points out deeper divergences in healthcare understandings and behaviours. Conceived in this way, a multiplicity of factors is critical for a qualitative analysis of the phenomenon of Evil Eye. These factors cannot be easily seen or addressed, since they do not constitute an explicit part of the frame-dependent choices and assumptions that tend to prevail when health decisions are made on the basis of accepted beliefs.

Therefore, it is doubtful that a single model can fully explain all the aspects that are part of the production of illness and health. Different models tend to highlight specific facets of people’s health burdens. Whatever the differences in their approach, the imperatives to ‘increase access’ to health or ‘enable specific interventions’ leave us with the problem of how the empirical data can be developed into effective implementation of interventions. Even when behavioural studies base their approach on a holistic understanding of health, they face the reductionist frameworks of the ‘donors’ priorities and funding decisions, as well global health evaluation schemes’ (Biehl & Petryna 2013:9). Furthermore, although the consequences of illness in terms of pathology are discussed, the non-pathology con-

sequences, such as questions of individual and family support and the implications of diagnosis and treatment, are rarely addressed.

The analyses of beliefs and specific culturally defined illnesses that are not addressed or regarded as relevant (in contrast to illnesses that have a potential pharmaceutical impact on their research or are highly virulent) suggest that the conceptualisation of ‘improvement in health’ remains related to a narrower domain of well-being and illness experience. As long as research frameworks evolve within the biomedical frame, it will be difficult to recognize that illnesses do not operate only according to ‘epidemiological scenarios’ but on an always unstable relationship among individuals, environment, disease vectors, and reservoir hosts. For example, previous studies using varying health-behavioural models have focused on the predictive correlations between beliefs about diarrhoeal and respiratory infections and healthcare practices. Among the rural population in San Marcos, beliefs in (super)natural causes of Evil Eye have been statistically associated with reports of diarrhoeal and respiratory infections. In these studies, quantitative analysis is employed to draw a connection amongst the components of an explanatory model. Quantitative associations for responses to these two illnesses are combined to report statistically significant results. Following this approach, Evil Eye, among other folk or culturally defined illnesses, is associated with specific symptoms, such as fever and chest pain, and connected to a p -value, showing the caretaker’s response to co-occurring diseases and symptoms. However, the rationale of such models includes Evil Eye within a *generalizability* theory, in which the symptoms are explained as a part of diarrhoeal and respiratory infections instead of representing a separate illness category. This focus excludes Evil Eye as a possible element in the decision-making process when choosing between treatments and health systems. The resemblance of symptoms between Evil Eye and other illnesses is therefore considered an example of ‘heuristic cultural fallacy reasoning’ when the question of why people treat the same symptoms differently arises.

Despite the promotion of biomedicine and standardised healthcare models by international healthcare organisations, traditional and popular medicine remains an important form of healthcare, especially within pluralistic medical systems. Folk illnesses continue to play a strong role in local perceptions as factors that influence child survival, especially in managing diarrhoea and pulmonary infections. Interventional programmes since the early 1980s have researched how mothers or caretakers utilize public health facilities, and how healthcare decisions are made. By assessing the mother’s knowledge and practices in these settings, we find that biomedical care is sometimes utilised prior to popular or traditional medicine, which is not the usual sequence. Furthermore, many mothers and caretakers cor-

rectly recognize symptoms for diarrhoea and respiratory infections. Additionally, traditional healers who are commonly sought out, in particular midwives, have specialised knowledge not only of folk illnesses but also of communicable diseases. However, in spite of high rates of infant morbidity and mortality due to diarrhoea and acute respiratory infections, this directs the focus on health-seeking behaviours and folk illnesses since these are correlated to the domain of treatment choices. The concern with culturally defined illnesses is that they are normally treated under a traditional healthcare model and do not necessarily follow standardised case management, resulting in an increased rate of complications. Further, even when international health standards regard particular interventions as essential, the mothers may have different health concerns and do not necessarily concur. Thus, the failure to apply standardised treatments for children with ADD and ARI is directly associated with the mother's behaviours. Still, mothers are encouraged to prefer the biomedical interventions when they are called for.

In the next chapter I contextualize the setting of the analysis associated with the phenomenon of Evil Eye and different aspects of health-seeking patterns within the context of medical pluralism, drawing upon all of the data collected in two municipalities of San Marcos, Guatemala. The analysis evaluates the theoretical conception of the interdisciplinary 'epidemiological and anthropological' research. It describes extensively the methodology of the problem within a public health study and the concern about health-seeking barriers at different phases and levels. It also explains the choice of this geographical area for study, based primarily on morbidity and mortality rates among children under five years old due to respiratory infections and acute diarrhoea. The resources and materials employed for the analyses in the chapter reflect the proposition that there is a need to ground health policies and recommendations on empirical information if available. It also reflects on how ethnomedical beliefs regarding a range of illness conditions remain a central point of analysis in order to understand people's predicaments when juxtaposing biomedical and traditional healthcare practices.

2 RESEARCH DESIGN

‘A questionnaire can ask about symptoms and evaluate disability, but it cannot get at the qualities of experience that are so deeply at stake in [a] family tragedy.’

— Kleinman & Seeman (2000:232)

2.1 Reflecting on concepts and meanings

This chapter describes the phenomenological ethnographic approach I used for the research on the ‘problem’ of health-seeking behaviors concerning Evil Eye. Evil Eye is perceived to be more common than other diseases that produce diarrhoeal and respiratory symptoms. This has implications from a biomedical perspective in terms of how the decisions made by caretakers to provide care for their children might affect the recognition of danger signs and keep the disease from becoming serious. Phenomenological research on Evil Eye means *aiming* my gaze towards experiences and health-seeking behaviors concerning Evil Eye, and drawing attention to the *meaning* of these experiences and the practices that surround them.

This can be done by initially focusing upon the emic (insider) perceptions and practices of recognition and treatment of Evil Eye, diarrhoeas and pulmonary infections which I describe below, and then moving forward to etic (outsider) concepts that link to other concepts within a different domain of people’s reality. An emic perspective is necessary in order to understand behaviors that might delay care-seeking for symptoms of acute diarrhoeas and pulmonary infections which appear to be similar to those of Evil Eye. Such a perspective should not regard health-seeking patterns influenced by illness beliefs as a barrier consequence, as previous research, health programmers and healthcare personnel have done. Instead there is a need to understand people’s perceptions of the aetiology of illnesses, recognition of symptoms, and experiences of being ill, as well as issues such as access to drugs (i.e., medicine-use behaviour), government roll-out programmes to encourage the use of health facilities, communication strategies, and power relationships, all of which are interconnected.

One of the limitations in previous research concerning Evil Eye has been the criteria of inclusion/exclusion of the characteristics selected for analysis. This orientation has depicted the illness according to its similarities, capturing or exploring aspects that appear to be alike among groups that make use of the concept—in other words, a strategy to elicit cross-cultural concepts. As a result, Evil Eye’s similarities are easy to find among groups or cultures, whereas the variety of experiences is normally not unfolded. For instance, fear of hospitals can be a non-verbalised concept specific to individual situations and thus represent a hindrance to seeking medical help as would be expected. For example, if we look only at the fact of not taking the child to the hospital when advised, we could interpret this as a ‘language barrier’ and a behaviour that is measurable but inappropriate (e.g., how often parents bring their children to the hospital when seriously ill after a reference at the primary or secondary level of care). Fear can be a subjective experience, but it is also triggered or influenced by contextual factors, which group themselves into ‘themes’ (healthcare models, family-power dynamics, etc.). Of course, this poses the problem that non-verbal communication is more difficult to grasp and interrogate, and easy to misinterpret or even ignore. Further, by eliciting ‘experiences’ we imply that they are ‘coherent’ and ‘objective’ rather than fragmentary and disjunctive (cf. Jackson 1996:42). But by approaching the ‘insider’s’ point of view we can understand behaviours that show the discrepancies between individuals’ statements and observed realities. Thus, an emic approach to Evil Eye locates the folk concept of the illness as central to other ideas and behaviors. By adopting this view, it is possible to elaborate how Evil Eye influences specific behaviours and experiences.

2.2 Understanding Evil Eye within a phenomenological approach

Phenomenology is concerned with the study of *lived experience* from the perspective of the individual, emphasising their own perspectives, interpretations or consciousness and its structures (van Manen 1997), which Heidegger calls “*being-in-the-world*” (cf. Spinelli 1989). The term *lived experience* draws attention to the individual’s lived situation and social world rather than the interior world of introspection. In order to take such a view, Edmund Husserl (1859-1938), the founder father of phenomenology, emphasised the need of ‘bracketing out’ our own experiences or the “natural attitude”. As a result, unlike ethnography, phenomenology does not produce “empirical or theoretical observations or accounts. Instead, it offers accounts of experienced space, time, body, and human relation as we live

them" (van Manen1997). Husserl's notion of phenomenology was to pursue the specificity of experience by looking at particular 'things' without theoretical pre-suppositions. In other words, 'to return to the things themselves, is to return to *that* world which precedes knowledge, of which knowledge always speaks' (Merleau-Ponty1962). The idea of *lived world* is that we exist in a day-to-day world that is filled with complex meanings which form the conditions of our everyday experiences. It includes subjective feelings, actions and interactions with values, goals, laws determining what actions and interactions are right and wrong, and unconscious biases as factors that drive perceptions, provoking people to make assumptions based on their own upbringing and influences (Barber et al. 2010).

According to Husserl, perceptions are formed through different orders of cognition, i.e. a pre-reflective self-consciousness and reflective self-consciousness, which can be distinguished by focusing upon what we access in our 'pure' reflection. Experiences, therefore, always involve these two processes. Husserl took a similar approach to mathematics, which is not based on empirical evidence but relies on postulates to reach its conclusions. Science and knowledge, according to Husserl, work on a similar foundation. Merleau-Ponty (1908-1961) takes up Husserl's approach but includes an important aspect of the idea of experiences. According to Ponty, 'consciousness' has no meaning separately from its self-givenness that is, mind and body are part of the same system, influencing directly how we perceive, understand and experience life. Thus, phenomenology is concerned with the problem of 'meaning' as a part of a whole experience which mediates between object (the world) and consciousness (ideas about the world), undermining the Cartesian mind/body dualism (Lavery2003). Husserl's phenomenology was subsequently taken up by his student, the philosopher Martin Heidegger (1889-1976), who developed a theory of hermeneutic phenomenology. This differed from Husserl's approach, in that it takes experience and its interpretation as the point of departure. For Heidegger, in contrast to Husserl, it is impossible to separate our lived experience of the world from the historical context in which we encounter it (Lavery 2003). This he conceptualised as *being-in-the-world (Dasein)*, where experience and things are mediated by, and thus are a *product of*, one's specific position or background. The world is therefore interpreted by individuals, rather than pre-reflexively experienced.

In this sense Schütz argues that 'the thought objects constructed by the social scientist, in order to grasp this social reality, have to be founded upon the thought objects constructed by the common-sense thinking of men, living their daily life within their social world. Thus, the constructs of social sciences are, so to speak, constructs of the second degree, that is, constructs of the constructs made by

the actors on the social scene' (Schütz 1962:59). Here, Schütz aligns the process of knowledge construction with an objective, scientific approach. It is his view that the researcher should objectively classify and analyse, in order to interpret people's common-sense 'recipes'. However, different from the natural sciences, Schütz also proposed the notion of first- and second-order constructs in research on "self-reflecting humans" (Aspers 2009). First-order constructs refer to the common-sense thinking of research participants: how they make sense of the world around them. Social scientists' interpretations of these first-order constructs are thus second-order constructs (idem 2009). Schütz also argues that it is important for the researcher to initially forgo his own familiar frameworks of reference. This is how one avoids interpreting phenomena along the lines of "thinking as usual" (Schütz 1944:502), where one understands the research topic in the context of one's own, rather than others', understanding of the world.

According to Schütz (1944), the investigator must act as a disinterested observer, with the intention of obtaining *knowledge* about people's taken-for-granted behaviour, rather than necessarily integrating himself within their 'world'. In interpreting the phenomenon of Evil Eye, then, it is only *through* these first-order constructs—entering the 'world' of those involved in the process of illness and care—that would allow me to entirely understand the research problem. According to Peltó & Peltó (1997), an integrative use of the concept of belief/knowledge is necessary to overcome the idea that a behaviour is only a potential threat or obstacle for individuals whose perspectives or actions rely on "non-objectively true, universally applicable or empirically verified" acts. According to this, folk-belief concepts are practical knowledge. It is through the experience of examining and interpreting such 'worlds', i.e., experiences, that the researcher must also acknowledge his own position and its influence on the study, in a reflexive research process. Gadamer (2004) emphasised an ongoing process of interpretation as the key to understanding the world through two 'senses' of interpretation. Firstly, interpretation is about accentuating what is already there, but which may be concealed in its everyday appearance. Its second level involves interpreting the meaning that we have revealed (van Manen 1997). Accordingly, there is a limit to narrative understanding, since all explanation is ultimately interpretation, because in describing the world and its objects we have already mediated between it and ourselves (cf. Zahavi 2007). Hence, the difference between *beliefs* and *knowledge* in the realm of illnesses and healthcare should be understood as forms of representation, reflection and selective behaviours. While *knowledge* 'is detached from disembodied objectifications of disease, patients, nature and much more' (Johannessen 2006:5), which is a significant part of biomedical discourses and practices,

beliefs are meaningful embodied experiences that include (inter)subjective aspects (e.g., emotions, expectations, status, values, family and social dynamics, etc.) of individual and collective significance in the frame of illnesses; these beliefs elicit not only awareness of and responses to the illness' symptomatology, but also more complex dynamics.

Decision-making processes and practices connected with illnesses are influenced by family and social dynamics which frequently make healthcare responses uncertain. In addition, decisions and expectations are not exclusively 'objective' but constantly influenced by factors 'on the hoof', meaning that they involve arguments that cannot be measured by the quantitative data in which facts are an 'objective entity'. According to Napier and colleagues 'emphasis on data more than basic human interaction—at home, with neighbours, or in clinics—contributes not only to devaluation of personal meaning, but also to widening of health disparities' (2014:1626). This way of researching fits within a phenomenological epistemological approach, enabling rich insight into the sense-making practices of those involved with health-seeking processes when their motivation is Evil Eye. This implies that while the concept of Evil Eye might be more or less 'standardised', the practices are more dynamic and have a particular meaning to a particular socio-cultural group. Experiences with Evil Eye are therefore of primary importance, because they penetrate into specific models and structures of thinking and acting, common to the experience of a group. Some folklorists, like Dundes (1992), regard folk concepts as unconscious, overlooking the fact that all actions are purposive even if people lack awareness of their motivation.

In an analytical sense, a comprehensive inquiry into the symptoms of Acute Diarrhoeal Diseases (ADDs), Acute Respiratory Infections (ARIs) and Evil Eye needs to link the three types of illness together. An attempt to make artificial and fragmentary conceptualisations of concepts or categories, especially those called 'Western medical' and 'traditional' systems, means to assume that there are "clear" or "pure" realities. Moreover, the categorical designation of 'sick' or 'healthy', 'biomedical' or 'native', implies a rigid dualistic notion of each medical orientation and its associated aetiology and behaviors. Yet, behaviours are the result of designations and settings, resulting in perceptions and choices that are more complex than such a dualism permits. It is therefore important to understand what people mean when they use these designations, since these diseases cannot be adequately studied if we focus on one category or another and ignore their reciprocal influences, not only with respect to their social-cultural process but also on their biological nature.

Making use of an interpretive phenomenological approach I sought to reflect on

the *meaning* of Evil Eye in the rural area of San Marcos. This interpretive framework enabled me to examine the effect of the production of biomedical knowledge, the relationship of models and institutions of healthcare and agreed-upon national/global health initiatives on the specific socio-cultural context of Evil Eye. Using the concepts of knowledge and beliefs in the realm of health and health promotion-interventions within a phenomenological frame, I discuss the inter-relationship between models of healthcare, concepts and perceptions of diseases, and illness actions in response to cultural representations of Evil Eye, acute diarrhoea and respiratory infections as life-threatening, in order to improve our understanding of health-seeking behaviours and predicaments. Theoretical models often used in public health interventions (e.g., health belief model, theory of reasoned action and planned behaviour, etc.) usually address particular health behaviours as problematic in particular populations or settings, yet the evidence of this research shows that public health discourses and interventions tend to blur and marginalise specific local understandings and practices that engage with social relations and bounds, which are important in the provision of healthcare. Additionally, public health approaches are based on specific medical sceneries, health institutions and discourses. The ideas of illness, treatments, deviant behaviour and interactions between patients and their healthcare providers that these institutions and discourses support, always influence the production of knowledge and beliefs, yet health behavioural theories tend to reduce the multiple determinants and levels of health to treatable ailments or follow a treatment regime valued as ‘adequate’ or ‘right’.

By incorporating a phenomenological perspective on illness experiences, we can understand how conceptual frameworks of social and behavioural theories, relevant to public health interventions and medical anthropological debates, allow us to discern the growing number of health-related issues that have an impact on perceptions and practices, that otherwise remain invisible. The phenomenological approach acknowledges how theoretical orientations link different aspects of health and illness that develop among, contest, or support economical, political, social and environmental factors, which create different ideas, perceptions, meanings and practices of healthcare.

2.3 Setting

According to the National Institute of Statistics (INE), Guatemala is the most populous and densely inhabited country in Central America. It has a population

of approximately 15.44 million as of July 2014,¹ an annual population growth rate of 2.5%, and an average population density of 132 inhabitants per km² (ranging from 1,460 inhabitants per km² in the City to only 17 per km² in El Petén).² Guatemala has one of the highest violent crime rates in the Americas, which has a direct correlation to health. Life expectancy for men in 2010 life was 70 years, compared to 65.8 years for women, the second lowest in Latin America.³ Even though Guatemala has the largest economy in Central America, its rural and largely indigenous inhabitants live in poverty, politically and socioeconomically excluded as a result of their ethnicity, linguistic and geographical isolation, and high rates of illiteracy.

Today, the indigenous population accounts for approximately 50% of Guatemalans. It is composed of 23 officially recognised linguistic groups, the most prominent of which are Kaqchiquel, Mam, K'iche', and Q'eqchi'. A 2002 census determined that the last three groups constituted 81% of Guatemala's indigenous population. While the non-indigenous population is distributed across all social classes, the great majority of the indigenous population is concentrated at the bottom of the income distribution (Gragnotati & Marini 2003:12). In 2011, 69.5% of the indigenous inhabitants (15.2% of the total population) were living in extreme poverty on less than USD1.25 per day, which directly contributes to the prevalence of malnutrition in rural and indigenous communities (Varité 2012:7). Indigenous women account for 73% of all maternal deaths in Guatemala, and they are two times more likely to give birth without the assistance of a doctor, compared to non-indigenous women (CESR & ICEFI 2008:3).

Although the maternal mortality rate has declined recently (from 120 deaths per 100,000 live births in the 1990s to 81 per 100,000 in 2010), it remains one of the highest rates in the Latin America and Caribbean (LAC) region (Lao Pena 2013:1). High levels of adolescent pregnancy are also a significant problem and are linked to perinatal health risks, hindrance to schooling, social exclusion and discrimination for the future mother and child (cf. ECLAC & UNICEF 2007). Due to the impoverished conditions, the indigenous population is greatly afflicted by viral diseases such as influenza, measles, dengue and malaria. ARIs, ADDs, tuberculosis (TB), and hepatitis, among other diseases, are exacerbated by widespread chronic malnutrition. Additionally, residents of tropical and subtropical areas are at risk for trypanosomiasis, leishmaniasis, onchocerciasis and cysticercosis (OPS/OMS 1993:67). Government investment in health infrastructure and technology is low,

¹http://www.prensalibre.com/noticias/comunitario/Poblacion-sumara-22-millones-2030-GuatemalaCentroamerica_0_1289871003.html (accessed on 22.01.2015)

²Ministerio de Ambiente y Recursos Naturales; Información Poblacional de Guatemala 2010.

³<http://www.hrw.org/world-report-2012/guatemala> (accessed on 11.11.2014)

resulting in poor quality of healthcare. According to the PAHO more than 50% of the Ministry of Public Health hospitals in Guatemala were built more than 35 years ago. In contrast, the private health sector provides better care, but at elevated costs that few people can afford (OPS 2007:42).

2.4 San Marcos

San Marcos is one of 22 departments in Guatemala, with a total territory of 3,791 square kilometers. It has an estimated population of 1,095,997, and 29 municipalities.⁴ It is situated 7,868 feet above sea level, in western Guatemala, adjacent to southern Mexico of which 60% are indigenous, mainly Mam and a small number of Sipacapenses, who suffer higher levels of extreme poverty. The under 5 years mortality rates is likely to be considerably higher in rural areas of San Marcos, particular those with a high percentage of indigenous population. The Department is located in the Western Highlands which also includes the Departments of Quiché, Alta Verapaz, Sololá, Totonicapán, Quetzaltenango and Huehuetenango. Climate varies widely throughout the area, and the elevation ranges from sea level to high mountains. The Department of San Marcos presents many challenges, including organised crime and drug trafficking. The main uses of land in the area are coffee cultivation, palm oil and banana plantations, gold and silver mining, and illegal poppy plantations. Unequal distribution of land contributes to high levels of poverty, and thus to high rates of child malnutrition and child mortality. The two most important causes of death in children under 5 years are pneumonia and diarrhoea and malnutrition greatly increases the risk of mortality.

Government health services are administratively organised in 22 health districts, which contain 102 health facilities: 20 health centers and 82 health posts. Most municipalities have at least one health facility, and the larger municipalities have more: San Pedro Sacatepéquez (7), Tejutla (7), San Marcos (6), Concepción Tutuapa (5), Tacaná (5) and Tajamulco (5). These healthcare entities provide services to an average of 8000 inhabitants each. There are 2 hospitals, one located in the town of Malacatán and one in San Marcos, the departmental capital. Some health districts, including Comitancillo, Concepción Tutuapa, Tacaná, El Tumbador, Malacatán, Ayutla, San Pablo and Ixchiguán, provide healthcare to between 10,000 and 20,000 inhabitants. The health services in the remaining municipalities serve fewer than 10,000 inhabitants. The average distance to the nearest healthcare service throughout the department is 8.81 kilometers. However, in some cases, such as Tajamulco, Tuiquiac and La Vega Suchiate, the average distance to the

⁴Instituto Nacional de Estadística de Guatemala www.ine.gob.gt

nearest health facility is 38 kilometers. Health posts frequently lack medicines and other essential equipment.

2.5 Methodology

A methodology is more than a set of rules and methods. Its aim is to provide the necessary reflection that leads the investigator to question the apparently objective validity of some type of knowledge (cf. Barber & Nenon 2010:7). In the life-world, a person's consciousness is always directed at something in or about the world. When we are conscious of something, we are in a relation to it and it 'means' something to us. Therefore, the subject and object are connected together in a reciprocal fashion. This is an imperative phenomenological concept termed *intentionality* and it is a key focus for this research. The researcher's aim is to explain this intentionality related to the directedness of subjects' consciousness: what they are experiencing and how. The phenomenologist van Manen (1997) points out that there are specific ways of doing a research project which lend themselves to a phenomenological approach. He argues that the methodological choice that is made, and thus the methods that are employed, need to reflect the concerns of phenomenology, which 'tries to ward off any tendency toward constructing a predetermined set of fixed procedures, techniques and concepts that would rule-govern the research project' (van Manen 1997: 37).

In order to arrive at an ethnographic methodology based on a phenomenological approach, my findings unfold from their empirical materials, i.e., the experiences of the participants, rather than being based on theories that explain these experiences. Phenomenological theorists argue that there are certain essential features of the life-world, such as a person's sense of selfhood, embodiment, temporality, spatiality, sociality, project, discourse and mood-as-atmosphere (Ashworth 2003). These interconnected 'fractions' operate as a lens through which we examine our data. Thus, researchers should elucidate these dimensions and explain the full structure that is socially shared (cf. Dahlberg et al. 2008:37). In this connection, van Manen suggests that a 'phenomenological understanding is distinctly existential, emotive, enactive, embodied, situational, and non-theoretic; a powerful phenomenological text [that] thrives on a certain irrevocable tension between what is unique and what is shared, between particular and transcendent meaning, and between the reflective and the pre-reflective spheres of the life world' (van Manen 1997: 345).

Employing a phenomenological methodology, therefore, involves looking at different places and parties to represent the multiplicity of the phenomena. In relation

to Evil Eye and health-seeking patterns these places and parties encompass, among others: patients, mothers, other family members, health providers, and health institutions. I have adopted an ethnographic approach to address the phenomenon of Evil Eye in a way that a quantitative approach would not allow. It widens the examination of the ‘problem’ to encompass the perspective of different actors, such as the caretakers, families, and health providers. As outlined in the research objective, the original focus for the study was health-seeking behaviours, and the meaning(s) attached to this illness. The healthcare practices in relation to Evil Eye were to be elucidated by starting with the process of perceptions and healthcare decisions. In the next part of the methodology section, I detail the ethnographic approach to Evil Eye, how I went about accessing this concept, and the methods I employed to conduct the research.

My research employs multiple methods: participant observation, scratch/field notes, informal and semi-structured interviews and narratives (interview narratives and in-depth narratives). I explored how the phenomenon of Evil Eye not only constitutes a threat from a biomedical lens, but a possibly an opportunity to confront the paramount reality of everyday life and illness experiences. Throughout my inquiry into cultural health-related practices, I seek to understand and explore what the phenomenon of Evil Eye and its relation to ARIs and ADDs can tell us about local healthcare-seeking behaviours and subsequent outcomes. Furthermore, I will discuss how the professionalisation and rationalisation of biomedicine, even when it recognises societal influences upon health, fails to fully understand what is at stake in people’s lives. I examine the idea of ‘risk’ implied in biomedical terms and in the subsequent particularities of people’s medical choices, including culturally defined illnesses, as a reference to health-seeking behaviours. I deliberately make use of the concept of ‘illness belief’ as something that contains knowledge, yet is in constant conflict with biomedically defined diseases. The epistemological reflection of Evil Eye as an illness concept refers to objective attainments, entangled with folk ideas and different types of knowledge, including biomedical understanding.

In subsequent chapters I will provide information that considers the phenomenon of Evil Eye as an epistemological predicament open to different systems of medical domains (allopathic and traditional), linked together but also contained within certain boundaries. Research concerning Evil Eye in Guatemala lacks an in-depth emic or contextual rationale. Hence, different methods will be used in order to give people the opportunity to talk about their own perceptions and practices—behaviours that are frequently viewed as problematic by epidemiologists and medical personnel when they result in inadequate or inappropriate health decisions.

In order to achieve this, I will make use of an *interpretative approach*,⁵ utilising diverse ethnographic sources of mothers and caretakers who were part of the ACCESS⁶ study as the original source of my research. I employ a critical cultural phenomenology framework, which involves looking at people's 'lived experience' of Evil Eye, emphasising the social context, e.g., meaning and roles, that shapes an individual's orientation towards an illness, together with the health policies and socioeconomic framework that directly affect the inequities in health outcomes. Emic concepts develop from data initially obtained through etic research. For example, quantitative data showed that symptoms of ARI and ADD were associated with the concept of Evil Eye. The anthropological approach focused on Evil Eye (its characteristics, development, context, and outcomes) and traced the way in which this illness belief relates to healthcare and influences these two illnesses as they are locally defined and understood.

A three-year epidemiological study in San Marcos, in which I took part during the final year, concluded that Evil Eye appeared to increase the risk of serious morbidity and increased mortality for some diseases, including ARIs and ADDs,⁷ the two leading causes of child mortality (UNICEF 2013a). Patterns of care-seeking and patient management, where Evil Eye is involved, directly influence treatment decisions. Since symptoms of Evil Eye are consistently viewed as having both biological and social-cultural origins,⁸ the multiple attribution of symptoms

⁵Interpretive studies assume that people create and associate their own subjective and intersubjective meanings as they interact with the world around them. Interpretive researchers thus attempt to understand phenomena through accessing the meanings participants assign to them' (Orlikowski & Baroudi 1991:14). Moreover, an interpretive anthropology allows an understanding of how people perceive illnesses and how emotions shape their decisions. As a part of a family member, community and society, this *intersubjectivity* is of course intrinsically interlinked with micro and macro levels, which play a role in the constitution of a conceptual framework for understanding illness.

⁶Between 2007 and 2010 the Division of Public Health at the University of Liverpool worked on a project called "Improving Child Survival through Enhanced Understanding of Barriers to Healthcare Access in Rural Guatemala"(ACCESS for short) in the Department of San Marcos in order to 1) investigate pathways through care (all providers), and the reasons behind these pathways, for cases of ARI and ADD and for maternal care (pregnancy, delivery and post-partum); 2) identify which social, economic, cultural, and related factors are the principal determinants of care-seeking for childhood illness; 3) conduct mapping and assessment of healthcare provision for children and pregnant women/mothers; 4) describe providers' perspectives on reasons for low uptake of healthcare among children under5 and for maternal care; and 5) engage with communities and health service stakeholders (local and national) to feed back the findings in order to inform practical measures and policies for improving access (Bruce et al. 2011).

⁷Though the mortality rate for children under five suffering from acute diarrhoea has fallen from 4.5 million deaths annually worldwide in 1979 to 1.6 million deaths in 2002, acute diarrhoea continues to exact a high toll on children in developing countries (WHO 2004a).

⁸Similarly, studies of malaria in Africa report that in local perceptions, seizures were not recognised as a consequence of malaria, but rather attributed to supernatural agents which require treatment by a traditional healer; alternatively, malaria is sometimes understood as a consequence of the heat from the burning sun (Idowu et al. 2008; Makemba et al. 1996; Okeke et

frequently leads to problems of diagnosis, affecting therapy decisions and becoming a source of tension in the dialogue between biomedical and traditional forms of medicine.

Within an interpretative approach, cultural and symbolic perceptions and practices have an exceptional position in generating particular forms of treatment linked with diseases, ‘creating the form the disease takes’ (Kleinman 1973:209). Effectively, the ‘embodied’ illness is ‘existential ground of culture and self’ (Csordas 1994a). This is, how people make sense of their world, how they understand and perceive what they experience and what they do (Benner 1994). This approach is strongly influenced by Clifford Geertz’s notion of ethnography as “thick description” (1973). Therefore, adopting a phenomenological perspective for this study permits a focus on how people make sense of illness experiences regarding Evil Eye, ADDs and ARIs, the practices they employ in the process of recognition and treatment, and how these illnesses fit within the cultural context.

In this regard Finerman (1989) states that it is an error to distinguish any health system as “traditional”, since medical systems undertake continuous transformation. From a theoretical perspective, we need to understand that the category of Evil Eye is not a stable entity, but is constantly negotiated through different dynamics, economic and social contexts, healthcare entities, family relationships, and medical systems. These aspects create spatial-temporal hierarchies with the aim of finding a cure for the illness at hand. During the early 1980s this hierarchical approach to therapy management unfolded along the axis of healthcare therapies and relational dynamics. Young and Garro (1981) termed this the *correlational paradigm* and the *decision-making approach*, which became widely used by scholars to analyse treatment choices. *Correlational paradigms* focus on the outcomes of the decision process, where medical choices are linked with the patient’s attributes or the disease’s features (Young & Garro 1981:129; Módena 1990). They seek to establish a relation/association between variables, namely, the elements or features of people who are making choices and the attributes of the illness. These key variables are seen to be related, and influence people’s decisions about where to go to seek help. This focus drew particular attention to the ways in which correlational factors, such as ethnicity and the inclination to use specific therapies or treatments were related to risk in the decision-making process. The intention was not to blur how other aspects are implicated in the decision-making process, but by implicitly establishing specific aspects, such as ethnicity, as risk factors, it reinforced the link between cultural practices and perceptions and detrimental health behaviours (cf. Lock 1993; Nichter 1996, 2002).

al. 2006).

At a concrete level, the problem is not labeling the illness as Evil Eye, ARI, or ADD, but the cultural consensus that needs to be reached for a decision on treatment, and the social and biological implications of such strategies. Therapies are embedded in experiential categories and spiritual or religious practices, rendering the ailment not as a state, but as a more fluid domain (cf. Lewis 2002; Leyn 1999). Thus, health behavior is always “rational” in terms of the cultural context (cf. Nichter 1989). This orientation is important when examining the phenomenon of Evil Eye in order to understand how people adapt to their environment and explain how their lives and their bodies are affected by organic, i.e. biological, and social events (cf. Csordas 1994a, 1994b; Oths 1994, 1999).

Phase One

The field research took place during a period of around sixteen months, divided into two phases in 3 municipalities in the rural western highlands in the Department of San Marcos. San Lorenzo (high proportion of Ladino, Spanish-speaking) is 35 kilometres from the town of San Marcos (the departmental capital, and about 45 minutes distant by road), and Comitancillo (predominantly indigenous, Mam-speaking) is 30 kilometres farther north with a population of the Mam-indigenous group. Both areas are high (above 2,500mts), poor, and rely mainly on subsistence farming. San Lorenzo, however, is somewhat more developed in terms of infrastructure, with a higher proportion of Ladino inhabitants who are more acculturated to the Spanish-speaking culture.

Carried out jointly by the Universities of Liverpool and Del Valle de Guatemala a population-based survey was conducted twice from 2008 to 2009 among 1605 households in these communities with children younger than 5 years. A 14-day retrospective interview recorded recent episodes of pneumonia and diarrhoea, and availability of formal and informal healthcare options. Qualitative research was based on some of these cases and focused on mother’s perception of their children’s health status. Initially, in more than 70 in-depth interviews, I focused on specific cases identified in the 14-day retrospective interviews. The first 9 months, between February and November 2009, were dedicated to a general survey of specific illnesses, their diverse connotations, and the impact that perceptions of illnesses identified as ADDs, ARIs and Evil Eye have on treatment decisions. During the second period, the 5 months between August and December 2011, I conducted extensive interviews with traditional healers, midwives, and caretakers who were not part of the ACCESS survey. It was important to compare data from rainy (April to October) and dry seasons (November to March), since climatic conditions affect the prevalence of cases of ARI and ADD and, by association, cases of Evil Eye.

The assumption of a correlation between cases of ARI, ADD and Evil Eye turned out not to be true, as Evil Eye was constantly mentioned during both seasons, although with some differences in its symptoms and their interpretation.

When I arrived in San Lorenzo, I joined the ACCESS study group in the project which had been underway since 2007. The objective of the study was ‘to understand better the reasons for low uptake of medical care for critical childhood diseases in rural Guatemala, and work with community and service stakeholders to initiate change at local and national levels’ (Bruce et al. 2011:17). In addition to the collection of quantitative data, the project required the adoption of qualitative methods, in order to better understand the various ways in which people make sense of their illness experiences (e.g. how they understood symptoms, how they related these to ‘disease’ concepts and treatments, when do they make use of healthcare facilities), rather than focusing solely on the actual *diseases*. Initially, I made use of quantitative surveys (survey of sick children) to locate cases of ADD and ARI where the children displayed WHO danger signs.⁹ This first phase was exploratory, to better understand the local terms and references regarding symptoms and health-seeking behaviours. All interviews were carried out in Mam or Spanish, depending on the preference of the mother; in some cases, a mix of Spanish and Mam was used.

Based on the results of the first phase, a semi-structured interview schedule was developed. Topics covered during the interview included illness recognition, healthcare-seeking behaviour, and recovery. The interviews did not have a linear character, but examined health-seeking behaviours in general, so caregivers often made reference to other episodes of illness, referring to a wide range of different so called-barriers, critical moments and facilitating factors. The interview had three phases. The first phase was exploratory, to identify the *key issues* from the caregivers’ perspectives in regard to the illness. The second phase moved on to examine caregivers’ *practices* in relation to care seeking. This part included possible concerns, situations and predicaments related to caregivers’ or families’ situations that played an important role in the decisions taken. The final phase attempted to bring together the various aspects of the caregivers’ stories, exploring those aspects that appeared to be contradictory or incomprehensible. It included a discussion of any

⁹“General Danger Signs” were defined and recognised according to the WHO guidelines. They include symptoms common to pneumonia and diarrhoea, among other severe illnesses, such as “inability of child to suckle or drink”, “convulsions”, “lethargic or unconscious” and “vomiting everything”, while two were specific signs of severity for each illness. Specific signs for pneumonia were “fast breathing” and “lower chest wall indrawing”. For diarrhoea, they were “blood in stools” and “sunken eyes” (WHO 2005a Handbook—IMCI—Integrated Management of Childhood Illness).

previous experiences of illness and care seeking, and how this might have been related to the most recent episode.

I tried to encourage people to elaborate and provide more details about the development of the illnesses, but I found the responses convoluted, which in turn detracted from the clarity of my understanding of their responses. I started to sense an element of ambivalence in their attitude, as if I were pointing out an ‘undesirable’ behaviour by ‘questioning’ their responses. I changed the order of the questions to enable the interviewees to be more open about health-seeking behaviors, flipping through the questions backward and forward for clarification. With this method, people revealed more sensitive aspects of events, which was particularly helpful for identifying multi-dimensional aspects of the problem. An example of this is when the interviewee began talking about issues that seemed ‘outside’ of the event, but were relevant (even if this was not immediately evident), such as ambiguity or conflict between self, family or healthcare facilities.

Alongside this new strategy, I also decided to ‘follow the development of the illnesses’ by accompanying caregivers when they took their children to the post or health center, healer or midwife, or when they sought help at the local pharmacy. This process also required a post-visit to follow the sequence of the events. This follow-up created additional closeness to the caregivers, which gave me the opportunity to talk about what was at stake for them. However, following the ‘problem’, rather than the ‘outcomes of the disease’, introduces the dilemma of intrusion, which might seem distorting or exploitative (cf. Hughes 1996). Consequently, I only followed a few cases where the caregivers accepted my accompanying them, especially if the visits were to the health center.

Another activity during the first phase was exploring the perspectives of different community actors regarding recognition and treatment of ARIs, ADDs and Evil Eye, to better address the socio-cultural perceptions within the communities and elucidate subjective experiences (cf. Barbour 2008). For this purpose, I conducted interviews focused on health-seeking behaviours. This method enabled a critical approach to what appear to be ‘significant aspects’ of people’s experiences within their communities, aspects that express *systems of representation*, ‘an essential part of the process by which meaning is produced and exchanged between members of a culture’ (Hall 1997:15). These interviews made it clear that Evil Eye is used as a concept that relates to a set of ideas, interpretations and actions, establishing complex relations between individuals concerning healthcare practices.

Mid-fieldwork

Important risk factors for ARIs and ADDs in rural areas of San Marcos include problems that are undoubtedly related to poverty, such as undernutrition¹⁰, household indoor air pollution, poor sanitation and inadequate clean water, all of which increase susceptibility and environmental exposure to diseases. Some of the interviews showed that, while pneumonia and diarrhoea were the primary causes of death, undernutrition was frequently a contributing factor. As has been noted, ‘mortality, as well as physical and moral debilitation of the population, rise in direct proportion with impoverishment’ (Virchow 2010:48).

These dimensions dominate the specific moments of life that constitute episodes of illness. They are incorporated into two broad, coexisting realities: one based on objectivity and one on subjectivity. People’s interactions (with each other and with the two realities) continuously influence reality; this in turn influences people’s perceptions, resulting in *routinisation* and *habitualisation* of behaviours (cf. Berger & Luckmann 1991), including the behaviours associated with illnesses. However, the disassociation between emotions and diseases that characterises the “objective” reality emphasises the point that “biomedicine by definition focuses on the biological aspects of sickness and relies on the scientific paradigm of investigation to visually observe diseases” (Loustaunau & Sobo 1997), ignoring the more subjective aspect of ‘suffering’, which is more difficult for an outsider to understand. The stories of illness that I obtained elucidated aspects of practices and experiences surrounding ailments that would otherwise have been disregarded. Eliciting those stories or narratives, and recognising their value, enhanced the theoretical importance of this method. Narratives express the extent of relationships and emotions that are involved in people’s decisions and the ways in which the expectations of the health system affect these decisions. Even when the information was fragmentary, experiences proved that the quantitative data alone did not necessarily confirm or validate the reasons people gave for making one decision rather than another. According to Tyler, ‘a post-modern ethnography is fragmentary because it cannot be otherwise. Life in the field is itself fragmentary, not at all organised around familiar ethnographic categories such as kinship, economy, and religion. . . nor do particular experiences present themselves, even to the most hardened sociologist, as conveniently labeled synecdoche, microcosms, or allegories of wholes, cultural or theoretical’ (Tyler 1986:131, in Pool 1994). The influence of factors such as power relationships and gender differences are examples of influential conditions that often are not measured in quantitative surveys. Nevertheless, they are important to

¹⁰ *Undernutrition refers a poor nutritional status, but also implies underfeeding. Is caused primarily by an inadequate intake of dietary energy, regardless of whether any other specific nutrient is a limiting factor* (Shetty 2003:18).

gain an understanding of some health-seeking decisions.

The collection of narratives allowed me to ‘search for regularities in how people, within and across cultures, tell stories’ (Bernard 2011:416), and to better understand health-seeking practices, since through narratives ‘we come to know, understand, and make sense of the social world. . . and constitute our social identities’ (Somers 1994:606-607). Caretakers were able to elaborate details of previous illnesses, which revealed how social conventions and cultural practices mediated their responses and highlighted how expectations, power relationships and emotions influenced their decisions. Occasionally, responses were tailored to what the interviewee thought I was expecting to hear. Another problem which proved difficult to avoid occurred when attempting to obtain the ‘whole picture’ of the development and outcome of an illness. This is not only because mothers choose what to tell me, but also because some details are forgotten (even if they are intrinsically close to the source or development of the problem), are labeled as unrelated, belong to the unconscious mind, or are in certain contexts ‘obvious’ to the interviewee, even if they are not obvious to the researcher. Illness narratives showed that many of these omitted aspects deeply shaped certain outcomes. It is clear that when dealing with prolonged ‘silences’ or gaps of information, quantitative surveys struggle to handle dynamics that are not represented within the ‘story telling’.

A broader life-story of the child illnesses framed the particularities of this phenomenon, displaying the impact of people’s perceptions, opportunities, knowledge, and outcomes. The general structure included the origin of the illness and how it developed, the process of care-seeking, and the caregivers’ perceptions of the effectiveness of care received. In-depth narratives complemented the verbal autopsies,¹¹ which were carried out using standard WHO methods to explore in greater detail the sequence of events that led to the death of the child. This study also suggests that perceptions of health and illness are more complex than

¹¹Verbal Autopsy (VA) is an instrument designed by the WHO for all age groups, covering deaths caused by injuries, and maternal and perinatal deaths, as well as illnesses, becoming ‘a primary source of information about causes of death in populations lacking vital registration and medical certification. [It is] an essential public health tool for obtaining a reasonable direct estimation of the cause structure of mortality at a community or population level, although it may not be an accurate method for attributing causes of death at the individual level. It recollects information based on users’ feedback and further evidence from the field as a method to ascertain the cause of a death based on an interview with next of kin or other caregivers. The users are asked to share the information collected in their VA in a way that allows assessment of validity and feasibility of the questions in the field’ (WHO 2012: Verbal Autopsy Standards; NLM classification: QZ35). In 2012 a new VA was developed by the WHO in which some of the conditions and questions have been eliminated or reformulated to enable responses with an easy yes or no answer. However, during the time of the research the 2007 VA version was used.

the simple dichotomy that exists between traditional¹² and biomedical systems and treatments, and contradicts the general hypothesis that economic resources always limit peoples' options and actions; people seek health options even when the cost for treatment constrains other spheres of their lives. Moreover, the community does not necessarily prioritise one healing system over the other and folk remedies are not necessarily perceived as being more efficient than pharmaceutical treatments. However, when communities access the biomedical system they do not make reference to traditional therapies, as they feel silenced by the system. The rural population is aware of the unequal coexistence between the systems and therefore negotiates mostly among themselves which regimen to follow.

However, there is a large problem in the widespread use of pharmaceutical medicines, mostly due to a lack of regulation. Treatment efficacy is a concept that, in experience, is interrelated with a multiplicity of factors and expectations. In the case of biomedical treatments, 'efficacy' is defined as immediate results. In traditional or folk medicine, efficacy may include the use of other resources not necessarily symptom-related. Traditionally, medical systems have not made a distinction between healing efficacy and provision of meaning for the personal and social experience of sickness. Efficacy, itself, is a cultural construct. The healing dialectic has been considered effective when the bonds between the sick individual and the group, weakened by disease, are strengthened, social values reaffirmed, and the notion of social order no longer threatened by illness and death; or when the individual experience of illness has been made meaningful, personal suffering shared, and the individual leaves the marginal situation of sickness and has been reincorporated in health or even death back into the social body (Kleinman 1973:207).

According to Harrison (1980) and Annis (1981), although the role of illness beliefs and traditional practices is important in the process of recognition of symptoms and treatment, the main aspect when approaching healthcare behaviours is to

¹²The most common interpretation of folk medicine in both popular and professional thought is that it represents a body of belief and practice isolated in various ways from the social and cultural 'mainstream' and intriguingly unaffected by 'modern' knowledge, with which it is frequently compared on the apparent presumption that 'folk' and the 'modern' are mutually exclusive classifications' (O'Connor; Hufford 2001:13). The WHO defines it as 'the sum total of the knowledge, skills, and practices based on the theories, beliefs, and experiences indigenous to different cultures, whether explicable or not, used in the maintenance of health as well as in the prevention, diagnosis, improvement or treatment of physical and mental illness. Practices of traditional medicine vary greatly from country to country, and from region to region, as they are influenced by factors such as culture, history, personal attitudes and philosophy' (World Health Organisation 2000: "General Guidelines for Methodologies on Research and Evaluation of Traditional Medicine"; Geneva, http://whqlibdoc.who.int/hq/2000/WHO_EDM_TRM_2000.1.pdf. (accessed on 07.05.2009). However, I use the term 'traditional medicine' or 'folk medicine' as an interweave system that at times includes etiologies and/or treatments from the biomedical model, which does not operate only in a '*biologised* body/mind'. See Chapter III.

understand that people seek to overcome the disease ‘clear-cut biologically’ (Annis 1981:521). To stress her point Annis writes: ‘as Ryan has pointed out in regard to fertilizer adoption in Guatemala: if it works, farmers will use it; understanding may come later’ (idem). Further, Harrison has pointed out that ‘the most likely impact on behaviour will come from demonstrated success [of the treatment]’ (1981:42). This is without doubt part of the healthcare process, but it also reduces illnesses to physical signs and symptoms; it ignores aspects of recognition, labelling of the illness, social relations surrounding illnesses, preferences, and perceived benefits and threats when choosing treatments or a healthcare model. ‘Appropriateness’ in biomedical jargon is therefore not considered a relevant factor, suggesting just a normative understanding of healthcare. Although these scholars’ perspectives were based on studies carried out during the 1980s and 1990s, the idea of improvement of health, as well as programmes to ensure access to healthcare, are still powerful tools, creating the illusion that decision-making still relies largely on biomedical standards and value-base care models and that illness belief can only threaten children’s health and well-being by misguided practices.

Phase Two

The aim of the second phase of the research was to compare and complete the information collected during the first period of research, and to focus specifically on practices connected with Evil Eye. Because of the difficulty of winning the trust of people, I decided to pay a visit to people I already knew, using a ‘snowball sampling’ format (cf. Biernacki & Dan 1981). I accompanied them when they were about to perform a healing or just talking casually about the phenomenon of the Evil Eye. My intention was to gather those responses to illnesses that are resolved through decisions based on economic capital, emotions, perceptions, and values that appear to be *culturally natural*, i.e., attributes that are considered significant and therefore intrinsic to people’s social landscape and social relations.

In addition, I observed that the types of attention given to someone who is ill are normally referred to as simply the ‘proper handling’ for such situations, because those responses are socially expected or constrained. Following the course of the illness revealed unexplored aspects, such as the importance of both health systems (biomedical and traditional knowledge) within a pluralistic medical system, challenging the positivistic idea that ‘folk medicine in both popular and professional thought is that it represents *a body of beliefs and practices isolated in various ways* from the social and the cultural ‘mainstream’ and intriguingly unaffected by ‘modern’ knowledge, with which it is frequently compared on the apparent presumption that ‘folk’ and ‘modern’ are mutually exclusive classifications’ (O’Connor & Huf-

ford 2001:13; the emphasis is mine). Even when an ethnography study is only partial, and it is impossible to show every angle of an illness phenomenon (Tyler 1986), I tried not to reduce the phenomenon of Evil Eye to a practice inserted into an apparently closed system of healing. Evil Eye is neither a synonym for ADDs and ARIs, nor an anthropological category to be superimposed on biomedical categories.

Some medical personnel from the National Hospital in San Marcos, and health promoters from the health centers in San Lorenzo and Comitancillo, were interviewed, together with practitioners from private clinics. Some of them displayed reluctance to discuss this topic or local practices for treating symptoms of pneumonias or diarrhoeas, but their answers provided me with information that was important to understand the impact that the perceptions and handling of medical personnel have on people's management of illness. In this connection, some biomedical practitioners have taken for granted the unilateral power to define diseases, which results in trying to seize control of situations by removing them from their original framework, a privileged hegemonic position within national health programmes embedded in a social and political normative. Examining the role of culture and illness beliefs in healthcare practices, Napier et al. state that 'to perceive different cultural practices as sources of trouble occurs especially when those who represent dominant forms of care provision feel threatened and vulnerable. In these circumstances, the biomedical validity of other cultural practices (and notions of health and wellbeing) can be challenged outright' (2014:1618). Furthermore, illnesses are normally seen as individually centered rather than a collective phenomenon. For example, the cultural framework demonstrated how mothers often feel that their wishes and opinions are ignored by health practitioners. This marginalisation of the caretakers' views means that health encounters are apparently one-sided instead of being negotiated. It is an important factor in the lack of community trust in health services and it results in delays in help-seeking in a number of ways. For example, since families often feel silenced by the system, this often leads to late presentation of sick children. As a result, children who are sent to hospital are usually extremely sick by the time they get there and consequently many do not survive. This has led to a fear of visiting the hospital, as it is associated with death or prolonged suffering, and families therefore often avoid visiting the health centers in order to evade the possibility of being referred to the hospital. Thus when they do finally go, it is often too late to institute effective treatment and the cycle continues.

This second phase of the research represented a methodological shift that inquired into behaviors expressed in social representations such as opinions, metaphors,

and implied attitudes, indicating the judgment criteria, the categories of thinking and the attitudes that are disclosed when individuals talk about their experiences. Hence, this frame included ‘new’ categories that are crucial for the focus of the research, since such aspects influence the effects that diseases have on people’s lives. Typically, diseases not only affect people physically, but undermine broader societal and family forms, as well as disrupting daily activities, emotions, and other aspects of life that are not directly associated with the condition. While the ‘context dependency’ of the disease condition deals with only certain aspects of the situation, it is possible to identify perceptions, meanings, interpretations and actions by using a broader approach that includes other categories. Experiences of illness shape practices, and those practices frame a possibility of outcomes. Thus, the dimensions of illnesses are formed and developed in a sense of a *healthcare system*,¹³ within which additional relations are negotiated and decisions are reached. This approach introduces other settings into the analysis, which then constitutes a biographical sequence of events mediated by the contextual frame (cf. Miller 1984) of how Evil Eye is explained by caretakers, rather than something which can be treated in isolation by biomedical health-providers, decontextualising people’s perceptions and attitudes towards healthcare.

On this basis, illness is not only explained as the polar opposite to health or as a ‘state’, but also as a process that calls for a direct behavior with the purpose of obtaining concrete responses from a functional system. In order to examine this view of illness, I spent a few intermittent days at the health center of San Lorenzo and the National Hospital in San Marcos, observing the daily dynamics of the medical personnel, seeing people coming in and out, and talking to them when possible. From a marginalised position I benefited from the occasion when I fell ill myself with a pulmonary infection. The incident provided me with first-hand experience of the public national services. Since my condition was deteriorating quickly after I contracted pneumonia for the second time, I decide to leave the field and was taken to a private hospital in the capital city. One of the problems with the national hospitals is that they do not have the capacity to attend to all the patients, including insufficient beds and inadequate resources for diagnosis and treatment. As a result, 1) an accurate diagnosis is not always possible; 2) many patients are treated as ambulatory, which has the disadvantage of multiplying the costs to the

¹³The healthcare system is a concept, not an entity; it is a conceptual model held by the research. The researcher derives this model in part by coming to understand how actors in a particular setting *think* about healthcare. . . The model of the healthcare system also is derived from studying the way people *act* in it and *use* its components. It is both the result of and the condition for the way people react to sickness in local and social cultural settings, for how they perceive, label, explain, and treat sickness. The healthcare system, then, includes people’s beliefs. . . and patterns of behavior. Those beliefs and behaviors are governed by cultural rules’ (Kleinman 1980:25-26).

family when the child must be brought repeatedly to the hospital, and occasionally leads to interruption of the treatment; 3) medicines are not always available and need to be acquired at private pharmacies, leading many people to assign similar status to medical doctors and pharmacists; 4) follow-up care is mostly done at home, increasing the use of antibiotics; and 5) local and traditional knowledge clash with ‘western’ medicine rather than working in a more integrated way with acute diseases. An illness is a personal and social terrain that shows conflicts, responsibilities, emotions and praxis; the resulting struggles, resistances, concerns, and manifestations of self-interest insert themselves into the health system. Therefore, previous experiences of illnesses when expectations have not been met increase prejudices against the national health services and its providers, with the result that hegemonic medicine constitutes a ‘process by which capitalist assumptions, concepts, and values come to permeate medical diagnosis and treatment’ (Baer et al. 1997:31). Being ill gave me the opportunity to critically reflect on the opinions and perceptions of people I had interviewed in relation to acute diseases and medical personnel. This influenced my decision to concentrate on case studies related to deaths, which showed how previous experiences at the national hospitals resulted in future decisions to avoid them. Conversely, trying to be aware of any possible biases and reflect on the phenomenon without bringing any subjectivity into the analysis seemed only possible only by reflecting¹⁴ on some keywords that appeared to be of major importance, such as ‘uncertainty’, ‘vulnerability’, ‘negotiation/empathy’, ‘trust,’ ‘fears/concerns’, and of course ‘possibilities’.

This first-hand experience was of significant importance because it gave me a valuable insight into the broader problem. It is not only the scarcity of personnel and resources that has a direct impact on the negative connotations that frame peoples’ decisions, but my personal experiences also showed that the structures of care and attention are spaces which create conflicts and frictions when things are not adequately explained, such as how long the treatment will last, the cost, the implications of following (or not following) the treatment, etc. This uncertainty in what might be called the personal aspects of illness goes beyond the material care provided, to include considerations based on emotions, morality, expectations, and responsibilities: ‘One would have to take the role of the actor and see his world from his standpoint. This methodological approach stands in contrast to the so-

¹⁴Thus, for example, instead of letting all the answers I was given stand as they were, as ‘data to analyse’, I asked the mothers or caretakers directly for clarification in order to avoid misconceptions. This challenged people to reflect on their responses and decisions, and sometimes to suggest alternative ‘outcomes’ that they might have considered in their decision-making process. This became very significant information because it provided me with people’s own thought processes (or lack thereof). This phase of ‘debriefing’ also gave the caretakers the opportunity to vent their thoughts and emotions concerning the diseases and the risks of taking certain decisions to ‘solve’ the problem.

called objective approach so dominant today, namely, that of viewing the actor and his action from the perspective of an outside, detached observer. . . The actor acts toward his world on the basis of how he sees it and not on the basis of how that world appears to the outside observer' (Blumer 1966:562).

Final Fieldwork

Between 2009 and 2013 I completed another three visits to San Marcos. I got in touch with some of the women I knew well to investigate the possibility of learning about how they treat common illnesses and prevent certain diseases. Although these encounters did not offer 'new' information in terms of introducing different perspectives of practices regarding health and care, they offered me better insight in to individuals and families afflicted by different diseases or problems—which were mainly caused or aggravated by poverty—as well as the strategies and practices that interact to overcome illnesses and suffering. Evil Eye was often present, if not as an illness, then as an established pattern to define relationships and as an expression of solidarity or socialisation. Social support refers to 'the help and assistance that individuals can anticipate and receive in times of felt need' (Dressler 2007:2059). For this portion of the research, I chose two midwives and one healer. This period provided important case studies that were related not only to Evil Eye, ADDs and ARIs, but also to essential characteristics that are part of health discourses, especially amidst political campaigns and programmes. In this last phase of research, I put an emphasis on processes and practices that are integral parts of a social and cultural system, including moral support, control of social and economic resources and the effect that health policies (that is, formal organisational and infrastructure health services) have on people's choices of health and care.

2.6 Methods

Participant Observation

This method was used throughout all the phases of the fieldwork. I started with a *participant observation* in the communities of San Lorenzo and Comitancillo, which were selected because of their geographical and ethnic features. San Lorenzo is close to the principal city of the department, but Comitancillo is more difficult to reach - in other words, it suffered from a geographical barrier. I use this method of participant observation in ethnological research in order to take a more active part in the daily life of other people. This allows the researcher to identify 'explicit' and 'tacit' habits (cf. DeWalt & Dewalt 2011) that otherwise would be

difficult or impossible to account for. In this situation, ‘qualitative and quantitative data inform each other and produce insight and understanding in a way that cannot be duplicated by either approach alone. Whatever data collection methods we choose, participant observation maximises our chances for making valid statements’ (Bernard 2011:267). In the beginning, I chose to accompany the fieldworkers to the hamlets where they were conducting the survey. This allowed me to obtain a working knowledge of Mam, become familiar with the local communities, learn how to get there and how to calculate the travel time, become acquainted with the people who would participate in the survey (even if I would not be interviewing them), talk in a very informal way with the fieldworkers about illnesses or other things, and most importantly, become someone that people could recognise.

Being part of the ACCESS group put me in a position that not only facilitated my entrance to the communities but also compromised some of my information. Because of the nature of the survey, the programme put a special emphasis on taking children to the health center or national hospital, if necessary, in case of danger signs (with the parent’s consent). Even after two months, people didn’t distinguish my position from that of the fieldworkers, leading to the difficulty that they did not provide ‘honest’ responses about their actions but expected advice, medicines or some form of economic support. This kind of permeability obliged me to rethink my approach, since my role as a member of the team directly influenced their responses. I could easily see the conflict between relationships inserted within power structures. The tension of this dilemma developed in a more productive way when I started to work on my own with only one of the fieldworkers, Linda, who became my research assistant during the rest of the first phase of the research. Even though she was part of the ACCESS team, people started to see our work in a different way. The first two months allowed me to (1) learn about family and social dynamics that were important to my research, including the best times and places to approach people; (2) become acquainted with local references, as persons or places that play an important role in health-seeking practices; (3) identify some possible key informants; (4) reflect on the problems I wanted to evaluate; and (5) talk to people in a very informal way to determine the clearest way to formulate my questions (cf. Bernard 2011: 256-290).

Participatory observation at different health facilities was a good opportunity to connect my research with people’s experiences of suffering, vulnerability, fears, and disappointments, as well as hopes, expectations and recovery. The emotional and social realm of health is often itself an expression of fundamental (bio)medical practices. People’s behaviours under such circumstances were very challenging, since although everybody knew I was an outsider, I became a more active par-

ticipant when people started to include me as a part of their social milieu. This, sometimes created trouble when a personal crisis took place. For example, being with a woman who could not understand the implications of a diagnosis triggered the feeling that I could be of help or support, yet explaining something to a person is inherently full of one's own preconceptions and operates on an automatic or subconscious level. Trying to avoid my own biases was not always easy, especially because it did not just mean giving an opinion, but it also had implications for a child's health. However, not getting involved also posed a dilemma because I might be withholding an explanation that would be helpful to the mother. Having to face this dilemma added to my understanding of people's experiences and sharpened my research focus. Sometimes my presence allowed women to feel more comfortable around 'ladino¹⁵ doctors', as I could explain answers and behaviours that they otherwise found difficult to comprehend. When a doctor offers a diagnosis, for the clinician this is a straightforward recommendation, but the patient may be evaluating it in a very different light. The value of participant observation, and the consequent immersion in day-to-day lives, is that people's behaviours begin to reveal what is at stake, why people trust certain individuals and not others, why people prefer one thing over others, why people react in one way and not in another. In order to grasp this better, I interacted with people in different activities that were out of my scope of research but provided me with experiences that were important for understanding people's social and physical environment once I built rapport with them.

By using participatory observation, I could integrate some observed behaviours into specific settings, allowing me to understand concepts and meanings that, without their social context, could have led to false conclusions or interpretations. For example, ethnographic data concerning 'risk' practices suggest that the chronicity of an illness has largely to do with the effects of broad use of antimicrobials or antidiarrhoeal drugs for case management. Drugs are overused and therefore become less effective. Consequently, doctors regard respiratory and diarrhoeal illnesses as "easily preventable and treatable" and think that they recur chronically only because the caretakers do not follow advice. Further, from a biomedical perspective caretakers cannot learn the danger signs of serious illness. This results in an almost universal diagnostic process among physicians, assuming that the majority of diarrhoea cases are related to poor hygienic practices and therefore bacterial, encouraging the use of antibiotics. I thus observed that the concepts of 'easy to prevent' and 'easy to treat' often resulted in increased use of antidiarrhoeal drugs, since this seemed to be a standard biomedical management

¹⁵It makes reference to mixed-race or Hispanicised peoples.

for diarrhoea infections. Overmedication occurs for different reasons, and even though resources were a constant constraint, it always seemed more important to establish the necessity of administering drugs.

Additionally, since parents continue to bring their children to public health facilities for what often seem to be the same illnesses, doctors generally provide standardised treatments without a definite diagnosis. Some of the physicians explained to me that ‘it is difficult to make an accurate diagnosis because taking blood or stool samples is not always doable, [yet] the majority of the cases are relapses of diarrhoeas or respiratory infections, which only makes these kinds of diagnosis expensive and unnecessary’. The caretakers’ perceptions were influenced by these assumptions. The misuse or overuse of antibiotics is not seen as potentially deleterious to the patient’s health because they are assumed to be indispensable. Physicians also frequently inform parents that a prognosis is poor, leaving out ‘non pertinent medical details’ including the side effects of pharmaceutical treatments, hoping the parents will take the child to the hospital, which the doctors perceive as responsible clinical practice. However, this emotionally disturbing news sometimes triggers only fear and the result is the opposite of what was hoped: the parent seeks help at a pharmacy instead of at the hospital. This type of interaction also demonstrates that beliefs about Evil Eye’s nosology did not change even when biomedicine was found to be effective.

Semi-structured Interviews

Semi-structured interviews focused on the main topics of the ACCESS research, which were (1) previous experiences with Evil Eye, ADDs, and ARIs; (2) responses to signs and symptoms of ADDs, ARIs and Evil Eye; (3) social and material resources available and their use within the family and community to prevent, cure or treat ADDs, ARIs, and Evil Eye; and (4) perceptions and understanding of these illnesses. The participants included mothers in the survey and their extended families, personnel of health posts/health centers and health workers, hospitals (private and public), midwives and some healers. These interviews provided a general framework for examining health-seeking behaviours, including specific practices and important features of health and healthcare.

Semi-structured interviews explored topics concerning not only specific practices related to Evil Eye, ARIs and ADDs, but also ambiguities or particularities that I came to observe. When particular behaviours contradicted, or did not explain certain outcomes, I designed a follow-up semi-structured interview to cover such events. By examining and incorporating such topics I identified what appeared to

be ‘standardised’ behavioural patterns that explain(local) understandings, practices and influences in terms of the interrelationships between medical systems. The interview structure also examined the outcomes rather than the expectations (e.g., practices that would trigger specific results). Questions that dealt with what had actually happened could explain better how complex responses are oriented to value judgments, and how people organise the ‘event of an illness’ within their families and communities.

Narratives

Some topics were too sensitive to be addressed through interviews, especially events concerning death or chronic diseases. Despite the differences in outcomes, personal narratives show some regularities in how people deal with certain problems in ways that seem culturally appropriate. One feature of the use of narratives is that they account for *multidimensional variables* (Bernard 2011:23-53). Having a ‘broader picture’ of the phenomenon increased my understanding of its causes and its implications. Like most narratives, the personal narrative ‘does something in the social world... [it] participate[s] in the ongoing rhythm of people’s lives as a reflection of their social organisation and cultural values’ (Langellier 1989:261), allowing them to understand the significance of their actions. Events are recalled in a more ‘performative’ way and actions are explained as ongoing events grounded in cultural practices: ‘depicting illnesses in the form of narratives is a way of contextualising illness events and illness symptoms by bringing them together within a biographical context. By weaving the threads of illness events into the fabric of our personal life, physical symptoms are transformed into aspects of our lives and attain meaning within the framework of personal life—what Early calls ‘the costumisation’ of the illness’ (Hydén 1997:53). In this sense, individuals define the logic of the events by linking various aspects, since ‘personal narrative places the individual in a dialogue with history, social structure, and culture, which themselves are dialectically revealed through action, feeling, thought, and language’ in accordance with their reality (Ellis & Bochner 2000:739).

Ambiguously concepts of pain and suffering can be better expressed when related to their effects and not purely pathology-centric: ‘the stories people tell are important not only because they offer an unmatched window into subjective experience, but also because they are part of the image people have of themselves. These narrative self-representations exert enormous power. They shape how we conduct our lives, how we come to terms with pain, what we are able to appropriate of our own experience, and what we disown—at the familiar price of neurosis’ (Ochber 1988: In Hydén 1997:50). Since illnesses disrupt the ‘normal’ way of life, a special

intrinsic meaning develops and becomes attached to it. Narratives about illnesses broaden our understanding of how illnesses affect individuals, but also how individuals or groups influence illnesses (cf. Kleinman 1988). Since biomedicine is normally only nosology-focused (i.e., aetiology, pathogenesis and symptoms), narratives about illnesses help to reflect not only on the ‘temporal’ symptomatic states and their treatment but also indirect determinants and interrelated factors. Narratives also ‘offer an *opportunity to knit together the split ends of time*, to construct a new context and to fit the illness disruption into a temporal framework. Narratives can provide a context that encompasses both—the illness event and the surrounding life events—and *recreates and creates a state of interrelatedness*’ (Hydén 1997:53; the emphasis is mine). Narratives help to give coherence to those events and subsequently a logical structure, similar to a ‘story line’. Even when the narrative is built around the illness, it is not only illness-centered. The temporal orders of events simultaneously reference both the biological and the social body. Prime examples of this are the stories reflecting on the reasons why a child has died. People exclude or include aspects of the situation that are in discordance within their own social/cultural group, with the medical personnel, and with health institutions, highlighting new events or a topic that in the logic of the narrative leads to the fatal event. However, the narrative does not necessarily go through the ‘restitution’, ‘chaos’ and ‘quest’ sequence. Rather, illnesses mutate in different ways, transforming the events every time the story is told when emphasis is put on certain aspects or new interrelations are made.

Narratives touched upon issues that were more complex, yet more fully captured experiences that were not always visible. It also provided a broader picture of what was happening not only within families (i.e., an individual behavioral focus), but within health facilities or in situations at the national level to which people were exposed. Thus, narratives provided a deeper and more complete view of actions and understandings that seemed ‘lost’ in the semi-structured interviews. For example, when people were asked in an interview about specific symptoms and treatments, individuals would refer to rather standardised procedures with which they were acquainted, but the use of narratives reduced the problem of reactivity. It also raised issues that were not addressed in the interview questions, helping me to establish hypothetical scenarios, learn about behaviours and values people considered appropriate, how people perceived each other’s roles and responsibilities as caretakers or health providers, explore dissonances between perceptions and practices, etc. Therefore, narratives gave me the opportunity to learn about experiences that were not ‘clear-cut’, reflecting on real-life dilemmas.

When Evil Eye and correlated illnesses appear among the rural population of San

Marcos, people evaluate which medical system offers the best solution to cure and heal the illness. In the next chapter I examine the concept of Evil Eye within a medical pluralism setting and evaluate why and how decision-making about health-seeking favors traditional healing practices, even though they might sometimes only cure symptoms temporarily. Although biomedical aid is frequently sought, traditional healing is largely preferred when treating symptoms of Evil Eye. The standard explanations of inaccessibility and inadequate treatments are still important as so-called barriers to biomedical healthcare, yet common practices suggest that traditional healing is undeniably the preferred model, based on what Dressler et al. (2007) call “cultural consonance”, the degree to which an individual’s beliefs and behaviours come close to the paradigms for belief and behaviours encoded in shared cultural constructs. Thus, the next chapter presents the conceptual framework that will allow us to understand and analyse how people’s health and illness are influenced by the cultural, social, political and economic conditions that contextualise their experiences of illness, especially within the pluralistic model of healthcare where Evil Eye takes place. This conceptual framework shows how behaviours—even when culturally consensual—can sometimes be conflictive, presenting different levels of representations and significance. I will emphasise in particular the role of traditional knowledge in coping with and curing illnesses as part of people’s capacity for agency (and resistance) when confronting models of healthcare that become problematic. However, this approach is not based on a dualistic dimension. It addresses the interaction of micro and macro structural factors that affect individuals’ health and the shift between models of health and care.

Judgement under (un)certainty among healthcare systems in Guatemala

‘It is hardly surprising...that concepts of health tend to be highly contested because they involve struggles over the moral significance of life. Concepts of health tend to merge into or be based on fundamental religious and moral views about existence, and differences in orientations towards health tend to reflect or to express basic structural and cultural differences in power relations in society. The result is that there is little consensus about what constitutes ‘health’ and ‘illness’, which are and remain ‘essentially contested concepts’.

— Turner (2000:9)

I sat outside the house with Rita, a nineteen-year-old woman and the mother of a child who had died a couple of weeks previous to the last interview. Rita was with her mother and some of her siblings and nieces. That day Rita barely talked while her mother was chatting with me. Rita had dropped out of school after she became pregnant, and she stayed at home and helped her mother with the household. Rita’s mother, whom I will call the ‘grandmother’, was a traditional weaver who worked at home. Evert was Rita’s first baby. “He was always ill, but never *too* ill”, she explained to me. “Evert always got sick after his vaccines. Almost every month since Evert was born I took him to the convergence center, with the SIAS community health workers, where afterwards he got ill with fever. I asked other women if their children also were feverish after they had been given the vaccines but some of them said no, while others said only occasionally. Then I asked a community facilitator but he only gave me some pills for [my son’s] fever. ‘Children are different’, he said to me”.

Parental awareness in acute diarrhoea and respiratory infections, in addition to preventive interventions such as vaccination and exclusive breastfeeding, are regarded as fundamental to improving children’s health and preventing deaths. Most of these deaths are due to dehydration and therefore preventable. In light of the

impact that preventive programmes and parental practices have, improved outcomes should be expected when these infections are properly managed. Evert's case is one of many which led to death due to a combination of enteric infections and malnutrition. This case illustrates the complexity that caretakers face when seeking care from community health workers who operate within an allopathic framework. Treatment decisions within pluralistic settings frequently reflect the extent to which specialists make recommendations, and the extent to which the caretaker's conceptions of aetiologies and treatment efficacy influence therapy choices.

Rita: "it was Saturday during the evening when Evert became ill with *fever*. Before that he was just fine. It all happened quite suddenly. I had been at the SIAS a couple of days before because one of my sisters was ill with cough and fever. They gave me some syrup and pills for her. Then my mother also got ill. They told me that it was probably the same [illness] so they said we should buy something at the pharmacy. Since many children in town were ill that time, they couldn't provide all of us with medicines. We prepared some home remedies to alleviate her cough".

In most of the cases where the cause cannot be identified or classified, especially after treatments have failed, people identify the illness themselves and address the symptoms accordingly. In such cases the integration of traditional and allopathic treatments occurs almost simultaneously. Even when health-workers have been trained to practice standard approaches to treat acute diarrhoeas and respiratory infections at the primary healthcare (PHC), the model of care and therapy does not correspond to that formulated by the WHO or national health criteria and standards. Even when clinical symptoms and signs are not specific enough for definitive diagnosis, the recognition of signs of danger that should prompt the caretaker to seek treatment or referral is a major part of the strategy to reduce pneumonia and diarrhoea mortality among children. Rita was provided only with acetaminophen and 'other pills' that she couldn't identify for her son after she explained Evert was 'suffering from fever'. Fever is a common symptom of pneumonia, diarrhoea and Evil Eye, which may vary in magnitude and duration. However, mothers may refer to 'fever' very freely, when they perceive their children are too warm, too cold or sweaty in different parts of their body, without actually measuring their temperature.

"On Friday morning Evert was fine but at night he started to cry and cry...On Saturday I sent my daughter [Rita] to get more acetaminophen. 'What did they say?' I asked [my daughter]. 'Nothing', she told me. People from SIAS only ask

you ‘What does your child have?’ and give you medicines or tell you to go the health centre or the pharmacy if they don’t have more medicines. She went there in the morning and they told her to give Evert two pills of acetaminophen but around midday he still had *much fever*. Later that day he stopped eating. He didn’t want to eat anymore. He fell unconscious so we both went to the pharmacy. The man [at the pharmacy] was mad at us! ‘This child is too ill; you should take him to the hospital’. I told him that we wanted an injection for Evert to reduce his fever, so he agreed, but after he was given the injection Evert’s body was very flaccid and the man at the pharmacy yelled, ‘This child is dead!’”.

The story of how Evert had died and the explanations of his death were very fragmented. Neither the grandmother nor Rita could remember which medicines were administered or the time when Evert first started to show symptoms of a possible illness. The various types of medical resources include a wide range of available pharmaceutical treatments which are used in combination with folk remedies. Since the only symptom, fever, was perceived as having appeared too quickly, this left them without an aetiological explanation. Consequently, their empirical approach to the initial therapy was that, in all likelihood, the symptom was part of Evil Eye. In Rita’s narrative she mentioned other episodes of coughing, diarrhoea, and fever but these, according to her, were not related to his death. When Evert had been treated previously with antibiotics and natural treatments, in Rita’s experience the symptoms disappeared within the first 48 hours. When I inquired about Evert’s general state it became clear that, at only eight months of age, he had been exposed to several antibiotics. Over-the-counter medications to treat acute and chronic conditions are rather common and sometimes encouraged when the PHC cannot provide treatment. From Rita’s mother’s account of the short story of Evert’s life we know that he suffered from malnutrition, which probably was the primary cause of his death. Since he seemed to recover after one illness episode, Rita never sought help at the secondary level of healthcare, nor was she advised to do so.

“He was skinny since he was born, very prone to catching the Eye, or had diarrhoea. But we always took him to the midwife or to the convergence center. The doctors there never told us he had ‘something’ so I don’t know what killed him”. The descriptions of different diarrhoeas provided by caretakers were accurate in terms of biomedical definitions and therefore the proper drugs were used to treat them, but they failed to recognise the danger signs.

“Evert once had a period of diarrhoea for which we had to give him antibiotics. It lasted almost two weeks! It was like mucus. Because of the colour we knew it was

not the Eye but another type of diarrhoea. Sometimes children get diarrhoea when they eat foods that are not adequate for them, but since he was only breastfeeding his diarrhoea was some kind of infection, they said. First he was vomiting and vomiting, and then the diarrhoea started. At the SIAS they gave me Santemicina (tetracycline) but he vomited it, so we gave him [infusions of] rue and mint. A couple of months later he had ‘dysentery’, I think it is called like that. I was afraid when I saw that he had blood in his stool.¹⁶ The doctors gave me a prescription for some medicines”.

I inquired about the dosages but Rita did not remember: “I think the medicines always have a little spoon”. Evert’s loss of weight, persistent cough, prolonged periods of diarrhoea, high fever and drowsiness were not identified as a part of any specific illness.

“The midwife who saw Evert told me that I could still breastfeed and give him food, which I did. We are used to eating *hierbitas* so I gave him those, and *atolitos*¹⁷ too. When he was ill with Eye the midwife cured him...but it was the vaccines that made him weak. When he was six months, yes, I think it was when he was six or five months old, I told my mom, ‘No, I’m not bringing him to the SIAS because he’ll have fever’ and he had been just cured from Eye. So I didn’t take him. Then my sister-in-law told me that day the people from SIAS had been in a meeting because the government had not supplied them with vaccines and medicines”.

Some of Rita’s siblings were receiving some micronutrient supplementation offered by *Mi Familia Progres*a,¹⁸ which they shared on occasion with Rita’s son. The shack in which they lived housed twelve people, most of them children, aged between three and eighteen years. That year many areas of Guatemala, including San Marcos, experienced poor harvests. A prolonged drought, followed by heavy rainfall, caused crop losses. These crops are primarily cultivated for the families’ own consumption, while a modest surplus generated some income. That year they were consuming the last of what they had harvested the year before, but it was not “sufficient to feed all these mouths”, as the grandmother said. “I told Rita that she

¹⁶ As in Bangladesh, the perception of dysentery (a severe form of diarrhoeal disease) has not been closely investigated in the Guatemalan context. However, people recognise it as ‘dangerous’, as they do in Bangladesh, if there is blood loss (cf. Blum & Nahar 2004).

¹⁷ A traditional high-nutrition carbohydrate drink made with corn, rice, or beans.

¹⁸ This was a conditional cash transfer programme linked to behavioural practices implemented in areas that were selected as ‘high priority’ by the government of Guatemala. It was initiated in 2008 and changed its focus with the next government in 2012. Families who were eligible for it were provided a monthly payment of around US\$18 given to women with the condition to bring their children under the age of six to national healthcare facilities when ill or if pregnant or breast-feeding to attend health centres to receive a basic package of nutritional and preventive maternal-healthcare services (see Chapter IV).

should give Evert some of the *atoles* of her siblings. She is too skinny! She didn't have the strength to produce more milk. That's why Evert was always thirsty, because she couldn't quench his thirst". It is considered acceptable to receive these food supplements, but since there are no monitoring methods, some families, such as Rita's, stockpile the free food with the intention of 'giving these to the children when there is not much food'.

"They tell us to bring our children to the SIAS when they get ill, but children are *always* ill (Rita's mother tells me). Then when we go there they tell us that they don't have medicines or the medicines they do have do not work. Once I fought and fought for months for these *patojos* here (indicating two children between five and eight years old). My boy got sick with pneumonia and was referred to the hospital. We spent a week there but he never recovered. He is always ill with cough. The medicines they gave him weren't good enough; that's why he never got completely well. Then *she* got ill!, *ay no!* I said to my husband: 'I don't want to be at the hospital again. What for? If the medicines they give you are the same we can buy at the pharmacy!' It's not easy with children. There is a good *curandero* near to Tacaná but we cannot afford to get there. He cured my brother-in-law. He was always weak, continuously losing weight, with night sweats. He spent so much money for private doctors but no one cured him. The medicines they give you just work for a short period of time but don't *cure* you. That's the problem. See, with Evert, all the medicines that we gave him were just to help him but none of them *cured* him" (emphasis mine)

The behaviours that are followed to improve children's health show that traditional/folk practices do not necessarily interfere with biomedical case-management activities. Midwives and folk healers provide healthcare and treatment and have a key role in detecting and treating common childhood illnesses. Integrated practices, combining folk and biomedical components, are strategies to improve children's health and nutritional status. Children may be at greater risk for morbidity and mortality because, although access to PHC has improved recently, it is still insufficient and sometimes inappropriate. In addition, maternal and child nutritional status need to be addressed as a part of the ongoing health initiatives. Return visits to health institutions and post-treatment assessments show that allopathic medicines can improve children's health. However, patient history and physical examinations are not part of the diagnosis and initial treatment. Despite the recommended guidelines for acute respiratory and diarrhoeal infections, there is no adequate supervision of community health workers for case management, counselling and referral. The importance of the recognition of danger of signs and compliance with treatment has also been stressed, yet the relationship between

(chronic) illnesses and the continual use of antibiotics or other medicines presents a problem. Furthermore, symptoms and danger signs are biomedical concepts which, when used by caretakers, blend with personal experiences and thus become ambivalent.

I left Rita and her family that evening and promised to come back again. I had the opportunity to see them one more time and found her sitting on the ground cleaning some corn with two of her siblings.

“*Je’ky Rita*, everything okay?” “*Je’ky se’n ta’ya*, seño!. So good to see you. My mom is not at home today. She had a meeting at the school because the money she received from *Mi Familia Progresada*¹⁹ hasn’t been given, so they are telling the people from SIAS that if they don’t keep their promise, they won’t bring their children to the convergence center” [she laughs]. “Why not?” I asked, “Because they only made us go, and when we went they said we don’t have medicine. It is just a waste of time. They only keep promises when they want us to give our vote during the elections, then they stop coming.” (Record Tuijala_04747)

The outcome of pluralistic medical settings is a mix of different models and treatments that traditional/folk and allopathic medicine can provide, arising from a diversity of factors that determine their effectiveness and the values attached to them by the users. Thus, pluralistic medical models can play a central role in healing. In San Marcos this pluralistic medical model has developed as part of the long-term inequalities in the area, and the exclusionary patterns of social, economic and political development.

¹⁹In this regard Maluccio (2005) points out that the benefits of attaching conditions or co-responsibilities to the provision of cash benefits in conditional transfer programmes are highly controversial. While conditions may play a political role in terms of increased utilisation of healthcare services, from a human rights perspective there are concerns about the assumptions of the causes of poverty and the moral underpinnings behind the behavioural change sought. Additionally, these conditions continue to reinforce traditional gender roles and care responsibilities among families (Gammage 2011).

3 MEDICAL PLURALISM IN GUATEMALA

‘The general theories of health and illness that explain the medical condition of humanity are shaped and organised around the dominant ideologies and beliefs of a culture (its domain assumptions).’

— Turner (2000:22)

3.1 Introduction

Biomedicine only began to dominate the medical system during the first decades of the 20th century. Its spread was facilitated by the process of colonialism. During this period, transformations in physiology and bacteriology helped to develop and strongly influenced the understanding, classification, diagnosis and treatment of diseases (cf. Tansey 2006). Although diseases became more standardised in biomedical terms and were treated with biomedical methods, societies with other forms of medical systems still rely on a wide range of healing practices and health providers. Thus, the increased use of biomedicine and biomedical technology does not necessary lead to the replacement of traditional models (Cominsky 2001; Kleinman 1988, 1980; Lock & Nichter 2002; Nichter 2008, 2002, 1997, 1996). Traditional and allopathic medicines differ not only in their approaches but also in their illness aetiologies, diagnoses, ideas of transmission or contagion, prevention strategies and treatments, and social structure. Although ‘complementary’ (CM) and ‘alternative’ (AM) medicine have become increasingly popular in European countries and North America since the late 1960s (Cant & Sharma 1999), in other regions of the world plural healthcare structures have a long tradition. However, governmental policies of integrative medicine, i.e., the combination of biomedical and traditional systems of healthcare, have not been regulated or successfully incorporated into health programs everywhere.

The concept *medical pluralism* emerged in the context of social research in the mid-1970s where the provision of allopathic medicine was not (or not yet) the main form of healthcare but was intertwined with other health practices and non-biomedical

models of care, called ‘traditional’ or indigenous medical systems (IMS), as opposed to biomedicine (Cant & Sharma 1999; Sujatha & Abraham 2009). Even though the rationality and efficacy of traditional medicine or IMS have been highly criticised, there has been increasing political awareness worldwide of pluralistic medical systems and the integration of its models (cf. Birhan et al. 2011; Gold & Clapp 2011). Costs associated with the healthcare delivery of allopathic medicine, changes in primary and secondary healthcare services, barriers to access, the importance of incorporating traditional healers into prevention and treatment initiatives, and the increasing consumer awareness in traditional medicine, among other factors, have created policy responses that serve to validate and make use of available healthcare resources. Some countries have received significant financial support from international agencies for this purpose (cf. Denham 1999; Hyma & Ramesh 1994; Sujatha & Abraham 2009). While the debate on the concepts of ‘pluralism’ and ‘system’ prevailed until the late 1980s, in the 1990s the concept of medical pluralism shifted its focus to the realm of the body and self in medicine, a conceptual frame that permitted an understanding of patients’ behaviours as phenomenological ‘embodied expressions’ and recognised them as structures of knowledge. These structures connect experiences as part of treatment modalities, social structures and networks, preferences, and struggles. They are confronted, supported or authorised by multiple dynamics, which include self-reflective choices, family or community practices, and healthcare policies (Johannessen 2006:1-8).

Traditional medical practices differ across geographic regions and cultures, and traditional healthcare is sought for different reasons. Yet, although there are significant differences in treatments and outcomes, the terms ‘traditional’ and ‘folk’ medicine are often used imprecisely to identify therapeutic practices and specific illnesses that differ from those of institutionalised allopathic medicine. These concepts show certain distinct characteristics: they are transmitted orally; they are marginal to the official institutionalised medical system; they contain magical or supernatural aspects; they connect the experiences of illnesses to the body, mind and spirit; they include spirits and energy as aetiological factors; and they include self-treatment and religious, ritual, and faith healing (cf. Csordas & Lewton 1998; Laderman 1994; O’Connor & Hufford 2001; Nichter 1991; Poss & Jesewski 2002; Rubel & Hass 1996). Traditional diagnosis and treatments incorporate a broad variety of therapeutic methods or systems, comprising naturopathy, homeopathy, herbalism, osteopathy, acupuncture, massage therapy, chiropractic, and traditional orthopaedic surgery, among others (cf. Adams & Hawkings 2007; Fabrega 1997; Foster et al. 2011).

While there is a demarcation between the therapeutic models of traditional/folk

and allopathic medicine, illness categories within pluralistic settings are actually interrelated (cf. Agbor & Naidoo 2011; Baer 2003; Keefe 1981; Torri 2012). From the biomedical perspective, however, when comparable clusterings of signs and symptoms cannot be related to any disease category and are considered to lack clear or probable diagnosis, they are usually assigned strictly to categories of *folk illnesses* (cf. Agbor & Naidoo 2011; Disderi 2001). From the patient's perspective, folk illness aetiologies are part of a traditional healthcare system, although not necessarily exclusive, and they reflect more dynamic processes of healthcare practices. As a result, folk or traditional health-related practices have usually been regarded as deceptive, illegal, dangerous, marginal, or inappropriate within biomedical settings, practiced most frequently among the poor or uninsured where the role of traditional medicine is particularly relevant (Chávez 1984; Chávez & V.M.T. 1994; Gameraen 2010; Holliday 2008; Nyamongo 2002; Night 2002; Okeke et al. 2006; Pebley et al. 1999; Trotter 1998). Folk-health practices have also garnered attention as a result of education campaigns that justify them as “culturally accepted” or that seek to explain illness categories and practices that are “culturally relevant” and understandable (Anderson et al. 2003; Gomez-Beloz & Chavez 2001; Gorter et al. 1995).

In the Guatemalan context, the concepts ‘indigenous medicine’, ‘traditional medicine’, ‘alternative medicine’ or ‘Mayan medicine’ are used arbitrarily. I use the term *traditional medicine* to refer to practices in the San Marcos area that are part of the indigenous discourse that stresses aspects of ‘identity’ and ‘values’ that are consciously referred to as ‘ancient’, rooted in or strongly influenced by the Mayan cosmology, usually separated from the conventional biomedical epistemologies. The views of a common cultural understanding, in which health and illnesses are embedded, situate a cultural-political boundary, where traditional beliefs regarding illnesses and treatment are preserved. The term *folk* incorporates concepts, perceptions, beliefs and practices from various sources that are not necessarily related to the indigenous-belief system. Due to the growth of biomedical practices, as well as local economic changes, aetiologies and treatment choices are influenced by both ‘traditional’ and ‘folk’ healthcare practices, adapted to the illness experiences which in turn are part of local particularities. The ‘traditional’ and the ‘folk’ categories are intertwined, and can incorporate biomedical concepts or models in varying forms and degrees.

Whereas biomedicine operates within apparent universal approaches and standards that originate from the idea that ‘diseases are universal biological or psychological entities, resulting from somatic lesions or dysfunctions’ (Good 1994:8), traditional medicine has been recognised as culturally confined or appropriate to

people's beliefs, ideas, and necessities, and therefore carries a particular sense of belonging or *identity* that corresponds to their perceptions, emotions and expectations (O'Connor & Hufford 2001; Nichter 2008, 2002,1998; Nigh 2002). It has also been described as 'symbolic' and 'subjective' (cf. Waldram 2000:604). Yet traditional practices are also selected and purposive '*curing/healing*' actions—an important dimension, as Waldram explains, that is always found within the dichotomous health discourse. This distinction has its theoretical foundation in the approaches formulated by medical anthropologists on the study of *efficacy* in traditional medicine and the old debate concerning the distinction between *illness* and *disease*. While *curing* indicates the absence of any pathology, *healing* refers to a wider psychosocial domain that restores the 'affective, social and spiritual' aspect of illness (Waldram 2000:604). However, Waldram notes, 'the elimination of disease is not always the ultimate goal of traditional medicine. This is also true, of course, of biomedicine, but critics of traditional medicine often ignore this fact, leading to hypocritical allegations of charlatanism' (ibid., p. 605), resulting in the mistaken idea that *healing of illness* and *curing of disease* are separate attributes of the 'treatment of sickness' (ibid., p. 606). Thus, to a large extent, the concept of *efficacy* is not only a purposive action involved in just curing or healing, but an adaptive process that generates a course of actions based on affective processes, social motivations, and selected behaviour in the face of failure or setbacks within models of healthcare.

This chapter explores the conceptualisations of pluralistic models of healthcare and how diverse health discourses have limited or neglected traditional and folk practices for the case management of illnesses. The politics of health remain minimal, and focus specifically on reforms that integrate 'safe' and 'effective' traditional behaviours while still intrinsically rejecting indigenous illness categories or practices concerning public health frameworks in favour of biomedical ideas based on concepts such as 'available evidence', 'risk', '(in)adequacy', etc. It also examines fundamental factors that contribute to a pluralistic medical model where the effectiveness of biomedical and traditional/folk medicine intersect. The need for collaboration between traditional and biomedical models of healthcare is especially evident when health-seeking practices negatively affect health delivery efforts. However, the importance of each model of care is not limited to physical outcomes. Healthcare interventions show that aetiologies and medical systems entrench social values and encourage a culturally sensitive adherence to treatment regimes. Evil Eye is addressed by both medical systems; its holistic nature highlights and takes advantage of the efficacy that each of these healthcare models provides. In Waldram's words, '*efficacy*...must be viewed as something that is essentially negotiated, in part, in each encounter of a patient and a practitioner in

both biomedical and traditional medical systems' (2000:607). The last section of this chapter examines the role of the pluralistic model of health for Evil Eye. It specifically considers practices that explain why and how people assign Evil Eye to different sets of symptoms and different styles of case management, it identifies people's perceptions of the traditional and allopathic healthcare models; and it explains the expectations that drive people's choices and practices in combining the available pluralistic resources.

3.2 The Recognition of Medical Pluralism

In the 19th and 20th centuries, when modern bacteriology became hegemonic, biomedicine was transformed into a healthcare paradigm. Its subsequent integration into other kinds of healthcare systems did not necessarily eradicate those other systems; it did, however, displace many of them politically and legally (Starr 1984), making biomedicine 'a metonym for modernity in the domain of healing' (Conner2001:7). According to Otibhor, 'how a given [healthcare] system becomes dominant or unconventional has as much to do with temporal, economic, and political factors as with the legal norms of a state' (2010:59-60). Thus, ideological, political and economical considerations are the principal reasons a state decides to support or restrain the development and integration of a plural medical system, defining the degree to which other healthcare practices are recognised as legitimate. An example of this practice is the approach of the Ministry of Health of Zanzibar, which since 2008 has implemented several policies with the aim of regulating and integrating traditional health practitioners into the public healthcare sector, in order to prevent malpractice and reduce 'risk factors' connected with health-seeking behaviour and the use of medicinal herbs (Meier zu Biesen et al. 2012). In the Latin American setting, the Chilean Ministry of Health began promoting, in the early 1980s, a governmental initiative for "intercultural health". Chile's Makewe Hospital is managed by the Mapuche, an indigenous community; biomedical and traditional products and practices (including the work of *machis*, Mapuche traditional healers) are integrated and provided to patients (cf. Torri 2012).

Medical pluralism has been defined differently within the contexts of specific world-views. Of particular importance is that each definition emphasises the fact that the biomedical paradigm is just one among other philosophies and paradigms for diagnosing and treating diseases and illnesses. Medical pluralism constitutes a broad and heterogeneous set of medical strategies that coexist or compete in an integrated system that includes all sectors of healthcare. It can be described as

an encounter of allopathic, traditional, complementary and alternative medicine (TM/CM) and therapies which locate health practices as ‘popular’ (managed by a lay person) or directed by ‘folk’ curers and ‘professionals’ (cf. Jansen 1978a 1978b; Kleinman 1980; Wade et al. 2008). It comprises traditional and biomedicine, self-treatment, pharmaceutical and patent treatments, and faith or religious healing, among other healthcare practices (cf. Finkler 1994; Wade et al. 2008). Hence, a pluralistic model acknowledges that important cultural beliefs and practices influence illness behaviours, contributing to the shaping of illness representations (experiences, meanings, risk-related behaviours).

A pluralistic model also elicits the problem of ‘governmentality’ (Foucault 2002; 1979) and regulatory discourse in connection with health and care. Illnesses and health behaviours are categorised as ‘right’ or ‘negligent’ practices within the biomedical framework (Mechanic 1979). According to Lock and Nichter, ‘governmentality’ is exercised by the use of terminology and professional authority that establishes control an ‘evidence-based approach’ as the standard by which to assess the *efficacy* of healing methods, using prescribed techniques such as double-blind trials, in order to label ‘who gets to define what constitutes evidence, what sources of information and forms of knowledge are privileged as well as overlooked, and who determines the way ‘disease categories’ are classified as well as samples of subjects selected’ (2002:3-4). Thus, strategies of curing and healing are always based on specific circumstances, on discourses of particular moral, social, economical and political motivations. For example, the understanding of ‘cure’ has changed over time and across cultures. Whereas in the sixteenth century ‘to cure’ only encompassed the activities of looking after those who were sick, by the mid-eighteenth century the term ‘cure’ comprised the use of innovative medical procedures and understandings that were acknowledged as increasing people’s chances of recovery or improvement, resulting in handbooks and manuals that provided specific instructions for specific interventions (Few 2012:311).

Assessing ‘healing success’, Etkin (1988) pointed out that ‘traditional healing’ should be understood as a ‘process containing several levels of success’ which restores the patient’s well-being and provides a *proximate success*, which differs from the *ultimate outcomes*, i.e. the mere restoration of symptoms. This framework emphasises the value of a meaningful system of traditional medicine and contains the formulation that traditional medicine not only responds to physiological aspects of health status, including the application of measures to effectively treat an illness (what traditional practitioners accomplish and what they ‘do’ as a process), but also includes entities within the sphere of household and community production of healthcare (roles, responsibilities, family and community healthcare assets). Thus,

efficacy is located at the personal experiential dimension of illness, which moves towards a conception of flexible interaction between the socio-cultural reality and the production of locally distinctive patterns of bodily and social responses or strategies. The relevance of this approach is that it underlines the importance of the patients'/caretakers' understandings of the effect treatments have, their motivations, and how healthcare and health status can be 'negotiated' between health practitioners and patients/caretakers.

By exploring Evil Eye healthcare behaviours, I suggest that in a pluralistic model, traditional and biomedical healthcare perspectives and practices are continually integrated, yet sometimes they collide, combine, or work in parallel. This kind of intersection demonstrates resilience, enabling practices of special significance, in which the illness concept contains an 'active meaning' determining and allocating arguments that motivate specific behaviours. The result is a conception of healthcare practices as a bio-psycho-social phenomenon that disrupts the false dichotomy of medical models. Healthcare behaviours within pluralistic settings aim to reduce the possibility of treatment failure and, like any other care and healing method, seek to restore the status of health and well-being (cf. Gesler 1984). Moreover, whatever their aetiological conceptualisations, people treat symptoms by relating them to specific ideas about the efficacy of alternative therapies. Diagnosis and categorisation of illnesses therefore can be labelled within a specific model of care as a cognitive orientation, while the approach to treatment becomes a point of interconnections. Yet, while from caretakers' perspectives the involvement of different healthcare systems involves an 'adjustment' (by approaching illness differently, changing strategies, making use of different resources,), in the biomedical view a pluralistic healthcare model can only undermine biomedical efficacy.

Hence the intersections of pluralistic medical models are not without conflict. First, the term 'therapeutic efficacy', i.e., *cure* and *healing*, has a personal and cultural meaning that does not necessarily correspond to its meaning within the biomedical conceptual framework. Within a pluralistic model, the powers that derive from the different therapeutic frames challenge each other, so to speak, for the determining role in individual choices, which will have major implications for the selection of treatments and health services or providers. Secondly, illness or case management is strongly influenced by cultural practices concerning aetiologies and therapies. Family and social dynamics, transmitted practices, illness perceptions, and exposure to the market economy and commercial drugs, among other factors, all play a role. The growth of national health services and providers has outpaced the development of pluralistic models, providing broader resources and tools which are selected and integrated amidst contradictions and clashes. In rural San Marcos,

within this pluralistic model Evil Eye is also a social domain, shaping and broadening the beliefs and practices associated with the traditional healthcare framework. This broadening effect provides references and tools that enables caretakers to expand healthcare practices, and produces a space in which social dynamics can play a role.

3.3 Contemporary Models of Traditional Care

Traditional medicine (TM) is defined as a lengthy history of indigenous health practices of a particular culture based on its knowledge, skills, expertise and medicinal products. TM is legitimised by theories, beliefs, and experiences that are employed in the prevention, diagnosis, improvement, or treatment of illnesses (WHO 2013a:15). *Complementary medicine* (CM) and *alternative medicine* (AM) comprise an extensive set of healthcare practices that are not part of the allopathic healthcare model (Holliday 2008). While CM practices are usually integrated with allopathic models of care and health, AM can be exercised only on its own, not in combination with other models. Since the late 1990s, the use of TM/CM/AM has increased in industrialised countries, which has increased the interest in evidence-based studies of these systems (Bodeker & Kronenberg 2002; Holliday 2008; WHO 2005b), especially within the domain of medicinal plants (cf. Rutert & Dilger 2011). Patients who rely on a plural medical system frequently make use of one or more of the therapies provided by a medical doctor, healer, homeopath, herbalist, diviner, etc., depending on variables such as perceived benefits, risks, beliefs, religiosity/spirituality, nature of the illness, personal networks and interpersonal processes. The existence of medical pluralism, where individuals have access to many different types of medical practitioners and systems, often leads to serial and simultaneous utilisation (Garrison1976; Tujal 1993; Waldram2000; Whitaker 2003); this implicitly supports the notion of a fluid conceptualisation of efficacy (Waldram 2000:615)

The nature of medical pluralism relies on its particular historical, social, cultural, political, religious, and economic background, which shapes and influences the distribution, accessibility, efficacy, and significance of health delivery systems (cf. Joseph &Phillips 1984; Wade et al. 2008). One of the concerns about traditional health practices within a pluralistic setting is that they tend to appear in socio-environmental contexts with extremely high rates of infant mortality, fertility and population growth—factors that encourage the spread of infectious diseases related to poor sanitary conditions, safe drinking water, lack of access to PHC, and malnutrition. This conceptual framework suggests that specific diseases have

therefore been poorly treated or understood. This may be true to some extent, but it is important to understand what has been the precise effect of the absence or deficiency of particular health factors, and to suggest adaptations or changes that can provide practical solutions. Unfortunately, TM has been seen to be an obstacle to providing primary healthcare for the most prevalent diseases. Since the 1960s, several different models have been used to infer the factors that determine patients' utilisation of health services (discussed on chapter I). One of these is Andersen's Health Behavioural Model (HBM), which utilises a number of variables to identify predisposition, enabling and needing factors when seeking healthcare, in order to identify and avoid risk patterns. In a pluralistic healthcare model, seeking behaviours are of primary importance, especially the factors that have been identified as a "lay referral system" (Freidson 1970), which play a significant role within case management and which directly influence the type of healthcare people seek first, as well as the course of health-seeking. This theory, among other behavioural models, bases its approach on "positive" or "desirable" practices (cf. Rhodes 1997).

Despite all efforts to understand and predict behavioural patterns, practices of care and health within a pluralistic model are difficult to grasp. One of the reasons is that there are several independent variables that determine how the various factors affect the decisions people make, such as interpersonal relationships, perceptions of the severity of the illness, knowledge of its symptoms, previous experiences, stage of the illness, time required to access a health institution, cost, satisfaction with national or private health services, and exposure to specific health services. Variables that influence decision-making may be regarded as proximal or distal.¹ The interplay of all of these factors affects the choice of one or another healthcare model, or the use of both models in parallel. Thus, the idea that increasing the availability of specific 'modern care and health' services will automatically translate into an increase of their use overlooks the fact that, in the minds of the intended users, the practices and the treatments available in each model are meaningful strategies.

People in rural San Marcos seek care from a variety of health providers and professionals, who in turn use a variety of therapies. These encounters support a pluralistic medical system in which patients try to secure the resources necessary to ensure recovery and health improvement. This practice strengthens or debilitates curing/healing traditions but also suggests a mixture of health beliefs that are open to alternative and combined treatments and ways of understanding the

¹*Proximal factors* act directly or almost directly to cause disease, whereas *distal causes* are further back in the causal chain and act via a number of intermediary causes. <http://www.who.int/whr/2002/chapter2/en/index4.html>

body and its management. Among traditional healers the prescription of antibiotics, for example, is not necessarily an unusual practice. On the other hand, some mainstream health professionals recommend treatments that do not require a prescription or are not based on pharmaceutical products, such as the use of compresses for certain pains, infusions for specific ailments, consumption of particular food supplements, avoidance of specific types of foods (which in lay terms is often perceived as a basic intrinsic principle of humoral medicine), and the like. Traditional medicine constitutes the main source of reference and treatment for Evil Eye. Biomedical practitioners, however, when confronted with the illness's symptomatology, rely on allopathic theories and approaches, contributing considerably to conflicting attitudes towards traditional medicine and folk illnesses.

3.4 Folk illnesses within pluralistic medical models

Folk illnesses are sometimes described as 'culture-bound' or 'culturally defined' syndromes (Hughes 1996; Rebhun 2004:319; Weller et al. 2002). The concept *culture-bound syndrome* was coined in the 1960s by the Chinese psychiatrist Pow Ming Yap to explain certain clusters of symptoms that were recognised as an illness in one culture or society but not necessarily within another. Since 1994 the American Psychiatry Association (APS) has included in the Diagnostic Manual of Mental Disorders (DSM) an index of 25 culture-bound syndromes (Rebhun 2004:319-327), defined as follows:

The term *culture-bound syndromes* denotes recurrent, locality-specific patterns of aberrant behaviour and troubling experience that may or may not be linked to a particular DSM-IV diagnostic category. Many of these patterns are indigenously considered to be "illnesses", or at least afflictions, and most have local names. Culture-bound syndromes are generally limited to specific societies or culture areas and are localised, folk diagnostic categories that frame coherent meanings for certain repetitive, patterned, and troubling sets of experiences and observations. (DSM-IV, p. 844)

The DSM has been published by the APS since 1917 to synchronise mental health research and diagnosis with biomedical standards of examination and classification (Pettus 2006). It contains a heterogeneous collection of folk terms which describe 'real' syndromes and others that were referred to as 'cultural notions' of disease causation or idioms of distress. The ICD-10² (WHO 1993a) also included the term

²The 10th revision of the International Statistical Classification of Diseases and Related Prob-

‘culture’ as a factor in the diagnosis of particular (psychiatric) conditions. Yet, the term ‘culture’ was used to define syndromes that were considered rather ‘exotic’ and lacked clear biomedical diagnoses in non-Western societies. Anthropological research on illnesses such as *koro* and *dhat*, for example, was vital to understand that men who suffer from particular syndromes may present similar symptoms and signs, yet the circumstances of onset, the treatments, and the personal and social implications of the illness may have their own pernicious effects that run parallel to the physical symptoms (cf. Chadda 1995; Chowdhury 1991).

Before the 1994 edition, the DSM included little information about the cross-cultural diversity of psychiatric categories. In his criticism of culture-bound syndromes, Yap stresses that one of the problems of such categorisations is that ‘psychiatric problems’ are based on the standardised textbook notion that outside the disease classifications known in biomedicine, other illness categories can only be a clinical condition derived from an already described disorder (cf. Yap 1969). Analyses of culture-bound syndromes focused on ‘predominant somatic symptoms’ in order to assess their psychobiological causes. For example, in the context of the Latino population living in the United States, illnesses such as *nervios*,³ *evil eye*, and *susto*, among others, were described as psychosomatic symptoms that could be explained as a result of a ‘cultural-social world’ amidst social uncertainties, vulnerability and experiences of disadvantage (Guarnaccia 1989, 1992; Rogler 1996). *Nervios* or *ataque de nervios* provides an example of how the identification of the ‘predominant symptoms’ can be difficult when the social characteristics, somatic responses, emotional expressions, and action aspects—in other words, the context specificities—are not considered (cf. Baer et al. 2003; Cabassa et al. 2008).

Studies of *nervios* as an example, making use of Kleinman’s explanatory model, have helped to develop a phenomenological approach to understanding the possible differences and similarities between the psychobiological explanations, as well as to comprehend the personal and cultural meaning of the illness (Guarnaccia 1992; Low 1988; Rubel 1984). An important aspect of ‘culture syndromes’ is therefore

lems (ICD) by the WHO.

³ *Nervios* was defined as ‘an idiom of distress principally reported among Latinos from the Caribbean, but also recognised among many Latin American and Latin Mediterranean groups. Commonly reported symptoms include uncontrollable shouting, attacks of crying, trembling, and verbal or physical aggression. Dissociative experiences, seizure-like or fainting episodes, and suicidal gestures are prominent in some *ataques* but absent in others. A general feature of an *ataque de nervios* is a sense of being out of control. *Ataques de nervios* frequently occur as a direct result of a stressful event relating to the family (e.g., news of the death of a close relative, a separation or divorce from a spouse, conflicts with a spouse or children, or witnessing an accident involving a family member). People may experience amnesia for what occurred during the *ataque de nervios*, but they otherwise return rapidly to their usual level of functioning’ (DSM-IV:845).

the social relations of therapy management, which are associated with particular conceptions and dynamics specific to certain disorders and illnesses. The term ‘weak lungs’ (Nichter 1994), for example, used in popular healthcare to refer to a broad variety of respiratory illnesses, reflects a multiplicity of predominant relational orientations depending on the premise as to what the condition might be. In this sense, if ‘weak lungs’ is related to tuberculosis, the specific social commitments will show the importance of its meaning since families and communities respond to it with a distinct sense of duty; a collective construction of the illness will be different if, for example, ‘weak lungs’ is associated with asthma. Obeyesekere (1985) called this ‘the work of culture’, in which affections and feelings (e.g., suffering, pain, vulnerability) are transformed into meanings and symbols in the course of an ailment. Illnesses ‘make sense’ (cf. Jackson 1996) by translating sensations, emotions and ideas into a communicative purpose.

The DSM-IV-TR, published in 1994 by the APS, defined Evil Eye as a ‘syndrome affecting many children in the Caribbean and Mediterranean cultures. The belief is that due to their physical and psychological vulnerabilities, children and infants are at high risk or serve as receptacles for evil thoughts or wishes intended for adult members of the family. Symptoms of this syndrome include disrupted sleep, crying without cause, vomiting, diarrhoea, or fevers’ (Dziegielewski 2010:140). The DSM-IV thus relegated the concept of Evil Eye to the status of a pseudo-ailment, as a simple cluster of misinterpreted symptoms that could ‘fit’ into biomedical concepts⁴ (cf. Hughes 1996:132-150; Lock & Scheper-Hughes 1996:42-43; López & Ho 2013). Similarly, Rubel and Hass observed that ‘ethnomedical studies are often conducted in societies in which such killer diseases as infant diarrhoea, pulmonary tuberculosis, ‘river blindness’, and schistosomiasis are rampant with little, if any, attention to the local population’s cultural response to these diseases. Instead, research fastens on concepts, preventions, and curing folk diseases or diseases with psychiatric implications’ (Rubel&Hass 1996:117). The result of this emphasis on infectious diseases in the public-health literature is that the term ‘culture-bound syndrome’ has, over the years, simply overlooked important cultural meanings attached to specific ailments, reducing the symptom picture to physical outcomes⁵

⁴Although Evil Eye has been labelled and recognised as a ‘culture syndrome’, I make use of the concept *folk illness* when referring to perceptions and practices concerning this illness, since the term is closely associated with traditional healthcare understandings and approaches rather than clinical ones.

⁵According to Cassidy (1982) and Ritenbaugh (1982), ‘1)The symptoms [of culture-bound syndromes] may be recognised and similarly organised elsewhere but are not categorised as the same dysfunction or ‘disease’; 2) Treatment judged as successful in one cultural context may not be understood as successful from another perspective; 3) The fact that biomedicine does not include culture in its basic explanatory model leads to: (a) a failure to recognise culture-bound syndromes within Western cultures and within the biomedical system; (b) a

(cf. Hughes 1990, 1996).

This model of ‘fitting’ indigenous concepts and healthcare models into allopathic epistemologies is also found among early anthropological studies of “primitive surgery” and “primitive psychiatry”, which had a large impact on the research into ‘culture syndromes’ (cf. Ackerknecht 1948; Devereux 1940). In this context the term *culture*, even when it explicitly specifies the socio-cultural context of an illness, is frequently ignored or taken as a barrier in a biomedical model. Lock and Scheper-Hughes summed this up in the following way: ‘with respect to health and illness, [an]objectivist perspective assumes that the entire range of human explanations and practices regarding health, illness, disease, and death, from evil eye beliefs to the chanting of sutras in a temple, can be rendered superfluous through the availability of affordable Western medical care’ (Lock & Scheper-Hughes 1996:43). This “mechanistic biomedical framework” (cf. Scheper-Hughes & Lock 1987) describes an understanding and construction of the body’s functionality and disease categories within ‘false dichotomies’—body–mind, beliefs–knowledge, medical–supernatural categories—in which experiences of diseases are divided between the ‘bodily realm’ (the ‘condition’) and the ‘individual/social realm’ (the ‘collective body’).

A striking improvement has been made, however, with the publication of the most recent edition of the DSM-V, published in 2013, which focused on the psychiatric nosology of illnesses that were listed as ‘culture-bound syndromes’ in previous DSM editions. Based on the review of literature from a wide range of international researchers, one of the thirteen working groups of the DSM-V Task Force, the ‘Culture and Gender Group’, underlined the importance of the criteria of gender, race and ethnicity in diagnosing and treating mental disorders. The new DSM-V replaced the concept of *culture-bound syndrome* by different dimensions of diseases and culture⁶ as follows: (1) *cultural syndromes*: ‘clusters of symptoms and attributions that tend to co-occur among individuals in specific cultural groups, communities, or contexts...that are recognised locally as coherent patterns of experience’; (2) *cultural idioms of distress*: ‘ways of expressing distress that may not involve specific symptoms or syndromes, but that provide collective, shared ways of experiencing and talking about personal or social concerns’; and (3) *cultural explanations of distress or perceived causes*: ‘labels, attributions, or features of an explanatory model that indicate culturally recognised meaning or aetiology for symptoms, illness, or distress’ (DSM-V 2013:758). This endeavour was largely

redefinition of syndromes from other cultures into medical terms so that potentially important cultural patterns (may) become irrelevant to diagnosis or treatment’ (Cassidy 1982:326; Ritenbaugh 1982:151).

⁶<http://www.ds.5.org/Pages/Feddback-Form.aspx>

influenced by public health interventions and transcultural psychiatry to address differences in classification systems, treatment criteria, clinical representation and responses to treatments for mental disorders (Regier et al. 2013).

As a result of these new definitions,⁷ *culture* is no longer a pervasive hindrance to health but a cumulative social framework. Similar to the concept *idiom of distress* (Nichter 1981), ‘a culturally sanctioned way of expressing dissatisfaction with one’s position or role at a given time’ (Wiley & Allen 2012:30), ‘culture’ refers to a collection of influences and convergences rather than an isolated, static aspect. In this sense, illnesses are always cultural, since nosologies, categories, symptomatologies and treatments are subject to cultural influences. However, although culture and social contexts were explicitly included in understandings of help-seeking behaviour and diagnosis, culture, together with gender and age, were demoted to distinct aspects of divergence in symptom presentations, risk and prevalence when making a diagnosis. Furthermore, although these aspects are supposed to be considered important, they are only considered pertinent in certain specific diseases. Additionally, the DSM-V, according to the British Psychological Society, the American Psychiatry Association (APS) ‘is promoting medicalisation of human diversity wherever symptoms seemed to vary from the DSM’s own cultural norms -i.e., where symptoms could be identified as subjectively unique...falling the APS victim to its own cultural prejudices by defining as symptoms whatever behaviours did not conform to the dominant North American behavioural model from which the DSM emerged, and by allowing for diagnoses that rely on value-laden, subjective judgments that showed little or no evidence of being caused by biological mechanisms requiring pharmaceutical treatment’ (Napier et al. 2014:1615).

Nevertheless, the recognition of cultural syndromes as a category calls attention to the importance of when and where the ‘syndrome’ takes place. In this sense, every illness is culturally constructed. Thus, even if the clinical authority prevails, extended and subsequent events become a cumulative and *meaningful* explanation that can identify and establish a diagnosis that can work for the patient and the clinical setting. Hughes (1996) stressed the point that the ontological status of ‘culture-bound-syndromes’ needs to be considered outside the biomedical, i.e., psychiatric, interpretative approach. Obeyesekere states that ‘symptoms are not disarticulated entities that have a phenomenological reality independent of culture,

⁷The new edition includes, in Section III, “Emerging Measures and Models”, a chapter regarding cultural formulations; a segment concerning “Cultural Concepts of Distress”; an Appendix, which comprises a “Glossary of Cultural Concepts of Distress”; and an approach to assessment using the Cultural Formulation Interview (CFI). The CFI consists of a semi-structured interview for research and clinical evaluations in order to better assess cultural factors and enhance clinical understanding and decision-making. It consists of 16 questions that focus on personal experiences and social context.

even though it is the culture of contemporary science. Here, too, symptoms are ‘fused into a conception’ which is the disease known as [such]’ (1985:150). Hence, the distinction between ‘folk-illnesses’, ‘culture-bound syndromes’ and ‘illnesses’ faces the same problems of personal and local importance, differentiation among individuals and groups, and treatments available or inherent to the illnesses. According to Prince and Tchong-Laroche (1987), ‘culture-bound’ syndromes (or whatever their ‘label-grip’ is) need to be approached according to their particularities: every illness is geographically delimited; illnesses are designated differently in different societies or groups; they diverge epidemiologically (e.g. prevalence rates, gender ratios and age); and the symptoms themselves do not allow for a differential diagnosis. Illnesses are not only ‘culturally’ defined but may also be socio-economically dependent, or gender-specific.

The relationship between health conditions, illnesses and the position of psychosocial and biological disorders are dimensions of cure and healing shaped by their particular system of medicine that designates not only therapeutic options but a way of life. Explanations are therefore embedded in a larger personal and social experience, encompassing historical, religious and legal grounds, for which illnesses and help seeking behaviours and beliefs can be homogeneously (i.e., in pathological terms) or heterogeneously (i.e., in psychological and psychosomatic terms) described at their different levels of functioning and effects. The fact that cultures are complex systems, each of which has its own peculiar interactions and perception, is beyond the scope of this paper. Yet by focusing on symptoms as concepts, as well as on the multi-axial aspects of aetiologies and care management, we can consider the consequences of the manifested symptomatology, their diverse interpretations, and the behavioural responses to illnesses.

Over the years, definitions of what should be considered ‘culturally delimited’ have produced different classifications, such as ‘unclassified’, ‘rare’, ‘exotic’ and ‘collective’ syndromes (Ariete & Meth 1959), ‘ethnic neurosis’ and ‘ethnic psychosis’ (Devereux 1940) and ‘hysterical psychosis’ (Yap 1969). However, these afflictions or illnesses have a cultural or social relevance that goes beyond a ‘psychiatric’ categorisation. The attempt to classify illnesses within a biomedical framework usually focuses on inclusion criteria based on the symptoms presented. Allopathic explanations can therefore provide an account of pathological causes and results in standardised treatments, yet many of the ‘culture-bound syndromes’ suggest that their physical causes are more likely to appear within one group than another, and that an individual’s beliefs about the characteristics of a dysfunction result from the strong relationship between cultural attitudes and symptoms that are recognised as ‘pathological’. In the late 1970s, John Carr outlined a behavioural-cognitive

model of culture-bound syndromes which contributed to a heuristic understanding of ‘deviant behaviour’ represented and determined culturally. The aetiologies and the cultural significance of culturally defined syndromes fall into two domains: the cultural context that determines different response variants, and the biological outcomes and pathology that are culturally encoded (Carr 1978). The potential clinical practicability of this approach, however, is still undeveloped.

One of the constraints is that folk illness categories are not ‘labels’ for specific biological pathologies. They are socially produced, modeled, integrated and shared. Thus, a ‘cultural syndrome’ should be understood as a disorder that arises not only from specific biological causes but also under certain social dysfunctions. The appearance of what is considered a culture-bound syndrome or a folk illness not only indicates important aspects that are relevant in terms of their epidemiological impact (i.e., prevalence and incidence of specific organic dysfunctions) and therapeutic covariates involved in case treatment (i.e., behavioural responses associated with specific symptoms), but also social determinants in the provision of healthcare (i.e., social and emotional support). Society and culture are not only a framework of experiencing an illness (a patho-elaborating effect) that is bound to be exclusive to particular groups or areas, but also a key to understanding what makes people to display and express (or not) a particular condition. Although there have been no public health efforts to provide a culturally appropriate treatment for Evil Eye within a ‘collaborative model of health’, the integration of models occurs among caretakers. Traditional and folk beliefs and responses to Evil Eye disclose socio-culturally constructed factors, based on self- and cultural perceptions of ethnic identity (cultural beliefs), medical access, and resources, as well as interactions with healthcare providers.

Evil Eye as a Folk Illness

Although the concept of Evil Eye has previously been regarded as a culture-bound syndrome, or generally accepted as a *belief* (a concept opposite to an acknowledged illness category) with ‘diverse biological manifestations’ attributable to cultural forms of response to adverse events, I describe Evil Eye as a socially adaptive response to symptoms and illness outcomes. Evil Eye constitutes a fragmented and unfixed aetiology concept, with the capacity to adjust into a variety of ongoing practices that can be redirected in order to overcome its symptoms. This means that Evil Eye is not a ‘secondary phenomenon’ derived from maladaptive responses in assessing symptoms derived from the illness. Moreover, it can be observed that Evil Eye acts as a meaningful stimulus involving principles of health and care that influence social relations and environments. This idea underpins dif-

ferent elements of the condition. As an idiom of distress (Nichter 1981), Evil Eye represents an ambiguous category of inappropriate social behaviour which harms the person who has been ‘looked upon’, organising behavioural, affective and social concerns regarding personal vulnerability, and transforming ambiguity into meaningful categories that trigger specific responses. This practical subjectivity is crucial in recognising what is at stake during specific Evil Eye episodes, both for those who suffer the illness and those around them, revealing that Evil Eye is ingrained in the realm of emotions and social expectations (cf. Kleinman & Kleinman 1996). When it is conceptualised as a by-product of a biological condition, Evil Eye responds to a pathology pathway that can also be understood as a clinical condition, but actually, and more importantly, it denotes an extensive experience of illness, containing overwhelming feelings and stressful life events that involve dealing with biological dysfunctions. Being a ‘by-product’ suggests that a symptom that is treated only physically and not linked to its socio-cultural variables will often be mislabeled and misdiagnosed, with the consequent possibility that that patient will become more ill.

Thus, Evil Eye should be understood as a folk-illness which occurs under specific circumstances and is always related to explicit health-seeking conditions. Evil Eye displays a need for meaning, treatment, and restoration of the social and environmental realms. The basis for defining Evil Eye as a folk-illness is not simply the subsequent effect of its perceived *nature*, but the fact that it is an illness that corresponds to specific cultural coping responses to otherwise unsolved situations, unclear pathologies and detrimental social outcomes. The integration of these traditional and folk practices derives from the Mayan native medicine system, not only as an expression of healthcare but also as an expression of social practices and organisations. Mayan ancestral medical systems and Mayan healers, although marginalised within the public healthcare system (NU 2005:14), are routed and legitimated among families and community-health practices⁸(cf. Eder 2004, 2005; Eder & García 2002). They play an important role not only in terms of treating illnesses but also as part of their indigenous cultural identity⁹and an arena of political negotiation,¹⁰within the framework of the peace accords signed in 1996,

⁸For a good example see the work of the Atitlan Ajq’omanela’ Association, a group of Mayan healers from the Lake Atitlán region of Guatemala, founded in 2013 to promote indigenous Mayan medicine and access to knowledge about ancestral healing practices.

⁹The recent Pan-Mayan identity movement in Guatemala is characterised by the use of an indigenous cultural frame, in which language, religion, spirituality, native knowledge, and symbols, among other aspects or expressions considered important parts of the Mayan culture, are revitalised and strengthened as a response to political violence and social and economic exclusion. They provide legitimacy to non-hegemonic practices or hierarchies as alternative relations of power in their communities that condemn or exclude existing Mayan manifestations (cf. Warren 1998).

¹⁰A good example of this process that recognises traditional healers as part and parcel of the

promoting indigenous Mayan medicine and access to beliefs about ancestral practice (cf. Berry 2005; Icu 2007, NU 2005). Traditional medicine in Guatemala combines concepts of health/illness, ancestral spirits, social interrelationships, religion and environment strongly connected with the Mayan vision of the cosmos, which is still present and plays a central role within the healthcare model (García 1986, 1994; Molesky-Poz 2006).

3.5 ‘Origins’ of a Mayan Traditional Medical System

The Mayan civilisation comprised the present-day area of Yucatán in Mexico, Belize, Guatemala and Honduras. It consisted of many small empires and several kingdoms, and developed an advanced (“Classic”) civilisation between 300 and 900 C.E. Some scholars refer to the structure of Mayan states as centralised, hierarchical and militaristic (Chase 1992), others as segmentary and highly decentralised (Fox et al. 1996). Through their hieroglyphic writing system (engraved on pyramids, temples, steles, artefacts, and books) and based on a pantheistic and polytheistic religious order, the Mayas expressed life as a struggle between good and evil. Within this interface, health and disease were located. Yet this dichotomy was not straightforward, since gods could change their benevolence or malevolence. The Mayas worshipped hundreds of different gods, however there was no a specific god that reigned or had completely control over the process of health/disease; instead, for each disease there was a deity who caused it and another that protected people from it (cf. Vail 2000:126-133).

The Mayas also developed three different calendar systems. The *Long-Count* (a non-repeating vigesimal and 18 base) calculated times and dates according to astronomical events. It kept track of time by using different units that range in length from a single day to millions of years. It was used for the purposes of rituals and ceremonies associated with celestial and terrestrial cycles. The *Tzolk’in* is the

new interactions that claim traditional medicine as a “strategic resource” (for identity, politics, status, and healing, and not only for medical practices) is the text of Michael Knipper, “Traditionelle Medizin als strategische Ressource in Ecuador. Indianische Heilkunde im Kontext”, in Hansjörg Dilger and Bernhard Hadolt, eds., *Medizin im Kontext: Krankheit und Gesundheit in einer vernetzten Welt*, 2010, pp. 203-222. According to Knipper this process is the result of two developments within society and the political arena that draw attention to practices of traditional medicine. One is that during the last few years the dynamics of complementary and alternative medicine have enjoyed a global recovery, which has had an impact in Ecuador. The second aspect concerns the social movements among indigenous groups in Ecuador and other Latin America countries, such as Guatemala, since the 1990s. These have caused substantial changes in the political landscape, which justify the legitimacy of traditional medicine and the need for its official recognition and promotion as a part of the identity rights of the respective indigenous groups (Knipper 2010:205).

ritual or sacred calendar which used a count of 260 days, giving each day a name (Aveni et al. 1995; 1996). There were 20 day names and the days were numbered from 1 to 13 (Marcus 1976). The numbers 13 and 20 held great significance for all Mesoamerican cultures, and were particularly important in the Mayan rituals of divination. The *Haab* calendar (equivalent to the 365-day Gregorian calendar), used for Mayan zodiac astrology, is made up of 18 months, each consisting of 20 days, and one month that consists of 5 nameless days called the *Wayeb* (cf. Bricker 1982).

Celestial events such as equinoxes, solstices and eclipses were marked by ceremonies at Mayan temples. The Mayan priests interpreted these cycles and predicted the future or looked at past events based on the number relations among all the calendars. They believed in the existence of three levels of the cosmos: the sky, the earth and the underworld (Xibalba). Hunab Ku, translated as “the creator god” or “only god”, was completely restrained after finishing with the world’s creation. His son Itzamná, founder of the Mayan culture, the sun god, lord of heaven, god of life and therefore associated with fertility, became interested in terrestrial matters, and is said to be the inventor of hieroglyphic writing and books of omens and medicine. Itzamná was worshiped as the god of medicine during the Mayan ‘zip’ (September) month. He taught people to grow maize and cacao. Ixchel, Itzamná’s wife, was the goddess of the moon, water and flooding, and also the goddess of midwifery and medicine. These two were part of the Bacabs, the four siblings who were positioned on each of the cardinal points, held the universe, were associated with various natural phenomena, and could cause illnesses. While Itzamná and Ixchel were protective gods, the other two siblings, Ah-Puch (god of death) and Ixtab (goddess of suicide), stalked the sick. Another deity was Cit-bolon-tum, protector of health and god of medicine and healing (Tedlock 1996).

The *Pop-Wuj*, the Mayan mytho-historical book of the post-classic era (1000–1697 C.E.) of the K’iche’ people, mentions several demonic gods who lived in Xibalba, ruled by Hun Camé and VucubCamé. The book also refers to at least 200 pathological syndromes (Birman 1996). Among the gods mentioned are Ahalcaná, who caused jaundice, painful swelling and dropsy; Ahalpuh, who caused pus; Ahalto-cob, who ‘caused misery’, and Ahalmez, who ‘made filth’ around wounded men, leaving them unprotected; Cuchumaquic and Xiquiripat, who caused bleeding; Chamiabac and Chamiaholom, who weakened people until they died; and Patán and Quicxic, who caused vomiting of blood and sudden death. Shamans or *ah-men* belonged to the Mayan priestly class, which was a hereditary profession. They maintained a close relationship with the Chilam Balam (jaguar priest), repository of the traditions of the people and the calendar manuscripts; they were also div-

ination experts, who understood the astrological causes of diseases and epidemics. Because of their relationship with the Chilam Balam, the *ah-men* learned healing techniques and therapeutic management of animals, plants and minerals, who were intermediaries between natural forces and men (Roys 1934). Parallel to the *ah-men* were healers, who had extensive knowledge of medicinal herbs, and *kasbac*, who cared for dislocations and fractures.

In the Mayan system, diseases could therefore result from various aetiologies: punishment from the gods after any offense, transgression of any taboo, disobedience or violation of the divine laws, human intervention such as black magic, and as the result of natural imbalance (body temperature or food) (cf. Foster 1994; Selin 2003:259-284). When a disease appeared, villagers sought to restore health through religious therapies, no matter the origin of the disease, being cured by some deity to whom they prayed, made offerings, and sacrificed. Practices of communal expiation, self-sacrifice, wound suction, thermal baths, herbs, and amulets were also among the cure or prevention practices (Chinchilla 2003).

The worldview that prevailed during the pre-Hispanic period underwent a radical change with the conquest. In general terms, the roots of people's current understanding and treatment of diseases derive from the views of both the pre-Hispanic and the colonial periods (Cerón 2007; Newson, 2006; Orellana 1987; Wilson 1995). Present-day events and meanings have become part of a pluralistic medical system and understanding of health and illness. An illness is still primarily lived as an expression of alterations of subjective and intersubjective orders, revealing ties with the social and (super-)natural world, and healing is always a process of restoring the lost balance or 'healthy state' (cf. PIES 2009). An illness can also be a collective event that affects the whole community. Healing processes seek to restore order, repairing the damage through the use of ritual and symbolic elements significant for both the patient and the community. According to modern Maya, Qtxu'Tx'otx' (mother earth) and her inhabitants are intrinsically connected, a fundamental holistic idea that influences the understanding of diseases and the inclination to choose folk medicine over biomedicine (Calan 2012). Tedlock (1992b) noted that among the K'iche' of Guatemala highlands, some illnesses can be a sign—part of a call to serve gods and ancestors. In this sense, illnesses are not a punishment but a form of blessing, an opportunity for the sufferers to endure and prove themselves as healers.

During the Classic and post-colonial Mayan periods, medical and religious practices were integrated in order to deal with epidemics. Divination was an important strategy to develop actions to ensure recovery, inform afflicted people of an imminent death, and protect the community from the effects of impending epidemics.

Measures against the new epidemic diseases introduced by the Europeans were also incorporated into a wide array of indigenous ritual practices (Few 2012:306). New saints and rituals were created to protect people against epidemics and disease events, such as the cult of San Pascual Baylon, considered the patron saint and protector of Guatemalan towns against illnesses, especially among indigenous people (idem, pp. 308-309); he is one of many Catholic saints hybridised with Mayan religiosity.¹¹ As a result, the complex modern-day set of beliefs and behaviours relating to illnesses, healing, wellness and healthcare is the product of several different cultural and social interactions in which religious syncretism extended into the sphere of medicine. Tedlock's interpretative approach to humoral medicine explains that 'when Latin American medical systems are described phenomenologically and interpreted hermeneutically, it can be seen that they are like those of other colonised and now 'modernising' societies. They have combined and continue combining indigenous, colonial, and modern medical beliefs, values, and institutions in various complementary and contradictory patterns' (1987:1071). Similarly, Cosminsky concludes that 'much of what is regarded as 'traditional' medicine today is the amalgamated syncretism of this earlier pluralism of indigenous and sixteenth-century Spanish medicine and religion' (1983:160). Colonial and post-colonial history deeply shaped what is now the contemporary indigenous pluralistic healthcare system. Furthermore, more recent political and social struggles, such as the 36-year civil war, have promoted narratives and practices in which traditional medicine has emerged as a 'cultural project' for the formation of a pluricultural state that recognises traditional healthcare practices (Palacios 2009).

¹¹Olintepeque, a municipality in the Quetzaltenango department of Guatemala, located on the Xekik'el River, has a temple which is believed to hold the skeleton of San Pascual Baylon himself. The saint is said to have materialised in this part of the world in the form of a miniature human-like skeleton that was discovered buried in the surrounding hills during Spanish colonial rule. According to the historian Francisco Antonio de Fuentes and Guzman, San Pascual's name was Friar Pascual Baylon of Spain. In 1650, an indigenous person in San Antonio Aguacaliente (now Ciudad Vieja) was dying of an epidemic fever called *cucumatx* in Kaqchikel. He had received the last rites when he had a vision of a tall skeleton dressed in bright clothes. The figure presented himself as "San Pascual Baylon". San Pascual promised to intercede and remove the scourge of *cucumatx* if the community adopted him as patron and venerated his image. As proof of his identity, he predicted that in nine days the ill man would die and end the epidemic. When the man died in the predicted period and the epidemic passed, San Pascual (or Pascualito) became popular despite a ban by the Spanish Inquisition. San Pascualito is also known as San Pascualito Death and San Pascual King, represented as a skeleton carrying a cape or crown. According to some historians, it is possible that the roots of the tradition of San Pascualito date back to pre-Columbian times, representing a pre-Hispanic god of death (cf. de Fuentes y Guzmán 1969).

Medical Pluralism in the Americas

Medical pluralism in the Americas flourished during the colonial period that began in the sixteenth century. New institutional frameworks were created in the Spanish colonies, applying laws and establishing institutions that transformed and affected every aspect of peoples' lives. Colonialism had a considerable impact on health-care and medical practice. At this time, secular medical knowledge and practices dominated by the Hippocratic medicine of the ancient Greeks (Foster 1994) were introduced in the New World. Even in Europe, perceptions and practices regarding illnesses made little distinction between religion and magic; therefore, they did not differ significantly from the ideas of witchcraft, spirit possession, soul loss, or punishment for transgressing taboos in pre-Columbian Africa and the Americas (cf. Aguirre, 1963; Warinner et al. 2012). Moreover, the similarities between humoral medicine and the conceptions of hot-cold, balance and equilibrium among the Maya and Aztecs may have eased the adoption of the Greek humoral system, rather than causing a major clash between models of healing (López 1980:300-311; Birn&Necochea2011:510; Orellana 1987:167-169; Viesca 2001).

During the colonial era, the providers of health services included hospitals, convents, pharmacies and gardens (from where convents obtained herbs for *boticarios*). These corresponded to the institutions and religious orders of the Spanish empire, promoting medical care as a 'charity' which repressed native practices that ran contrary to Catholic beliefs (Campagne 2000:421-425; Newson 2006:379; Sowell 2003). A few exceptions were granted to some native healers in Mexico who received permission to continue practicing, since licensed physicians were outnumbered while the institutionalisation of universities across the continent was underway (Viesca 2001). Indigenous beliefs and practices, however, were not completely suppressed, but performed clandestinely or in a syncretic way (Taussing 1980:170-171). Additionally, during the Inquisition, the Crown tolerated "traditional" healing practices due to the lack of physicians or technical practitioners in Spanish territories (López 2009).

Since sickness was viewed as the result of God's punishment or the Devil's act, the Church instituted hospices and hospitals controlled by religious orders to take care of the ill rather than provide them with treatment (Lindemann 1999). During the 15th and 16th centuries, Spain exercised power over the practice of medicine through university chairs for teaching medicine, and regulatory boards that licensed practitioners such as physicians, surgeons, and apothecaries (TePaske 2000:55-64). The formal training provided to surgeons and apothecaries gave them a privileged status over other medical experts such as bonesetters, phlebotomists,

and barbers (Goodman 1988:219-221). It was during the Renaissance that Paracelsus, with his hermetical views, influenced an approach to disease that favoured practical procedures used by surgeons, apothecaries and unlicensed practitioners. This also enabled cross-cultural exchange of texts and practices (cf. Porter 1999; Porter 1997). This kind of exchange was later banned by the Catholic Church during the Reformation, when the Inquisition maintained that chemical theories were the consequence of witchcraft (Newson 2006:370-371). Spanish medical domination in the New World was in part the consequence of the demographic collapse of the native inhabitants due to exposure to Old World diseases such as smallpox, malaria, and measles, etc. Furthermore, the European trading posts and settlements in the Americas, Africa, India and China had a detrimental effect on the practices of traditional local healers, despite the lack of efficacy of many of the Spanish treatments (Few 2012). New epidemics in the Americas proved that European medicines were inadequate against such diseases. The progress of scientific medicine in Europe and the colonies, however, did not develop into a homogenous system of medicine, even when there was a deliberate attempt to establish and regulate medical practices as a part of the colonial administration, such as the regulatory royal boards (*protomedicatos*) and the introduction of humoral medicine at hospitals (Newson 2006:368). Instead, the newer practices coexisted with the ways and understandings of the indigenous people.

In Spain itself, popular healers were also consulted by the majority of the population, including the elite, even though secular medicine was already embedded there (cf. Aguirre 1963; Gutiérrez de Pineda 1985). The persistence of folk medicine in Spain inclined some of the missionaries and other Spaniards in the colonies to take into account the systematised knowledge of the native people regarding medicinal plants as well as the exercise of magic-religious beliefs (cf. Flores 2003:8). The empirical healers who made use of natural treatments included midwives, bonesetters, and dentists, but also practitioners referred to as astrologers, necromancers, conjurers, magicians, sorcerers and witches who combined natural treatments and magical practices with Christian prayers and relics to cure ailments such as Evil Eye and other folk illnesses (Newson 2006:373). Subsequently, beliefs, perceptions, practices and traditions from Spain and its other colonies were integrated into those existing in the Americas. The forms and shapes that these borrowings took in the region were environmentally, politically, and socially dependent (Gutiérrez de Pineda 1985), underlining both the heterogeneity and the shared (neo)colonial conditions around the region.

According to Few (2012), smallpox was not only the most destructive epidemic introduced in the Americas; it also introduced significant new practices among

the native Guatemalan population, launched by the colonial elite to protect the Crown's economic interests, as well as for 'humanitarian' reasons. Smallpox was known to be especially deadly to indigenous populations. With the publication and distribution of the medical manual "Method Used for Curing Measles and Smallpox" in 1769, medical treatments and religious traditions became intertwined in order to provide care to those who were afflicted by the epidemic. Therapies and treatments included practices rooted in Galenic humoral theory, but also contained specific prohibitions of indigenous cultural, dietary, therapeutic and ritual practices considered to be a threat to official medical interventions (Logan 1973).

In 1780, the practice of variolation (an early form of vaccination) to stop smallpox and other epidemics, was introduced through the *protomedicatos*, along with political and religious discourses from the Catholic Church and the 'Royal Audiencia of Guatemala', a superior court established during the colonial period (Lanning 1985). These 'discourses of medical humanitarianism' encountered local resistance when the population resisted coercion in connection with public health campaigns and medical therapies that were not part of the local therapeutic practices (López 2009; TePaske 2000). The techniques of domination included imprisonment, physical abuse, temporary occupation by local militia, forced medical measures, and the destruction of ritual therapeutic sacred spaces (Lovell & Lutz 2000). Audiencia officials established a special "smallpox tax" which was supposed to be used to cover the expenditures of helping indigenous communities, excluding from such assistance those who belonged to another social order or 'race'. Indigenous elites, however, were forced to become 'allies' of the colonial governing powers in order to enforce the prescribed guidelines. When disobedience occurred, indigenous elites were publically lashed and suspended from their political duties (Few 2012).

Before these actions took place, public health measures based on the conception of 'moral responsibility' were enacted. These consisted of quarantine, strategies for food distribution and shelter, and Catholic ritual strategies (such as public processions and public prayers) to intercede for the ill, especially when biomedicine was ineffective (Orellana 1987). Interestingly, handbooks about smallpox and other medical practices and procedures not only denounced some indigenous practices as risky behaviours, but reinforced and transformed other local strategies of healing. For example, Galenic medicine and humoral theory—which focused on the hot-cold dichotomy to restore health—considered that the weakness of the indigenous people in resisting smallpox and measles was the result of the use of steam baths and the consumption of 'hot' food and drinks. Some of these ideas reinforced cultural perceptions and responses to illnesses, which strongly affected the response to biomedical concepts of disease—accepting some of these concepts, adapting

others, and refusing still others (cf. Hernández & Foster 2001, Orellana 1987).

Medical Pluralism in Contemporary Guatemala

At present, complementary and alternative medical consultations appear to be confined mainly to urban areas, while traditional medicine is still heavily concentrated in the rural areas of Guatemala, in particular within the realms of maternal health, birth attendance and child care (cf. Harvey 2011; Replogle 2007). Traditional and folk medicine are still easier to access and practice in these regions than allopathic medicine. This has become an important focus of national programmes seeking to introduce safe practices to reduce maternal mortality from haemorrhage, preeclampsia, complications caused by obstructed birth and abortion, and other problems that are not easily recognised or treated by traditional or alternative medicine (Chary et al. 2013; Cosminsky 2001; Foster et al. 2011).

Faith healing also constitutes an important resource to treat unexpected conflicts, bad crops, misfortune or illnesses. Traditional values, cosmology and ideology together shape the ceremonies and practices that are employed to restore the well-being of the person who falls ill. In faith healing, divine intervention is invoked to protect the sick person from death or prolonged suffering through prayers, sacrifices and special rituals which are the result of religious syncretism in rural areas of Guatemala (Mayan spirituality, Catholicism, and more recently, evangelical Christianity, which has been spreading since the 1976 earthquake) (cf. Adams & Hawkings 2007; Fitzpatrick 2009; Icó 2007). In some cases, faith healing—usually performed by an *ah-men* who can communicate with spirits and control them—is also practiced when the ailment is considered to be the result of a spirit invasion or provoked by another human. The presence of religious groups since the 1960s, such as the Maryknoll Sisters, a Catholic women’s religious order that became the center of a medical programme in the Department of Huehuetenango, has deeply impacted healthcare behaviours, particularly their selective integration and transformation of rituals, beliefs and practices of faith and healing (cf. Fitzpatrick 2009). Catholic groups such as these, who are the only biomedical providers in some remote rural areas, have transformed some aspects of the traditional medicine of these communities.

One of the traditional healing methods still widely practiced is the curative and preventative use of herbs. A few clinics called *naturalistas* have specialised in treating a variety of ailments with the use of herbal plants. These new forms of commercialisation of traditional medication have, however, displaced certain indigenous medical practitioners. There are no laws regulating patents or other intellectual property rights in connection with the use of traditional plants for

healing purposes. One of the government health initiatives to include traditional medicine in the primary and secondary levels of healthcare refers to optional use of some of Guatemala's medicinal plants,¹² whose availability, medicinal properties and efficacy (in biomedical terms) are 'guaranteed'. The use of medicinal plants is referred to as 'common wealth' and is not restricted to traditional practitioners. As a result, most of these *naturalistas* clinics are staffed by health professionals such as nurses (mostly men) who have acquired some experience as healthcare workers. Herbal remedies are the main form of therapeutic health management despite the access to pharmaceutical treatments, yet the provision of PHC in rural communities has obviously affected the exclusive use of traditional medicine and self-therapy management.



Figure 3.1: 'Clinica Naturalista' in Comitancillo

The ethnographic foundation of this research shows that women who are subjected to various forms of discrimination, economic dependency and isolation make use of therapeutic methods that are not necessarily economically driven, but rather follow social practices that provide access to therapies and case management in which the use of medical herbs play an important role. For Evil Eye treatment, self-efficacy and the use of medicinal plants is integrally related to caretakers' behaviours. By using local resources that do not require economic capital, caretakers not only provide healthcare but expand their agency as direct providers of thera-

¹²http://mispas.gob.gt/salud/web/images/stories/proteccion_de_la_salud/medicina_tradicional/MedicinaAlternativa1.pdf

peutic treatments. Yet, pharmaceutical treatments are also widely used, and are sometimes a primary and direct contact to a biomedical therapy management that has facilitated and increased self-medication. Because of a lack of regulations, monitoring and sanctions, many pharmacies can provide pharmaceuticals without a prescription even when a prescription would normally be required (cf. Cosminsky 1994; Smith et al. 2000)—a practice that threatens to reduce drug efficacy through overuse.

In parallel to both biomedical drugs and locally available herbal remedies, private (and sometimes unregulated) mini-industries have started to profit from traditional plants and treatments, selling traditional medicines as well as generic pharmaceutical drugs. This is a new form of public health providers, operating under the descriptive umbrella of ‘plural medicine’ identified by Harvey (2011) and known as ‘Maya mobile providers’. They are usually men, who work as wholesalers and distributors of a variety of therapeutic products produced by emerging manufacturing industries. Cheaply manufactured traditional medicines and drugs are propagated through these itinerant wholesalers who promote the ‘power’ of certain plants and balms that are “less dangerous and expensive” than standardised pharmaceutical drugs against common pains or illnesses that can be self-diagnosed. The use of both biomedical resources and folk concepts and approaches has thus attained a new image, promoting a pluralistic health model based on the interaction among allopathic medicine, pharmaceutical companies and an imagined form of *modernised* traditional medicine.

3.6 Traditional health system within a globalised world

At a World Health Organisation (WHO) meeting on the ‘Promotion and Development of Traditional Medicine’, experts from the African region defined *traditional medicine* as “the sum total of all the knowledge and practices, whether explicable or not, used in diagnosis, prevention and elimination of physical, mental or social imbalance and relying exclusively on practical experience and observation handed down from generation to generation, whether verbally or in writing...might also be considered as a solid amalgamation of dynamic medical know-how and ancestral practices” (WHO 1978b:8). Although the WHO recognised the importance of this specific model of attention, it also simplified and misrepresented its nature when it referred to it as essentially weak and offering only ineffective measures: “[traditional medicine] needs to be evaluated, given due recognition and developed so as to improve its efficacy, safety, availability, and wider application at lower cost...it

is particularly effective in solving certain cultural health problems' (ibid., p. 13). It also suggests that traditional medicine 'in some developing countries has tended to stagnate through not exploiting the rapid discoveries of science and technology for its own development' (ibid., p. 9).

The term 'traditional healer' (TH) usually evokes the notion of a lay person who has informally learned (by a supernatural call from ancestors or by the tradition passed on from an elder) to manage or treat illnesses of a physical and/or emotional nature that fall in the realm of 'ambiguous medical diagnosis, i.e. of cultural order', as well as chronic diseases that are perceived as impossible to cure. A TH may make use of medicinal plants and minerals, among other palliative measures that help to treat or alleviate a patient's ailment. In some cases the healers function as diviners or intermediaries when an illness is of a supernatural order. The term TH is a generic term to designate a variety of healthcare providers who vary widely in knowledge, practices, and realms of care.

Traditional healers are a very important social resource in communities. In rural San Marcos, they not only help people to overcome problems related with illnesses, but occasionally also offer traditional ways of resolving social tensions among families or communities, or give advice to prevent environmental threats or hazards to their communities. They are active members of their communities because of their recognised social power. The term 'healer' is used in local contexts. The WHO refers to them as traditional health therapists who are 'recognised by the community in which they live, as competent to provide healthcare by the use of plants, animals and minerals, applying other methods of social, cultural and religious meaning, based on the knowledge, attitudes and beliefs of the community in regard to physical, mental and social, physical, mental, and social well-being and the origin of the disease and disability'.¹³

Within the Guatemalan context these healers include therapists, midwives, *chayeros*,¹⁴ bone setters, wise guides, prayer makers and Mayan priests who are recognised by the community to treat afflictions that are embedded in cultural particularities (Eder & García 2002; Ellsworth 1996). Traditional healers often specialise in particular ailments or specific ages or genders. Normally, the work of a healer is due to a 'call' or family tradition which defines his/her duty to serve the community he/she lives in. Because of this, their work is usually not directly or explicitly

¹³ Organización Mundial de la Salud (OMS) (1978): "Promoción y Desarrollo de la Medicina Tradicional", Serie de Informes Técnicos No. 622, Geneva, p.7.

¹⁴ *Chayero* refers to a Mayan physician in charge of healing physical ailments related to blood circulation, such as swelling of veins in hands and feet and anaemia. He uses blows, squeezes, baths, bloodletting, and similar techniques to treat the ailment or disease, usually accompanied by incantations, prayers and the use of medicinal plants (Mendizabal 2007:100).

remunerative, although people offer them gifts or pay a symbolic sum appropriate to the problem, cure or treatment¹⁵ (cf. Huber & Sandstrom 2001). In the context of Evil Eye in San Marcos, healing practices are generally performed by other members of the community and not solely traditional healers, and payment takes the form of reciprocity. This not only promotes solidarity among the community, but also means that a sufferer need not depend on specific persons when help is required, with the result that *ah-men* or midwives or healers are not automatically sought out, as long as the child is not perceived as requiring particular care.¹⁶

Whereas the work of midwifery coexists with the biomedical system, other types of rural medicine are relatively autonomous (cf. Chary et al. 2013; Maupin 2008, 2009, 2011). Shamanism and bone-setting continue to be practiced in a relatively rudimentary way in which biomedical paraphernalia is not employed, and the relationship between healer and patient does not take place in a ‘sterile’ and ‘fixed’ environment such as a clinic. Although some studies regard their presence as a result of the lack of national medical services (cf. Adams & Hawkins 2007), some ethnographic studies also mention the importance of their presence in settings where PHC is inappropriate. This orientation, however, does not imply that indigenous healing practices are used only occasionally. Traditional medicine comprises a complete social and community health system that reaches and treats many kinds of disorders or ailments, sometimes with outcomes superior to the allopathic medicine model because it relies on particular notions, values, social dynamics and networks that have positive effects on the therapy management (cf. Jansen 1987).

The effort to incorporate TM practices into national health systems has failed precisely because it emphasises the distribution of standardised health programmes and procedures, following specific diagnoses and treatments oriented towards a more medicalised and clinical approach. As an ideal image of ‘modern treatment’, allopathic medical models allocate to traditional healthcare the role of a palliative system. It fails to recognise that some people are reluctant to accept a biomedical health model based on the idea that acute and infectious diseases can be effectively treated and cured by biomedical health professionals. However, chronic diseases, or illnesses that are “magical” in nature and defined by vague features, could remain

¹⁵ Within this framework, people differentiate between traditional midwives and ordinary midwives (*parteras*). The former is recognised as women who have had revelations or dreams, have a specific *nahual* (animal spirit) or suffered a dangerous illness; these experiences mark them for work in their communities, and they work for free. The latter are defined as females who learn allopathic approaches to attend deliveries. They lack ‘energy’ or spiritual connection with their patients, do not apply traditional practices such as the use of sweat lodges, and work for payment.

¹⁶ These aspects are explained in depth in Chapter VI.

within the realm of traditional healers (cf. Foster 2010:396), as long these do not prevent compliance with a fully biomedical treatment. Studies of the acceptance of allopathic medicine have always drawn attention to a ‘natural order of things’, placing the work and services of TM in a naturalistic or ‘Darwinistic’ approach, in which the ‘old’ or traditional model needs to evolve, adjust and become incorporated into the modern national health systems in order to survive, or else accept its inevitable disappearance. Some countries, however, encourage exceptions to this assumption. For example, in Nepal there is a formal training programme and a department for Ayurvedic medicine (Cameron 2009). In Zanzibar in 2008, the Ministry of Health announced a policy aimed at managing the activities of healers and developing traditional medicine in the private and public health sectors (cf. Meier zu Biesen et al. 2012). Several other WHO member states have national policies, laws or regulations on TM/CAM, such as Mexico, Ecuador, Peru and China, where TH practitioners are officially recognised (cf. Knipper 2010; WHO 2002c).

The Alma-Ata Declaration of 1978 was the first international attempt to recognise practices of traditional medicine. One of its goals was to incorporate traditional practices as a part of the PHC strategies to reduce communicable diseases. Thus, since its introduction in 1978, the WHO’s ‘Primary Healthcare Initiative’ has actively recognised situations where medical pluralism models prevail, with the idea of encouraging members of the community to take advantage of their own local resources to respond to the specificities of their context (Stone 1986). Such guidelines have had different effects on the use of traditional medicine and the authority of traditional practitioners. The WHO also advocated the incorporation of traditional medicine into health planning and promoted the regulation and professionalisation of traditional healers, recognising that this model of care is low-cost, easily attained, and culturally acceptable among a large population in developing countries (WHO 1978b). This initiative resulted in several studies that have documented the value of local knowledge and the practice of traditional medicine and care. In some countries this research has led to the integration of traditional practices into the official health system (cf. Agbor & Naidoo 2011; Maclean & Bannerman 1982; WHO 1991a). However, folk/traditional practitioners, who sometimes play a specific role in their communities with great independence and authority, are sometimes questioned or ignored within the ‘production of health’ (cf. PIES 2009). As a result, the priorities and programmes of WHO’s proposed global health initiatives, the models that typically received funding in order to strengthen national health systems, did not include traditional practices.

Prior to the 1978 WHO resolution, indigenous healthcare or traditional medicine

was recognised as an important and sometimes exclusive resource, especially in areas suffering economic crisis and political disruptions (Hyma & Ramesh 1994). Yet the Primary Healthcare paradigm hoped for a transition of traditional medicine from being the only source of healthcare, to a complementary resource, and then towards a palliative option when necessary. Discussing the role of traditional healers, Foster noted that ‘the question of recognition of traditional healers is important because ...the fact remains that no scientific medical system completely satisfies all health needs of a nation’ (2010:402). Some THs have been successfully integrated (after some training in guided programmes) within the institutionalised health services, although with a subaltern or supplementary role, as assets to community advisory boards. Countries such as South Africa (see Kale 1995) that have integrated THs in this way have given them a key role as a “bridge” between their communities and formal health services. Promoting referral of patients to biomedical health facilities has been a strategy to include THs in public health programmes to collaborate in health promotion (Meier zu Biesen et al. 2012).

Within the biomedical community, traditional medicine is regarded as problematic because, in communities where it is an important part of healthcare provision, THs are seen as a cause of delay in seeking effective healthcare, and as a source of ineffective treatments. However, although behaviours diverging from standard biomedical treatment are often perceived as ‘problematic’, the work of trained birth attendants (TBAs) remains important because of their major role in the provision of primary healthcare and the reduction of maternal mortality in rural areas (cf. Goldman & Gleit 2003; Hinojosa 2004). The scarcity of resources for allopathic models of care means that the inexpensive work of TBA is valuable in addressing maternal and child health problems, especially since the work of THs normally takes place in rural or indigenous settings in which the process of healing integrates a shared world-view, values, and theories of causation and treatment of illnesses (cf. Berry 2005). Through specific ‘child healthcare’ agendas, TBAs also support facility-based care by referring and encouraging pregnant women to seek help at health facilities (cf. Berry 2005; Eder & García 2002; Hyma & Ramesch 1994).

PHC strategies regard allopathic healthcare and facilities as fundamental to defeat preventable diseases in developing countries. Although limited personnel and equipment, as well as problems of inappropriate care, are recognised as barriers to implementation, the allopathic health system is generally considered superior to traditional models, which have been associated in unequivocal terms with poverty, ignorance and unsanitary conditions. In this regard, Briggs and Manti assert that ‘Snow’s success story [of environmental contamination and its role in cholera epidemics] was used as a compelling model of how modernity could be achieved:

scientists would generate authoritative knowledge that public health officials would use to enlighten the press, politicians, and public, thereby catalysing the modernisation of institutions, infrastructures and behaviour' (2004:287). The promotion of pluralistic health models within globalised guidelines that are supposed to establish the 'effectiveness' of an allopathic health system are constantly confronted with local dynamics that not only struggle against, but also transcend, the boundaries of discursive approaches to healthcare policies.

Revamping the role of traditional medicine within global healthcare programmes

Global health initiatives have sought to confine the role of traditional medicine to areas with limited access to formal healthcare services. It was often identified as a *cultural* resource of healing rather than a qualified tool of care. Referring to traditional medicine as a cultural practice suggests that its efficacy is only contextual and needs to be constantly validated and evaluated through drug and clinical trials (cf. WHO 1978b). In this context, medicinal plants have received special attention, with research to test their effectiveness in order to produce pharmaceutical drugs. Traditional pharmaceuticals have become an 'international commodity' with national and international markets (Davey 2013; Grifo 1994). Furthermore, this process of bioprospecting (the exploitation, extraction and screening of biological diversity and indigenous knowledge for commercially valuable genetic and biochemical resources) has broad political and economic implications (Rutert & Dilger 2011:2). Increased interest in phytopharmacology has resulted in the study of medicinal plants to treat re-emerging diseases (cf. Wangchuk 2008) and tropical diseases (such as lymphatic filariasis, leprosy, leishmaniasis, malaria, schistosomiasis, and trypanosomiasis). The WHO has even created a special programme to investigate the role of traditional medicinal plants in countries where these diseases are endemic (WHO 1978b:31-35).

In 2002, the WHO developed a framework to assist countries in the promotion of traditional medicine in national health services through the 'Traditional Medicine Strategy 2002-2005' and with the current 'Traditional Medicine Strategy 2014-2023' (WHO 2013a). This framework also stresses the importance of studies to evaluate the generalisability and applicability of medicinal plants, their control and regulation (including intellectual property rights of traditional medical knowledge), and the production of herbal medicines via normative guidelines and documents, with the involvement of the holders of this traditional knowledge (cf. Davey 2013). However, instead of an exchange of knowledge, both traditional and biomedical understanding of the use of medicinal plants have been ambiguous and isolated.

The study of medicinal plant knowledge with contemporary biomedical resources is perceived as relevant to this framework, since traditional medicine is not based on clinical trials which generate mistrust of its efficacy and safety.

In response to the many difficulties that have been encountered in fully adopting the WHO/UNICEF recommendations for primary healthcare services, health policy makers and researchers have explored the reasons for their underutilisation (especially pregnancy-related programmes and child care). These studies identified socio-economic factors, accessibility to health services, social cost, and ethnicity as important factors (cf. Foster 2010; Gleit & Goldman 2000). Thus, ethnomedicine gained political interest in the late 1970s, after the WHO and UNICEF developed policies to ‘integrate’ and ‘acknowledge’ traditional medical models within ‘modern’ Western health systems (cf. Pigg 1997; Pillsbury 1982) through the program “Health for All by the Year 2000” (Rohde 1983; Mahler 1981; WHO 1982b). Thus, these international agencies sought to promote an equitable distribution of PHC resources (Hyma & Ramesh 1994), especially for impoverished indigenous and marginalised people. Specifically, effective PHC:

VII (1) reflects and evolves from the economic conditions and socio-cultural ... characteristics of the country and its communities...; (5) requires and promotes maximum community and individual self-reliance and participation in the planning, organisation, operation and control of primary healthcare, making fullest use of local...resources...; (7) relies, at local and referral levels, on health workers as well as traditional practitioners as needed...to work as health team and to respond to the expressed health needs the community (WHO, Declaration of Alma Ata 1978).

Further, the WHO programme “Promotion and Development of Traditional Medicine” of the same year 1978 was developed as a plan of action to make practical suggestions to integrate traditional medicine within healthcare systems. Subsequently, international agencies established health programmes which targeted countries in Africa, Asia and Latin America to ‘overcome diseases’ via biomedical models and therapies in which indigenous medicine was included. However, the incorporation of traditional systems and practitioners, especially healers, into national health systems was rarely accomplished. Instead, a more globalised perspective regarding healthcare and understanding of ‘well-being’ and a healthy physical condition has prevailed within the international health plans. A ‘globalised healthcare model’ in the context of plural medicine tends to assimilate indigenous medical plurality, particularly among midwives or female healers, disempowering and transforming (gendered) practices (cf. Cameron 2009; Cosminsky 2001; Mc-

Clain 1989). Accordingly, Foster underlined three main principles that prevail in international health policies:

- (1) The institutional forms and clinical practices of the medical systems of technologically advanced nations are the appropriate models for the development of health services in all countries; an ethnocentric approach which allocates implicitly other health systems in disadvantage.
- (2) Medical and public health programs in developing countries will be more successful if in design and operation they take into consideration the social, cultural, and psychological characteristics of the target group. This principle relies on the assumption that a Western (health) is a role model, therefore excluding traditional healthcare models; and
- (3) The most successful medical and public health programs in developing countries require knowledge about the social, cultural and psychological factors inherent in the innovating organisations and their professional personnel i.e. major barriers are found in the target group and culture bureaucracies (Foster 2010:394-395).

Thus, a 'globalised healthcare model' is based on 'westernised' standards that fail to take into account traditional practices that do not operate within an institutionalised clinical knowledge and approach, since the policies, and the illnesses themselves, are framed, defined, evaluated and enacted by the dominant discourses and trends in healthcare. Public health services therefore were reluctant to integrate traditional practitioners who could not adapt to biomedical models. The claimed superiority of scientific knowledge also made it clear that socio-cultural aspects embedded in health practices were a potential threat or barrier to allopathic treatment adherence. A hierarchical relationship of inclusion and exclusion was thus formed within the international discourse (including the World Bank, the International Monetary Fund, USAID, the World Trade Organisation, and UN agencies, among others), requesting specific actions to implement these meta-policies in countries that would depend on international financial support of these agencies. Under globalised health policies and models, each individual member nation of the WHO brought into rural communities medicalised programmes that reflected cultural understanding and norms that sometimes conflicted with local practices. Although modern scientific guidelines encouraged the incorporation of traditional medicine and recognised its empirical validity, in practice, the programmes failed to provide room for traditional medical healthcare (cf. Pillsbury 1982:1826-1827). In its Thirteen World Health Assembly, the WHO stipulated that:

'considering that immediate, practical and effective measures to utilise traditional systems of medicine fully, are necessary and highly desirable: 1. Records with appreciation the efforts of WHO to initiate studies on the use of traditional systems of medicine in conjunction with modern medicine; 2. Urges interested governments to give adequate importance to the utilisation of their traditional systems of medicine with appropriate regulations, as suited to their national health systems; 3. Requests the Director-General [of the WHO] to assist Member States in organising educational and research activities and to award fellowships for training in research techniques for studies of healthcare systems and for investigating the technological procedures related to traditional/indigenous systems of medicine; and 4. Further requests the Director-General and the Regional Directors to give high priority to technical cooperation for these activities and to consider appropriate financing of these activities' (WHO 1977; emphasis added)

Since traditional healers are found in most societies, they are quite often referred to as a relevant part of their local communities due to their influential role in local health practices. The "Primary Healthcare Programme" stresses that the provision of care 'relies at local and referral levels on health workers, including physicians, nurses, *midwives*, auxiliaries and community workers as applicable, *as well as traditional practitioners as needed*, suitably trained socially and technically to work as a health team and to respond to the expressed health needs of the community'. They are formally included throughout the "technical and operational aspects", which gives '*high priority* to the improvement of adequate manpower in health and related sectors, suitably trained for and attuned to primary healthcare, *including traditional workers and traditional birth attendants where appropriate*' (WHO 1977; emphasis added).

During the 1990s, an attempt was made to strengthen indigenous medical services with the Health of the Indigenous Peoples Initiative, developed at the Workshop of Indigenous People held in Winnipeg, Canada in 1993. The initiative sought to develop national strategies to improve the health of aboriginals and integrate other health models into national public health strategies. The Pan American Health Organisation (PAHO) proposed at this conference the establishment of the Initiative on the Health of the Indigenous Peoples of the Americas (SAPIA), an initiative for addressing indigenous people's health in the Americas which incorporated key elements of indigenous conceptions of health and well-being. This initiative not only focused on indigenous health status but also on the conditions that are related to health and well-being, such as poverty (high rates of unemployment and a dependency on social assistance), poor living conditions (including lack of water and electricity and overcrowded houses) and illiteracy (cf. Montenegro & Stephens

2006; Stephens et al. 2006; Stone 1986).

While some countries in the Americas, such as Canada, have made progress in this regard, Mayan indigenous medicine and traditional practitioners remain excluded from official health services. The local health systems initiative *Sistemas Locales de Salud* (SILOS), developed in the late 1990s, included a strategy to promote indigenous participation in the formulation of policies and strategies and in health activities, including traditional medicine and medicinal plants. This in turn required the ‘acceptance’ of the allopathic health model, which was described as low or marginal (Becerill & López 2011; Cerón 2007). The participation of leaders and representatives of indigenous people, although mentioned as relevant to facilitate and establish mechanisms of consensus, was not achieved. As a result, the ‘necessary transformation’ of alternative models of health did not take place as hoped. During recent decades, several NGOs have conducted programmes where traditional and allopathic health models are practiced in parallel, in integrated care systems promoting collaborative healthcare (ASECSA 1989; Cardelle 2003; Eder & García 2003; Solimano & Salinas 1991). This kind of integrative model selectively applies different approaches and treatments based on the patient’s needs, health problems and preferences, enabling a flexible approach to healthcare. While these few articulated and institutionalised programmes have succeeded, the successes tend to be local; the ‘adjustment’ of national programs to strengthen the traditional-medicine component remains largely inadequate.

Traditional Medicine in Guatemala

In Guatemala, the traditional practitioners most frequently consulted are traditional birth attendants or midwives, bonesetters, *sobadores* (massage therapists), *chayeros*, healers (herbalists) and spiritists (Cosminsky2001; Icó 2007; Replogle 2007). In general, the source of their knowledge is empirical: practitioners are self-taught or have learned by observing other healers, although some have attended formal classes (cf. Icó 2007; Yukes 1997; PIES 2009). Becoming a midwife, healer or *ah-men* can take years, even if they have been ‘chosen’ to follow that path, and the training is followed by a process of initiation. Their ‘gift’ or sense of duty can be revealed in dreams, signs, suffering and illnesses (Icó 2007:11; Cosminsky 2001; Ellsworth 1996; Rogoff 2011; Yukes 1997). THs are recognised members of their villages. Male shamans (or doctor-priests) normally do not treat illnesses; rather they conduct ceremonies for community members or families and serve as an intermediary with the ancestral spirits. Shamanic rituals differ from region to region (different language, clothing, ritual activities, sacrifices, offerings). Unlike individual healings, shamanic ceremonies can include communal healings

and prayers for entire communities, for example, to ensure the fertility of crops and animals or to bless a place. Some places, such as caves, mountains, lakes and rocks, are considered sacred, and prayers, sacrifices and veneration are offered there by pilgrims (cf. Huber & Sandstrom 2001). Worship of Mayan gods is part of these rituals, including those to preserve or restore wealth and health, or to perform a healing. THs and shamans do not make a distinction between body and soul, or between physical and spiritual health (cf. Lagarriga et al. 1995; Rosales 2009). The body and soul are perceived one and as linked to the universe and the four elements (earth, air, fire, water), an indivisible identity within the social and natural world (Icú 2007; PIES 2009).

In this conception, since the four elements are ‘pragmatic forces’ (an integration of energies that contribute to effective solutions), these are vital to restore people’s balance, an essential element of the Mayan vision of the cosmos. Holistic healing is based on an understanding that the various healing techniques (both spiritual and physical elements, such as prayers, massages, herbal infusions, gems, stones, oils and organic wraps) are important to restore the flow of energy in each person. Altars built to perform healings normally represent the universe in which the sun, moon and stars—representing the Mayan zodiac, or *Haab* Calendar—provide a guide to the interpretation of events, including illnesses¹⁷ (cf. Appel 2003; Fedy-niak 2006; Viesca 2001). Healing rituals or ceremonies are therefore performed even if a person is not considered to be ‘sick’—in biomedical terms—in order to preserve or restore the patient’s balance. Accordingly, Maya priests perform sacred ceremonies of soul purification and rituals of gratitude to bring harmony and welfare to families, communities, crops and buildings, which are in connection with earthly and ancestral energies (cf. Calan 2012; Villatoro 1997). Mayan healing rituals and ceremonies are especially important to purify an individual’s energy in connection with inanimate and life forces that can make a person ill if the spiritual and physical worlds are unbalanced. The balance restoration takes place when the *ch’ulel* (translated as ‘life force’) has been purified, achieving a balance that is considered necessary to remain healthy. Mayan healers have a special ability to restore the *ch’ulel* in patients. A good example of the loss of this balance state is the principle of hot-cold, which applies to a variety of ailments, causing symptoms of diarrhoea, vomiting and paralysis, among others (Appel 2003; Villa Rojas 1981; Villatoro 1986, 1990, 1996). By purifying the *ch’ulel*, health can be restored. During the 36-year civil war, between 1960 and 1996, traditional practices became threatened when the military dictatorial government outlawed many of the Mayan holy places and rites.

¹⁷These aspects are further discussed in Chapter V, ‘Situating Evil Eye among Aetiologies’.

Traditional Medicine and Practitioners during the Civil War

The civil-war period marked a time in which a great deal of traditional medical knowledge and practices were lost (cf. Hawkins et al. 2013; Icu 2007). Many rituals were practiced in secret, forcing people to seek assistance in a clandestine fashion (cf. Adams & Bastos 2003; AVANCSO 2006). The conflict produced a deep social rupture within the communities, as torture, murders, rapes, kidnappings, displacement, disappearances and forced recruitments into the military forces provoked radical changes in community structures (Calan 2012:18-20; Wilson 1995). The role of THs and *ah-men* was altered. However, it has seen a little revival since the late 1990s with the implementation of the peace accords (Cosminsky 2001). The civil war primarily affected the indigenous rural population, particularly in the highland region, severely restricting access to social services and literacy programs; in these areas, infant mortality, illiteracy, and lack of potable water and electricity caused by the war and the consequent social exclusion are still present. Therefore, since the late 1970s, aid programmes conducted by national and international NGOs have been extremely important (cf. Bowser 2009; Rohloff et al. 2011). Communities became dependent upon them instead of restoring indigenous Mayan medicine (Cardelle 2003).

During this time NGOs, such as ASECSA,¹⁸ played an important role in the provision of healthcare, not only as part of the preventive care strategies, but also in providing treatment (cf. Rohloff et al. 2011). However, the war had a negative impact on NGOs, which were threatened when they interfered with the interests of the military forces or guerrillas. Civil organisations, regardless of their type of work, were considered subversive (ASECSA 1993). In this regard, Dr. Ramírez, a physician who worked in ASECSA during those years, explained to me:

“The position we assumed in ASECSA made the idea of working with other groups interested in healthcare unsuccessful, since these [NGOs] did not want to assume a political role, opting for strategies such as the focus on medicinal plants for possible marketing, and not as part of activities to develop community-based health programs. However, many health workers who were also part of ASECSA were

¹⁸ASECSA was founded in 1978 for the provision of primary healthcare, community health work and public health in Guatemala. It is composed of 58 programs and community health organisations, including clinics, community hospitals, associations of health promoters and midwives, cooperatives, traditional healers, dioceses and pastoral healthcare. Its main programs and projects are training of facilitators, midwives and Maya therapists, a network of essential medicines and medicinal plants, strengthening community health organisation, responding to natural disasters, political advocacy, sustainability and food sovereignty. It played an important role in the provision of primary healthcare during the civil war. It now comprises a central office in Chimaltenango and 5 regional offices in Petén (San Francisco), North Eastern (Cobán, Alta Verapaz), Baja Verapaz (Rabinal), Central (Chimaltenango) and West Area (Tonicapán). <http://asecsaguatemala.blogspot.de/>

involved in the revolutionary movement. This meant that their training and awareness of the health problems had another scope and impact. But it was precisely this aspect that caused many of them to be killed. Both the revolutionary movement and the army saw the issues of health as another weapon for social change. Health promoters who were involved in the war were able to see health as an integral part of the human being and as an educational tool for social transformation. The right to health became therefore a self-vindication claim. However, there was a gap between the group of intellectuals and people involved in the processes of change. [Whereas] the issue of health was never an important aspect for the intellectual elites, the rural people involved in these processes saw the importance of covering issues of Maya cosmology, traditional medicine and topics of integral health that were and are still important for the communities they come from and live in, aspects that are part of their identity and culture”.

As a result, institutional guidelines for long-term health initiatives at some national NGOs lacked consistency, since they were reluctant to make decisions that might have brought repression to the indigenous communities (cf. Anheier 2009; Cardelle 2003). Yet some local NGOs, such as the health promoters of the Behrhorst Foundation, began to adopt a more radical attitude, taking a clear political position, which resulted in forced disappearances, extra-judicial executions or displacements of its members, who had proposed solutions to health problems in rural areas as a demand for social change and as a necessity for community development.¹⁹ Furthermore, several health promoters were threatened by both parties in the armed conflict. The army accused them of being guerrillas due to their community-based work, while the guerrillas accused them of being traitors and army informants if they did not enroll with the guerrilla movement (Flores et al. 2010). As a result, their programmes could not be implemented, since the political situation deteriorated during the early 1980s, making it difficult to even hold a meeting (cf. ASECSA 1993; Wilkinson 2004). Thus, some areas were neglected, especially the West Guatemala; more attention could be given to the eastern part of the country where the presence of military and guerrilla forces was smaller.

According to several documents published by ASECSA,²⁰ religious groups who had initially organised community work in rural population began to leave their areas of work, or left the country entirely. This initially posed a serious dilemma, since health promoters in some places were afraid to maintain direct contact with

¹⁹Comisión para el Esclarecimiento Histórico, Guatemala Memoria del Silencio, TOMO VIII, Casos Presentados Anexo II (Guatemala: CEH, 1999), http://shr.aaas.org/guatemala/ceh/gmds_pdf/anexo2_1.pdf

²⁰Archivo CIRM, Colección ASECSA GT-CIRMA-AH-056, Antigua Guatemala.

NGOs who had a left-wing political line. Furthermore, many health workers became refugees or were isolated from the programmes of which they had been a part, or even died as a result of the war. However, those who realised that the conflict was leaving the villages completely isolated, without any assistance for rural populations, took steps to make several organisations start working together. Meanwhile the situation in the refugee camps and in areas that had been destroyed was terrible; people were suffering from many kinds of problems, including mental illnesses (cf. ASECSA 1989; Cabrera 1994; Wilkinson 2004).

Some ex-members of ASECSA whom I interviewed stated that the war also determined the approach for some specific health programmes, focusing some NGOs, for example, on problems affecting children and women, aspects that seemed to be 'less radical'. From the 1980s onward, people began talking about mental health, as the effects of the massive internal displacement came to light. Working closely with the University of San Carlos, members of NGOs had access to the population of elders within rural communities (ASECSA 1988, 1991), who played a major role in the initiatives that were being introduced into more oppressed communities, where many women had been raped, hundreds of children orphaned, families torn apart, many people killed and villages destroyed or exterminated (cf. Lujan 2004). While midwifery was being sponsored by governmental and international institutions, involving women as health promoters (cf. Eder 2005), these elders took the role of 'spirit guides' in the realm of social health, where the topic of mental health, as part of programmes of 'traditional psychology' was an issue of primary concern for local initiatives. The topic of mental health continued to be promoted during the 1990s with the assistance of international NGOs focusing primarily on children, such as Doctors for Global Health and Médicos Descalzos (cf. Lykes 1994).

By 1982, limited progress had been made by several health promoters from different countries, who conducted their own research on medicinal plants in the context of the worldview of traditional health providers. However, the political conflict also affected the impact of these organisations. They began to fight for recognition among particular populations or groups to maintain their status within the communities (cf. Ceidec 1993). On this subject, one of the documents produced by an NGO assembly states that:

“at this level, some NGOs were playing almost a paternalistic role towards the health promoters, who in turn lost their belligerent force and were only working or involved with programmes of these organisations or churches. This shows much of the current position of the promoters...all past and present programmes have

technically trained health workers...but these have not developed strategic partnerships where they could have a more active role for their organisation within their own communities, where they could give voice to those traditional health providers who have been always silenced and repressed". (ASECSA 1980:32-35)

In the mid-1980s some NGOs changed their work strategies, developing training plans for health promoters and educators, so that they could in turn train other members in their own communities, who came to be called 'health technicians'. Midwives who had broad experience in maternal health were involved in this effort (cf. Maupin 2008, 2009). However, such initiatives usually failed. According to Arturo Domínguez, an ex-member of a guerrilla group in Guatemala, and later a health promoter in San Marcos, one of the main problems was that the technicians who had to train promoters focused far too much on the political situation: '[they] spoke and taught subjects of historical matter, such as the conquest, the 'Indian-Ladino' problems and topics of current interest, which motivated promoters to help out in their communities, but they lacked the technical skills to provide healthcare at the primary or secondary level of care'.

As a result, many health programmes were lost, and the figure of the 'health promoter' changed. The health promoters had held to the structures of the NGOs rather than their own community-based programmes, causing inter-institutional conflicts. The 'health technician' was a different figure, and health promoters made it a priority to train them in specific health concerns. The idea was to standardise training courses nationwide through the Ministry of Health so health workers could then study at a university and earn a bachelor's degree in health. The Ministry of Education made a first attempt at this, but there was a strong negative response among the civil population because people were afraid that NGOs were involved with the guerrillas (cf. Luján 2004). There were also some lobbying attempts with the health committee in the Guatemalan Congress to authorise the project, but the allegations of possible association with armed groups made this project unsuccessful (Cabrera:1994).

Thus, during the war years many international health programs and support projects were lost. While the Maryknoll Sisters remained, other religious or non-governmental groups abandoned their health promoters. This meant that many co-operatives or associations of health promoters that were thus left unattended could be reorganised as independent providers. Several health organisations which did not depend on churches or international initiatives emerged in this way (ASECSA 1988, 1989). However, the lack of clear policies and financing to make interventions affordable and accessible caused these initiatives to have little impact or to become

unsustainable (cf. Ron 1999). The influence of ‘liberation theology’, the subject of citizenship, social participation and methods of popular education taught by Paulo Freire that emerged in the 1970s also had a strong impact within rural populations. A very influential book was *Training for Transformation*, a compilation of the experience of the church in Kenya, which used Freire’s methods, including group dynamics, psychology and Christian messages, for faith healing. Another important aspect of the liberation movement was that people began to understand that diseases were not God’s punishment but the result of structural causes of the Guatemalan reality (ASECSA 1980).

Until 1982 the only direct references to health and indigenous people by the Guatemalan state were limited to the adoption of the International Convention on the Elimination of All Forms of Racial Discrimination. Until 1990 the issues of health and indigenous people were not included in the state’s plans or agendas. Further, official documents acknowledged only the existence of different social sectors with ‘particular needs’, making references to the differences between rural and urban areas and socioeconomic levels, such as the lack of access to healthcare and sanitation in rural areas (Hernández 2010:31). Historical differences among ethnic groups and cultural diversity were emphasised as problematic, an aspect that needed to be tackled to consolidate national identity and the democratic process. The concerns regarding healthcare and services within the democratic process and ‘national unity’ concentrated on the marginalised urban areas and groups considered at greater risk, in which rural populations were homogeneously included. Thus the health policy documents from the 1990s do not make specific mention of the cultural appropriateness of healthcare. But unlike the previous decade, these official documents do mention the ‘existence’ of different worldviews, customs and needs. They also recognise problems regarding health and education, especially among the indigenous population. Examples of these legal documents are the reports, agendas and initiatives of SEGEPLAN²¹ during the government of President Alvaro Arzú Yrigoyen, between 1996 and 2000.²²

The Rise of (Selective) Traditional Medicine in National Agendas

With the establishment of the peace accords, ‘traditional medicine’ became an important aspect of the nation-building process in the post-war era. The recognition of different ethnicities and languages was seen as the ‘strength of the multicultur-

²¹ Secretaría de Planificación y Programación de la Presidencia de la República de Guatemala.

²² http://www.segeplan.gob.gt/2.0/index.php?option=com_remository&Itemid=274&func=select&id=52

alism and pluriculturalism' of the nation, and traditional medicine was seen as a way to generate a space of 'reconciliation' and 'acceptance' in order to acknowledge and respect diversity.²³ Traditional medicine was used as a generalised concept, consolidated in several policies and law reforms. One of the outcomes of this political reform was the possibility of affiliation of many NGOs, which could create bonds and allow them to become part of a network of organisations and practitioners (including naturalists, herbalists, spirit healers, and midwives, among other indigenous practitioners). Through the process of democratisation and political activism, traditional-medicine groups were able to influence official agendas to include certain health care practices that are significant to the traditional process of curing/healing. Many organised indigenous groups who are restoring Mayan spirituality and traditional healing are promoting the use of medicinal plants. Allopathic therapies are valued and integrated into ancestral therapies in a programme of public-health advocacy work (ASECSA, Healers2Healers mission, CIEN, and others). Some of these organisations promote health programmes throughout the country in which community-based organisations, healthcare promoters, cooperatives, traditional therapists, dioceses, and pastoral-care groups participate. This integrated work has shown that the affected population can benefit from culturally appropriate therapies rather than exclusive models (cf. Desjarlais et al. 1996).

In support of the indigenous right of self-determination stipulated in the 1996 peace accords, succeeding governments established federal offices to attend to the needs of the indigenous population at local and departmental levels (Barillas 2005; Becerill & López 2011). However, these programmes have had little impact due to underfunding. Nevertheless, the role of traditional medicine, suppressed during the civil war, is currently gaining space in indigenous communities. A special focus has been on the long-term trauma as a result of the civil war, for which self-organised groups, together with national and international multidisciplinary teams, have been providing services for people suffering from posttraumatic stress disorders and depression.

Policies or regulatory frameworks were created or ratified based on international and national agreements, such as the frameworks defined in the articles of the National Constitution, Human Rights, Indigenous Rights, and the Convention N°169 of the International Labour Organisation on Indigenous and Tribal Peoples, as well as the peace accords. Within the context of these agreements, some demands were included to achieve reform in the health sector in socio-economic terms. These agreements identified the inequalities in the healthcare sector and discrimination

²³See Governmental Agreement 165-96 and 129-2002.

against indigenous forms of healthcare. Article 161 of the 1997 health code affirms that the state, through the health sector, ‘[will] incorporate, regulate and strengthen alternative [healthcare] systems, such as homeopathy, herbal medicine, traditional medicine, and other therapeutic measures for healthcare, establishing mechanisms for approval, evaluation and control’. Despite these reforms, in practical terms Guatemalan governments have reduced the role of the state since 1997 through neo-liberal policies that favour privatisation of the health services, adopting market-driven policies rather than establishing a social policy of funding and investment.

In 1998 the Guatemalan congress approved a new regulatory framework that empowered the Ministry of Health to contract with NGOs to deliver health services, with a focus on maternal and child health in order to reduce infant morbidity and mortality. The delivery of coverage under these programmes has been inefficient, mostly due to political instability and several constraints, such as economic, political, and international pressure (cf. USAID 2010). Most of the present NGOs, such as Common Hope, John Snow Inc., La Asociación Nuestros Ahijados, and Asociación de Servicios Comunitarios (ASECSA), among others, work in rural areas of Guatemala. They focus on children’s and women’s health, family planning, food and nutrition security, HIV/AIDS, tuberculosis and tropical diseases, providing services of prevention, intervention and treatment, as well as implementing ‘behavioural change models’. NGOs and international missionary organisations, in particular Christian and charity missions, are trying to advocate an approach of holistic ‘community development’ instead of targeting aid to a particular segment of the population or implementing inadequate (vertical) healthcare programmes. The newer approach focuses on socio-economic development, educational programmes, food security measures, and adequate housing as proximal factors to reduce morbidity and mortality, intervening with strategies of “participatory development” or “assisted self-reliance” through micro-credits. However, among other problems, most NGOs are dependent on donor funding and initiatives, which expect to see specific health impacts within specific time frames—assessed by controlled trials and similar measures—in order to continue their support (cf. Edwards & Hume 1996; Fisher 1997; Solimano & Salinas 1991).

In 2000 the ‘National Programme of Traditional Folk and Alternative Medicine of the Ministry of Health and Social Assistance’ (PNMPTYA-MSPAS, its Spanish acronym) was instituted in accordance with the peace accords, especially in response to the section on ‘Identity and Rights of Indigenous Peoples’, and the agreement on ‘Social and Economic Aspects and Agrarian Situation’ (MSPAS 2003). This ‘traditional model’ includes selected practices that are considered ap-

appropriate for the allopathic medical model and its associated infrastructure that operates at health centers. Pregnant women are allowed to be accompanied by a member of the family or midwife²⁴ during childbirth; to choose their delivery position; to use natural *ixbut* tea herbs (such as *besmut* and *sapill*) to the mother; to use ‘symbolic elements’ such as protective bracelets; and to use the local language if possible, among other procedures.²⁵ It has the support of the Presidential Commission on Discrimination and Racism against Indigenous People (CODISRA) as well as of several international organisations. Of particular importance has been international pressure, especially by the Consultative Group for implementation of peace agreements and the United Nations Development Programme (UNDP), which provided the initial funding during the first 18 months of a 5-year strategic programme. This programme has been developed during the last three administrations, with the support of external cooperation (such as APRESAL/UN, PAHO/WHO, PNUD, Medicus Mundi Navarra, and others).

According to the PNMPTYA-MSPAS, by 2007 the Ministry of Health was to have implemented a system that entirely recognised traditional folk medicine through operational strategies that created a pluralistic, multiethnic and multilingual healthcare network. The programme’s mission was to develop and promote the training of local health promoters and to reinforce social participation. The goal was to create conditions to support the incorporation of social, spiritual, psychological and biological care provided by health services, appropriate to the cultural characteristics of the population they serve, complemented by culturally acceptable primary healthcare. This initiative also aimed to ‘know, rescue and acknowledge’ the different practices of the Mayan therapeutic model (MSPAS 2003:5-10), as well as to build an agenda ‘from’ the indigenous people to address specific health demands and build a non-hierarchical healthcare model. Between 2004 and 2008, the actions under the PNMPTYA project were considered cutting-edge efforts for the formulation and implementation of health sector goals. However, a concrete work agenda was not developed, and these initiatives did not include or encourage the presence of the civil health sector. Interest in the programme re-emerged in 2009 with the creation of the Healthcare Unit of Indigenous Peoples and Interculturality (UASPII²⁶ in its Spanish acronym), derived from the Constitution of the Republic of Guatemala, Convention No.169 and the New Public

²⁴ Although midwives are seen as ‘central’ to maternal health, they play only a marginal role in the health centers as ‘cultural intermediaries’ between the medical personnel and the woman in labour. They do not take an active role in labour and delivery.

²⁵ Ministerio de Salud Pública y Asistencia Social et al. (2010), “Sistematización de Servicios de Salud con Pertinencia Cultural”, pp.17-20.

²⁶ Acuerdo Ministerial No.1632-2009 conforme al Artículo 194 literal (a) de la Constitución Política de la República de Guatemala; Artículo 27 literal (m), de la Ley del Organismo Ejecutivo, y Decreto Número 114-97 del Congreso de la República de Guatemala.

Health Code (MSPAS 2009).

The UASPII addressed more fundamental aspects in relation to the development and strengthening of traditional medicine. In fact, it explicitly identifies technical, organisational and political functions that should be created and transformed under this agreement, funded by the Ministry of Health and through national or international donations or contributions. However, although it makes clear that these efforts should be conducted under the ‘worldview of the indigenous population’, this has not always been the case. Furthermore, initial healthcare coverage within this framework has not yet come into effect, since its accessibility and affordability has been reduced by the diversion of resources into the biomedical model (cf. Becerill & López 2011; MSPAS et al. 2009).

The first law proposed regarding the health of indigenous people was the Preliminary Draft Law of the People’s Health Traditional System (Anteproyecto de Ley del Sistema de Salud Popular Tradicional), a normative initiative debated at the National Congress in 2005 which sought the recognition, respect and implementation of traditional customs. This incorporated the traditional health system and alternative medicine modalities, which were acknowledged not only as ‘forms of healthcare’ but also as aspects of identity, culture, knowledge, sacred and secular values and social organisation of indigenous people, including ideas, practices, resources and institutions (PIES 2009:27). As noted, this proposal included political considerations to modify old structures or models in order to engage the participation of traditional medicine in the formal sector—the Ministry of Health and Social Welfare, the Guatemala Institute of Social Security, private clinics and medical insurance, and NGOs. However, although the Committee on Health and Welfare filed the proposed law, it was never approved.

In 2006, ‘Traditional Mayan Medicine’ was recognised and integrated for the first time into educational programmes to ‘improve awareness’ of its importance, and was endorsed in the curricula of nursing schools and in undergraduate and master’s programmes in public health at the National University of San Carlos de Guatemala. However, the integration of traditional medicine, and dissemination campaigns to promote it, have been incorporated into the legal regulations of the healthcare system. The authority of traditional healers over their medical practices has decreased due to these regulations and the consequent professionalisation. For example, if midwives are not registered with their respective healthcare representatives, they are not legally able to practice. Through unsystematic training to ‘professionalise’ midwives, they are provided with certificates that attest to their competence in order to officially legalise “traditional practices”—a certification process that actually promotes allopathic standards of care and attendance

(cf. Prechel 1998; Rogoff 2011; Tedlock 1992b). Thus, forms of care and treatment that are perceived as not ‘dangerous’, such as faith healing, are supported and considered a part of traditional medicine, while bonesetters, *chayeros*, *sobadores*, and other Mayan traditional practitioners are still excluded at the institutional level (cf. Maupin 2008, 2009; MSPAS 2010, 2009).



Figure 3.2: Doña Cipriana with comadrona certification card
Picture: Lisa Thompson

Also in 2006, the Ministry of Public Health, in cooperation with the Universidad de San Carlos de Guatemala (USAC), published the ‘Vademécum Nacional de Plantas Medicinales’, a compilation of studies on the use of plants as a therapeutic resource. This document was circulated throughout the national health sector (professional, technical and volunteer) as a reference for the use of 101 medicinal plants and their most popular traditional uses. The book was published as a form of ‘negotiation’ between the national health sector and the lay sector for an “intercultural approach” (MSPAS 2004a:5), so that the standards of care at the primary and secondary levels of care could include the preparation and use of some medicinal plants (MSPAS 2004b:293-214; 2009:31). Yet the standards of healthcare described as ‘culturally relevant’ within governmental guidelines, in which the importance of traditional medicine and phytotherapy is pointed out for ‘the attention of most common diseases in communities such as diarrhoea, fever, respiratory infections among others’,²⁷ lack clear implementation guidelines. There is also the additional problem that the traditional remedies are discussed in terms of their use in the biomedical categories of ARIs and ADDs, rather than in terms of folk illnesses.

²⁷Module “Atención a la Demanda”, inciso VI, “Medicina Popular Tradicional y Alternativa” (MSPAS 2010).

A period of (un)implemented changes

Nichter suggests that although healthcare systems are shifting as the result of governmental and private attempts to promote use of modern medicine, ‘training course for community health workers explore the possibility of developing healthcare decision trees and algorithms oriented toward a differential diagnosis of popular folk illness categories, rather than ignoring local conceptualisation’ (1989:142). However, Guatemalan national public health campaigns aim to increase attendance at health facilities in order to reduce or prevent risks of death among children when they present life-threatening illnesses, acute symptoms or danger signs in this process, traditional medicine is viewed as a space where misperceptions of health and case management, based on cultural beliefs and practices, tend to prevail. In this sense, public national healthcare programmes (in both prevention and treatment) influence the perception of folk illnesses such as Evil Eye.

Indigenous segregation, combines with ethnic discrimination, social inequality and political exclusion, has had a geographical impact, resulting in a lower exposure to hegemonic practices and latest technologies. The exception is TBAs, who have been exposed since the 1960s to governmental health policies that promote standardised allopathic practices; other traditional practitioners have not been, in practice, incorporated in the healthcare system even though they are now constitutionally recognised (cf. MSPAS 2003). Although for the new ‘democratic’ government it became crucial to situate traditional medicine as a part of the ‘democratic national process’ and the indigenous population has gained some constitutional rights and political space (even though the indigenous population is still unrepresented in the legislature), local medical practitioners have not been given rightful acknowledgment or financial benefit for their labour as health providers, remaining a largely secluded and disadvantaged group (cf. Hinojosa 2004; Hurtado & Sáenz de Tejada 2001). Further, governmental healthcare programmes still condemned some culturally embedded practices as causes of maternal and child deaths (cf. Goldman & Gleib 2003; OPS & OMS 2013) or of health-seeking delay at biomedical health facilities.

After the signing of the peace accords, organised indigenous groups worked for a national plan through a series of political reforms, seeking legal rights at different levels, with the aim of promoting the recognition and integration of their plural and multicultural practices, worldviews, and languages that have been systematically segregated (Maupin 2009:1458). Although the referendum on constitutional reforms was rejected, the discursive claims established in the peace accords were an important platform for indigenous people to revitalise their identity, as well as to articulate some of their demands for culturally appropriate development strategies.

However, the indigenous movement, in comparison with other political movements in the Americas, is rather fragile and fragmented due to a lack of representation and legitimacy (Bastos & Camus 2003). Nevertheless, some specific efforts have been translated into particular demands. Similar initiatives in other places, such as the Zanzibar region of Tanzania, have promoted the integration of traditional and alternative medicine, as well as healers, into the national healthcare system, based on the principle of involving all stakeholders to provide culturally appropriate care to patients. Of special interest is the use of ethnobotanical resources, as well as the role of healers in mental healthcare, chronic diseases, and other illnesses of epidemiological importance. These initiatives aim to develop a strategic policy plan and programmes to regulate and control the utilisation of traditional/alternative medicine so as to ensure ‘safe practices’ supported by scientific evidence in accordance with local legislation (cf. Meier zu Biesen et al. 2012).

In Guatemala, as a result of this kind of political framing, some traditional practitioners became important subjects in the reconciliation of traditional and allopathic medicine. Midwives, for example, via a system of ‘professionalisation’ to medical standards, are trained in prenatal care and delivery with an increased focus on advising pregnant women to deliver at a health center or hospital. However, other actors, such as healers or bonesetters, have never been integrated into governmental health policies, although they are regarded by the government as part of indigenous rights and identity in the realm of healthcare (cf. Eder & García 2003; PIES 2009; Reploge 2007; PIES 2009, 2011). One of the methods of implementation of ‘appropriate’ health programs has been through the project Provision of Health Services with Cultural Relevance (*Servicios de Salud con Pertinencia Cultural*), which is focused on public-health interventions for maternal and child care that correspond to the ‘own logic and worldview of the indigenous people in such a way that the public health services *adapt* and respect their *traditional ways of life*’ (Ministerial Agreement 1632-2009; emphasis is mine). Despite the stated approach of ‘cultural relevance’, i.e., ‘understanding of indigenous health systems based on perceptions and values—systems that determine the processes of maintenance, health restoration and the use of community resources’ (MSPAS 2010:7), the program guidelines take a strongly allopathic approach in terms of procedures, concepts and standards.

Based on the agreements established in the new health policy, the Ministry of Public Health and Social Welfare published the “National Health Plan 2000-2004”, which included the following objectives: to bring healthcare to population groups not traditionally reached by such services, especially indigenous women and migrant workers; to provide for women’s overall health needs; to give renewed im-

portance to traditional medicine; to decentralise healthcare; and to improve coordination within and among sectors (MSPAS 2001). However, the national public health sector has continuously suffered from budget cuts, hampering the provision of healthcare, particularly in rural areas. In 2001 the Extension of Coverage–Integrated System for Healthcare (SIAS) covered just 2.9 million people, only 50 per cent of the target population, and its budget was 23% lower than the previous year (Verdugo 2000; Verdugo et al. 2002).

SIAS was introduced as part of the peace accords and sought to expand healthcare coverage to the rural population by providing basic health services to pregnant and lactating women, as well children under 5 years of age, through contracts with local NGOs. The provision of basic health services was designated as a key role for midwives, community facilitators and health workers as a part of the Basic Health Services Team. Article No.161 of the National Health Code acknowledges the existence of ‘traditional medicine’, and although this has not been fully incorporated into national health guidelines, a few NGO projects have included the use of traditional healing, such as the ‘priests’ (spiritual guides), healers, *ah-men*, *chayeros* and midwives who perform preventive, palliative, or curative services. These include healthcare services formed by multidisciplinary teams that treat patients with holistic methods, allowing a pluralistic healthcare model without (much) conflict, such as ASECSA, PIES de Occidente, and other community-based organisations.

In 2010 the Ministry of Public Health conducted an activity called Dialogue for Universal Health, which included representatives of government and international organisations, the academic sector, the Maya, Garifuna, Xinca and Mestizo ethnic groups, and NGOs, with technical support and funding from USAID, as part of the project Dialogue for Social Investment in Guatemala. One of the objectives was to identify specific health issues that could be included in the proposal of Universal Health, contemplating aspects of gender and multiculturalism. These ‘dialogues’ have highlighted the importance of including within the public health sector traditional practitioners who can work as representatives in their communities and in the national health sector (USAID 2009). The role of traditional health providers also became important amidst nationwide protest to strengthen the health-care system since the last government. Health workers (biomedical and traditional) have been one of the most militant unions in recent years.²⁸ Health unions began with several demonstrations during the government of Álvaro Colom,

²⁸<https://dempeusperlasalut.wordpress.com/2010/11/05/guatemala-cartas-de-protesta-denunciando-la-ola-de-violencia-y-muerte-a-sindicalistas-del-sector-salud> (accessed on 05.10.2010)

the first center-leftist to be elected with the participation of former guerrillas, often suspending their work in order to urge the government to solve the continual problems in this sector, such as lack of personnel, equipment and medical supplies, precarious conditions in health facilities, and failure of the Ministry of Health to pay the loans of the healthcare personnel.²⁹



Figure 3.3: El Observador, Año 3, Nr. 11 & 12, Análisis alternativo sobre política y economía Feb.-Abril 2008

The health union leadership signed an agreement with the ministries of health, finance and labour and suspended the demonstrations when Otto Pérez Molina, of the right-win Patriotic Party who became president in 2012, decreed a ‘state of calamity’ within the public health sector and began sending medicines and supplies to some public hospitals. However, a few months later, in April 2012, the public health sector, together with peasant organisations, organised another series of marches, protests and roadblocks to pressure the government to fulfil their demands and honor the accords that had been signed but not acted upon.³⁰ Protests spread into other parts of the country and ultimately escalated to the point of police and military intervention. Several protesters and union leaders,

²⁹<http://cerigua.org/article/retaltecos-viviran-jornadas-de-protestas/>;
http://estamosdefrente.blogspot.de/2010_07_01_archive.html; <http://www.taringa.net/posts/noticias/9031292/Salubristas-del-Hospital-Nacional-manifestaron-en-Escuintla.html>

³⁰<http://www.elsoca.org/index.php/america-central/guatemala/2651-guatemala-el-gobierno-de-otto-perez-molina-crisis-pugnas-movilizaciones-y-fortalecimiento-del-aparato-represivo>

including a few from the health sector, were murdered, which the government described as a “security” response.³¹ Pérez Molina’s government has now become another example of excessive corruption, extortion, abuse of authority, influence peddling, violation of fundamental freedoms that are guaranteed by Guatemala’s constitution, increased criminality and endemic poverty.



Figure 3.4: Diario la Nación, Guatemala 18.11.2014

As a result, although the autonomy of indigenous peoples in the management of their natural resources, conduct of development projects, and freedom to practice their spirituality and traditional medicine has been recognised as important since the late 1990s in light of the ‘Indigenous Rights’ and peace-accord agreements, these rights have not been adequately addressed within domestic legislation.³² The criteria of cultural diversity, recognition of indigenous identity and heritage, territories, autonomy of jurisdiction, community-based participation, gender-specific approaches, family law and the promotion of effective local participation are considered ‘relevant’ and ‘appropriate’, they continue to be framed as international issues, to be dealt with by NGOs and other international initiatives, rather than being addressed at the domestic level. The ethnic discrimination and social exclusion suffered by indigenous peoples due to various political and economic power structures continue to make them vulnerable, especially the indigenous children and women who are particularly targeted in the planning and delivery of health services. These factors put indigenous peoples in a position in which the issue of identity is marginalised to less problematic aspects, i.e. not invasive or not in conflict with people’s cultural identity and spirituality; yet traditional medicine and

³¹Human Watch Rights 2013, http://www.acnur.org/t3/uploads/media/guatemala_sp_2013.pdf?view=1

³²See "Compilation of Legislation on Indigenous Issues", IDB, 2002.

folk illnesses are viewed as problems of limited education, insufficient or inadequate public health services, and poverty. When ailments that present symptoms of the kinds of infectious diseases that are considered important by international agencies are attributed to folk illnesses such as Evil Eye, it becomes even more problematic to recognise traditional medicine as an important resource with a people's cultural identity. Accordingly, since ADDs and ARIs are associated with higher morbidity and mortality rates among children under 5 years, Evil Eye (which presents many of the same symptoms) is perceived by biomedical practitioners as part of the concerted efforts that need to be changed.

3.7 The production of health: Evil Eye within a pluralistic model of healthcare

The term 'healthcare' is used in a general way; the concept is rather ambiguous and lacks clarity when actually applied to health-seeking practices. This research suggests that healthcare behaviours concerning Evil Eye in rural San Marcos are dynamic and complex constructs, consisting of several therapeutic interactions within, and across, the boundaries of differentiated health systems. Evil Eye is embedded within a cultural context characterised by purposeful, contextual and structural interactions. The concept of Evil Eye is only used when distinctive social realms and biological symptoms can be linked, indicating a culturally accepted healthcare provision that (a) explains the illness, (b) shapes the course of treatment, and (c) determines the ways in which individuals need to respond to it.

Evil Eye contains elements of supernatural or non-empirical logic and notions that biomedical medicine cannot explain, and therefore cannot properly treat (cf. Ortiz & Davis 2009; Weller et al. 2014). Ethnographic data from this research shows that although the symptoms are not exclusive to the illness, the person afflicted by Evil Eye can only be optimally treated by well-defined traditional healing practices. The events (of organic or social nature) that trigger the ailment, however, determine the use of one or another health system at different stages, overlapping and intersecting at different points when the outcomes suggest that a different approach might be necessary. Since Evil Eye corresponds to a folk-illness concept, traditional healthcare resources are used primarily, but by no means exclusively. If, however, the illness is only treated with resources that do not include traditional healthcare, the health outcome is perceived as ineffective or of short effectiveness. From a caretaker's perspective, frequent episodes of Evil Eye, or a prolonged state of the illness, can contribute to a lingering debilitation

that can predispose the child to other illnesses or even kill the child if not treated promptly or correctly.

It should be observed that Evil Eye accounts not only for health behaviours driven by the person afflicted by it. Because of its multiple aetiological determinants, the illness also provides indicators that can identify hazards or risks in the social and natural environment. Thus, to prevent, identify and treat Evil Eye requires an outcome-driven healthcare model that is already structured among families and communities, based on traditional values, perceptions and ways of relating to one another. Since symptoms of ADDs and ARIs are so frequent in San Marcos's rural setting, as the result of multiple influences and conditions, it is only through the practices of a traditional healthcare model that caretakers can respond to these life-threatening conditions: the very nature of folk illnesses encourages solidarity and periods of empathy and assistance that help people to deal with out-of-control situations. Empirical research findings in rural San Marcos demonstrate precisely the fact that cultural behaviours among individuals who fall ill with, identify, or treat Evil Eye are frequently responding to an actual perception of uncertainty or vulnerability. These feelings or perceptions are stressed by caretakers when dealing with healthcare facilities where they do not speak Mam, when they are asked to take decisions without their partners, or when they lack money to pay for treatments:

Lina: “When I have to go the health center I always get *nervous*. Doctors ask me questions but I cannot reply because I do not understand much Spanish and sometimes there are not enough nurses who speak Mam [who can help you] to translate what they said...who at times just yell at you. So, if my children fall ill with diarrhoea I try to cure them at home first.” (Chicajalaj)

Matilde: “Last time [my child fell ill] I told Jairo [my husband] to come with me [to the health center], because once I took Martina [my youngest daughter] and they sent me to the hospital, but I couldn't go—how could I?—if I first needed to see if Jairo agrees. You can't just say ‘okay’ to the doctors and go...I feel *unprotected* (*desprotegida*) when I cannot quickly decide for myself what to do, but what else can I do?” (Tuichilupe)

Sebastiana: “Of course you feel bad when you get a prescription because normally I just have [money] for the household expenses, you know, to buy soap, food...So when you go to the [health] center and they don't have the medicines I better try with herbs [at home] before I ask for money. I'm *afraid* my husband will say, “What have you done with the money I gave you?” or “Why is the child ill?” (Piedras Negras)

Among caretakers these aspects of vulnerability or uncertainty were transformed into health-seeking practices within their communities, receiving the support offered by traditional health practices and treatments, which, although not always perceived as effective in terms of curing the illness, provided temporary solutions to alleviate symptoms, an exchange of experiences with others in order to identify solutions, or a chance to borrow some money. While the alleviation of symptoms is important because it deals directly with the illness, outcomes unconnected with the physical symptoms involve specific responses that require other forms of support and social resources (such as alternative treatments or a different diagnosis). Consequently, Evil Eye has become an adaptive mechanism within an interpersonal domain of somatic and subjective content. Whereas in a biomedical system the results appear to be narrowly defined, with no possibility of dealing with the somatic, economic and psychological consequences of an illness, traditional healthcare models assign meaning and makes the possible outcomes of the illness more manageable. However, the more critical and challenging the symptoms of Evil Eye are, the more likely people are to deal with and perceive the symptoms as Evil Eye and not as an acute diarrhoea or respiratory infection, since rewarding positive cognitive or affective responses usually only emerges from the traditional healthcare model.³³

According to this research, symptoms of ADD and ARI are addressed within healthcare practices of a biomedical system when the possible response strategies correspond to specific identified factors (e.g., consumption of inadequate food, presence of acknowledged 'germs', previous experiences with specific diseases). Among caretakers, both diseases are perceived as a consequence of controlled and uncontrolled sources. Because of the difficulty of correctly identifying a symptomatology in diseases whose symptoms can vary significantly,³⁴ the explicit interventions provided by the standardised biomedical approaches are not always effective. Furthermore, within a pluralistic healthcare model, the perception of efficacy is easily blurred: when enough time elapses between the application of the treatment and the reduction of symptoms (such as pain or fever), it is not necessarily obvious that the treatment caused the improvement. A caretaker's judgement as to whether a specific treatment has been effective will directly influence future decisions as to whether or not to treat a disease in terms of a biomedical diagnosis. In many cases where children were suffering from acute diarrhoea that was believed to be related to Evil Eye, for example, specific antibiotics that had previously been used successfully for some types of diarrhoea and 'Evil Eye' were administered by caretakers

³³These aspects are discussed in much more detail in Chapter VI, "Healing (Collective) Bodies".

³⁴See Chapter VIII, "Simple Terms, Different Understandings and the Translation of Medical Concepts into Folk Illnesses".

without prescription.

Despite the limited biomedical resources in the San Marcos area, people are aware that allopathic treatments had been proven effective in most patients with ARI or ADD (cf. Bruce et al. 2014). However, the impact of the efficacy of biomedical treatments in terms of symptom relief has had longer-term effects on the work of caretakers and traditional providers. Now that some traditional birth attendants have received training in biomedical practices through workshops, many of them have incorporated the use of drugs as well as concepts such as ‘pneumonia’ and ‘acute diarrhoea’ for frequently encountered symptomatology. Thus, while the symptoms of Evil Eye as identified by caretakers have remained the same, some of the treatments for it have changed over time. Traditional medicine and allopathic treatments are continually integrated, yet understood in terms of traditional concepts. For example, caretakers classify and use drugs, as well as food and medicinal herbs, according to whether they are perceived as cold or hot, an idea that is integral to the traditional concept of illness. If the illness is the result of loss of heat, then drugs perceived as ‘hot’ will be used. Drugs or other therapies that might increase the heat (if the illness is classified as hot) or coldness (if the illness is classified as cold) are considered to be a risk for the patient. In the case of Evil Eye, caretakers fear the use of injections to reduce the fever, since Evil Eye is considered a ‘living organism’ that grows inside the body, which can ‘burst’ if punctured, causing the child’s death.

The healing process, in which the resources of different models of health care are directed at a child afflicted with Evil Eye, is consistent with (1) prior experience of the disease; (2) active interpretation of the symptoms; (3) response to specific treatments; and (4) the social impact of the child’s diagnosis. Traditional healthcare practices can also be dominated by reinforcement of the detrimental conditions, negative ideas of self and others, and negative responses to treatments. Hence, decision-making processes between different healthcare models demonstrate social strategies that suggests that the caretaker’s process of defining the illness, establishing the criteria of treatment, considering all the possible alternatives, recognising the best options and finally making a treatment decision is not fixed, but can change in order to maximise the benefits of each healthcare approach. In this sense, biomedical and traditional models of care are fragmented systems, constantly challenged; caretakers locate particular illness conditions at a presumed or defined symptomatic concept, organised by the desired outcome, with implications for care management. Failure of treatments and reduced expectations, for example, can increase or decrease the preference for one or another healthcare model, no matter how powerful the system seems to be. Free health services, for example,

have not necessarily increased the rate of compliance at the primary or secondary health levels, since the management of health this not driven only by the cost of treatments, even though it is a major restraint in an impoverished setting. In the specific case of Evil Eye, traditional elements continue to predominate in aetiology and treatment. Though still subject to an ‘illness adjustment’ if the symptoms are relegated to other illness categories after treatments have repeatedly failed, Evil Eye traditionally calls for specific, culturally defined case management and categories of illness. Thus, healthcare behaviours concerning Evil Eye are organised primarily within a folk or traditional health system. Biomedical approaches or elements integrated in the realm of traditional practices (which varies considerably among families or communities) constitute dependent practices, usually applied to symptoms which are classified as illnesses of another order.

The interlocking structure of a pluralistic model to treat Evil Eye can therefore be explained as a result of a *critical point*, i.e., the symptomatology, and the principle of *value* or meaning assigned to the delivery of healthcare. As a result, healthcare processes and practices are not linear. They are based upon a set of mutually reinforcing factors that are always dependent on the same elements (biologically or socially driven). Thus, practices to treat Evil Eye can become duplicative or integrative (e.g., use of both medicinal herbs and antibiotics) as well as fragmented (e.g., long periods of unsuccessful treatment of symptoms before finding an effective management). While some of these practices can be beneficial, others can have adverse impacts on outcomes and costs.

In this medical dialogue, taking the example of the use of injections for the management of fever, caretakers will never make use of any injections as long as the perception remains that the *Eye* is still inside the body. The perceived risk of dying due to the use of injections would prohibit the use of that particular measure to treat the illness at a certain stage, according to the Evil Eye’s aetiology. However, injections can be used at other stages when certain symptoms have been successfully treated (the *critical point*). Conversely, a recognised case of ARI will be treated by consulting a biomedical practitioner; in this situation, asking a layperson will not constitute acceptable case management, especially if recognised danger signs have appeared. Thus, a pluralistic model permits or forbids particular practices according to the nosology of the illness. Since any illness has simultaneous, multiple levels—physical, emotional, economic and spiritual—individuals first organise or classify the illness according to their own predominant health assessment with the purpose of making a right diagnosis, determine the risk related to a concrete approach, and evaluating the vulnerabilities of a specific model of healthcare. Therefore, the establishment of pluralistic therapies and the relationship between

healthcare systems allows for meaningful changes in individuals' health-seeking behaviours when specific approaches or treatments are identified as effective and reliable, in order to maximise the effects and ensure the desired outcomes.

3.8 Conclusions

Today's Mayan or traditional medicine, a syncretic healthcare system, is a holistic approach to health in which the concepts of spirituality and balance are central to restoring health or avoiding misfortune, based on the idea that everything and everyone that exists is interconnected. It relies on treatments or rituals that involve cleansing, bathing, prayers, and the use of medicinal herbs, stones, and other paraphernalia in order to restore the flow of *ch'ulel* or life-force in the body. Much of the ancient knowledge of the Mayan civilisation deteriorated or disappeared due to several political events, such as the Spanish Colonisation, the period forced conversion to Christianity, and more recently the 36 years of the civil war, times when indigenous people were systematically suppressed or killed.

The integration of traditional Mayan medicine into the national healthcare system began in the late 1990s as a result of the peace accords. Before this period, TM was not legally recognised or considered valuable. Various political and social conflicts resulted in the loss or restriction of traditional practitioners. This situation changed in response to international and national strategies to strengthen indigenous identity by recognising the need to provide 'comprehensive' healthcare services that are part of the traditional Mayan health heritage, especially at the primary healthcare level. Most of these concerns were part of global initiatives, such as the UN Declaration on the Rights of Indigenous Peoples, which acknowledged traditional medicine as a human right. However, governmental strategies have been guided by frameworks based on allopathic knowledge and practices, structured and maintained by ideologies of racism and discrimination, instead of advocating self-regulation towards a traditional, community-based frame. One of the reasons for this is that allopathic medicine is considered outcome-based, whereas TM is perceived as a placebo. It has not been incorporated into national healthcare initiatives because its practices have not been evaluated scientifically and are therefore considered unreliable. Another factor is that the traditional medical practices are used mostly in places where people have limited access to national health services, giving the impression that TM is not reliable and safe, but merely a limited, and therefore inadequate, resource to treat illnesses. A few of its elements, such as medicinal plants evaluated by evidence-based research, have been acknowledged as 'useful' and incorporated into biomedical approaches, but only when taught by health professionals at the primary and secondary healthcare

level. Thus, TM is seen at present only as a palliative resource in marginalised and impoverished settings. Consequently, more recent legal agreements have led to the loss of specific aspects of traditional Mayan health practices, with biomedicine taking control over terminologies and practices.

However, TM, far from being an isolated practice, is actually part of a pluralistic healthcare model where allopathic, complementary and alternative medicines have become integrated. After the peace accords, some organisations, with the support of international agencies, managed to incorporate plans and programmes into the Ministry of Public Health agendas in which ‘Mayan medicine’ was claimed as part of the political recognition of the indigenous culture. Furthermore, traditional medicine and practitioners are now often embedded within a market economy, where allopathic health services are also offered in an integrated, holistic approach. While these policies of integration are recent, TM has provided healthcare to the majority of the indigenous rural population in Guatemala over the years (cf. Gleit & Goldman 2000; USAID 2010:9). At the national-policy level, major attention has been focused particularly on midwives. Problems during pregnancy, postpartum complications, nutritional deficiencies and childhood diseases have been a priority of legislation and regulations, of national health policies, and of international economic and research assistance. In particular, international agencies such as the WHO and UNICEF have placed significant emphasis on the integration of traditional practices and biomedicine in order to promote cooperation between models of healthcare, and have encouraged research on the socio-cultural context, especially when biomedical health perspectives seem to be less effective. Priorities for women’s and children’s healthcare have included educational programmes, standardised practices in maternal and infant health, improved availability of basic equipment, and involvement of midwives in the national health system.

Outside this specifically selected area of traditional healthcare, TM remains unregulated. People’s behaviours have therefore been the main focus in addressing the potential uses and risks of folk and traditional practices and in developing case management for children suffering from communicable diseases. Folk illnesses such as Evil Eye, as part of the traditional health system, present an unresolved issue in terms of case management. Evil Eye is perceived by biomedical providers as a cultural barrier, a source of delay in seeking health services. With national and regional variations, case management for infectious and parasitic diseases takes into account traditional practices that sometimes seem to cure or ameliorate Evil Eye. The national health care system in Guatemala has promoted and perpetuated forms of exclusion and discrimination, causing people to distrust these services and resulting in negative outcomes in terms of international health standards and

indicators. Certain behaviours have driven the use or rejection of these healthcare facilities, especially at the primary and secondary levels, particularly with respect to the ARIs and ADDs that have high rates of morality among children.

The next chapter presents different commitments and programmes that the government of Guatemala and the Ministry of Public Health have designed and approved to assist the populations most vulnerable to poor health and multiple risk exposure, such as poor nutrition, contaminated water, polluted environments, or living in areas of endemic disease. Political instability, ineffective government policies, ongoing financial crisis, unsustainable biomedical models and competing interventions are other factors that interfere with the provision of care, including primary healthcare. The inclusion of traditional medicine in the provision of care is still uncoordinated, lacking clear regulations and ways to include traditional approaches and practitioners within the public healthcare model. Patients must navigate a weakened allopathic healthcare system in which a variety of stakeholders have different roles in decision-making, revealing a segmented and fragmented health system that compromises treatment. The following chapter provides an understanding of how these structures and programmes intertwine and affect the dynamics of the public healthcare sector, weakening or strengthening people's healthcare behaviours and affecting the process of their illness.

Health as Social Change

During the 1960s there was considerable concern within Guatemala for the revolution in Cuba. People in villages and rural areas had little idea of what was going on, or how the Cuban revolution would affect them. It was known that the US government was interested in products that were cultivated or manufactured in Guatemala, but people did not know about the political and social impacts that other interests implied. Over the years Guatemalans began to perceive a rapid change in the patterns of the economic development in Central America, which had initiated in the 1950s and started to decay in the 1970s. The industrialisation process and its extension to agriculture in Guatemala was why peasant leagues arose, which had been forming since the early 1970s, parallel to the cooperative movement that emerged in the Catholic Church. In this context other peasant organisations like the Peasant Unity Committee (CUC) arose. Within the CUC several peasants were also health workers, while others were working in other types of cooperatives. The government of Kjell Laugerud in 1974 began to develop the confederation of cooperatives, while NGOs remained disjointed. A year later Kjell tried to form a confederation of unions and NGOs, which were known as “Private Voluntary Organisations”, but this attempt failed because the welfare and developmental approach of these NGOs did not correspond to the approach of ‘market development strategy of cooperatives’. There had been other organisational efforts by the Catholic Church and Peasant Leagues previously to that, but it was not until the earthquake in 1976 when construction committees were formed, resulting in the cooperatives changing their structure. When peasants realised that they could be organised around emergencies such as the one that had occurred, they began to organise themselves for other concerns within their communities.

During the years of the civil war the repression against leaders of certain movements was very selective. Cooperatives were not targets of many attacks as these were part of a project of the ‘Christian Democracy’ party, which at the time of the earthquake was a progressive wing in Guatemala. In Central America the ‘Christian Democracy’ was an important movement in which many revolutionaries gained a lot of experience. This changed when the party was divided into an extreme right and an extreme left, the last aforementioned being linked to various guerrilla groups. The selective repression started to occur against any movement

leadership that emerged, focusing the repression against university students, peasant leagues and unions. The military force was not initially concerned about the situation in the rural areas, as prior to the earthquake there was little organisation in such areas and peasants were organised around topics that were not considered politically relevant. Another reason was that the military had churches and cooperatives controlled. Through infiltration they knew what their members were doing, who were part of subversive activities, etc. This initially gave the military force the power to create a mechanism of control and repression without much violence. The presence of the Catholic Church was of utmost importance in this context. Since the 1960s, particularly in Guatemala, an agreement between the Catholic Church, some parishes and dioceses in the United States originated, forming many missions in Latin America. The presence of these missionaries was relevant for aspects of health and education, although their primary objective was focused on working on evangelisation. Many dioceses, however, had a health programme within their pastoral plan. Furthermore, after the earthquake the Catholic Church had an impact regarding humanitarian services, which also supported other organisations such as the CUC, cooperative movements and peasant leagues. Although the work of the Catholic Church was not political, health projects and education resulted within the rural context in revolutionary changes, although these changes were for the missionaries simply acts of charity. These missionaries also held a position of respect for the customs and languages of the indigenous people, although some ladinos perceived this as paternalistic. However, for the indigenous population this was something never seen or experienced before. In fact, this behaviour was the opposite the majority of the ladino population had towards the indigenous. These missionaries opened hospitals and parish clinics, but there were not people in the community who could occupy any position within these organisations, since the poor and rural people did not have a minimum level of education and therefore were not able to even conduct preventive health work. This meant that there were only foreign missionaries working as doctors and nurses in rural areas. As a result, there were health programmes of the Catholic Church, evangelical missions and non-sectarian organisations, all working in isolation in different areas doing what everyone thought was best for the indigenous population.

The Ministry of Health of Guatemala also already had a programme or strategy in primary healthcare, but in those years it was known as ‘assistant training in rural health’. However, the training of healthcare promoters was only for doctors, corporations, medical colleges and universities, not as a process of development, but as a response of the academic health sector towards community health programmes. The professional jealousy was latent because it implied a loss of status that the professional sector had. The result was that for a long period of time

the newspaper *El Imparcial* published articles or editorials in which they made a call to the population to avoid being seen by people ‘untrained’ or ‘charlatan healers’ concerning health issues, including rural midwives. But this obviously never got to have an impact in rural areas where it was happening. The illiterate and poor could not read or buy the newspaper, and precisely that model of traditional health was almost their only source of access to healthcare, which prevailed until the 1990s. Dr. Ramírez, ASECSA

4 GUATEMALAN NATIONAL HEALTH SYSTEM AND REFORMS

‘Policy makers and health professionals are more comfortable discussing program delivery to high-risk populations and clinical responses that avoid political conflict or contingent historical and economic dynamics that remain outside the boundaries of scientific analysis’.

— Hofrichter (2006:21)

I want to turn attention to the particularities of the national health structures in Guatemala in order to understand people’s options, orientations, decisions, responses and predicaments concerning healthcare. It is a small country with a widely dispersed population, which has consequences for adequate access to public services. Traditionally, indigenous groups and poor rural populations have received less than a proportional share of the public healthcare expenditures (World Bank 2005). Such health inequalities¹ have implications in the distribution of illnesses across groups and geographical areas. Therefore, different forms and modalities of health are not necessarily attributable to selective cultural practices, but to pragmatic mechanisms of healthcare actions and relations related to conditions of vulnerability, insecurity and structural violence resulting from neoliberal economic and political reforms that intensify gaps or conditions of illness (Velimirovic & Velimirovic 2004). In this context, where traditional medicine provides essential forms of care, this type of care is subordinated by structural policy reforms to allopathic healthcare, which considers cultural factors that influence people’s decisions not to seek biomedical help as ‘cultural barriers’ (World Bank 2007:75-76).

National health programmes are concerned with the decentralisation of policies of care, with no real interest in creating or applying national guidelines that would

¹Inequity in Health implies systematic and potentially remediable differences in one or more aspects of health across population groups defined socially, economically, demographically, or geographically’ (ISEQH 2006).

incorporate traditional healthcare into national health interventions, and recognise cultural practices not only as a domain ‘to make sense of the social world’ but also as organised knowledge that is intimately central to healthcare. Further, this ‘traditional knowledge’ and other forms of cultural resources have received little or no real protection apart from formal recognition under global legal regimes. Under such regimes, several illnesses remain an unresolved burden to populations, while macro-models tend to neglect local modalities or ways of domestic and community healthcare (cf. Armus et al. 2002). Dynamics of power within governmental and other forms of institutional control of care suggest that, in Guatemala, the national health system and structures remain a means of exclusion and discrimination among indigenous and poor populations;² for centuries this system have disregarded and denied traditional medicine and practitioners as legitimate resources.

Health and access to health have entered the domain of international and national rights discourses, in addition to indigenous rights, which are central to the peace process in Guatemala. This has allowed various national and international NGOs to raise awareness about health inequalities; yet it has also blurred the meaning of ‘cultural rights’, regarding it as an expression of smaller-scale practices towards individuals but not as part of the institutional promotion of specific actions. It also has created the illusion that the NGOs are community-based organisations involved in the implementation of national and global programmes, yet their initiatives in the realm of health provision are limited and even marginal for local actors. Further, the health facilities and other organisations of the Ministry of Public Health and Social Welfare (MSPAS) that are located in rural and urban areas around the country do not necessarily provides better and appropriate healthcare to the population.

In addition, the public provision of healthcare in Guatemala is always confronted by financial crises. Inadequate health policies are a parallel problem. While economic accessibility and socio-cultural factors remain closely associated with the (non-)utilisation of health facilities, it is very important to note that the lack of continuity or the unavailability of national health programs are directly associated with the patient referral/counter-referral system, healthcare capability at the primary and secondary levels, and the lack of follow-up at, for example, the health post. International programmes, in the form of financial support provided directly to the government of Guatemala in order to ‘strengthen national policies’, rarely get to the bottom of the problems since donors just assume implementations will reach the poor effectively or do not take into account the specific health concerns

²Almost 75% of the indigenous population live in poverty—mostly in rural areas, where 72% of the extreme poverty is concentrated (USAID 2010:4).

of communities. Health programs and strategic planning tend to be temporary and targeted to specific groups, corresponding to the five-year Guatemalan presidential cycle, an inconsistent pattern which is insufficient to grapple with the problems that arrive when new administrative resolutions affect legal norms. Political and economical forces are active ideologies that seek to influence practices of health, but do not always take a pragmatic approach, even when they promise to do so. The experiences of caretakers with acute diarrhoeal diseases (ADDs) and acute respiratory infections (ARIs) are examples of how household, community and gender dynamics work to limit access to biomedical outreach. In this sense, health is a social concept and not only a medical one, organised according to family and community relationships, rather than simply a response to public health programmes and services (Hofrichter 2006:9).

Since international and national health strategies are committed to eradicating preventable and communicable diseases, specific diseases have become a priority. Many of these, however, such as ADDs and ARIs, are still a major cause of morbidity and mortality among children. In 2005, the Universal Health Coverage (UHC) programme, based on the World Health Organisation (WHO) constitution of 1948 and Alma-Ata declaration of 1978 and led by the World Health Assembly, launched a movement to increase funding for healthcare systems in low- and middle-income countries in order to provide health services to those who cannot afford them. The UHC programme covers health promotion, prevention, treatment, rehabilitation and palliative care normally provided by government-contracted NGOs. This programme works in association with other international health institutions, as well as financial institutions such as the World Bank. The goal is that standardised measures will become incorporated into national health policies and included in each country's healthcare models. But why do such programmes not produce long-term solutions? According to Maupin (2009), the presence of NGOs in Guatemala is part of a key governmental strategy of neoliberal health reforms to reassess contentious relations among state and civil society, rather than to promote equity in health and the efficiency and quality of health services delivery.³

Therefore, although several laws in social development and on health sector reform, which cover reproductive health, sexual and health education, have been passed since the peace accords, maternal and infant health continues to be in a precarious

³According to the WHO (1996:1), the difference between 'equity in health' and 'equity in the delivery of healthcare services' is that the first concept implies that the whole population should benefit from the highest level of physical, psychological and social well-being that is allowable by biological limitations; the second concept refers to the access and utilisation of resources and services of the health sector, distributed and delivered in accordance with the needs of the population (taking into account, for example, gender, ethnicity, and religious differences), and financed in accordance with the population's capacity to pay.

situation. Even when there have been some achievements in reducing inequities in resource allocation, health expenditures have decreased greatly, which makes the implementation of programs unsustainable; for example, between 1999 and 2005 the government spending on health declined from 2.3% to 1.9% of GDP (Estrada 2008). In addition, the health system in Guatemala is divided into different types of services that correspond to socially distinct classes. The most impoverished and vulnerable rely on facilities and programmes of the MSPAS. They receive poor-quality health services, suffer several forms of discrimination, and also sometimes pay elevated fees at point of service. This chapter focuses on the policies and programs of public health implementation to analyse the impact of the healthcare system and the challenges related to provision of healthcare.

4.1 Introduction

In Guatemala, allopathic and traditional medicine interact in conflict. Biomedicine is acknowledged on a national level but traditional medicine continues to be practiced, especially by indigenous people. The Guatemalan healthcare system⁴—divided into public, private and private non-profit sectors—has emerged from a colonial medical framework (Werner et al. 1997), as well as from thirty-six years of civil war conducted by US-supported military forces (cf. Wilkinson 2004). Health is a right guaranteed by the Constitution of the Republic (Article 93) and the Health Code (Decree 90-97). The right to health is theoretically ensured by the state to the whole population through the Ministry of Public Health and Social Assistance, which is responsible for the provision of health services. According to the legal framework, the health system must be decentralised, establishing the right of communities to actively participate in the planning, implementation and evaluation of health initiatives. Community participation in the partial or total management of their health programmes is provided for in the Health Code (Article 5). The health system is constituted of a mixture of Western models of health that have been directing their actions towards certain ‘processes’ or ‘diseases’ or to ‘vulnerable groups’ (such as ethnic groups, social groups, occupational groups, territorial or housing-situation groups). By 1995, 46% of the population had no access to primary healthcare (PHC)⁵ (SIAS 2010:2). As a result, informal health-

⁴ The WHO defines healthcare systems (HCS) as the framework that ‘includes all the activities whose principal purpose is to promote, restore or maintain health’ (WHO 2000a).

⁵PHC is defined as ‘essential healthcare based on practical, scientifically sound and socially acceptable methods and technology made universally accessible to individuals and families in the community through their full participation and at a cost that the community and the country can afford to maintain at every stage of their development in the spirit of self-reliance and self-determination’ (WHO Declaration of Alma-Ata: International Conference on Primary Healthcare, Alma-Ata, USSR, 6–12 September 1978).

care continues to be an important factor, provided by traditional healers, midwives, bonesetters, and medicine sellers, among others. The local health system in rural Guatemala can be described as pluralistic, fragmentary and incohesive (cf. ICEFI & UNICEF 2011).

According to Guatemalan health policy laid down by the MSPAS, the provision of healthcare at national facilities is free of charge, yet there are some costs that always need to be covered by the patients or family members, which differ between areas. However, it is not only the issue of cost, but barriers to accessibility such as discrimination, language, and long distances,⁶ that play a major role in the distribution of illness and disease. According to the Ministry of Finance the total public spending on health⁷ represents only 2.6% of GDP. This includes all facilities run by the MSPAS, which includes health posts, health centres and hospitals.⁸ Different forms of external lending (investment loans and results-based credits) from official financial institutions have supported most of the externally contracted services targeted for coverage of the extremely poor (World Bank 2007:134). Although the total health expenditure has risen over the last few years, the healthcare system continues to rely heavily (64.5%) on private investment (WHO 2014a). Guatemala has the lowest per capita public spending on health as a share of GDP in the region, below the Latin America and Caribbean regional average of 4.0% (Gragnotati & Marini 2003:3). In addition to the Guatemalan MSPAS, formally employed workers who contribute to the Guatemalan Institute of Social Security (IGSS⁹) and the private health sector are also part of the national health system. IGSS and MSPAS facilities have traditionally had vertical structures, with very limited coordination between them (World Bank 2007:47).

Public health services are free, including medication prescribed in the MSPAS facilities when available, but medication obtained elsewhere must be paid for (Giedion et al. 2010:175-192). However, the provision of healthcare for many rural localities is extremely limited. People in these locations receive only the outreach Cover-

⁶ The WHO defines health services as physically accessible when they can be reached in 60 minutes or less. In Guatemala, only 10.7% of the adult population can access health services within this time (ENCOVI 2000).

⁷ Expenditure on health includes the sum of government, social or compulsory, and private (including external borrowing and grants) provision of medical services (including preventive and curative services) in a given year.

⁸ Ministerio de Finanzas Públicas, Superintendencia de Administración Tributaria SAT, Banco de Guatemala, Instituto Guatemalteco de Seguridad Social IGSS.

⁹ The Guatemalan Institute of Social Security was created under the government of Juan José Arévalo in 1946 and ratified in the constitution of 1985. IGSS is a medical insurance fund with healthcare services accessible to employees of companies who contribute to the system, as well for their spouses and children under 5 years of age. It operates through two programmes: 1) Diseases, Maternity and Accidents (Enfermedad, Maternidad y Accidentes—EMA), and 2) Disability, Old Age and Survivors (Invalidéz, Vejez y Sobrevivencia—IVS).

age Extension Programme (*Programa de Extensión de Cobertura*, PEC), an entity established in 1997. It provides basic health services for around 4.7m individuals in 198 municipalities around the country and has not changed in the last 18 years. In some cases, the package consists of a single monthly visit to the doctor or community nurse. PEC services comprise a mobile team through national and international NGOs that are selected by the national coordinator of the PEC.

The expenditure for the MSPAS submitted by the Executive government is, according to the healthcare syndicate,¹⁰ inadequate to provide minimum healthcare services for the whole population. This forces people to rely on home management and NGO providers, increases the risk of privatisation of health services, and increases the disease burden. By October 2013 a decrease of the budget allocated to the PEC programme had resulted in inadequate or completely absent healthcare in many places, including the interventions of the Zero Hunger¹¹ programme, with the harshest impact on pregnant women and children under five years old.¹² In July 2014 the president of the PEC officially reported that, of the 67 NGOs that were providing health services, only 16 would remain in operation, substantially reducing the PEC programme.¹³ This reduction also left 1,528 community health workers (*vigilantes de salud*), 7,176 health facilitators, 10,105 midwives and 18,718 maternal counsellors jobless.¹⁴

Adequate healthcare infrastructure, such as sufficient medical staff, essential equipment, and indispensable treatments, are limited to urban areas, where less than the 45% of the total population lives. Presently, approximately 40% of the population are reported to have limited or no access to health service (Lao Pena 2013:22; PAHO 2012). The rural people of Guatemala continue to experience higher rates of mortality amongst children under five than the urban Guatemalan population, with the Department of San Marcos not only one of the poorest zones in the country, but also with high rates of mortality, malnutrition, and poor household environments, particularly with respect to indoor air pollution and inadequate water/sanitation. It is also one of the departments at the greatest risk from environmental factors, affected by hurricanes, storms, earthquakes, landslides, and

¹⁰<http://www.lahora.com.gt/index.php/nacional/guatemala/actualidad/185014-solicitan-aumento-al-presupuesto-de-salud.html> (accessed on 07.01.2014)

¹¹ *Pacto Hambre Cero*, http://web.maga.gob.gt/wp-content/uploads/pdf/home/pacto_hambre_cero.pdf

¹² http://www.prensalibre.com/noticias/comunitario/Cobertura-salud-fondos_0_1009099115.html (accessed on 12.12.2013)

¹³ http://www.prensalibre.com/noticias/politica/falta-presupuesto-cartera-Salud-obliga-rescindir-contratos_0_1179482268.html (accessed on 25.07.2014)

¹⁴ The material counsellors seek to promote breastfeeding during the first six months of life as part of the MDG to reduce chronic malnutrition beginning in 2010, a measure that also has a direct impact on the Zero Hunger programme.

volcanic activity as well as by human impacts such as deforestation, migration, road accidents, and violence (cf. INE 2013).

4.2 History of the Institutionalisation of Guatemala's Health System

Colonialism and wars greatly affected the health of indigenous people by producing social, political and economic inequalities. The economic and political expansion of the colonies had devastating effects on the colonised territories, bringing not only genocide but also the loss of cultural identity, deprivation of freedom, depopulation, disease transfers, exploitation, violence, dislocation from land, and economic collapse, all of which ultimately prejudiced their health and well-being (Warinner et al. 2012; Lovell 1991; Lovell & Lutz 2000). The political colonial system and its legislation created inequalities based on social stratification along ethnic lines, ensuring hierarchical distribution of resources and power. This was followed by a systematic abuse of wealth and opportunities to the advantage of the dominant culture based on racism and social exclusion, leaving the rest of the population excluded and in unfavourable conditions (Bastos & Camus 2003; Cook & Lovell 1992).

In 1477 the Spanish Crown created the *Protomedicato*, an institution designated to regulate and guide institutional medicine through examination and licensing. A medical system was legally authorised in Guatemala in 1793 in order to teach medicine, surgery and pharmacy, and to provide legal regulation to promote the study of medicinal plants (Few 2002:71; Cazali 1996). However, the 'ideology of colonial healing' did not include native healers, i.e., local practitioners. Europeans located their own rationality, and Western medical theories and practices, as 'natural' forces of modernity, designating native medical beliefs and tradition as superstitious and primitive (i.e., irrational), which justified colonialism as an ultimately civilising enterprise through the eradication of such practices (Comaroff & Comaroff 1992:222). As epidemics became a serious threat and native populations and practices posed a threat to individuals, the primary priorities of 'public health strategies' (based on miasmatic¹⁵ theory as source of infections) centred on the interests of colonial powers, guaranteeing the well-being of Europeans in new

¹⁵The miasmatic theory has its roots in the Hippocratic tradition and was reformulated throughout the medieval and early modern periods. It was generally accepted that *miasmas* (pollution in the air) were the result of the decomposition of organic material. This theory was brought into question the Renaissance and the nineteenth century, when theories of transmission and disease generation (germ theory and contagion theory) began to influence the explanations of diseases outbreaks (Rosenberg 1992).

environments and control of the colonised territories, for which the strategies of avoidance and segregation were established (Cook & Lovell 1992).

Later the focus shifted to the health of indigenous populations, principally to secure the availability of productive labour (Arnold 1988). Around 1541 and 1553 the first two hospitals, Hospital Real de Santiago (designated specifically for Spaniards), and Hospital de San Alejo (restricted to the indigenous population) were founded in *Santiago de los Caballeros*, the capital of the Spanish Kingdom in Guatemala, now La Antigua Guatemala (Few 2002:72). In 1630 the religious order of San Juan de Dios took over the administration of both hospitals but continued the ethnic segregation. In 1636, by order of King Philip IV, a third hospital was constructed outside town, Hospital San Lázaro, in order to isolate people affected by Hansen's disease (leprosy), since it was believed to be contagious. This hospital was damaged in 1717 by an earthquake and abandoned entirely in 1773 when a second earthquake hit the country. The Hospital San Pedro Apóstol, now Obras Sociales del Santo Hermano Pedro, founded by Dominican friars for clergy patients and built between 1636 and 1663, started to accept community patients; it is the only colonial hospital that is still in service. Outbreaks of several pandemics through the seventeenth century (typhus or pneumonic plague, and smallpox) killed one-tenth of the inhabitants, mostly indigenous and poor (Lovell 1991; Byrne 2008:414). After Guatemala declared its independence from Spain in 1821, a long process was set in motion to create an independent national state, which comprised several decisive moments or stages. In the immediate post-colonial period, the political instruments of social domination that served the interests of the conservative European creoles continued to exist. The highest person in the colonial authority, Captain General Gabino Gaínza, remained in power (Woodward 1999). Insalubrious and poor conditions of life continued for the majority of the population, which contributed to several epidemics. Guatemalan society was marked by an 'episteme of separation...no culture obsessed more about borders than the one taking shape in the mid-nineteenth century, insisting on national, racial, gender, and class lines' (Maier 2000:819).

A significant fraction of the dominant, former colonial group, led by the Honduran liberal Francisco Morazán, worked towards an annexation to the Mexican Empire which ended in failure. This led to the foundation of the Federal Republic of Central America in 1823 with the creation of a federal constitution in 1824, and then to the creation of the United Provinces of Central America or Central America Federal Republic, consisting of five autonomous provinces and a federal district strongly influenced by the U.S. model (cf. Palmer 2005). Within this structure, Guatemala adopted its first national constitution in 1825, which established execu-

tive, legislative and judicial structures (Ruggiero 2013). With the establishment of the republic, slavery was prohibited, but the impoverished condition of the indigenous people did not change, including the sanitary conditions. In 1840 Morazán was defeated by the conservative-backed rebel army led by Rafael Carrera and the federal republic dissolved into the present-day countries of Guatemala, El Salvador, Honduras, Nicaragua and Costa Rica.

In the late nineteenth century, during the liberal regime, better public-health standards were established through the Health Boards, which were formed in 1773 at a time when epidemics hit the region. In 1881 the government of Justo Rufino Barrios created the “Security, Health and Public Beatification Police”, who became part of the institutionalisation and control of public health policies, such as making use of military forces to combat epidemic outbreaks. Some of the measures promoted during this time were the prohibition of burying corpses inside churches, banning the establishment of cemeteries outside the urban areas, vaccination campaigns against smallpox, and the foundation of an asylum for lepers. Yet the cholera morbus epidemic (the ‘Second Pandemic’) that hit Guatemala in 1837 clearly displayed the lack of efficient public health measures and lack of health facilities (Byrne 2008:414). The sanitary code entitled the Superior Council of Public Health was created in 1906 under the auspices of the Ministry of Interior and Justice. It remained in effect until 1925, when the General Direction of Public Health was founded. It was renamed the Department of Public Health in 1932, directed by the University of San Carlos of Guatemala, Guatemalan Social Security, and the Ministry of National Defence and represented by the Bureau of Military Health, the Social Welfare Council and other government bureaus.¹⁶

During the dictatorship of Manuel Estrada Cabrera (1898-1920), a political stalemate caused the stagnation of public health policies, except during outbreaks of epidemics, such as the yellow fever epidemic in 1915 that killed 42,733 people (Adams 1996). During this period—between 1824 and 1893—significant demographic changes occurred, such as an increase in the population (from 633,500 to 1,497,185 inhabitants), with nearly 40% of the total population concentrated in the City (Arias de Blois 1995). Natural disasters (several earthquakes between 1902 and 1918, floods and droughts) and epidemics (malaria, smallpox, typhus) continued to affect the rural, impoverished and indigenous population, destroying several communities. The 1918-1919 influenza epidemic caused nearly 44,000 deaths, the majority of which were indigenous people from the highlands and workers from coffee plantations (Adams 1996; Rivera 1985). Between the 1940s and 1950s, the

¹⁶ Boletín Sanitario de Guatemala, órgano de la Dirección General de Sanidad Pública de Guatemala, 1935-1940.

involvement of the Guatemalan government in social affairs expanded, in particular in the areas of health and education (Martínez 2013:7). During the dictatorship of Jorge Ubico (1930-1944) the military became responsible for healthcare, with just a few substantial improvements, such as massive vaccination campaigns against smallpox for which the state was responsible, included in the new Health Code.¹⁷ Yet the lack of resources and biomedical personnel, combined with low school attendance, reduced the impact of these campaigns. By 1940 the illiteracy rate was close to 67% and poverty continued to contribute to the poor health of indigenous and rural population, especially children, who died of acute diarrhoeas, parasitic diseases and under-nutrition (PNUD 2002:268). By 1950 the population doubled to almost 3 million, with a mortality rate of 26 per 1000 among indigenous inhabitants, and 17 per 1000 people among other groups (Arias de Blois 1997:197-200).

The Guatemalan revolution of 1944 constituted a major period of democratic resistance in Central America, which offered a structural opportunity for the state to integrate the indigenous population and other exploited groups within the fragmented society, encouraging civil participation in politics and in labour unions. During this period many reforms in healthcare and education were developed, and a social security system was established. As a part of these social reforms the General Direction of Public Health came under the control of the new Secretariat of State of Public Health and Social Assistance (Rivera 1985:21), thus being separated from the Ministry of Interior and Justice, ending the coercive and militarised dimension of healthcare and taking charge of hospitals and preventive health programmes (Idem, p.33-35).

The Secretariat of State of Public Health and the Social Assistance department were subsequently transformed into the Ministry of Health and Social Welfare. Mobile health units were created throughout the whole national territory, sanitary delegations were organised in all departments, and by 1950 the municipal dispensaries programme commenced. In 1945 the Constitution of the Republic came into force, establishing 'compulsory social insurance', which included insurance against disability, old age, death, disease and accidents, funded by premiums paid by employers, workers and the state. A year later the Guatemalan Congress approved the Organic Law of the Guatemalan Institute of Social Security (*Instituto Guatemalteco de Seguridad Social*, IGSS), establishing it as an autonomous institution, whose purpose was to apply national health benefits within a unitary and compulsory regime of social security in accordance with the system of minimum protection¹⁸ (Valenzuela 2009:290).

¹⁷In 1979 the Decree of the Congress of the Republic 45-79 promulgated another health code, which remained in effect until 1998.

¹⁸During this period the Biological Laboratory was also founded in order to create vaccines

National institutional reforms in 1949 created the Institute of Nutrition of Central America and Panama (*Instituto de Nutrición de Centro América y Panamá*, INCAP), later incorporating Belize and the Dominican Republic with the objectives of (1) determining the nutritional problems of the region, (2) finding solutions and alternative approaches to secure the availability of food through research, and (3) helping the region through the implementation of consultancy, education and training.¹⁹ The so-called “Democratic Spring”, between the years of 1944 and 1954 under President Juan José Arévalo, a democratic-socialist, and Colonel Jacobo Arbenz Guzmán, was disrupted by a counter-revolutionary movement in 1954 when the United States of America, supported by the Eisenhower administration, led a putsch that hindered the democratic process, putting off all the initiatives and programmes of the MSPAS and IGSS (Martínez 2013:7).

By 1965 the country had 54 health centres and 123 health posts. In 1969 the General Direction of Public Health was again reorganised by governmental agreement. The General Direction of Public Health Services was established, with divisions of Maternal-Child and Family Healthcare, Epidemiology, Environmental Health, and General Technical Services, as well as executive and administrative branches establishing five regions for healthcare services. During the same year, the Community Health Programme (*Programa de Salud y Comunidad*, PROSAC) was launched, developing a holistic model of healthcare in coordination with public health services (Ángel 1993). The oligarchic and racist ideology that prevailed until the late 1980s reinforced an ultraconservative economic system without social investment. Consequently, the Organic Law was amended and minimised, its autonomy limited by political, social and financial factors, with negative consequences to the further development of social security of the population.

Although the PROSAC programme rendered remarkable service during the earthquake that hit Guatemala in February 1976,²⁰ its activities were reduced as a result of counterinsurgency measures until its suspension in 1980. This period was defined by oppression and massacre of the indigenous population after General Efraín Ríos Montt came to dictatorial power in a 1982 coup. Ríos Montt replaced

against rabies, typhoid and smallpox. The Pathology and Biotechnical Laboratory was also established, with emphasis on the control of vector-borne diseases, creating in 1953 a section to fight against cutaneous leishmaniasis (first described in 1928) and American trypanosomiasis (Rivera 1985:30-35).

¹⁹<http://www.incap.org.gt/index.php/es/acerca-de-incap/resena-historica/historia-completa-del-incap>

²⁰ The earthquake, with a magnitude of 7.5 on the Richter scale, left around 1.23 million of people homeless, almost 23,000 dead, and 77,000 injured. It destroyed railways, roads, bridges, schools and hospitals, affecting 40% of the national hospital capacity. UN (1977): ‘The Guatemala Earthquake Disaster of 1976: A Review of Its Effects and of the Contribution of the United Nations Family’, United Nations Development Programme, Guatemala.

the search-and-destroy mission of General Romeo Lucas García with his Plan of Assistance to Areas of Conflict, better known as the Beans and Rifles' programme (beans for those who cooperated, rifles for those who did not) to keep guerrillas out of indigenous villages (Bastos & Camus 2003). The constitution was suspended, a 'state of siege' was declared, public meetings were banned, and Civil Defense Patrols (PACs) were instituted to control the population, replacing elected officials and censoring the press (Lovell 2010:61; Sanford 2003; Wilkinson 2004). The effects of the armed conflict were devastating, including the suspension of many health facilities, leaving entire villages across the country without health provision. Other communal organisations were also affected by direct reprisals against the communities and service providers.

The internal armed conflict from 1960 until 1996, in conjunction with natural disasters such as the earthquake of 1976, had long-lasting detrimental consequences which directly and indirectly affected the health of Guatemala's population. Moreover, natural disasters²¹ have become more frequent, increasing inequities and aggravating existing problems, such as lack of sanitation services, inadequate shelter, inappropriate medical care, and food insecurity, etc. (Glass et al. 1977.) A national survey of food and nutrition by INCAP in 1976 found a high prevalence of anemia among children, pregnant women and women of childbearing age, vitamin A deficiency mainly among school-age children—riboflavin deficiency, and low intake of protein, calories and other essential nutrients among the whole population. The high rates of protein and calorie malnutrition, especially among children under 5 years of age, corresponded to high incidences of chronic and acute forms of malnutrition. During that period, 81.5% of children under 5 were suffering from malnutrition to some degree, while more than 3% suffered from severe malnutrition (INCAP 1967). By the end of 1976 Guatemala had a total population of 6 million inhabitants, of whom 65% lived in rural areas, a high infant mortality rate (84 deaths per 1,000 live births), 53% illiteracy (in rural areas, seven out of ten people were illiterate), and life expectancy of only 52 years (Arias de Blois 1995). At that time malnutrition was the main direct cause of hospitalisation, and there was only one physician per 4,570 individuals.²²

²¹ In 1998 Cuban medical aid began after Hurricane Mitch hit the country. The resulting *Convenio de Colaboración Cuba-Guatemala* agreement sought to replicate in Guatemala the Comprehensive Health Programme that exists in 16 other countries in Latin America, Africa and Asia. Normally Cuba provides human resources, while the host countries provide infrastructure and logistics. In Guatemala's case the costs are distributed between the two countries. While the Cuban government pays the salaries and air transport for the doctors and their families, the Ministry of Health of Guatemala gives a monthly payment to each doctor to cover living expenses, accommodation and internal travel. The Ministry of Public Health also decides where the doctors will work.

²² SEGEPLAN (1976), "La Problemática de la Desnutrición en Guatemala. Bases para su solu-

The war also produced enforced disappearances, massacres, arbitrary executions, and internal and external displacement, all of which had a huge impact on the physical and mental health, nutrition, and well-being of the affected population. The indigenous people, in particular, suffered violation of their cultural identity and ethnic rights, leaving thousands of people disabled and injured (Luján 2004). Between 1986 and 1990 the government proposals maintained inappropriate assumptions about conceptual models of healthcare and civil participation was limited and marginal, and health policy continued to favour the policies and interests of the army. During these years, health funding was only 1% of GDP, as the military and public debts were the priority. During this decade, civilian health organisations were still direct targets of state repression, and government programmes such as the Health Census Channelling were used as measures of control and surveillance (Verdugo 2000:309-311).

4.3 Current Guatemala Health System

Public healthcare in Guatemala is organised regionally. The MSPAS, responsible for implementing national health policies within the healthcare system, oversees the country's public health system through a network of hospitals and health centres, together with the IGSS and several NGOs. The MSPAS is made up of a central administration, eight regions, and 27 health areas. Hospitals, health centres, and health posts are allocated throughout the 23 departments, each of which is subdivided into at least 10 municipalities. Normally, each department has one central referral hospital, and each municipality has at least one health centre with one or two physicians and several nurses. Health services overseen by the MSPAS are located in both rural and urban areas, and are arranged into three levels of healthcare.

The *primary care services* (PCSs) are the first level of contact between patients and the health system in their local community. They are oriented towards basic preventive and curative services, and are run by a certified nurse or auxiliary nurse. PCSs are small facilities, some without electricity, located in outlying communities, towns, or plantations, representing 74% of the total national services with 1,101 health posts. They include Health Posts, Post-Centres, Convergence Centres, Strengthened Health Posts, Strengthened Health Posts on weekends, and Minimum Units, which provide basic health services (BHS) (PAHO 2007; Bowser2009). BHS offers health services in each jurisdiction with at least 10,000 individuals and provides basic drugs (with per capita funding ranging from US\$6 to US\$9²³) (Becerill

ción”.

²³ Per capita amounts depend on whether the jurisdictions belong to priority municipalities,

& López 2011; Icó 2007). Medications are purchased by the providers with funds transferred by the MSPAS; the medications are selected according to the needs of the population that attends the particular facility. Mother-child pairs receive their drugs for free during the medical consultation. Iron supplements and folic acid are distributed by traditional midwives to pregnant and lactating women. Health guards are in charge of the provision of acetaminophen and oral rehydration salts, and keep track of the treatments prescribed by the travelling physician and the institutional and/or community facilitator (Masterson 2010; PAHO2007).

The community facilitator provides 22 essential medicines, which are inventoried by the community organisations. Quarterly reports of stocks and demand are made to the provider or administrator via the institutional facilitator. At the primary level the staff normally includes NGO personnel, namely an ambulatory physician or professional nurse, and an institutional facilitator. There are also community personnel, composed of community health workers²⁴(CHWs) which include a community facilitator (10 to 12 facilitators, at the rate of 1 per 1000 inhabitants), health guardians, traditional midwives, maternal counsellors,²⁵ three health and nutrition educators in areas with high malnutrition rates (since 2010), and on occasion, a rural health technician and a health worker from the Vector Control programme. These personnel comprise the basic health team (Castillo et. al. 2012).

CHWs are central actors at the community level, promoting preventive and primary healthcare and treating common diseases,²⁶ with the support and supervision of a travelling physician and an institutional facilitator. CHWs are required to attend monthly training. They work four hours a day, monitoring health guards and taking care of patients referred by the health guards. They are responsible

(priority municipalities depend on the results of population census, emphasising nutritional vulnerability, malnutrition prevalence, morbidity and mortality) and the percentage of the target population with chronic malnutrition (Lao Pena 2013:5).

²⁴Community health workers are women and men who are recognised by their neighbors and communities. They receive formal training in order to promote and maintain the health of their communities; learn about prevention and public health to diagnose and treat common illnesses, and participate in major health initiatives carried out by the national government, local health post and/or nongovernmental organisations. Whether paid or voluntary, they are integral to the health and public health infrastructure, and are critical to any effort to improve health and wellbeing at the local level (Gottlieb 2000:7)

²⁵In the jurisdictions that also have the community-based Integrated Care for Children and Women (AINM-C) programme, communities select a maternal counsellor who is assigned to a group of 15 to 20 women of reproductive age. These counsellors hold monthly group meetings to provide advice on proper feeding practices and healthcare practices (Lao Pena 2013:5).

²⁶These activities include vaccination programmes; control of diarrhoea and acute respiratory infections; growth promotion; prenatal care; delivery care; postpartum care; birth spacing; detection of cervical and breast cancer; control of dengue, malaria, tuberculosis, sexual diseases, and HIV/AIDS transmission; and emergency care for the population in general.



Figure 4.1: Stock of medicines at the Primary Health Sector in Tuijala, Comitancillo

for developing effective health information systems for PHC with the assistance of consolidated bimonthly health information in their communities; they present the ‘situational room’²⁷ of the community assembly; and they maintain the supply of essential drugs. CHWs receive a monthly incentive for fulfilling these tasks. The entire basic health team is involved in a systematic local-level training process which improves their awareness of local health priorities. Constant monitoring ensures the accuracy of the information in order to strengthen the delivery of basic health services. Health guards and midwives receive a small payment of GTQ50 (\$6,51) for each training session (SIAS 2010:6).

Until 1996 primary healthcare services were provided by 860 health posts located in suburban and rural areas of the municipalities. They were mainly staffed by nursing assistants/auxiliaries and covered only around 2000 individuals. The model of service delivered in the first level is called Community Centre. It provides services of healthcare, training and periodic meetings, together with the community assembly, to analyse the health situation of the community. These community centres constitute a contribution of the communities, which are responsible for their maintenance through the communal organisations. By 2010 there were 1868 community centres nationwide (idem., p.7)

Secondary healthcare, in which patients from primary healthcare are referred to specialised health centres for treatment, is provided by 346 facilities. Twenty-three

²⁷ *Sala situacional* refers to a technical tool that presents indicators related to health status and nutritional data from a specific group and community. This information permits analysis, interpretation and decisions in order to propose feasible solutions to a problem. It focuses on advocacy, prevention, care and control of the problems identified. It includes participation and contributions from other sectors of the community.

percent of these are called Health Centres, which are generally 24-hour health facilities offering care for emergency cases, a few labor beds and a delivery ward with electricity, and a small laboratory. The centres are generally staffed by one physician and several nurses. They may also be known as Ambulatory Care Centres, Centres of Integrated Maternal and Child Care, Cantonal Maternal Health, Emergency Medical Centres, Peripheral Clinics, Centres of Permanent Care (CAPs) of either type A (with some beds, primarily for maternal care) or type B (ambulatory care only), and Maternity Clinics.

Tertiary level of care provides services of high complexity at 45 public hospitals of varying types at national, regional, departmental and district levels; they constitute 3% of all hospitals nationwide (PAHO 2007:33). Patients who seek help at the tertiary level are generally recommended for special investigation and treatment by the primary or secondary medical care personnel. In 2012 the health service network of the MPSAS had 1,101 establishments for primary care, 346 for secondary care, and 45 hospitals for the tertiary level of care (MPSAS et al. 2012:3-6). Apart from payments from certain public and military pension plans, the Guatemalan healthcare system is primarily financed by household contributions.²⁸ As much as 73% of spending on medication is out-of-pocket (cf. Gragnolati & Marini 2003).

According to the MSPAS, the government has not allocated any funds at the national level to cover emergency expenses for the health sector. The ties among healthcare areas (i.e., the primary, secondary, and tertiary care levels) are weak, impacting on the provision of health according to geographical regions in which the different government agencies deal with healthcare and varying medical conditions; there is a lack of analysis regarding vulnerability and risk factors; information related on risk in the provision of services on the primary and secondary levels is not available; and no periodic evaluation, control, or maintenance are provided at the primary and secondary levels (cf. MSPAS 2012).

Guatemala Institute of Social Security (IGSS)

The IGSS is an autonomous institution financed by compulsory payments from workers and employers in the business sector. It comprises 24 hospitals, 30 primary care facilities, 18 first aid stations, and 5 wards in national hospitals. Of these, 6 hospitals and 10 primary care facilities are part of the urban healthcare network (PAHO 2002:319). The payments required from their affiliates differ according to the services provided in each geographical area. Spouses of employees and children

²⁸“Health Financing in Guatemala: A Situation Analysis and Lessons from Four Developing Countries: Final Report 2009” <http://www.hsph.harvard.edu/ihsg/publications/pdf/GuatemalaFinancingAnalysisLessons7.23.09.pdf>.

under 5 years of age receive limited healthcare services related to maternal care, common illnesses and immunisations. Whereas in 2005 the Ministry of Health spent US\$32.22 per habitant, the IGSS spent US\$298 (PAHO 2007:35). However, approximately 67% of workers are not employed by a company or are not officially registered (*idem*.p.6), and the IGSS lacks the financial strength to contribute or cross-subsidise coverage for the extremely poor (World Bank 2007:134).

The IGSS has two main programmes, ‘Enfermedad, Maternidad y Accidentes’ (EMA), created in 1978, and the ‘Invalidez, Vejez y Sobrevivencia’ (IVS), created in 1977. The IGSS provides health services (and retirement benefits) to employers in the formal sector through its own health facilities that can be used by their affiliates and their families. The payments that the members have to make differ according to the services provided in each geographical area. The IGSS has sought to implement the provision of the SIAS programme by launching health promotion, development and preventive health services (Estrada 2008). With the approval of Law 1122 of 2007, total contributions by the employee were raised from 12% to 12.5% of income, with 8.5% of the 12–12.5% being paid by the employer (Guerrero 2008).

Private (Non-profit and Profit) Health Sector

The presence of nongovernmental organisations has been of significant importance in international development (Hulme & Edwards 1997). NGOs have covered the gaps left by the MSPAS in inaccessible areas because of supply-side constraints and deficiency of logistical, equipment, and material support (*cf.* Cardelle 2003). In Guatemala their proliferation became embedded within the social and political structures with the entrance of foreign priests who came to the country during the government of Colonel Castillo Armas (1954–1957), the U.S. chosen leader of the military cope, who toppled Jacobo Árvenz in 1954. Catholic NGOs have operated mainly in rural indigenous communities, especially in the form of secularised institutions such as Catholic Action (Wilson 1995; Fitzpatrick 2007; Fisher & McKenna 1997). Although religious groups were sometimes co-opted by the government for political purposes, they played a major role in the provision of primary healthcare in rural areas of Guatemala during the 1960s. For example Dr. Behrhorst, a missionary of the Lutheran Church who arrived in Antigua in 1959.²⁹

²⁹A similar situation to Dr. Behrhorst’s was that of David Warner, an ornithologist from California who moved to Sinaloa, Mexico after receiving a diagnosis of a fatal disease. The rural people of Sinaloa took care of him when he was ill. The affection of these people motivated Warner to learn how to treat common diseases, and he thus became the first rural ‘health promoter’ in Mexico and Central America. During his stay Warner wrote a book called *Where There Is No Doctor*, which served as a training manual for healthcare in rural areas

Initially Dr. Behrhorst had only a small clinic, which later became a hospital. The structure was innovative because relatives of the patients assisted in patient care. Dr. Behrhorst realised that patients he received at his clinic had very similar clinical manifestations, which gave him the idea of teaching, at the community level, people who would be able to treat common diseases. His students became the first health providers in Guatemala, specifically in Chimaltenango (cf. Rohloff & Kraemer 2013).

In 1964, in Huehuetenango, the Maryknoll Sisters found the same precarious health situation in that region. Like Dr. Behrhorst, the Maryknoll Sisters realised the importance of having people involved in the processes of healthcare within their own communities, people who knew and understood the customs and languages (cf. Fitzpatrick 2009). The same process of community work was also taking place simultaneously in Nicaragua, El Salvador and Mexico; yet by the middle of the 1970s Guatemala had a level of health coverage much better than other Central American countries due to the utilisation of health promoters. Unlike in the neighbouring countries, the health promoters made use of drugs, providing healing assistance and not just preventative care. In Nicaragua this changed with the war, and the promoters in that country also began to use drugs to treat the wounded.³⁰

The civil wars changed the structures of the community health services. In El Salvador the promoters were of two types, one focused on preventive work and the other on healing. The Salvadoran guerrillas, along with their fighters, had a group called ‘healthcare providers’ who, in addition to being involved in the war, also took care of civilians in militarised territories. Some were even surgeons. But in Guatemala the organisational structure was different, partly because of the difficulty of reaching some of the communities but also because of the ethnic segregation among the population. During these years the Alma Ata conference held by the WHO promoted the idea of training healthcare workers, but in Guatemala this existed already in other forms, such as the programme introduced by Dr. Behrhorst and the Maryknoll Sisters. There were also the Santiaguito Clinical Programme on the Pacific coast, the Bethany Clinic with Belgian nuns, and Canadian nuns working in Zacapa and Izabal, but there was opposition from the government to this type of work.³¹

(cf. Warner et al. 1992). This book is still widely used as a biomedical reference; it describes various diseases, offering illustrations, explanations, diagnosis charts, and treatments, to make it accessible to anyone. Because of its usefulness, it has been broadly welcomed, but also widely criticised since it contains several practices or techniques that are considered rather dangerous and lacking in scientific evidence.

³⁰Colección “María Luisa Cabrera Sobre Salud Comunitaria durante el conflicto armado interno”, GT CIRMA AH 092, Antigua Guatemala

³¹ASECSA (1989): “Documento resolutivo de la Conferencia Internacional de Organizaciones No

Thus, during the 1970s there were a variety of health promoters from both private and governmental entities. However, training programmes differed greatly. Some were one year in length, others up to four. Depending on the degree of literacy, some used Warner's book, *Where There Is No Doctor*, while others made use of brochures or even more basic educational plans. With the support of these various organisations, several entities called 'germinal base communities' emerged, comprising rural health promoters, midwives, agricultural promoters, social workers, and literacy promoters.³² Many children of healers and midwives were involved as health promoters, resulting in a combination of traditional and biomedical knowledge. This was very significant for two reasons. First, it became clear that the traditional healthcare knowledge had been silenced and oppressed. Second, people recognised they had their own resources and mechanisms to solve some of their health problems. However, the perspective of the religious groups in relation to the health workers' training was problematic. The logic that drove them was "what you have to learn is to serve your community's needs, and in one way or another we will teach you what those *needs* are" (Arturo Domínguez, ex-guerrilla member in San Marcos). Beginning in the late 1960s, religious groups approached the headquarters of the Ministry of Health to obtain official approval of the courses they were giving, providing a license to those who attended these courses. The attention they gave was on very basic health services, but people were just dying of common diseases and still dying after almost 50 years of the same diseases: diarrhoeal diseases, respiratory infections, malnutrition. Thus much of their work was on prevention. This period was very important concerning the issue of disease case management because through these clinics people had access to antibiotics for the first time (Dr. Ramírez, ASECSA). As a result, although religious groups transformed the structures of healthcare in rural areas by introducing Western preventive methods and treatments, they were also responsible for the displacement of traditional practitioners and the Mayan civil-religious hierarchy by engaging communities in the Western structures.

Via policies launched and supported by the conservative government, the Catholic Church maintained the status quo that favored ladino society above indigenous groups, in order to defend 'national security' over human rights (Holland 1982). Yet the role and work of some Catholic priests and religious workers began to change during the armed conflict in Guatemala (Berryman 1984). After the Second Vatican Council (1962-1965) and the Medellín Conference of the Latin American Episcopal Council (1968), the Catholic Action programmes started to get involved

Gubernamentales sobre refugiados, desplazados y retornados Centroamericanos. Conferencia Internacional de ONG's", ASECSA No. 26, San Salvador.

³²ASECSA (1980): "El fenómeno de las ONG's en Guatemala", ASECSA No.20, Guatemala.

in the communities at a very different level. Because they were aware of the needs the communities, their work shifted to help build schools, cooperatives and health services in areas where there was no public-sector presence (cf. Fisher & McKenna 1997). According to Dr. Ramírez, a physician who worked in ASECSA during those years, this had a practical importance for the rural poor areas, even if it occasionally created conflicts in the communities:

“We must realise that until the 1950s the indigenous population was completely segregated and socially annihilated. The existence of schools or health centres in rural areas was an unthinkable idea. It was the project of the Catholic Church to educate all people without distinction, especially the indigenous, which began with the introduction of literacy and health programmes. Priests of different congregations defined their role as missionaries supporting different local churches to form priests from the same areas where they lived, so these could then take care of their parishes. This involved youth literacy programmes to further educate them in philosophy and theology. We need to take into account the roots of [Guatemalan] history in order to understand this phenomenon and the impact that this process of education had on young peasants and indigenous people. For centuries in Guatemala, families assigned the rights to inherit land and assets to the firstborn. The second son would go to the seminary to become a priest, and the third would attend military school. Women were excluded from these three ‘titles’, as it was expected their life would be ‘resolved’ through marriage. This model existed in Spain and was transferred to Guatemala. Therefore, the priests and the church hierarchy depended on the ruling classes. This changed with Vatican II and even more with the Medellín Conference, since it was precisely the children of the upper classes who supported and joined the cause of the poor and excluded...The Church changed this and gave some people the opportunity to become literate, which would have an impact on the health of their communities”.

These initiatives caused confrontation with the Mayan leadership. As had happened with the Maryknoll Sisters in Huehuetenango, these conflicts divided communities, creating new alliances and networks and resulting in two different Mayan leadership groups, one that rejected Catholicism and another, comprising some midwives and health promoters, who had been educated under a westernised healthcare frame (Fitzpatrick 2009:29). The later assisted the process of implementation and coverage of the public health sector, although the problem of lack of basic medicines or medical personnel continued to be an obstacle. Thus, the presence of several Roman Catholic orders and lay groups, alongside other non-governmental sectors of a different nature, worked with the private and public sectors to support the poor and disadvantaged. Yet, as pointed out by Rohloff

et al., ‘the simultaneous presence of multiple local government health facilities and private physicians is further complicated by many small NGOs, each with its own funding mechanisms and accountability practices. Such chaotic healthcare landscapes leave consumers without a reliable therapeutic home’ (2011:429).

NGO efforts normally involve child and maternal health care, which has also been the focus of public health interventions during the past decades. Some church programmes include educational and nutritional projects, and advocate efforts to strengthen indigenous organisations. These strategies, which involve ideas of interconnected community, social, and public efforts, tend to fall back on models of behavioural change. Such behavioural strategies generally include existing health programmes, such as the focus on child healthcare. Child and maternal health remains a global problem with high morbidity and mortality rates, especially from largely preventable causes. As a result, the provision of child healthcare has been expanded through NGOs, of which there are estimated to be more than 10,000 in Guatemala (Beck 2011). Rohloff et al. point out that while community-based organisations that are often the “face of development” depend on minimal amounts of money, governmental and para-governmental entities such as USAID and UN institutions have increased their financial support only to larger, globalised humanitarian organisations (2011:428). Much of their work has centred on child health, with a preference for specific new technologies that seek to strengthen national health policies and therefore have only a minor impact on the communities.³³ Furthermore, these initiatives are not designed to address issues of social justice or encourage coordinated, active community participation.

Over the past 15 years the NGO sector has noticeably increased in size and importance. The non-profit sector is currently composed of more than a thousand NGOs, the majority being country-based, targeting primarily peri-urban and rural areas. Nearly 18% of these are engaged in preventive health activities, while only a few provide clinical services (Bossert et al. 2009:8), and some of these include the provision of traditional medicine. NGOs play a central role in the provision of healthcare, especially at the primary level, through governmental funding, reaching around 3.7 million people through 2,500 community centres. The provision of a BHS is based on the number of adjusted per capita registered beneficiaries (La Forgia 2000). One of the characteristics of projects involving NGOs is that they seek to build networks (normally involving community health workers, community

³³An example is the use of mobile cellular network technologies (e.g., emergency toll-free telephone services, mobile telemedicine, etc.) and other similar applications for the delivery of health services. For further information see http://www.who.int/goe/publications/goe_mhealth_web.pdf

volunteers and midwives) to guarantee standardised delivery methods in the provision of PHC, such as Pro Redes Salud launched in 2001, founded by USAID, to expand primary health services in Guatemala's Mayan highlands. Cristia et al. (2011) suggest that the large-scale contracting-out of programmes through NGOs are effective and have a significant impact, especially in the delivery of immunisations and prenatal care. NGO projects of this kind constitute a bridge to scale up global health strategies (e.g., case management based on the Integrated Management of Childhood Illness (IMCI) system, growth monitoring, etc.), improve MSPAS programmes (such as community health training), and mobilise communities to implement preventive (normally limited to maternal and child care) and curative services. Unfortunately, most of these initiatives are limited to a certain number of years.

NGOs are of two types: (1) international voluntary organisations with access to international funds affiliated with local groups, and (2) small organisations with limited budgets, which includes religious organisations (Gragnotati & Marini 2003:28). In 2002 there were 160 contracts with 88 NGOs that reached around 3 million beneficiaries, providing 32 kinds of health services in over 400 communities in isolated rural areas (USAID 2010:6; La Forgia 2005:10-11). Bilateral and multilateral partners for health are PAHO, UNICEF, United Nations Population Fund (UNFPA), the World Food Programme (WFP), various United Nations agencies, and the United States government (USG³⁴)—the major health donor in Guatemala, active for over forty years—and others. Through loans (especially from the World Bank), many of the components of the coverage extension have been expanded (USAID 2010:3-7). Some of the now existing NGOs originated from reasons different from the work they currently do. As a result, traditional medicine programmes started to revive, aiming to gain some independence from the biomedical model. A few have constructed an alternative healthcare model in the communities after the Peace Accords, in which allopathic and traditional medicine intertwine, especially alternative healthcare programmes that have always sought self-management and are generally different from governmental health policies. Some NGO health programmes originated from the specific need to provide affordable medicines, specifically to rural and poor patients (cf. Icó 2007).

The for-profit or private healthcare system is composed of hospitals, sanatoriums, health clinics, pharmacies and laboratories, mainly located in urban areas. According to CIEN (2010), even in geographical areas that are adequately covered

³⁴U.S. government agencies involved in these projects include the Peace Corps, the United States Agency for International Development (USAID), the Centers for Disease Control and Prevention (CDC), the Department of Defense (DOD), and the United States Department of Agriculture (USDA).

by public health facilities, many people still prefer to make use of private health-care when they can afford it, including people who are insured through the IGSS. Private care features modern equipment and personal nursing care, and is very expensive. The economically and socially privileged group that benefits from private medical care pays high out-of-pocket fees at clinics or hospitals that offer services usually associated with hotels (private rooms and bathrooms, television, selection of food). Two of the recurrent problems at national health facilities are strikes due to non-payment of wages and layoffs, and long waiting periods for treatment,³⁵ resulting in the closure of these facilities or reduction in the number of patients. Consultations with pharmacies are also a common practice among patients, who perceive the direct purchase of drugs as a straightforward way to seek health without paying large sums of money for consultation (cf. Kroeger et al. 2001). Public health facilities are not only perceived as inefficient, but they struggle with a serious lack of medical personnel, insufficient beds, lack of surgical and laboratory equipment (even equipment to maintain required standards of hygiene), overcrowded waiting rooms and inadequate sanitation practices. Private healthcare, however, remains an uncommon practice, since the monthly payments are normally prohibitive and insurance only covers specific illnesses or operations, potentially leaving people with further medical bills to cover. Specific medical conditions and income are required for some of the health insurance policies. Depending on the type of insurance, the covered person can use only certain health facilities and receive specific, limited benefits (such as semi-private or private rooms, or disease-specific coverage).

4.4 Internationalisation of Health Policies

Some of the international agreements related to health that Guatemala has signed so far are the International Covenant on Economic, Social and Cultural Rights (ICESCR) in 1966 and its Optional Protocol; the Convention on the Elimination of All Forms of Discrimination against Women (CEDEWA) in 1979; the Convention on the Rights of the Child (CRC) in 1989; the International Convention on the Elimination of All Forms of Racial Discrimination in 1965; the Convention on the Rights of Persons with Disabilities and its Optional Protocol in 2007 and 2009 respectively; the International Convention on the Protection of the Rights of All Migrant Workers and Members of their Families in 1990; and the Convention 169 of the International Labour Organisation (ILO) concerning Indigenous and Tribal Peoples in Independent Countries in 1989. Guatemala has also assumed regional

³⁵<http://noticias.com.gt/temas/huelga-en-el-sector-de-salud-publica> (accessed on 05.01.2015) <http://m.s21.com.gt/taxonomy/term/13608> (accessed on 12.02.2015)

obligations, such as the American Convention on Human Rights (also known as the Pact of San José) of 1969 (1978), and has also given its ratification and adherence to the Additional Protocol to the American Convention on Human Rights in the Area of Economic, Social and Cultural Rights (the Protocol of San Salvador), in 1988 (ICEFI & UNICEF 2011:13-14).

These agreements or programmes highlight the strong relation between social conditions and the problems of vulnerability, contagion, and mortality. They have played a major role in the decline of overall mortality from infectious diseases. However, Guatemala's health policies are not mandatory but ideological policies created within the international health community which have not been consistently applied. In the late 1970s Guatemala signed at Alma Ata, along with another 133 states, the strategy of 'Primary Healthcare' to effectively attend to the basic health needs of the poorest populations, emphasising the socio-political causes and consequences of poor health (Sanders 2004). Health is related to social and economical development of the population. The term 'health' includes not just treatment of disease, but also prevention, promotion of good health practices, and rehabilitation, with an emphasis on basic health services and the importance of government support.³⁶ In the context of war and militarisation, public health measures and social care in rural areas, in which community participation was necessary, were unsuccessful after being labelled as subversive practices. Paradoxically, during those years there was significant infrastructure investment in health services, as part of the state's investment policy to boost the economy of the country. However, it is also during this period that the largest private investment in healthcare was made (cf. Balsells 2003; Hernández & Miranda 2010).

Most of the health initiatives in Guatemala, as well as in the rest of the region, at this time were the result of Pan American Health Organisation (PAHO) and WHO programmes, such as the Plan of Priority Health Necessities for Central America and Panama (PSS/CAP), launched under the agenda of Health as Bridge for Peace (HBP) in 1983. This was a multidimensional policy and planning framework which involved different Central American countries, with a focus on supporting health workers in conflict and post-conflict situations, strengthening health facilities and human resources, providing essential medicines, food, nutrition, water and sanitation, and developing strategies for child survival, among other activities (OPS

³⁶ Eight components of PHC are identified: (1) educational programmes regarding prevalent health problems, including methods of preventing and controlling them; (2) an adequate supply of clean water and basic sanitation; (3) promotion of food supply and adequate nutrition; (4) maternal and child healthcare, including family planning; (5) Immunisation against major infectious diseases; (6) prevention and control of locally endemic diseases; (7) appropriate treatment of common diseases and injuries; (8) provision of essential drugs (World Bank 2013).

1987a:1-5; PAHO 2007). Countries affected by war launched several health programmes together. They began with the reconstruction of hospitals and clinics, training health workers, distributing drugs and food, and mass vaccination (Teruel 2008). The plan also included the participation of Guatemala in the Essential Drugs Revolving Fund for Central America and Panama (FORMED) in order to improve access to medicines, which was established in 1987 (PAHO 1988). Thus, since the 1980s two international healthcare models have influenced and guided the health policies in Guatemala. First was the PHC initiative mentioned above, an essential part of the goals of 'Health for All by the Year 2000'. This program had been declared the model for global health policy in 1978, but many international critics considered it infeasible due to the high cost of implementation and the fear of direct community participation.³⁷ Therefore it was formulated a second health model, Selective Primary Healthcare (SPHC), an 'interim' initiative with a more selective, disease-focused model to help kick-start the implementation of the PHC, neglecting Alma Ata's aim to help overcome social inequity by developing adequate health systems (cf. Magnussen et al. 2004). The SPHC narrowly targeted women of childbearing age and children under 5 years old, focusing on morbidity, mortality, and feasibility of control (including efficacy and cost) for the prevention and treatment of specified diseases (Walsh & Warren 1979).

In 1988 Guatemala adopted PAHO's Resolution XV, intended to guide the member countries of the PAHO in the development of 'local health systems' (SILOS³⁸) in order to reach the goals of 'Health for All by the Year 2000'. SILOS' operational tactics are to strength and develop the pre-existing healthcare system, particularly in rural and indigenous communities, through the installation of primary care centres near where people live as a fundamental condition for health coverage, thus playing a key role in the coverage of PHC, based on the idea of the development of a health system that incorporates social participation³⁹ (Cosovschi 2004:4). SILOS stressed the importance of transforming health systems through alternative models of healthcare for the indigenous population, including traditional medicine,

³⁷ Programa de las Naciones Unidas para el Desarrollo (PNUD) (2010): "Guatemala: Hacia un Estado para el desarrollo humano 2009-2010", Guatemala, Central América.

³⁸ 'Los *Sistemas Locales de Salud* (SILOS) constituyen la expresión concreta de la estrategia básica para reorganizar y reorientar el sector salud con la finalidad de lograr la equidad, con eficacia y eficiencia y la participación plena de los conjuntos sociales, a través de la puesta en práctica de la estrategia de atención primaria' (OPS/OMS 1992:12).

³⁹ El impulso a la participación desde los sistemas locales de salud, adquiere legitimidad en cuanto promueve la inserción de la producción social de salud en el desarrollo. Se reconoce la relación necesaria entre los sistemas locales de salud y el desarrollo local con las acciones, procesos y fuerzas que los determinan. Asumidos de esta manera, los sistemas locales de salud tienen como fin ser de aporte a la democracia desde el nivel local. Su función no es únicamente la de organizar los servicios y ampliar las coberturas, sino la de trabajar desde el sector y con la sociedad, en búsqueda del desarrollo de la salud a nivel local' (OPS/OMS 1992:15).

as well as the development of disease-prevention programmes for the diseases that most frequently afflict this group (OPS/OMS 1993:x-xi). The SILOS were created as a democratic alternative to integrate local actors, based on principles of ‘equality’, ‘integrity’, ‘intersectorality’, ‘sustainability’, ‘quality’ and ‘relevance’, with the aim of providing a working model where the various actors could link different social interests in the creation of health programs. However, local experiences have revealed conflicts of interest in the programming and delivery of other healthcare services. Moreover, those ‘local interests’ are limited to local programs financed by international organisations such as PAHO, in which such ‘community decisions’ have little influence on decision-making and service delivery in national or international health initiatives.⁴⁰

As a result of all of these factors, PHC concentrated solely on growth monitoring, oral rehydration therapy, breastfeeding, and immunisation. Family planning, women’s education, and food supplementation were added later on. Therefore, in Guatemala, as in many developing countries, public health initiatives have mainly been conducted by autonomous international programs, especially from PAHO/WHO and USAID, which have targeted specific diseases such as tuberculosis, malaria, frambesia tropica, and smallpox (Ehiri & Prowse 1999), and which provided some success after a short period of intervention, such as the eradication of wild poliovirus in the Americas in 1985. With the support of the Rotary Club of Guatemala, programmes boosted the effectiveness of national immunisation days for the administration of the necessary vaccinations, resulting in the complete eradication of polio cases in the 1990s (Hernández & Miranda 2010). However, these public health interventions did not target general problems and diseases in a broad population (Smith & Bryant 1988). In an effort to apply a more inclusive approach to the provision of basic health services, Guatemala, Mexico, Honduras, Nicaragua, Costa Rica, the Philippines and Bangladesh implemented ‘community-based health programmes’, which emphasised the international health discourse of ‘commitment to social equity in health services’ to improve health (Magnussen et al. 2004).

4.5 Democratic Transition

During the national and international economic crisis and the process of globalisation in the 1980s, Guatemala suffered from what the Economic Commission

⁴⁰For a deeper analysis of SILOS’ impact see Barten et al. (comp.) 2009, ‘Salud para todos: una meta posible. Pueblos movilizados y Gobiernos comprometidos’, Editorial del Ministerio de Salud, Gobierno de El Salvador.

for Latin America and the Caribbean (ECLAC) called ‘a process of economic development and social exclusion’, with health reforms of an ‘additive type’, with the result that the health system worked almost exclusively under the funding of international neoliberal organisations, primarily USAID. With the establishment of a democratic government in 1986, community participation in healthcare was again highlighted, along with a gradual decentralisation⁴¹ of some health services through private providers under contract, which in turn hindered the process of reducing health inequality in public spending on healthcare (Verdugo 2000:308). Contracting out is based on per capita payments to deliver a certain healthcare package implemented on a grand scale (Hecht et al. 2004); lack of accountability, and inadequate monitoring of contractual responsibilities by both the MSPAS and contracted providers, contribute to the disparities in public healthcare services. Further, although the new democratic government planned to increase the health coverage among the whole population, the policies of structural adjustment remained almost the same as during the military governments, with a state policy focusing only on mother-child care under the influence of international financial institutions (Hernández 2010:12).

Due to the lack of the proper infrastructure and health personnel, the MSPAS created the programme ‘Promotores de Salud’ during the first few years of democracy after 1985, redefining the role of government in health policies, in order to provide healthcare in rural areas. The curriculum included a five-volume general approach to the organisation of the healthcare system, basic preventive practices and methods of public health, instructions for giving injections, and basic treatments for acute diarrhoeas and respiratory infections (cf. Barillas 2003). During this period, the MSPAS was guided by the Political Constitution of the Republic of Guatemala, in which article 93, following the Code of Health of 1979, recognises health as a fundamental human right. Between 1986 and 1989 there were not any programmes for the healthcare of women and children, except for the sub-programme for mothers

⁴¹ According to Collins and Green, *decentralisation* should be understood as the ‘transference of authority to define policies, make decisions, implement managerial functions, and make use of resources. This transference of authority occurs within a determined government’ (1994: 460). Different processes and models exist within decentralisation, such as de-concentration, delegation, devolution, federalism and autonomy in service delivery units. These are differentiated according to the degree of responsibility, authority and autonomy that is transferred from the central level to the peripheral level (Ugalde & Homedes 2002). *De-concentration* implies transferring some authority and responsibility to peripheral levels that are part of the ministry and/or agencies of the central government (Smith 1997). In the health sector, this means that some administrative functions, such as budget development and resource allocation, are transferred from the central level to the peripheral level within same ministry, while the control remains in the central level. This model of de-concentration has been implemented in Guatemala with the aim of reducing inequities in the provision of healthcare services. However, the allocation of resources continued to be based on historical budgets, which did not correspond to the actual needs of the health districts (Daniels & Flores 2004).

and disadvantaged children. Furthermore, some programmes, such as Reproductive Health, supervised by the MSPAS, and the Programme for the Promotion of Breastfeeding, overseen by the Secretary of Public Welfare of the Presidency, had the same budget for at least a decade without any increase. In the same year of 1986 the Article 194 of the Health Code was modified to provide preventive and curative care for pregnant women and newborns (Estrada 2008).

From the mid-1980s until the beginning of the 1990s, the MSPAS was based upon three structures: (1) *senior management*, composed of the minister of health and two deputy ministers responsible for political leadership; (2) *technical direction*, in which the General Direction of Health Services is part of the area (DGSS) responsible for coordinating the executive and technical activities of the units; and (3) the *level of implementation of the programmes*, comprising the levels of general administration (central and district areas) and the area of services by levels of care (hospitals, health centres and health posts). The DGSS worked as a vertical executive unit responsible for (1) patient programmes, such as malaria, tuberculosis and immunisations; (2) the human resources division; (3) environment; and (4) public health services network (hospitals, health areas, health districts and health posts). As a part of the process of regionalisation promoted by the government, the MSPAS created the Directorate of Health Regions, which was at odds with the Directorate of Health Areas and public hospitals (cf. Verdugo 2000), generating problems in providing healthcare packages within rural areas. Nevertheless, of particular relevance was the influence of the PCH programmes on the role of public services, based on the SILOS, and community participation, such as health volunteers who visited families from their own communities to identify potential health risks.

Health and Care after the Peace Agreement

After the signing of the Peace Accords in 1996,⁴² the government made several efforts to improve its objective social indicators, especially among the indigenous population, whose health status was much worse than that of non-indigenous peo-

⁴² The accords stated: 'The Government undertakes to increase the resources it allocates to health. By the year 2000, the Government proposes to step up public spending on health as a proportion of gross domestic product by at least 50 percent over its 1995 level. This target will be revised upwards in the light of future developments in State finances. The system would give priority to efforts to fight malnutrition and to promote environmental sanitation, preventive healthcare and primary healthcare, especially maternal and child care. The Government undertakes to allocate at least 50 percent of public health expenditure to preventive care and undertakes to cut the 1995 infant and maternal mortality rate in half by the year 2000. In addition, the Government undertakes to maintain the certification of eradication of poliomyelitis, and to eradicate measles by the year 2000'. Article VII, paragraphs C and D, Peace Accords, December 29, 1996.

ple. It expanded by mandate the access to primary healthcare included within the Agreement on Socio-Economic Aspects and the Agrarian Situation (Section II, Subsection B) (Hernández 2010:21). Conforming to this Accord, the ‘new health system’, based on a holistic concept of health, pursued universal access to health services, especially for those with low incomes. The reforms sought to promote a coordinated national health system, incorporating all stakeholders in healthcare, especially the IGSS and the private health sector (both profit and non-profit), integrated under the leadership of the MSPAS. In order to achieve this goal, it was agreed to increase the public expenditure on health by 2000, as a percentage of the GDP, by 50% over the 1995 level. These agreements defined the priorities as fighting malnutrition, improving water and environmental sanitation, providing preventive and primary healthcare, reducing infant and maternal mortality to 50% of the 1995 rates by 2000, and maintaining the certification of polio and measles eradication until 2000. Another aspect considered in these agreements was the revision of standards and practices for the purchase and distribution of equipment, supplies and drugs, in order to promote mechanisms that ensure the provision and transparency of treatments, including the use of generic drugs. It also established the inclusion and value of Mayan medicine, encouraging citizen participation and the promotion of decentralisation (ICEFI & UNICEF 2011:14-15).

The NGOs played a key role in the provision of basic healthcare during this period of ‘democratic transition’. Due to MSPAS’s lack of access and resources within the communities, NGOs were integrated into the SIAS by two different methods. An initial model was a direct-contracting model as a health services provider, with centralised functions such as administration, sub-contracts for the basic health team, provision of health services, and a monthly training programme for the CHWs and midwives. However, a disagreement among the MSPAS personnel meant that NGOs working under this model shifted their responsibilities as administrators and financial managers to a separate health provider team in each jurisdiction, consisting of MSPAS (including an outpatient doctor and institutional facilitator) and NGO personnel (La Forgia et al. 2005). Many NGOs refused to participate in SIAS programmes under this structure for various reasons, such as the impossibility of addressing local conditions, shifting of their original focus, and uncertainty regarding financing, among others. This created a space for ‘Astroturf NGOs’, which Cardelle defines as organisations that are local but not community-based, that originated as a result of the economic stimulus created by the MSPAS, and whose personnel, mainly rural health outreach workers (*técnicos rurales de salud*) work as health services administrators (2003:76-77).

Thus, although the right to health is constitutional and many programs and ini-

tiatives have been launched, many rural areas in Guatemala still had no access to health services. The majority of rural areas are in regions difficult to access, widely dispersed and with high poverty rates. Infant mortality rates, for example, decreased four times faster among the non-indigenous population than among the indigenous between 1987 and 2001 (La Forgia 2005:4). Until 1996 the primary level of healthcare was oriented towards curative care, with the exception of vaccination campaigns as a preventive measure. Overall, there were no alliances with other healthcare providers and community participation was limited to announcement of immunisation days. The adoption of the new Code of Health (Legislative Decree No. 90-97) in 1997 served to underpin the organisation of the new service delivery model, establish the basis for health regulations, initiate new modalities for financing health, promote social participation, and an inter-sectorial and inter-institutional relationship. Today, most of the investment in healthcare comes from public sources, as well as international cooperation agencies, such as the PAHO, Agency for International Development (AID), United Nations Children's Fund (UNICEF), European Union (EU), and the German Development Cooperation (GTZ), which support training, development and technical cooperation in order to improve the quality of healthcare provision and health professionals.

Sistema Integral de Atención en Salud (SIAS)

Between 1991 and 1993 the Inter-American Development Bank (IDB) commenced research on health reform as a part of the 'modernisation of the healthcare system' through decentralisation and privatisation (IDB 1998). Reforms in the health sector were included in the National Agenda in 1995 after the IDB signed a loan. The same institution also managed the plan and structure of the health reform, to the extent of not taking into account the executive and legislative divisions (Verdugo 2004). The government began implementing the Integrated Healthcare System (SIAS) in 1997. SIAS based its strategies on the Government Programme 1996-2000, the Peace Accords, the Code of Health, and the goals of the Development Plan and Peace Building (La Forgia 2005:14). The SIAS programme is intended to provide access to healthcare services to the large and remotely located indigenous populations found in 12 Guatemalan departments, with emphasis on maternal and childcare, vaccination, and training of midwives and health workers (Rohloff et al.2011).

In 1996, the government of Guatemala and the IDB signed the agreement for the execution of the Health Services Strengthening Programme (PMSS-I), approved the year before in 1995 for US\$25million (a combination of an Adjustment Loan and a Technical Cooperation Loan). An investment loan for the Health Services

Strengthening Programme, Second Phase (PMSS-II) was approved in 1999 for US\$55million as a continuation of the previous loan (IDB 2004: Annex 5:8). The PMSS-I and PMSS-II operations concerned a set of specific macroeconomic measures in health-sector reform, involving several contracts with NGOs and other external providers in three pilot departments with the following goals: (1) to increase public health financing; (2) to extend basic healthcare coverage; and (3) to improve the management of public hospitals. The Technical Cooperation Loan provided financing for technical assistance activities to support the execution of the adjustment conditions. PMSS-I involved a decentralisation process to allocate resources based on the needs of municipalities and districts to reduce inequity, yet the reforms and responses continued applying the same criteria of population numbers and budget numbers instead of addressing specific diseases or preventive measures. Moreover, the decentralisation process generated a decline in the public healthcare budget (ISEqH 2006:22).⁴³

During this decade, based on a neoliberal ideology perspective, the idea of health as a fundamental social right and the responsibility of the state for the provision of healthcare were replaced with the mercantilist idea that an open market would allow the expansion of health services to make them more efficient and productive. Under this framework, healthcare became an asset to purchase and sell. This neoliberal-democratic discourse places health as a ‘free choice’ subject to competition. These structural adjustments had the effect of decentralising services through privatisation and state subsidies to private health institutions (cf. Barillas 2003). As a result, the changes taking place within the health sector were within a political, legal and juridical framework, and of an administrative and financial character. It regarded health as a ‘private good’, which should be under the responsibility of the family, of the community through self-management and sustainability, or individually through private payment for services (cf. Hernández 2010:26; Ugalde & Homedes 2002). Similarly, the supervision and regulatory mechanisms strongly encourage a clientele politics for the benefit of certain groups, as well as fraud, wastage, and embezzlement.

⁴³The PMSS-I showed shortcoming such as: ‘(i) inconsistency between the proposed dependence on an extensive monitoring, control and evaluation system and the prevailing context of institutional weakness; (ii) the supposed concept of a “basic package” clashed with that of integrality of services, and the definition of a single “basic package” for the entire country did not take into account differences in the epidemiological profile; and (iii) the per capita amounts defined for the reimbursement of services provided under the basic package were below actual cost, which reinforced the incentives for under-provision that existed in a capitation system discouraging the emergence of new providers, and making the system excessively dependent on voluntary work’ (IDB 2006:Anex 5:8).

Coverage Extension Programme

In order to meet the goals of ‘Health for All by the Year 2000’ and the goals identified in the Peace Accords, the Coverage Extension Programme (PEC) addresses the problem of inadequate or absent MSPAS health facilities, especially in rural areas, and alternative health service providers, consisting mainly of nongovernmental organisations contracted by the government. A medical team is in charge of monthly visits to the covered communities. These activities are supported by a network of volunteers and local leaders (Cristia et al. 2011:5). Commitments between the Ministry of Health and the managers of regional health areas were made to increase coverage and decrease the morbidity and mortality rate of certain illnesses. The PEC has expanded from three to twenty departments of the country, reaching 4.3 million people in 2012 compared to only 0.46 million in 1997 (Lao Pena 2013:4). Prior to these amendments, the MPSAS did not exercise a leadership role; national and international institutions worked in isolation directly with technical units or health areas. In addition, funding was mainly directed to the operational activities of health facilities, with emphasis on curative activities.

The PEC was part of a larger health reform policy, the Integrated Healthcare System, framed by neoliberal practices and global reproductive health standards (Maupin 2008), with the goals of modernising and decentralising the MSPAS, strengthening management and governance functions, improving the efficiency and quality of health services, increasing financial resources for the sector, promoting health and healthy environments, improving the living conditions of the population, extending the coverage of rural sanitation, and increasing the supply and improving the quality of water for human consumption. According to Cristia et al., ‘the [PEC] in a short time span has been able to surmount *very strong cultural hurdles against* western medicine within the rural mostly indigenous population’ (2011:6; emphasis is mine). Although the introduction of programmes with gender- and culturally-appropriate approaches were part of the health reform process, cultural barriers to access still persisted, and the benefits of biomedical approaches were stressed. Additionally, although maternal and child care were regarded as imperative, related to health determinants such as ‘poverty reduction’ through economic growth, no real efforts were made for health improvement, or for the creation of an economic system that could sustain this improvement.

The SIAS model focuses on monitoring activities rather than on a model of primary care. It lacked the inter-sectorial approach, the community framework and the preventive character that it was supposed to have. In fact, the title ‘health worker’ (which was to have been the basis of the community model) changed to ‘health guardian’, a figure who is less independent and who serves mainly as a

bridge to refer patients to higher-level public health facilities. Under this plan the PEC sought a more community-based approach at the national level, integrating the three levels of the health system and standardising basic health services. Although the SIAS continued to be maintained, it lacked sufficient budgetary support to operate fully and be sustainable (PAHO 2007). Nonetheless, by 1999 the PEC reached 3.5 million, representing 76.8% of the population not previously covered. However, the provision of some health services covered by the Coverage Extension Programme in some departments proved to be challenging, since travelling physicians are not easy to find, explaining why the programme occasionally relies on nurses for these positions (PAHO 2012).

PEC's strategy includes Women's Aid Integrated Services,⁴⁴ Children's Integrated Services,⁴⁵ Assistance for Morbidity and Urgent Illnesses,⁴⁶ Assistance Programmes for Environmental Issues,⁴⁷ and health education and promotion through two types of agreements established for NGOs: (1) for service provision, and (2) for health services administration, responsible for managing mobile teams (Guatemala Central, Guatemala Nord-West, and Escuintla) linked with public health facilities. A parallel endeavour has been to establish Convergence Centres that provide health services of sufficient quality, including permanent staff such as an auxiliary nurse and four community facilitators, to serve an average of 500 families or 2,000 people. The MSPAS strategy document for strengthening the primary level of care identifies PEC as an imperative to accomplish the targets set in the Results-based Agreement between the MSPAS and the Ministry of Finance, and for the main goals of the government (Lao Pena 2013:9-10). As a result, NGOs took an important role in these partnerships in order to extend the coverage of PHC and deliver the basic package of services, giving priority to maternal and child care in rural areas where services are irregular or unavailable, focusing not only on curative but on preventive health.

With the new administration of General Otto Pérez Molina, the PEC has been considered crucial in reducing child and maternal mortality through the initiative Zero Hunger, which seeks to reduce the prevalence of chronic malnutrition by 10%,

⁴⁴This program is limited to reproductive health (birth-control, childbirth, postpartum period, breastfeeding, sexually transmitted diseases, cervical and breast cancer), does not include chronic and degenerative diseases, and excludes other vulnerable groups, such as the elderly, and non-reproductive-related health issues in adolescents and women.

⁴⁵Mainly focused on immunisations, growth monitoring for children under 2, and control of acute respiratory infections, diarrhoea, parasitic and prevalent communicable diseases and nutritional deficiencies.

⁴⁶Focused on control of dengue, malaria, tuberculosis, rabies, cholera, and HIV/AIDS, among other kinds of urgent care.

⁴⁷Vector control, zoonosis control, promotion of safe handling of food, hygiene and sanitation, and water quality monitoring.

decrease the mortality rate from severe malnutrition, and improve food security in rural areas by increasing the package of basic services to deal with the health needs of other segments of the population, taking into account the country's epidemiological profile such as the increasing prevalence of non-communicable diseases. Yet this programme does not address correlated problems such as coordinated and complementary initiatives to reduce morbidity and mortality from infectious diarrhoea, acute respiratory illness (ARIs), and soil-transmitted helminths in children under 5 years of age. Furthermore, since 2013 the budget for this initiative has been reduced, resulting in a deteriorating situation for maternal and child health.⁴⁸

Essential Drugs and Policies

Drug spending constitutes the largest expenditure of the Ministry of Health. According to CIEN (2010), between 1999 and 2005 expenditures for pharmaceuticals accounted for about two-thirds of the total healthcare costs and half of private spending. In 2006 the MSPAS reported an annual expenditure for drugs of more than Q.3 million, of which 72% was covered by households, 20% by the IGSS, 4% by the MSPAS and 4% by NGOs. Whereas, for this period, total health expenditures for households increased at an average rate of 10% per year, the MSPAS and IGSS spending for medicines fluctuated slightly. These fluctuations however do not necessarily correspond to the rise in medicines purchased, but also to the prices due to their increased value (USAID 2008). According to the WHO, the annual spending on drugs in various countries of Latin America is around 20% of all health expenditures paid by individuals and by funding sources in the public and private sectors.

The medicine market is controlled by multinational pharmaceutical companies. This monopoly makes it impossible to obtain medicines at lower prices, mainly because of patent protection, 'brand loyalty' and segmentation of the market into therapeutic subclasses. Further, in conjunction with pharmaceutical companies, distributors endorse the use of drugs and health equipment that are not necessarily appropriate or the most efficacious and cost-effective for patients, exploiting the desperation linked to the disease and patients' lack of information about more affordable treatments (cf. WHO 2002b). Consequently, as part of the strategy to achieve UHC, the MSPAS seek to provide low-cost medicines at public health facilities, to reduce the expense to patients. In rural areas, three-quarters of the money paid for healthcare is for medicines (Bossier et al. 2009:6). In 2007 the Guatemalan Drug Registration and Control Department had nearly 16,000 registered drugs, not all of which have been commercialised; around 40% of these

⁴⁸<http://www.lanacion.com.gt/salud-reducira-las-ong-en-programa-de-cobertura/>

are generic drugs and 60% are patented. The Drug Registration and Control department is in charge of regulating and controlling pharmaceuticals and related products, as well as the facilities for manufacturing, marketing and importing them in order to assure accessibility and quality (PAHO 2007:41-42).

Almost simultaneously with the PEC, the Access to Medicines Programme (PROAM) was created in 1997, to provide better geographical and financial access to drugs that are not provided free by the MSPAS in agreement with NGOs (many of them linked to the PEC). It is intended to operate as a Social Drug Sales (VSM⁴⁹) entity offering affordable prices. The PROAM aims to provide affordable and good-quality drugs at state and municipal pharmacies, hospitals, clinics, and rural infirmaries (PAHO 2007:42). Parallel to this, the PROAM also established a rural first-aid kit which is administered by the communities and which sells at approximately double the cost of the basic first-aid kit. According to the conventions of the PEC, the NGOs—based on epidemiological data and the goals established in the Peace Accords—would define necessary additions to the range of drugs available, beyond the ones for specific diseases such as malaria and tuberculosis and those included in the Basic Package of Health Services. The government supplies drugs to NGOs and other community-led drug programs through central purchasing and economies of scale, in order to give access to drugs at market prices. The main objective of primary basic services (PBS) was to have a significant impact on infant and maternal health and nutritional services at a cost that was affordable and sustainable (Bossert et al. 2009:7-8).

Complementing this reform, and as part of the modernisation of the financial management system and reform of the health sector, the MSPAS and IGSS, with the support of the Ministry of Finance, signed the reform Open Contract⁵⁰ for the purchase of drugs on an essential drugs list, at relatively low fixed prices, excluding contraceptives and vaccines, from pre-selected suppliers. Later this system was extended to benefit the whole population, whereas before it was limited to only hospitals and health area officers, who received and redistributed the drugs, extending the role of non-profits and PROAM in the distribution of drugs, particularly to those who lacked access to health services (Bossert et. al 2009:7). The IGSS essential drug list was used to develop the Open Contract. IGSS's essential list is based on *level of use*—that is, the higher the level of the system, the longer the list. Community health posts have the smallest lists, since they focus

⁴⁹Venta Sociales de Medicamentos are 'establecimientos farmacéuticos de servicio, autofinanciables, no lucrativos que se encuentran ubicados en lugares que faciliten a la población el acceso a medicamentos, materiales de curación e insumos a bajo costo. Son administradas por ONG u organizaciones prestadoras de servicio' (Barillas 2005:22).

⁵⁰This is a contract whose terms do not describe the entire agreement between the two parties, with clauses or provisions that can be modified without mutual consent (usually by the seller).

on preventive medicine and have only minimally trained staff. Hospitals have the longest lists. Although hospitals and health area offices may request drugs and other products that are not part of the official lists through waivers from the financial officers in the health area offices, health posts and health centres cannot request anything which is not included on the official drug list (*idem.*, p.28).



Figure 4.2: Access to affordable treatments

The NGO that provided PBS for a catchment area in which the MSPAS had little or no presence would typically serve a population of about 10,000. It would provide the major elements of prenatal care; postnatal monitoring of mother and infant; well-baby care (including growth and weight monitoring); general treatment for common morbidities; and health promotion and sanitation. However, PBS was developed without input from the local population or NGOs based on a rigid, ‘one size fits all’ model, which did not respond to local priorities but followed the MSPAS biomedical guidelines including personnel structure, training programme, materials, and equipment. These broadly defined the services of the PBS and specified how they would be provided, based on national guidelines (La Forgia 2005:24). The norms also defined the assessments in terms of the amounts and types of services to be provided by each team in the catchment areas. It focused on pathologies that impact mortality based on estimates of the expected number of yearly cases of diseases such as ADDs and ARIs, excluding pathologies such as skin infections, gastrointestinal problems (in adults), and other disorders. Thus, for interventions that are not part of the PEC services for which free medicines are provided, patients have to purchase drugs at private pharmacies.

During the period of 2008-2012, however, public health policies were established to ensure accessibility to essential drugs and also to promote the recognition and use

of alternative and traditional medicine. A regulatory framework was implemented to promote the use of generic drugs and herbal medicine, and to ensure their development and use. This model sought to incorporate traditional medicine through the cooperation of municipality offices, social health clinics and pharmacies (cf. MSPAS 2012). Although this governmental policy endorsed the use of traditional medicine, the results suggest that access to traditional medicine operates only on an informal basis.

4.6 Current National Health Priorities

After the civil war, Guatemala presented the worst health indicators in Latin America, especially in maternal health and childhood mortality. These issues received particular attention in the public healthcare efforts launched after the Peace Accords in 1996, focusing mainly on nutrition, vaccination and prenatal care⁵¹ with the aim of eradicating extreme poverty and hunger, and reducing under-five child mortality and maternal deaths by the year 2000 (Lao 2013). Yet public expenditures remain the lowest in Central America, and the programmes have not had the expected outcomes. According to the NGO Mayan Families,⁵² Guatemala has the fourth-highest rate of chronic childhood malnutrition in the world.

In April 2008, the Conditional Cash Transfer (CCT) programme was launched, financed from public funds and several loans from the Inter-American Development Bank. It was called “Mi Familia Progresá” (MIFAPRO), part of a social policy of basic assistance. MIFAPRO was instituted by a coalition of the Social Cohesion

⁵¹The 2004-2008 administration, for example, launched a programme called “Vamos Guatemala”.

It contained a social component called Guate Solidaria with the aims of (1) reducing chronic malnutrition, especially within municipalities at highest risk; (2) formulating programmes to fight extreme poverty; (3) assisting out-of school youth who have no formal employment; and (4) ensuring that the cultural and ethnic diversity of Guatemala’s population is reflected in social policy. In 2005 the Secretary for Food and Nutritional Security (Secretaría de Seguridad Alimentaria y Nutricional, SESAN) launched an initiative to establish guidelines for the National Strategy for the Reduction of Chronic Malnutrition (Estrategia Nacional para la Reducción de la Desnutrición Crónica), to reduce malnutrition among children under 5 by 10% by 2012. This was a multi-institutional strategy among MSPAS, SESAN, SEGEPLAN, SOSEP, MAGA, INFOM, MINEDUC, and local governments. The strategy Growing Well (Creciendo Bien) focused on mother-child behaviours, seeking to reduce the prevalence of chronic malnutrition in children and pregnant and lactating women in selected municipalities. The programme included basic health services through the PEC, with an emphasis on food and nutrition, breast feeding and complementary feeding, as well as food and nutrition education. This initiative also comprised water and sanitation projects, improved household economy, and community organisation.

⁵²Maya Families is a non-profit organisation working with indigenous and impoverished communities in the Guatemalan highlands to provide education and development programmes. www.mayanfamilies.org

Council (a new political body created by the president and the First Lady) and the Executive Secretariat of the Presidency. This initiative targeted women and families living in extreme poverty in specific rural areas. It was a conditional money transfer linked to behavioural practices to encourage young caretakers to bring their children to school, to make use of national health institutions and to improve household welfare, with the aim of breaking the intergenerational cycle of poverty (Gaia 2010; UNDP 2011). It had a special focus on health and nutrition. A conditional transfer of around US\$20 each month was given to pregnant women and to breastfeeding mothers. They were required to visit health centres to receive a basic package of nutritional and preventive maternal-child healthcare.⁵³ A year after the programme was launched, an additional monthly transfer of US\$13 was provided to families with children under six years old, in order to further reduce chronic malnutrition. The condition was that the money had to be used to provide food, and the recipient was required to attend a nutrition education programme. Another transfer of the same amount of money, with an ‘educational component’, was given to families with at least one child between six and fifteen years old who was attending preschool or primary school (Lavinás & Székely 2011).

Since the 1990s, CCTs have been used in Latin America as a behavioural model to secure the desired impact of particular programmes, such as investments in children’s health and education (Maluccio & Flores 2005). According to Gammage (2011), efforts carried out since the end of the civil war to expand coverage of public education and achieve almost universal primary education seem to have been effective in creating a sufficient basis for the implementation of a conditional cash transfer programme. The same is not true for the health system, where problems in access to facilities in rural areas and by poor and indigenous populations have already been pointed out. The main limitations of MIFAPRO were due to corruption, lack of transparency in the provision of goods and services, inability to effectively distribute the assistance, the ‘conditional demand’ linked to it, minimal participation of beneficiaries, communities and municipalities, and lack of monitoring (Martorell 2012:28). Moreover, the payments were given directly by the First Lady in public meetings. This mechanism with a ‘hidden agenda’, which served as platform to the upcoming presidential elections, added costs and difficulties for the beneficiaries, who had to travel long distances in order to receive the money.⁵⁴ In addition, the mandatory education services lacked quality and resources, making the model occasionally ineffective. This initiative came under a

⁵³<http://idbdocs.iadb.org/wsdocs/getdocument.aspx?docnum=1881708> (accessed on 23.06.2012)

⁵⁴http://www.prensalibre.com/noticias/politica/Primera-Torres-Familia-Progresas-Zacapa_0_260974182.html

great deal of criticism due to lack of mechanisms to audit the transfers, ultimately resulting in the relocation of MIFAPRO to the Ministry of Education. By the middle of 2009, MIFAPRO had withdrawn US\$32 million from the various public health programmes, on top of the budget cut of US\$47 million from the Ministry of Health in that year (Gaia 2010).

With the new administration elected in 2012 this programme was eliminated, and the emphasis changed to the implementation of projects under the framework of the Council of Social Cohesion. Under the government of Otto Pérez Molina (2012-2015) it was incorporated into other social programmes under the Ministry for Social Development, which replaced the Council of Social Cohesion, changing its name to “Mi Bolsa Segura” and “Mi Bono Seguro”. Mi Bolsa Segura focused on providing food to impoverished urban families who are at ‘social risk’. Its beneficiaries included pregnant and lactating women, single mothers, mothers under 20 years old, elderly people (over 65 years old), and people with chronic diseases and disabilities.⁵⁵ The model of CCT has been carried out by Mi Bono Seguro, which, like MIFAPRO, was contingent on behavioural patterns to receive governmental health and education services. Under the current administration, a program named Super Tortilla targeted only about 9,000 children under five years of age and pregnant women, part of the Zero Hunger programme, focusing on 166 municipalities that have been prioritised after the results showed by the most recent survey.⁵⁶ However during the first year of intervention, the budget for the programme was only 21.39% (of the total budget). Further the implementation of the resources allocated for the pneumococcal vaccine until October of 2012 was zero, while the executed budget for reproductive health and immunisation of the same year was only 31%⁵⁷. Some of the aims were redefined goals of the National Health Plan from the previous administration of Álvaro Colom which had initiated a model based on institutional health-centres, replacing NGOs healthcare models that had been particularly important in maternal and child nutrition programmes.

In 2010 the MSPAS launched a National Maternal and Child Health Plan to reduce maternal and neonatal mortality and improve reproductive health by 2015. This plan includes (1) training health personnel (CHWs and midwives) to identify danger signs, (2) improving health infrastructure facilities, medical equipment, supplies and human resources, (3) strengthening the information network systems and monitoring for pregnancy and maternal and neonatal mortality; (4) promoting

⁵⁵<http://www.fss.gob.gt/presidente-de-guatemala-inaugura-programa-mi-bolsa-segura/>

⁵⁶ Tercer Censo de Talla en escolares de primer grado 2008/2009.

⁵⁷ Universidad Rafael Landívar (2013): ‘Informe del Primer Año de Gobierno de Otto Pérez Molina’, Programa de Opinión Pública, Guatemala.

and increasing demand for family planning methods through counselling strategies with emphasis on culture and gender factors (CIEN 2010b). In October 2010, the Decree 32-2010, “Safe Motherhood”, was approved by the Congress of the Republic in order to strengthen the Programme on Reproductive Health and the Unity Healthcare of Indigenous People and Interculturality. The Safe Motherhood programme aimed to promote the involvement of Councils of Urban and Rural Development, municipalities, NGOs and other institutions to reduce maternal and neonatal mortality. This law established a Multisectoral Commission for Safe Motherhood composed of the vice-ministries of hospitals, the SIAS, the National Programme of Reproductive Health, the National Centre of Epidemiology, the IGSS, the Health Commission of the Congress, the General Secretary for Strategic Planning of the Ministry of Presidential Government in the Republic of Guatemala (SEGEPLAN), the Association of Gynaecology and Obstetrics, and the Association of Medical Women.

However, since 1996 the execution of agreements and institutional reforms, including those that are supposed to provide healthcare and education, has been ponderous and partial. Reiterations of these commitments, such as the Law on Social Development in 2001, the Population and Social Development Policy in 2002, Self-Managed Education (PRONADE), and the Programme on Reproductive Health are examples of this. The implementation of different health projects and initiatives has created multiple laws and decrees that lack clearly defined institutional responsibilities and priorities for healthcare interventions. As in the education sector, civil participation has been stressed as a way to strengthen community health services. The Municipal Code promotes community involvement through Municipal Councils (COCODES), which are represented in the Commissions of Health and in the Development of Councils in the Ministry of Education. However, these normative reforms had little effect, and the ‘agency’ (decision-making power) of the social groups was rather limited. Moreover, the programmes are hindered by short-term policies, arbitrariness in application, clientelism, corruption and abuse of power by the state’s organisations, leading people to believe that the governmental policies are deficient and unsustainable coordination among civil society organisations and government is difficult due to widespread mistrust (BTI 2014:30-32). Additionally, unexpected expenditures for aid and reconstruction after several natural disasters and the global economic crisis have caused a shortfall in the health budget (USAID 2010:22). Thus, the delivery of healthcare became increasingly inefficient due to barriers that included unfavourable governmental policies, insufficient investment in water and sanitation programmes, inadequate nutrition interventions, lack of coordination between ministries and stakeholders, irregularity in financial support to projects specific to ‘at-risk populations’ or target

groups, insufficient support for caretakers, health workers and stakeholders, and insufficient expenditures for rehydration solutions, antibiotics and zinc, among others (cf. Gill 2013:1487). Another hindrance to past and present programs is that country-level strategies are typically ‘experimental’, and do not deliver necessary interventions on a full scale.

Thus, instead of total coverage targets there are still partial coverage interventions that tend to focus on curative practices rather than long-term prevention strategies, supplying ‘urgent goods’ without promoting long-term, large-scale measures to provide resources that have a direct effect on health. Vertical interventions in which caretakers, community and health workers are not included, or in which their roles are not well defined, further reduce the effectiveness of preventive measures. The non-compliance with the stated commitments not only reduces the provision of healthcare, but also creates conflicts among health workers and caretakers.

4.7 Conclusions

Only an adequate allocation of resources can deliver effective and necessary health-care services at any level. Yet the history of healthcare funding in Guatemala demonstrates that infrastructures and expenditures for preventative and curative health measures have not changed substantially and continue to be mainly short-term. In contrast to other countries that have been developing micro-insurance health programs⁵⁸ in order to attain universal health coverage, such as in Africa in the late 1980s and in Asia in the late 1990s,⁵⁹ such programs became the foundations for national health policies, most of the Guatemalan population is forced to pay high costs for healthcare because health insurance is unavailable and a lack of universal healthcare covering programmes. Governmental health financing strategies have not been efficiently implemented, while investment has been mainly directed towards hospital care in the formal sector, leaving the large informal sector without biomedical care. Even basic health services work without robust social structures, leaving institutions unable to deliver the expected level of healthcare. While governmental expenditures for healthcare do not meet people’s needs, there is a growing tendency to turn to private care and the contracting-out of services to non-profit organisations (Cristia et al.2011).

Through the Coverage Extension Program, NGOs became key actors in the delivery of healthcare, in particular for programmes focused on women, newborns

⁵⁸The ILO defines micro insurance health programs as the protection of low-income people against specific perils in exchange for regular premium payments proportional to the likelihood and cost of the risk involved (Kimball et al. 2013:5).

⁵⁹Bulletin of the World Health Organisation 2012; 90:685-692, doi: 10.2471/BLT.12.102301

and children under 5 years old, helping to improve access and reduce the cost of treating common diseases. Contracts with NGOs to provide standardised health-care services have been vital in Guatemala to provide interventions for children and help to reduce child mortality due to pneumonia and diarrhoea. However, while other countries are now going through an epidemiological transition, reporting a decrease of morbidity and mortality from ARIs and ADDs among children under five, Guatemalan healthcare interventions for children remain weak and debilitated by years of underinvestment, and by inadequate political and economic development.

According to Liu et al. (2008), the provision of healthcare through NGOs presents several problems. First, contracting-out models are not cost-effective in terms of administrative expenses. Second, the identification and selection of NGOs are based on the assumption that there are enough competent organisations to cover neglected geographical areas. Thirdly, this type of contracting may create discord within the health system when attempting to implement models of care that are not consistent with the national system. Fourth, the government does not have the financial means to monitor and evaluate public and private healthcare programmes to guarantee quality of care. Finally, an emphasis on short-term results can be detrimental to long-term targets, particularly if NGOs are encouraged by payment incentives to give priority to pre-specified outcomes that can be rapidly scaled up. Furthermore, the competition among NGOs to obtain governmental contracts has caused an explosion of nonprofit groups that have not previously worked in the health sector, which affects the quality of the services delivered (Cardelle 2003). The presence of multiple NGOs in the same areas can cause confusion and possible conflicts among beneficiaries, who sometimes become overwhelmed by the different health strategies and technologies introduced by organisations that are competing for funding (Anheier 2009; Clifford 2009). According to Clifford (2009), the proliferation of NGOs has provoked a development burnout of these organisations when their personnel come to feel indifferent towards the programs and doubt that they will have a long-term impact. Similarly, Rohloff et al. (2011) define ‘community burnout’ as the point when NGO projects cease to work towards community-based involvement and constantly shift their procedures or goals, resulting in uncoordinated efforts, inconsistent participation of the beneficiaries, loss of credibility of the NGOs, and insignificant health impacts.

Strategies to increase access to PHC through the SIAS, according to Maupin (2008; 2009), have narrowed the role of community-based NGOs to administrative operations, diminishing the authority of community health workers. Analysis of the impact of nonprofit organisations as part of decentralisation efforts and financial

reforms has demonstrated clearly that these processes quite often do not have the expected results. Instead, instances of supposedly decentralised healthcare are actually ‘astroturfing’ practices of older NGO subcontracted by MSPAS facilities, simply renamed (cf. Cardelle 2003; La Forgia 2005a, 2005b; Maupin 2009; Rohloff et al.2011). As a result, by limiting the participation of the NGOs in PBS design, the expected healthcare interventions were not provided. Even when PECs brought minimal health services to places that had previously lacked them, their efficacy was questioned by organisations such as the Association of Community Health Services (ASECSA) and the National Movement for Health Promoters,⁶⁰ since these new actors were not present at the time when the Health Reform 1996-200 was formulated, calling for improving coordination within the health sector, attracting more public and private participation, and broadening the participation of communities, cooperatives and NGOs (BID 1995: 11-17). In fact, the step of seeking consensus did not take place and the reform was characterised by lack of information and low participation of the population and their organisations. In this context, the reaction of the civil society was not immediate due to the lack of information and uncertainty, and to the perception of pressure and authoritarianism in the MSASP.

Consequently, new coalitions for the analysis of the health reform and the PEC were created in order to generate proposals that took account of ethnic and cultural factors and social, economic and political realities. Some of the specific concerns were: (1) the reduction in the basic package of services and poor quality of care (PBS); (2) inconsistent attention by the travelling personnel; (3) the utilitarian approach to the participation of the community, which is seen as a resource to pay for indirect costs of care, rather than as beneficiaries of that care; (4) over-reliance on voluntary community staff; (5) the precarious working conditions of institutional personnel, without benefits or social insurance; (6) the almost exclusive attention to maternal and child care, neglecting other population groups; and (7) the exclusive use of Western biomedical care, regardless of socio-cultural characteristics, without reference to the Mayan medical model, among others (La Forgia et al. 2005). As a result of this criticism of the health reform, the National Health Advocacy Platform decided in late 1999 to carry out research (using consulting firms, universities and NGOs) and to develop an alternative model for primary care (currently known as Model Inclusive Health, MIS). Their goal was to review the public and private provision of health services, access to medicines, and other factors, in order to develop new initiatives, proposals and advocacy on healthcare policy issues (Maupin 2009:1458).They found that public-private collaboration,

⁶⁰ The National Movement for Health Promoters, representing 57 health promoters across the country, was established in 1998.

such as the involvement of the Global Fund in fighting AIDS, tuberculosis and malaria has contributed to reduced costs and expansion of health coverage.

However, the limited financial capacity of national public facilities, including hospitals, to meet the demand for healthcare remains a major problem. The shortage of medicines, supplies, and medical personnel, and the limited and inadequate infrastructure and equipment, make for inadequate public services. Moreover, the referral system does not work properly and patients are referred inappropriately to higher levels of care, putting unnecessary stress on the hospitals. Further, the selection criteria for prioritising programmes to ensure financial sustainability is problematic and inconsistent. Public health policies need to enhance resources and provide more effective guidelines that can adequately address concrete national health priorities through direct involvement and contribution of the communities. International efforts are an important part of these practices and key to meaningful reforms, but they are normally limited to short periods of intervention. However, these efforts could foster cooperation and coordination between NGOs and the private and public sector to tackle the structural challenges for long-term solutions. National expenditures normally deal with immediate healthcare needs, especially among vulnerable groups, instead of addressing the root causes driving poor health. Furthermore, the irregularity of the programmes initiated every five years means that resources get lost in reprogramming (i.e., renaming) projects, adding administrative burdens.

Additionally, healthcare strategies normally target specific factors that in reality require another approach or additional resources. An example is family dynamics and the capacity of decision-making among women. A series of practical difficulties becomes evident when women attempt to organise, for example, around community development councils (COCODES) or SILOS. Although healthcare within the family is perceived as a women's activity, when women attempt to gain power to make important decisions they still confront patriarchal discrimination, which is even greater in rural areas. NGOs or COCODES appear to be a space for dialogue, empowerment and negotiation for decision-making, yet women or caretakers are likely to face conflicts. Political reforms and a democratic legal framework arising after the civil war have created the opportunity to introduce important health projects, such as an increase in health expenditures, gender-based initiatives and recognition of the traditional healthcare model. Yet new healthcare legislation and initiatives continue to fail due to a number of causes, such as disparities between governmental and civil-sector priorities, the trend towards a reduction of public spending in healthcare, the increase of private spending by households, the lack of negotiation capacity in the civil realm to allot resources in their own communities,

conflictive social dynamics, poor investment in promoting an integrated health-care system and the increase in hiring private entities to provide health services. Better processes of strategic decision-making (in both political and civil groups), in which power relations and social particularities converge, would contribute to a better understanding of health policies and systems, leading in turn to better policies and technical reforms.

A particularly important component of the health reform process—expanded coverage—has not yet been integrated. The lack of community participation in the development of plans has resulted, for example, in the neglect of specific interventions that recognise illness particularities, even when attention to indigenous rights has supposedly been addressed. The insistence on allopathic practices, and the lack of accommodation for traditional medicine, is perceived as a discriminatory barrier to public health services. The introduction of health programmers with cultural and gender relevance has introduced only minor changes within the structure of regulation and accreditation for ‘technical personnel’, in which midwives are included, but there is still no coordination with other traditional health providers who are involved in the dynamic of illness management. These providers are a key element in understanding the processes of the public health sector and behaviours associated with illnesses that are part of different visions of healthcare. This fragmentation and segmentation increases or decreases some practices, serving specific needs that influence health-related decision-making.

One of these factors is the role of Evil Eye. Morbidity and mortality as a result of Evil Eye symptomatology cannot be overlooked; yet the significance of the illness as a cultural mediation of healthcare has not been sufficiently explored. The problem of treatment choice is of a great theoretical importance to understand healthcare options when facing not only the illness but also the relationship between individuals and healthcare systems (e.g. process of decisions making, illness and decisions process outcomes). Although remarkably persistent in the context of traditional medicine practices, Evil Eye’s meaning, however, has been transformed into new concepts and strategies to cover different sets of symptoms, developing into specific care responses that constantly intertwine with ARIs and ADDs. In the next chapter I will explain how Evil Eye, like other illnesses, can be treated, mutate, become ‘endemic’, or signify a threat. It also shapes social relations with cultural consensus and intracultural variations (e.g., how people label the symptoms, how they treat it), aspects that are linked to a large and coherent cultural ensemble.

Evil Eye is to be found in rural San Marcos within a pluralistic medical model at the intersection of biomedical and traditional/folk medicine. The next chapter

focuses on the way in which Evil Eye has been ethnophysiologicaly conceptualised, and on its role in understanding specific symptomatology and the response of caretakers. Using the concept of ‘ambiguity’, the chapter draws upon ethnographic cases to explain Evil Eye’s nosology among mothers and caretakers in rural San Marcos. These cases also explore the ways in which people interact with public health services; how family and social dynamics determine curing and healing responses; how Evil Eye, being a flexible concept, locates traditional and allopathic notions of ‘contagion’ and illness amidst uncertainties and possibilities, including the adaptation of biomedical concepts to fit local aetiologies; and the legitimation and use of combined treatments to alleviate or cure. Evil Eye translates concerns about illness into ‘locally appropriate’ health responses, which in turn are part of a social and moral order. Evil Eye is selective, however, not only in its symptomatology but also in its conceptual framework. With the use of anthropological concepts, I aim to explain how this belief induces a consistent behaviour to adopt health interventions that suit local socio-cultural settings.

A Case of Several Encounters

Evil Eye is perhaps the most common folk illness among children in rural Guatemala. However, its characteristics, treatments and significance vary among different groups. In San Marcos, mothers often seem concerned about the possibility of their children being ill from the effects of the Eye. This pervasive fear is accompanied by cultural strategies to overcome this illness and other threats represented by communicable diseases that are considered easily treatable. The following case illustrates how inextricably personal and cultural dynamics are associated with public health services and models of care that give meaning to individual experiences of illness.

Marta, a 35-year-old woman and mother of seven children—two of whom were dead by the time of the interview—lived in a small shack in Tuizacaja, near Comitancillo, which she shared with her husband, mother- and father-in-law, and two brothers-in-law. Despite previous experiences with her other children, when her daughter Micaela became sick, Marta was unable to identify the illness. When Marta became pregnant with another child, she ceased breastfeeding Micaela, as there is a belief that breast milk goes ‘bad’ during pregnancy,⁶¹ and started to feed her daughter powdered milk instead. Thus, although biomedical practitioners encourage mothers to maintain breastfeeding, especially when children are ill, Marta believed that this was not possible. Micaela died at the age of 15 months and her death increased Marta’s mistrust of public health institutions. She told me the story, which took place a few months before we met.

A few days before Micaela died, Marta had seen that Micaela’s health was deteriorating and she took her to the health center in Comitancillo, a two-hour walk from her house. After waiting for an hour, they were seen by a nurse and received some syrup for the cough Micaela had, after being reprimanded for not having brought Micaela’s vaccination card. They were also reminded to take her for some

⁶¹Pool’s work explains this phenomenon in a village in Cameroon where people interpret the relation between diarrhoeal diseases and breast milk. In this case the illness intertwines acute diarrhoeas and kwashiorkor (Pool 1994:104-107). Other studies that explore the belief that diarrhoea is related to breast feeding are Nielsen et al. (2001) in Pakistan and Nichter (1988) in Sri Lanka.

vaccinations over the next couple of days at the convergence center⁶² in Tuizacaja. The day Micaela received her vaccines (the MMR vaccine against measles, mumps, and rubella), her fever got worse. Marta went back to the health center at Comitancillo, but the nurses told her that the fever was only a common side effect of the vaccines. However, Marta did not explain that Micaela had had a high fever even before the vaccines and that her cough had gotten worse. Eventually, Marta consulted a midwife, who thought the fever was a sign of an infection. She advised Marta to go back to the health center one more time and ask for a doctor. Marta's desperation was increasing but she could not believe that, if her daughter had an infection, the nurses had not recognised it or taken it seriously, so she sought a second opinion from a traditional healer. The healer explained to her that Micaela was suffering from Evil Eye and that this had damaged her health, in particular her 'weak lungs'. For three days she was treated for the Eye, which she thought Micaela had probably contracted one day when Marta went to the market in Comitancillo. At this point, Marta's explanation for Micaela's illness was that she caught a 'dumb eye', which is asymptomatic, and got worse after she received the vaccines. While Evil Eye is socially defined and recognised, respiratory and diarrhoeal infections are not only stigmatised in the healthcare system (unsympathetic biomedical personnel may imply that the caregiver is careless or unhygienic), but may also require caregivers to spend time and money at the national hospital or to resort to allopathic treatments. Because help-seeking dynamics and decisions are so important within a pluralistic health model, Marta was caught between aetiologies and power structures. She was aware of the danger signs, but the interpretation of symptoms varies with the illness or its source.

A few months prior to these events, Marta's five-year-old daughter, Sara, had also become gotten sick with a pulmonary infection, for which her husband paid for a private clinic, spending all their savings. Consequently, when Micaela became sick, they had to borrow money from neighbours or family, which they perceived as burdensome. The entire extended family depended on Arturo's (Marta's husband's) monthly income of only Q1200 (about €120) from working in a garage in Comitancillo to pay for food, transport, and the medicine Marta's father-in-law received for his heart problem. Marta's family's response to Micaela's illness was to try to make sense of it. Caught between many responsibilities, Marta could not ask her husband for money to take their baby to a private clinic or buy medicine at a pharmacy. As part of her help-seeking strategies within the community, Marta shared

⁶²Convergence centers are part of the extension model of coverage created by the Ministry of Health to provide basic healthcare to the rural population. They are staffed by community volunteers, a traveling (auxiliary) nurse and, during vaccine campaigns, a physician. This model of care is explained in the previous chapter.

her worries with a well-recognised midwife, who was trusted and expected ‘to do something’. However, Marta’s behaviour after her encounter with the midwife was not to follow her advice but instead to continue searching for other alternatives.

Seeking help with a healer was a type of therapy management that did not question the quality of Marta’s motherhood or care. Since she had no access to monetary resources, Marta made use of her social ones. Micaela’s case points out not only the economic constraints under which people live, but also the problems they have when confronting public health institutions. Diagnoses are normally vague and mothers or patients do not always receive full explanations as to what the disease aetiology might be, but are only instructed to administer medicines without further explanation. In this case, Marta believed the syrup that had been given was not solely to relieve the cough but to cure it. Therefore, she saw the symptom as the illness. Since the cough and fever only got worse, Marta’s conviction was that this was a case for a better-trained person, a trusted midwife.

Marta’s reluctance to return to the health center was formed not only from her doubt of an incorrect diagnosis, but also by the fear of a referral to the hospital. Normally patients go to the national hospital in San Marcos only when a doctor has made a formal referral. If patients fail to do this, they cannot make use of the primary healthcare level again to seek attention for the same problem. But public hospitals are also feared because they are seen as ‘a place where people go to die’. Because Micaela was a baby, this would have required Marta to stay with her in the hospital for the time Micaela needed to recover completely, which she could not afford. No food or personal hygiene items are provided for the mothers at the hospital. Driven not only by the lack of economic resources but also by her social relations, Marta could not afford to leave the rest of her children behind. Knowing that her husband could not provide the necessary money to buy more medicines, and with another baby on the way, she communicated her concern by letting people know that she had not found an efficient treatment without asking directly for help.

Ten days after Micaela got sick she died at home. Her death was explained in the family as a result of unsolved causes that overlapped and made her state worse. On one hand, by seeking help at the health center Marta resolved the conflict of priorities that arises when seeking help within a pluralistic setting, responding to the pressures that are put on mothers to bring their children to national health institutions. On the other hand, symptoms of Evil Eye carry some degree of ambiguity that encourages patients to seek help within other therapies that are accepted within the family’s social relationships, since illness categorisation is

multidimensional and is driven by ambiguity (Nichter 1997). The child's illness was seen at home as part of the inability of the government health personnel to diagnose a dangerous disease. Conversely, health personnel put the responsibility onto the mothers when the child's state deteriorates rapidly because they fail to recognize danger signs or do not use the prescriptions as they should, even though the problem of illiteracy is general and well known. A vertical relationship is practiced without taking into account the information that patients or caregivers could provide or making sure they understand the prescriptions.

Micaela's death certificate indicated that the main cause of her death was chronic malnutrition and dehydration. She had also often suffered from diarrhoea—a primary cause of malnutrition in children under five years old, and a problem that four out of ten children suffer in Guatemala, primarily in rural areas (UNICEF 2010). A few weeks after Micaela's death, Marta had a miscarriage. The loss of two children in a short period of time put her into a depressed state, suggesting that help-seeking behaviours are driven by multiple factors that include real or perceived barriers to healthcare access (cf. Harvey 2011). From a biomedical healthcare perspective Marta's case highlights the significant factors influencing Micaela's diseases, giving a simplistic impression of irrational health behaviour and a succession of bad decisions. Dr. Cali, a physician working at the health center at San Lorenzo at the time of this research, commented on this:

“When caretakers come here [to the health center] they usually come a week or even two weeks after the diarrhoeas or respiratory infections have started. This problem of ‘waiting’ makes our work less successful because we need to make use of more invasive methods such as intravenous therapy or make referrals to the hospital. Mothers frequently have also made use of treatments they buy at pharmacies without knowing which medicines are appropriate, but they trust people who work at the pharmacies. . . These behaviours are not proper because such actions produce secondary effects or make subsequent treatments less effective. . . but having sought help at the health center does not necessarily solve the problem either, because then women say that they need first to ask their husbands if the child can have intravenous infusions or be transferred [to the hospital]. . . We [at the health center] often experience such erroneous behaviours that can contribute to impaired immune system function and even death”.

This situation of few or no resources in a context of extreme poverty, overcrowded houses, poor or nonexistent water supply, rudimentary sanitary facilities, food insecurity and family dynamics, among other factors, influences the effectiveness of therapy management. Moreover, accessibility to allopathic medicine and pharmaceutical treatments is problematic, which can increase the risk when symptoms

mask the origin of a disease. The rationale that caregivers and mothers rely on to treat acute illnesses negotiates between risks and responsibilities. The role that Evil Eye plays within the context and outcomes of diagnosis and treatment of infectious diseases can increase the risk in healthcare and health-seeking. But to rely solely on simplistic notions of ‘cultural barrier factors’ condemns these actions without an understanding of the phenomenon in everyday practice. Moreover, as Harvey points out, it is important to analyze what ‘rational choices’ and ‘efficacy’ mean within different cultural environments (cf. Harvey 2008; 2011). In this way, Evil Eye articulates illnesses, therapy seeking and management on multiple levels that explain cultural understandings of symptoms or illnesses and the purposeful actions based on those understandings.

5 SITUATING EVIL EYE AMONGAETIOLOGIES

‘Everyone knows that suffering exists. The question is how to define it.’

— Paul Farmer (1997:261)

5.1 Introduction

The published literature related to Evil Eye is vast and rich with theories that explain how and why this phenomenon remains a specific feature of the manifestation of symptoms related to physical and/or psychological discomforts. Despite the diverse origins of the phenomenon, studies on Evil Eye have always been linked to illness and health practices. As a result, it has captured the attention of many scholars, primarily in the field of folk illnesses. These have a long history in anthropology, especially within indigenous and rural contexts such as in Guatemala, where it remains a major factor within some communities. At the same time, healthcare practices regarding folk-illnesses differ considerably from the standardised treatments envisioned by national healthcare standards. Hence, any explanation of the ethnophysiological concept of Evil Eye must also take into account the public health interventions that the biomedical community seeks to apply (cf. Baer & Bustillo 1993).

According to Adams and Rubel (1967), Evil Eye is a form of negative social sanction acting against mothers (but not fathers) who allow their infants to be exposed to strangers. According to this theory, which addresses the social implications of Evil Eye, protecting infants from strangers helps to maintain the integrity of the traditional local community. While this hypothesis might have been plausible in the past, Evil Eye no longer works as a social control device in this sense (Scheper-Hughes 1985). Yet the idea of gaze as a means of controlling, commenting or criticising remains important, making Evil Eye a strategy of resistance. In a Foucauldian view, Evil Eye is a mirror image, unacceptable to us because it either uses an inhuman perspective or gazes at our condition as it really is. In everyday

relationships, there are always expressions of power and control, situated amidst social and cultural practices. Speech or any other language-related concept that is used to communicate these relations has significance in order to situate peoples' roles: What can be said? What can be done?¹. Evil Eye, as a strategy of resistance against envy,² suspicion, danger and control, allows people to negotiate what is at stake in the roles and relationships among members of close communities. Its adaptive nature suggests that this phenomenon responds to practices associated with symptoms that become a significant burden of other diseases already prevalent in the area. Evil Eye thus is a way of resisting the public transcript, i.e., the standardised modalities of biomedical care and the stigmatisation associated with dirtiness and lack of care. As an embodied concept of illness, Evil Eye involves an intra-cultural understanding that carries significant meaning in regard to health-care, which in turn shapes socio-personal experiences of suffering (cf. Quaranta 2010:180). It provides forms of socialisation in daily practices, not only to prevent or cure the illness, but also to reflect on or discuss negative health outcomes associated with caregivers' experiences. Evil Eye is overloaded with so many meanings and repercussions that it is difficult to really predict behavioral patterns when confronted with the illness. However, it is precisely this multifarious deployment and fluidity of meanings that provides not only a multiplicity of ways to negotiate healthcare practices, but also a space in which to disclose conflicts and afflictions

¹In a similar sense Quaranta, with regard to the topics of the 'local processes of social production' and 'cultural interpretation' of AIDS in Kumbo, in the North West Province of Cameroon, explains how the concept of AIDS does not differ from the concepts *kinjuume* and *kinsenin*, yet these "speak about the indignation of the sufferers against those social processes that have historically as well as presently marked their bodies: in this guise they emerge as product, as well as embodied critiques, of hegemony. . . . Bodies are not only socially and culturally produced, they are also clearly productive in critically relating to the very processes of their construction/constriction, that is in articulating an embodied commentary on the social order within which they are captured, evoking a precise moral discourse on the social predicament of their existence" (2010:188). In this sense, since illness concepts entail essential meanings, these produce specific practices and relationships.

²To "throw an Eye" on persons or objects in states of vulnerability is also very common. If a person owns or acquires any asset that is envied, desired or sought after by someone else, this envy can cause the desired object to become contaminated. In the highlands of Guatemala, textile sellers, for example, have the practice of reducing the price of their commercial products if they perceive that someone wants a textile that they cannot buy, or even giving it away, in order to prevent envious people from throwing an Eye onto their business, since this could cause traders to be assaulted, businesses to fail, or garments to become unsalable. When the Eye is not deliberate, objects that are 'eyed' become damaged, deteriorated, broken or stained, becoming increasingly vulnerable and contaminated until their total extinction. The Eye therefore has an effect of 'decomposition'. For the K'iche' people the term *ruzap* means 'a person who has good hands'. When this person goes to a place and buys something, the sales multiply. This person is said to give or bring luck. On the other hand there is the person who is *ak'aj ux* (has 'heavy blood'), who may want to buy something but does not have enough money, which can lead to the ruin of the entire business. As a result, people who are considered to have 'strong blood' are often deliberately isolated or avoided by the rest of the community in order to keep them from causing Evil Eye (personal conversation with Apab'yan Tew, a K'iche shaman, in 2014).

within families and communities, turning a crisis into an opportunity to disclose concerns that affect not only one individual but a collectivity.

With the help of the concept of *ambiguity of illness* (Nichter 1994), this section seeks to understand Evil Eye as a cultural construct that fosters specific practices. In attempting to explain the existence and inconsistency of Evil Eye, several anthropologists have already explored the phenomenon in a *pragmatic system*. Migliore's work frames this phenomenon with reference to these two concepts, arguing that 'the evil eye is not something specific and absolute; it is an ambiguous cultural construct whose meaning varies cross-culturally, and it is open to interpretation, argument, and negotiation within specific socio-cultural context' (Migliore 1997:12-13). According to Nichter, Evil Eye can serve as both a *coping strategy* and an *idiom of distress* to communicate experiences of suffering in a culturally recognisable and appropriate way in order to seek and receive assistance from significant others (Nichter 1981:393). What is distinctive in the San Marcos case, however, is that rural people in San Marcos do not manipulate the illness or allow it great variability in terms of what factors trigger the illness and the symptoms with which it manifests in children; its onsets and outcomes are limited. It also—although not exclusively—plays a central role in illnesses that affect children without either expressing an embodied experience or dealing with mothers' or caretakers' physical distress, yet entailing social and personal burdens complicated by multiple interrelated factors (e.g., capacity to intervene or decide, economic dependence, therapy outcome measures). Hence, Evil Eye expresses physical pain, discomfort, and anguish that encompass the entire phenomenology of health and illness. Individuals rarely seek care at biomedical institutions when infants or children are afflicted by Evil Eye, since the local perception of the illness is that biomedical practices can be threatening—a behaviour that has also been reported in other studies of epidemiological interest (cf. Harfouche 1981; Sachs 1983).

In this chapter I focus on the fact that Evil Eye is a powerful concept with diverse meanings, manifestations and interpretations that occasionally result in ambiguous health-seeking and care behaviours in cases of severe pulmonary or diarrhoeal infections that eventually become life-threatening. Only through this concept is it possible to understand people's predicaments. As Kleinman and Seeman state, 'contemporary social science and medical accounts alike often focus on pathologies of individual choice and 'risk behavior' as if these were self-evident and untheorised constructs' (2000:232). While biomedical concepts and concerns exclude Evil Eye as an illness category, people pursue health practices that constitute a social resource for overcoming health problems and uncertainties.

I will elucidate the concept and meaning of Evil Eye in order to better understand

healthcare paths and to give a better insight into local realities and knowledge, as well as to draw attention to the importance of such practices, while questioning the universality of biomedical models that leave out important aspects of moral logic and emotionality which are central to health behaviours. Evil Eye also reveals that all the barriers, of whatever nature, are not stratified but constantly interact, entangling and disclosing spaces where struggles, negotiations and possibilities are taking place. Decision-making generally involves the consideration of values, preferences, judgments, knowledge and subjectivities—which may render behaviours difficult to grasp understand—that can be understood as either standardised or deviant. The failure to understand health-seeking patterns is a consequence of attempting to simplify each of these aspects by designating a particular value specific to limited criteria, rather than examining the cultural and/or social ‘proxy’ factors that influence behaviour. This section will review the conceptualisation of Evil Eye by scholars, but, more importantly, it will focus on the perceptions people have of this illness as a primary cause of specific symptoms among the indigenous and rural population in San Marcos, Guatemala.

5.2 The Nature of the Illness Category

According to some scholars, several traditional healing practices in contemporary Latin America are related to the Greek humoral pathology. They were created in the Arab world, transferred to Spain as scientific medicine during the period of Moslem domination, and expanded to America during the years of the Conquest (Foster 1994; Roberts 1976:244; Weller et al. 2014). In the humoral system, the body is regulated by four body ‘humors’, or fluids (blood, phlegm, yellow bile and black bile) and four corresponding personality types (sanguine, phlegmatic, choleric and melancholic). The world itself was conceived in terms of four basic elements (fire, water, air, and earth), and four qualities (hot, cold, dry, and damp). Health was defined as the balance of these humors, and illnesses occurred when the balance of one or more of the humors was altered (Turner 2000:13). Other scholars, however, have questioned the universality of this system, since “humoral systems, though sometimes discussed as if they were all derivatives of Classical Greek and Eastern high cultures, can be found in many different forms throughout the world” (Messer 1981:134). In this view, the humoral classification is a fairly general explanation many dysfunctions or ailments, and not necessarily consciously related to this classification scheme.

A number of studies conducted in Guatemala report that many objects and personalities are seen as having either cold-hot or dry-wet properties (Cosminsky

1975; Logan 1973; Rode 2000; Tedlock 1987; Weller 1983). These properties are perceived as having a direct influence upon the body. This system divides illnesses, foods, medications, water, air, and body conditions into either hot or cold categories. The labels of hot and cold do not designate temperature, but rather the essence of the component (Robledo et al. 1999:240). This perception that influences the way in which the aetiology and treatment of some illnesses are understood (Adams 1955; Adams & Rubel 1967; Baer et al. 2003; Cáceres 2008; Cosminsky 1975, 1977b; Foster 1994; Harwood 1971; Logan 1973; Weller 1984; Westsberg 1989; Woods et al. 1973). Illnesses and other health-related issues can also be understood and accepted as fate or God's will (Harris 1996; Rode 2000), or as the result of sorcery or prolonged emotional dispositions (cf. Appel 2003). John Gillin's³ book *El espanto mágico* was of great importance for the awareness of folk-illnesses among indigenous and rural populations, and for explaining the process of acquisition of knowledge, therapies, and use of medicinal plants by healers. His work followed earlier research on medical issues and folk illnesses which found that some symptoms of Evil Eye correspond to biomedical terms such as diarrhoea and respiratory infections with symptoms of fever, headache, vomiting, chills, sweats, and coughs (Adams & Hawkings 2007; Duncan-Jones 1995; Harris 1996; Leyn 1999; Paul & Paul 1975; Rubel 1984; Yukes 1997).

Illness Aetiologies

Many theoretical approaches to the study of Evil Eye have made use of some of the folk illness categories to better discern which beliefs correspond to certain symptoms. Madsen (1964:71-74) observed that illnesses among Latinos in the United States could be classified as (1) *natural illnesses*, the effect of disrupting the balance of the natural world, infection or simple misfortune; and (2) *supernatural illnesses* caused by black magic or witchcraft. Kay (1977:125-141) classified illnesses as *physical* and *emotional*. Saunders' categorization (1954:148-149) included (1) *natural diseases*, produced by external factors; (2) *magical diseases*, in which the causal factors are found outside observed knowledge and cannot be demonstrated; and (3) *psychological diseases*, caused by powerful emotional experiences. Clark's classification (1959:164-183) identified (1) diseases resulting from *displacement of internal organs*, as a consequence of real or imaginary parts of the body that had moved from their normal place; (2) diseases of *magical source*; (3) diseases of *emotional cause*, provoked by lingered emotional states; (4) diseases of *hot-cold imbalance* of the body; (5) other folk-related diseases that do not fall into

³John Gillin, a US anthropologist, conducted important field research between 1942 and 1946 in Guatemala. His work was not published until 1959.

any of the categories mentioned above; and (6) diseases designated by *biomedical* terms.

Within these classificatory systems, Evil Eye has been referred to as a magical illness (cf. Saunders; Clark; Westberg 1989), a supernatural ailment (cf. Madsen) or an emotional illness (cf. Kay). These early studies of illness identified their causation as being outside the biomedical medical system, explained in terms of magic or religiosity and the result of ‘primitive’ thinking. In this context Fortes points out that the ‘early twentieth-century medical science on such early medically qualified anthropologists as Rivers and Seligman... ‘obsessed with native theories of magical causality’ reduce[d] the study of health and disease to studies of witchcraft, sorcery, magic and in general curative or socially re-adjustive ritual practices, with herbalist and empirically rational diagnoses treatment and prophylaxis as residual categories’ (Fortes 1976:xiv-xv).

On the one hand, this literature has contributed to recognising isolated illness concepts of extreme importance in particular contexts; on the other hand, it has provided researchers with ontological, methodological and epistemic reductionist principles and models. The reduction of magical illnesses to ontological principles established a hierarchy of biological and physical categories among diseases, suggesting that some illnesses were ‘only culturally relevant’ and therefore not further investigated in terms of pathologies. In this framework, folk illnesses were not included in explanations of the ways in which illnesses generate healthcare responses. From epistemic reductionism, illness concepts were generally ‘translated’ into westernised understandings in order to validate these understandings, leading to an oversimplification of local ideas and experiences. A methodological reductionism tended to ignore aspects that were more subtle or that did not appear to be clearly related to the research. More importantly, although there was an advantage to outlining a theoretical understanding, reductionist approaches condoned the subjectivity of collective and personal experiences within a set of references of comparative order within a hierarchical system of references to classify illness experiences in terms of religiosity, ignorance, ‘primitive thinking’, or the presence of barriers to ‘effective treatments’ (cf. Etkin1988; 1994; Waldram 2000).

Indigenous Illness System

Folk illness aetiologies are frequently classified into ‘naturalistic’ and ‘personalistic’ categories (cf. Berlin & Berlin 1996; Harris 1996). Naturalistic explanations include organic weakening or breakdown, injuries, obstruction or malfunction of an organ, imbalance, malnutrition, and parasites; personalistic explanations consist

of spirit possession, harm or loss, bewitching, or intrusion of foreign forces into the body. Evil Eye, considered a naturalistic order, is never seen as a deliberate threat that can be influenced or changed. Although Evil Eye is usually referred to in the literature as an involuntary act, there is also a general consensus that certain people carry a special energy or innate power (cf. Appel 2003; Adams & Hawkins 2007), including feelings of jealousy, envy or desire (intermediate cause) that provoke people to cast the Eye (immediate cause), causing various symptoms. However, among the rural population in San Marcos a direct accusation of causing illness occurs only when the mother or caretaker suspects that this force has caused symptoms in the child. In this situation, the caretaker can ask the suspected person to remove the Eye from the child; this does usually not offend the person suspected. It is often believed that when the Eye is too strong, only sorcerers can effectively cure the affected person, since the profession of a warlock (*brujo*) is related to its *nahual*, which has a superior force, i.e. of extraordinary power or character. Warlocks are able not only to heal but also to make someone ill, precisely because of their contact with the underworld which allows them to perform their work as therapists or evil healers. The terms ‘warlock’ and ‘therapist’ in fact coexist (Appel 2003; Martínez 2011: 370-371)

Physical features that differ from phenotypes found in the area are associated with *personalistic* causes as a result of intrusion of a force. This kind of power is a reason why some children or youths are prone to cast the Eye. These unusual physical characteristics do not have a stigma, but rather refer to a state of vulnerability among children and an alluring feature when they are older that causes over-admiration. Thus, unusual physical features mean that a person is likely to be affected by Evil Eye. On the other hand, attributes such as ‘strong blood’ are connected to strong emotions or states within an individual, rendering them capable of injuring others and protecting themselves. An intentional act of harm, however, is normally not directly expressed. Furthermore, the description of ‘strong blood’ is not limited to people who can cast the Eye; it is also commonly used when someone is intoxicated or has been exposed to high temperatures. ‘Being hot’ after a prolonged exposure to dryness and heat, although linked to the environment, is perceived as an individual condition. These conditions are associated with the humors and their corresponding elements. Strong emotions (‘strong blood’) and an individual’s equilibrium belong to a classificatory dimension that represents how people perceive the attitudes and personalities of others. The same categories are used to express norms of emotion or morality. People try to calm ‘choleric’ persons using phrases such as ‘don’t get bile’ or ‘don’t let a bad thing destroy your bile’. Evil Eye is associated with similar ideas of humors formed in the body

and the ways in which these elements influence people and illnesses, although it is inconsistent with the whole humoral theory of disease. However, temperaments and bodily fluids are important attributes for illness classification as well as behavioural inclinations. They postulate the concepts of order and balance, which are perceived as necessary to maintain life and well-being.

The idea of balance

Sculpted representations, and inscriptions on ritual architecture and ceramics, produced between 2000B.C. and A.D. 1520 given evidence of the way in which most aspects of Mayan life were permeated by spirituality, orientated by natural features and cosmological understandings that guided social, political and economic relations (cf. Damarest 2004). Early studies suggested that the Maya perceived their universe as being closely guided by certain energetic properties. The causes and treatments of diseases were connected to their cosmology and to the curative properties of herbs. The Mayan cosmology and religion reflects ideas of dualism and balance⁴ (cf. Freidel et al. 1995). This belief system was compatible with the imported model of humoral healing practiced in some parts of Asia, the Middle East and the Mediterranean, based on the idea of balance between certain elements within the body and within the person's environment (Weller et al. 2014). Life, and by extension the body, could only maintain its balance within a stable range of 'heat' or 'warmth'; when this equilibrium was disrupted the body began to malfunction and people fell ill or died. This 'heat' did not indicate a thermal measurement or quality, but rather a powerful energy emanating from all things and persons on earth and in the universe. In this sense, everything that existed within the social and natural system was associated with a hot or cold property, which was vulnerable to change in the form of substantial heat loss. Thus, the restoration of balance was directly linked to the idea of the body recovering its own level of energy, strength or heat. Medicinal plants and food were also included in this system, having 'hot' or 'cold' properties (Nigh 2002). Contemporary Mayan communities maintain most of these perceptions, inextricably linked to ideas of illness causation, which influence practices of healing. Accordingly, the idea of the balance of opposites still prevails. Animate and inanimate nature (flora, fauna, and minerals) all possess a dualistic nature, a system that easily accommodates

⁴This is not a dualistic representation of good and evil in Christian terms. Its logic is that everything that exists in the physical and spiritual world has an inherent force or quality that needs to be in equilibrium. This 'essence' is fluid and in permanent connection with other objects, which can alter its properties. These opposites coexist and are inherent in all things. Historians suggest that this dualistic idea eased the adoption of the Christian rhetoric concerning good and evil, God and Satan, as justifiable elements of societal and political domination (cf. Rogers & Blank 2008).

Christian and syncretised saints.

Recent ethnographic studies, however, question the use of the term ‘Maya’ when referring to recent practices and understandings that shape modern social and environmental landscapes. According to Castañeda (1996), archaeologists and anthropologists created the narrative of ‘ancient Maya culture’, which has in part helped to build the idea of a continuum of beliefs and practices of the Mayan culture. According to Edgar Esquit (2003), ‘Maya’ is a term that has a political content, referring to social groups with different identities that are under formation and have been historically formed and transformed. In this understanding, Mayan groups deliberately take elements that are considered relevant for this ‘new formation’ as instruments of ideological legitimation among other socio-cultural groups. One group of scholars sees many of the recent practices of the ‘ancient’ Mayan culture as a result of ‘commoditisation’ of culture-identity representations specifically elaborated for the tourist market (Kroshus 2003). This argument is distinguished by two positions. One proposes that such practices are meaningless in terms of being authentic actions (cf. Greenwood 1977). The other is that these configurations offer people the possibility of preserving traditions by generating demand or attributed value (cf. Cohen 1988). Thus, some practices that were previously abandoned, changed or practiced in secret are now being restored as a result of discourses on indigenous rights.

Despite these debates, ethnographic research conducted among communities who were victims of the internal armed conflict has identified aspects of illness and healing that are relevant for the indigenous Maya people dealing with the effects of the war, poverty and exclusion (cf. Viaene 2009). Central concepts and practices that were essential parts of the indigenous identity, including spirituality, were manipulated or destroyed during this period; yet some beliefs and healing behaviours, rooted in ancient and post-colonial perceptions and practices, continue to persist. This is not an essentialist view of contemporary Mayan groups. Instead, it recognizes that practices have been maintained despite constant (past and present) socio-political impositions or confrontations in which indigenous communities and organisations selectively claim particular practices that account for specific behaviours of special significance.

Recent extensive in-depth ethnographic research conducted among the Q’eqchi’ group, the second-largest Mayan group in Guatemala, concerning the experiences of internal conflict and the process of socio-cultural reconstruction showed present cultural understandings of the war through ceremonies, healing practices and other community activities focused on widows, elders, spiritual guides and aid workers.

These practices displayed how aspects of the cosmos—the natural, social and spiritual worlds—are still considered important in maintaining the balance that defines a person and the community life. In this context, people’s explanations of *fright*, for example, were relevant not only to describe the understanding of one of the major causes of death during the war but also a manifestation of recent illness events, as well as an illness concept to deal with governmental policies to provide benefits and healthcare resources as a means of cultural self-empowerment (cf. Huet 2008). Yet not all the concepts of illness causation involve traumatic events rooted in the civil war.

Research among indigenous groups into theories of illness causation and the concepts of hot and cold continues, perhaps, according to Anderson (1987), because the idea is applied in a number of medical belief models worldwide. Several Mayan groups continue to perform various ceremonies in order to protect infants, children and adolescents, praying to the ‘king sun’ to give them a favourable energy which will shape their whole lives (cf. Harris 1996; Yukes 1997; Sullivan 2001). This corporeal, supreme deity is connected to the Mayan calendar, deciding on the personality, work skills, strengths and weaknesses of each individual. Likewise, medicinal plants are ranked and used according to their ‘thermal’ properties. To relieve a pain or cure a disease, hot/cold treatments are applied in order to restore the balance of the body (cf. Bricker 1982; Leyn 1999). The term ‘heat’ or ‘hot’ is related to ‘force’, ‘power’ and ‘ferocity’. A person considered to have ‘hot’ properties in this sense is someone who inspires force, fear, reverence and respect. As a result, many therapeutic procedures consist of carrying out ‘changes of energy’ through the use of ‘hot’ or ‘cold’ plants depending on the illness.⁵

⁵All the Maya words derived from the prefix *kin* (*sun*) are expressions of energy or heat. For example, the expression *kinam xiuob* means ‘the virtues of herbs’ (cf. Bourdin 2007). According to the Yucatecan Maya cosmology, *kinam* was a force radiated by humans, animals or stones that affected people’s behaviour, or the organic condition of people who were close to those with *kinam*, causing their bodies to lose their balance and resulting in various diseases (Villa Rojas 1981:22-23). *Kinam* was part of the ‘hotness’ and ‘power’ that leaders and wise men possessed, as a virtuous ‘emanation’ powered by the sun, a force that increased over time and had a direct effect on people considered weak. A number of sources, including the Florentine Codex (IV, 202-204) and Fray Diego de Landa, mention the existence of a ritual bath in which the introduction of various animistic entities into the infant’s body was reenacted. According to Ruiz de Alarcón (1999), this practice involved contact not only with water but also with fire. The presence of both elements in the ritual was a symbol of the formation of the subject, a symbol of opposites and complementarities. In the Dresden Codex, the image of Ixchel, the moon goddess of disease and medicine, who is depicted sending designs of evil or luck to human beings, is accompanied by the symbols of *chac* and *sac*. *Chac* signifies the attributes of ‘big’ and ‘red’, implying grave illnesses, like a plague or diseases with high mortality. It was also associated with suffering that was the result of ‘overheating’; the *kaak* (fire) symbol is also depicted with the moon goddess in multiple representations in this codex, such as those dealing with smallpox and measles. In contrast *sac* symbolizes ‘white’ and refers to cold diseases (Thompson 1993). The sun itself was also able to send terrible ailments (cf. Villa Rojas 1981; Ossado 1992). The book *Ritual of the Bacabs* (*Ritual de los Bacabes*, a manuscript which refers to the Maya deities who held up

This ethnographic research in San Marcos showed that plants considered hot have the ability to ‘steal’ a negative energy, since some of these are associated with *kinam*, a natural strength. The close association of the healing herbs with the sun is related to their ‘heavenly origin’ as a divine gift. Plants facing the sun are therefore considered hot, while plants that grow in permanent shadow and in direct contact with the soil are considered cold. This hot/cold duality persists in all aspects of medicine.

Medicinal plants are also often (but not always) labelled according to the cardinal directions, north (*sac*/white), south (*kan*/yellow), east (*chac*/red), west (*ek*/black), and center (*yaax*/green) (Álvarez 1997:35-37). This colour-direction relationship is also mentioned in several Mayan texts with respect to the ‘colour’ of the disease (e.g., a patient with jaundice) and organs (cf. Martínez 2011). Plants associated with a specific direction and colour are used for specific diseases: for example, ‘east’ plants are preferred for symptoms such as dysentery, bleeding and vomiting. At other times the plants operate through chromatic properties of ‘equality’. Red plants or fruits, for example red pepper, can be used for diseases involving bleeding. The colour red is used in some amulets to protect children (especially immediately after birth), objects or animals against Evil Eye. The idea of a powerful energy contained in plants is also a widespread element in the healing ritual for Evil Eye. Medicinal herbs used to cast the Eye are believed to have a property of strength that can induce the restoration of the body’s temperature, which is believed to have the ability to absorb the Eye’s energy.⁶ Thus

the four corners of the sky) explains how a disease could be the result of a part of the soul being in disharmony or the result of offending the gods (Foster 2002:337). The *Ritualde los Bacabes* consists of medical incantations intended for use in curing illnesses. Examples of these incantations include expressions a shaman would say to cure various types of seizures, fevers, breathing difficulties, parasites, toothaches, burns, insect and snake bites, rashes and skin eruptions, gout, ulcers, and broken bones, and to induce the emergence of the placenta after childbirth. This manuscript is believed to have been the property of a Mayan shaman, who used it as a handbook for his curing ceremonies and other rituals. It frequently mentions the influence of the king sun on the acquisition of the disease as a possession of man by this god, inducing diseases such as asthma, snoring and a ‘sore speak’ (Foster 2002). The *Chilam Balam of Ixil* is the book that records medical information (idem, p.302). The *Chilam Balam of K'aua* mentions loss of speech (*nunil ik*) and an oppressive pain on the heart (*chibal pucsik'al lap*), illnesses caused by the sun, whose symptoms were the fear of neighbours and of shadows (Bricker & Miriam 2002:353-371).

⁶According to some spiritual guides, when a person dies his shadow separates from the body and remains on the ground, tied to the place of death or burial until the completion of its final journey to the underworld. After the deceased has been buried, the anima-heart starts its journey to the underworld, whereas the ‘heat’ remains contained within the flesh of the deceased and acts as a ‘fuel’ that provides the soul with the energy needed to negotiate the various obstacles found in the underworld, heat that will shrink or vanish during the decomposition process. During this phase the anima-heart is released and cleared of all ‘brands’ that were printed on it during the person’s life, eventually becoming a kind of purified seed, ready to be inserted into the uterus of a woman in order to return back to life or to inhabit one of the dwellings of the dead (i.e., the Underworld (Martínez 2011:498-502)). According to this perception there are hot and cold people, and an excess of heat is a quality

Evil Eye ritual healing includes a combination of several plants considered especially useful to restore the balance. These are used in combination with certain numbers⁷ regarded as particularly efficient and necessary to cast the force. The numbers of repetitions of the procedures during the Evil Eye healing, for example, are multiples of three.⁸

The idea of (loss of) balance in Evil Eye

Mayan thought is based on what Eliade called a ‘cosmic cycle’, whose main principle is that everything has a creation, an existence and a return to chaos. This is the essential nature of the universe, revealed as an imbalance of forces that leads to a new cosmic order, and thus to another state, phase or period (cf. Stross 2007). In some cases, depending on their nature, things can return to a state of well-being or perfection, but in the case of humans this normally does not happen. Instead, people become prone to illnesses. López Austin defines this idea through the concept of *entidad anímica* (which differs from the Judeo-Christian idea of soul, or spirit, which are sometimes used as synonymous), defined as ‘a structured unit with an independent capacity, under certain conditions, [depending on] the organic place in which it is located’ (1996, I:197). This belief is widespread among Mayan groups.

According to the Maya narrative, a human being is conceived as a temporary union of components of different orders and natures, composed of various animistic entities: anima-shadow, anima-heat, anima-air and anima-heart, elements that are bound together but can also be separated from the body or its components (cf. Freidel et al. 1995). Some are material and tangible, while others are extra-corporeal and intangible. There are also immortal, hereditary and ephemeral elements of telluric, heavenly and alien origin. Each combination is unique, and is a source of vitality for the individual, intervening in bodily functions and mental processes. Their effects determine personal characteristics that can sometimes be

that can cause damage to both the individual and his environment. People with *kinam* are therefore the people most likely to cause Evil Eye (Villa Rojas 1981:381).

⁷This naturalistic view was linked with a symbolic representation of dosage and number of cures, among other therapeutic treatments, showing consistent use of the numbers 3, 4, 9 and 13. The first two numbers are believed to have a ritual or magical sense, which derives from the divination system in use among the Maya. The number 4 corresponds to the four cardinal points, and was also the representation of the ‘old man of heaven’ (Itzamma Kinich Ahau), who was the benign solar phase of Itzamma. The number 13 refers to the layers of Upper world, while 9 refers to the layers of the Underworld and their respective deities, who had to be begged not to send any disease to earth. For this reason some modern Mayan ceremonies, like the *hetzmek* ceremony, are performed when boys are 4 months and girls 3 months old, because there are four sides of the cornfield, a masculine realm, and three stones form the home, where women spend most of their life (Foster 2002:248-249).

⁸See Chapter VI.

modified, depending on the events and circumstances that affect each individual (Martínez 2011: 29-30). This idea of the body as a receptacle of hot and cold fluids, referred to as *elementos anímicos*, is necessary for the functioning of the individual, and continues to prevail among Mayan indigenous groups. Following this idea, healers in the rural area of San Marcos understand every human being and object as composed of several entities.⁹ These animas determine the qualities, character and mental state of each individual or element, while the individual's moral behaviour influences possible changes. Changes in behaviour, as well as states of health, well-being and illness, induce modifications in the balance of these 'personal essences'.

Ramona, a healer from Santa Rosa, San Lorenzo, frequently pointed out the importance of distinguishing between animas (which were also often referred to as forces, spirits or energies), which are important to the notions of illness and healing. According to Ramona and other healers interviewed, these *animas* are dynamic and cannot be characterised as 'bad' or 'good'. However, the nature of these animas explains why things or persons are the way they are and the role that the animas play in transforming, rather than merely representing, the people and things they are part of. The implications of the animas in illnesses vary greatly, including how people experience and overcome ailments.

Ramona: "When I treat people I first focus on the person's force. There are different types of forces but it's just one that explains, each time, why people or things get ill or damaged. Depending on people's situation this force can make them frail. For example, there are some patients that I see whose force makes them healthier or contributes to their illness, but because you don't necessarily know which one is manifesting or taking control over the other forces you need [to perform] some rituals to identify the source of the problem or harm. Some illnesses are [therefore] difficult to treat because it's not only about [how] the illness [manifests] but how a healer handles such forces and how people respond [to these]. For example, when some people get worried and feel sad the whole time [they are prone to] suffer from cases of *fright*, which usually causes people to lose their soul. If you don't notice the changes in the person who has been afflicted,

⁹The term 'soul' (*an'ma* in K'iche', for example), is borrowed from Spanish, since some of the Maya terms are syncretic; the word *anima* corresponds to 'heart'. Force (*choq'ab' alil*) and strength run through the blood. The 'soul' is said to reside within the blood and breath. The existence of the heart-anima is only possible through the simultaneous presence of blood and breath; these are considered bipolar energies with a hot-cold character, which must always be in balance. The excess of any part may cause *bad air* or Evil Eye (cf. Appel 2003:49-67). Accordingly, there are 'strong' and 'weak' types of blood. From the very moment of a child's conception, the manner and circumstances in which a person was conceived is perceived to mark the blood type a person will have (e.g., a strong, warm or cold blood, or a light or heavy blood). These are complementary opposites of hot/cold, light/heavy, male/female.

then this can result in terrible symptoms or even death. . . People with *fright* have problems with breathing, their heart beats really fast, they faint. . . because their body can't manage the lost of the force which is in this case is her/his soul. . . but if a baby has Evil Eye I can tell you right away if the Eye is in her/his heart because that is where the Eye usually goes, since the Eye is a force that seeks the heat of the heart to keep growing, debilitating the child's whole body" (Santa Rosa 29015-127).

The ability to recognise the illnesses' 'forces', or *animas*, is considered important for diagnosis and disease progression. These *animas* can also be regarded as complex understandings of people's attributes and predispositions. The ambiguity of the designation *animas* is not a symbolic interpretation of interaction applied to illness, objects, and situations, but it is a resource that makes use of language and embodied experiences to explore and limit meanings attached to the illness, which provides parameters to negotiate healthcare therapies and outcomes. The attention to ideas of illness causation involving concepts of *animas* and aspects of cold/hot were persistent among caretakers. In accordance with this understanding, people explained not only illness aetiologies, but also outcomes that contributed to shaping people's personal and social choices to adopt specific health-seeking behaviour. Although some of the illness or therapy attributes (e.g., medicinal plants or time of the day to perform the healing) were not consistent, eliciting the properties of the concepts hot/cold in different ways, Evil Eye's attributes were rather consistent. These ideas became more simplified when used by people who were not healers, spiritual guides or midwives. Vero, a Mam woman from Tuichilupe who was part of the ACCESS programme, explained to me the concept of 'the *chuj* soul' responsible for certain illnesses when people do not take into account specific practices when using the sweat lodge for cleansing purposes:

Vero: "When entering the *chuj* for the first time, people need to give a gift to the *chuj*'s soul. It can be some flowers, alcohol or anything that they give as an offering once the *chuj* has been built; it will be used to avoid any illness or misfortune. Everything has a soul and the *chuj*'s one is like a shadow, you can sometimes even see it before you are about to faint if the *chuj*'s soul gets mad. Some people say that they have seen an animal, saying that the *chuj*'s soul is actually a type of dog. If people forget to do this [offering] they fall ill with fever and a prolonged illness that affect your lungs; people can even die! Last month a family died in Caballería inside the *chuj*. At the health center doctors said that it was because the smoke inside the *chuj* killed the family, but we know how dangerous it can be if we ignore this [practice]. The *chuj* soul is hot, so it usually heats the body and provokes fever. That's why you can't take a child inside the *chuj* if she/he

has Evil Eye because the Eye is also hot and this would only aggravate the fever” (Tuichilupe 04043-1407).

The concepts of hot/cold and *animas* can be better understood by exploring the idea that people, environments and objects have the capacity to influence social relations, healthcare dynamics and forms of collective action. Although people or things may be described with a specific attribute, it becomes clear that such designations are a matter of developing strategies of socialisation and actions that engage people in multiple (and sometimes contradictory) ways. Caretakers mobilise social or material resources for prevention, support/avoidance and treatment with a coherent explanation of cause and consequence. It is precisely this coherence in designating a person or object with a property that allows to (re)direct people practices to best manage those differences. Thus, attributes or qualities define specific social engagements, strategies and interactions. In the explanation of the *chuj*'s soul, for example, this encoded belief unfolds social practices in which ritual performance is a powerful conceptual idea of transgression of cultural practices, resulting in Vero's explanation at the end of how the condition of a person with Evil Eye would worsen if they used the *chuj*. Since such forces or attributes are encoded, they provide a powerful conceptual tool not only for the interpretation of the illness outcomes, but also to offer significant variability in the goal in order to allow the participants to use specific practices or behaviours.¹⁰

The system of hot/cold condition is translated into states that apply to specific ascribed properties. Among the K'iche' and the Mam it is thought that warm blood is a 'strong' characteristic, whereas cold blood is a 'weak' one (Marshall 1986: 134). The Téenek (Huastec) believe that men are hot and hard workers, whereas women are cold and lazy. They also assume that when a woman is menstruating her body becomes heated, which is why such women are forbidden to touch cold water (Pitt-Rivers 1970:12). This idea is also present among the Mam, which explains why a woman who is menstruating is asked to avoid seeing or touching a child to prevent Evil Eye. Consequently, Evil Eye must be treated with herbs considered cold, since hot and cold conditions are imbalances that are treated with medicines of the opposite intrinsic quality in order to reinstate a healthy balance (cf. Appel

¹⁰During the ethnographic research, personal anecdotes or explanations about the use of the *chuj* were often mentioned. The use of sweat lodges has been the focus of several epidemiological studies concerning acute respiratory infections and death due to carbon monoxide levels and dehydration. As a result, biomedical healthcare practitioners advise people to avoid the use of the *chuj* if possible. However, in the rural landscape of San Marcos the use of sweat lodges is the only acceptable (and sometimes possible) resource for personal cleaning, as well as a central element for purification after women have given birth. The deaths attributed to the use of the *chuj* are therefore always convergences of interpretative ideas associated with the non-compliance with crucial cultural understandings or accepted models of construction, which are viewed meaningful practices constrained by biomedical perspectives.

2003:61). Among various Mayan indigenous groups, Evil Eye is the result of an ‘over heated heart’, produced by people with ‘strong blood’ or ‘hot nature’, which includes newlyweds, adulterers, copulating dogs (Adams1955; Marshall1986:162-170), pregnant women and intoxicated persons. Yet a hot or cold component does not in itself indicate health; these can also be a cause of illnesses. It is precisely a balanced condition which makes life possible and restores health. Caretakers believe that the soul of a baby is unstable or unbalanced and can only slowly start to recognise his or her ‘vessel or ‘driver’, from which she/he obtains protection and strength. The soul, or psychic entity that runs in the blood, is in a vulnerable state until the child enters a phase of total awareness of her/his being, which gives him or her an advantage over infants and toddlers and is also related to how strong the ‘blood’ is. Some people associate this belief with fallen fontanelle, based on the idea that the maturity of the cranial cavity is related to the *animas* till being unstable.¹¹ Children between the ages of seven and thirteen are considered to reach their maturity, becoming ‘safe’ in terms of their health not being easily affected or damaged. However, they can also begin to suffer what people recognize as bad luck, melancholy, and gloomy states.

People from the K’iche’ group perceive that a heat increase maybe caused by sexual intercourse, or by feelings of anger or envy (Marshall 1986:126). For some Nahua groups, increased heat can be affected by age, gender, social structure, and a particular kind of mood. It can also mean the possession of super natural powers that can cause damage if not properly channelled. Heat can be detached from the body during sleep, sex, drunkenness and shock (cf. Chevalier & Sánchez 2003). For the Ke’kchi the shadow (*Šmuel, de muh*) is an *anima* component of humans which is only weakly attached to the body. It is a cold and dark element, sometimes thought of as wind. When it is separated from the body or stolen by creatures of

¹¹According to the ritual calendar of 260 days (*tonalpohualli*), which was repeated eternally, people gain strength, warmth and vitality according to the combination of 20 signs, i.e. glyphs, 9 figures of gods and 13 numerals. Each one of the 20 signs was ruled over each group of thirteen days. The quantity and quality of energy which each person had, decided their destiny, measured and accordingly diagnosed, forecasted and if necessary remedied. It is said that, during the period when a child is maturing, caretakers should ensure that she/he is not scolded, abused or humiliated, since bad impressions cause a child’s *anima* to become weakened, as a child cannot question his own situation. Among several Mesoamerican groups the *anima* is associated with the *nahual* or ‘corresponding animal’. This condition affects or correlates with the character or temperament of each person. In other cases the *nahual* influences the good or bad behavior of the individual, has an effect on people’s morphology, and also exerts an influence on the profession or occupation a person chooses (Martínez 2011:94-95). Nahualism, unlike Totemism, is a network of complex symbolism structured around relations between signs that are established between humans and various other beings that are not humans but that are part of their environment. Some of the Mam terms that designate this entity are *t’kelel*, *kolel*, and *koleel an*, which share the root *kol*, which carries connotations of ‘protection’ and ‘save’. Nowadays the Mam use the term *kolel* (previously used with the meaning of ‘companion entity’) to refer to an angel or saint protector.

the Underworld, the result can be disease and even death. It is also believed that after death, the shadow can return to the earth's surface to cause diseases and death in those who do not observe moral norms (Carson & Eachus 1978:45-49). For the Totonac and Trique indigenous people, the 'shadow' or 'air' is an inner force that can radiate powerfully depending on its strength, sometimes causing Evil Eye (Martínez 2011:59-60; 78).¹²

Corresponding to the animistic idea, *anima* entities are located or focused within an organ or a part of the body. In this regard Evil Eye would be thought of as a caloric or heat-*anima*. The heart-*anima* is perceived as a source of vitality and core or essence of all that exists. However, this unitary essence does not just focus on the heart but is dispersed throughout the body. It is precisely its multiple and diffused nature which allows it to become detached from the body as a result of *fright*, for example, and be captured by telluric deities, or get lost in the forest, causing various pathologies in the person afflicted. When the separation with the body is prolonged, this can result in death. In humans, this *anima* acts as a source of action, excitement, knowledge, memory, will, language, ethnicity and individual energy. Among the Nahuatl, the *tonally* appears as a bright and hot entity, which spreads throughout the body but tends to focus on some specific points, such as the heart and the crown of the head (cf. McNeill & Cervantes 2008:278). Among the Mam from San Marcos, those points are precisely where the Eye is located. These attributes are important since they provide caregivers with a sense of coherence in relation to illness aetiologies and onsets, especially in cases of ambiguous symptoms, as well as social support in terms of healthcare. Thus, the first attempts to understand why a child fell ill with Evil Eye are based on these cultural elements, which offer an orientation for treating the illness rather than merely symptomatological explanations:

Elvira: “Lidia woke up feverish. Her eyes were sunken and her face was pale. She’s my first baby so I’m not sure what to do or what she might have. She was born *fragile* and began to fall ill when she was three months old. I went to the Convergence Center here [in Tuijala] but the SIAS people were not there, so I was nervous because I didn’t know what to do. Then I went to see my sister-in-law who

¹²According to Martínez, in old dictionaries written by Catholic priests during the Conquest, words related to the *anima* component were classified in to three groups. The first group corresponds to words concerning *gaseous* elements (air, wind, breath, blowing, etc.). The second group relates to terms whose roots mean *life*. The third group consists of words that refer to *heart* or *stomach* (in Mam the term *altzil* is used to refer both concepts). In some cases these words refer to the sacred, supernatural, likeness, fire, heat or irradiation. According to the translations of some friars from different regions, the term ‘soul’ was used (and still is in many regions) to make reference to ‘heart, liver and stomach’; ‘breath, blow, wind’; ‘shadow’; ‘heat, light, radiation, shine’; ‘life’; ‘knowledge’; ‘fontanelle’; and ‘divine, sacred’ (cf. 2009).

lives close by because I didn't know what I should do since my husband always comes home late from work. 'It may be the Eye', she told me. Then we took Lidia to Seño Estelita, who has a little store here and sells some medicines. I bought some *bebetinas*® [to reduce Lidia's fever] and then Seño Estelita removed the Eye. But at night Lidia was still ill. Because she was born fragile the Eye spreads in her whole body and makes her weaker, that's why she only wanted to sleep and her eyes were closed. Some children that have a stronger blood don't get too ill if they catch the Eye because they can fight it better. But not Lidia. This is when I learned about the *dumb* Eye... Lidia's extremities were cold but her chest was burning, that's where the Eye was. So now if she falls ill and the people from the SIAS are not there I know I can ask other women to help me out" (Tuijala 04747-1061)

Reina: "Gabriel has a strong blood, that's why when he falls ill he gets better quickly. When I was pregnant I never had any problems, he was born at home with the midwife and I didn't have to go to the hospital as many woman [have to] do when they have complications so they can't do the *diet*.¹³ When Gabriel is ill with Eye he only needs two cures to get better. If he's still ill after two days then I know he has something else because the Eye can't grow inside him [since] his blood is strong. He has a powerful character like I do, that's why I'm often asked if I can cure children [afflicted] with Eye because my character is dominant...but if I'm pregnant or breastfeeding I can't do it." (Los Bujes 04025-1119)

This innate energy or force is believed to form within the baby's blood during the pregnancy; it constitutes the 'internal blood' that manifests itself through personalities or the body's responses to illnesses. According to caregivers, there are two ways of acquiring a 'heavy blood'. The first is to be born with a strong, heavy or active blood bestowed by favourable conditions of pregnancy. Related to this is the fact that the children of mothers with strong personalities are perceived to have a lot of strength. These people are regarded as having stronger character and greater willpower, able to display stronger political leadership and directionality. Children with hot blood therefore are perceived as less vulnerable than those with 'weak blood'. The second way of acquiring heavy blood is for the blood to become heavy or stronger over time, turning into a more dynamic or 'loaded' blood. In

¹³Literally '*hacer la dieta*'. It consists of taking hot baths at the sweat lodge to restore the mother's body heat, drinking herbal teas specifically for lactating women and continually resting for a period of a month. It is considered extremely important not to expose the body to extreme changes of temperatures, which could result in an illness that affects the mother and the child. Caretakers believe that children born in hospitals are prone to fall ill because they and their mothers were exposed to an unbalanced environment at the moment of the birth. The loss of energy and heat after giving birth must therefore be re-established by these procedures.

these cases the blood is thought to be heated by external forces of brief duration. Examples of these cases are people who come into contact with the elements of nature—soil, seeds, water, air—in their fields, which heats the blood. The condition of strong blood is directly linked to an excess of heat, whether physical, such as sweat from working, or a spiritual heat absorbed through breathing.

This force or load can touch and ‘cool’ another person, meaning that it ‘debilitates’, ‘sucks from’, ‘comes close to’, or ‘touches’, or is ‘given’ or ‘delivered’ to (*kujach(o)*) a person. Anything that is vulnerable, simple, and cold—it need not be human—can be touched with warmth by another person or object. This is based on the idea that everything can establish a communication. The procedure is therefore to sweep, clean with herbs, or place candles nearby to keep the Eye from falling upon a child or baby (cf. Appel 2003:54). Ritual specialists carrying out ceremonies, for example, heat their blood in every ceremony or ritual they perform. People who work in activities that require important decision-making also heat their blood because of the stress to which they are subjected. In such cases people refer to being ‘highly charged’ or ‘coming to hot’ (*venir muy caliente*). Ritual specialists can therefore involuntarily afflict a person with Evil Eye because their blood has become hot. People say that these individuals can ‘contaminate’ or make a person ill because their blood is very hot at that time.¹⁴ A spiritual guide should therefore avoid holding a baby after finishing a ceremony, unless the baby has a strong blood.¹⁵

Within the conceptual system of hot-cold opposition, cold is constituted by the ‘breath’ or ‘shadow’, an element derived from the moon and celestial deities, which is renewed by the process of breathing and serves as a counter weight to the body’s heat entity. The cold element is usually associated with vitality, effort, the voice, taste, smell, motivation, talent and certain moods such as calm. The breath is widespread throughout the body and may, like the heart-*anima*, concentrate on specific points such as the head, heart and liver. The breath or blowing, used voluntarily, can be a source of sickness or health. During the rite of healing, the Evil Eye blowing liquor is a binary element containing the complementary ideas of hot and cold: the blowing is the cold element, while alcohol constitutes the hot one. People also prefer to cast the Eye away at night, when it is cold or the moon can be seen, since the healing is perceived as being more effective at this time.

When a person is affected with Evil Eye, the Eye is normally manifested through

¹⁴Similarly, it is said of *mixe nahualismo* that ‘people who have *c’okdeene* or lightning are capable of infecting adults with their gaze; those who have *co’k* of scorpion, *ka’pi*, may frighten children with just laying his eye on them’ (Lipp 1991:164-165).

¹⁵Personal conversation with Apab’yan Tew.

problems in the stomach. It is said that the stomach is ‘scrambled’, causing diarrhoea and vomiting. Therefore, people refer to it as ‘a blow on one’s stomach’. The return of appetite and the cessation of diarrhoea demonstrate that the Eye has been removed. Lungs may also be affected; this is because the lack of warmth and strength weakens people’s immune system. Some individuals, however, usually adults, do not develop such symptoms, but enter a state of strong melancholy, linked to a lack of momentum or force, feeling dejected, sad and deeply pessimistic, resulting in cases of deep depression until the person loses the will to live. These symptoms usually occur instead of stomach or respiratory symptoms because the stomachs and lungs of adults are perceived as less vulnerable than those of children.



Figure 5.1: Midwife blowing liquor to a child afflicted with Evil Eye

Plants such as ruta (*Rutagraveolens*), chilca (*Baccharis dracunculifolia* or *salicifolia*), ortiga (*Urtica dioica*) and estafiate (*Artemisialudovicina*) are commonly used to ‘burn’ the Eye. Herbs called ‘leaves of the seven hills’, red seeds called ‘deer’s eye’ and a few types of amulets are also used to burn or avoid the Eye. Plants that grow in the sun are considered masculine and are generally used to make ‘sweeps’ or ‘cleaners’. Caretakers believe that the herbs used for healing are hot, ‘masculine’ herbs that grow directly facing the sun. These plants are evergreen, but turn brown when they are used for healing, since they ‘suck’, ‘receive’ or ‘absorb’ like a clean sponge, retaining the pollutants. These plants do not necessarily need to be indirect contact with the sick person. If some branches, for example, are placed under the crib or bed of the afflicted child, the herbs can exert their healing powers through a homeostatic process. Peppers, tobacco, alcohol, candles, pine wood, feathers of high-flying birds (as they are closer to the sun), certain stones that are considered hot or can be heated, male or solar herbs and massages are considered hot and can be used to cast the Eye.

Attributes of illness and social healthcare

As mentioned above, the attributes of persons and objects are elements of socialisation and illness therapies. These properties can therefore pose problems when such attributes are some form of dominant or determinant values in the formation of behaviours. However, since such elements are not specifically ‘good’ or ‘bad’, they can be used as socialisation agents to overcoming limits and constraints among families, communities and healthcare facilities. The following case demonstrates how attributes can transform an illness into social relationships and provide care.

It was a Sunday morning when I accompanied Lude, a midwife from San Lorenzo, to vote in the presidential elections. We entered the school that was being used as a polling place. There was a long queue at the door of each classroom. The atmosphere was festive despite the presence of armed police units. Lude and I were surprised at the large turnout for the voting. Many women were even dressed in the traditional clothes that they wear for special events. Lude showed her identity card and we went inside, looking for the door of the room where she was assigned to vote.

‘I think this is the last time I’m doing this’, Lude said.’

‘Why?’

‘You know, we always hope for a change, we always believe the opposite of what we had will be better, but it never is’.

‘Do you sympathize with any of the parties?’

‘No, not really. Months before the election [the presidential candidates] come and assure us a better life, projects, houses, schools, better hospitals if we vote for them, but nothing ever really changes. Some people join the parties hoping for some kind of payback or benefits, but often this ends only in disputes. Most of the politicians only remember we [the poor] exist at the time of the elections because we are many and they need us [in order] to win. I just came today because I promised see how my *comadre*¹⁶ is feeling. She fell ill a couple of days ago and called me yesterday to ask me if I could pay her a visit, so I thought I could kill two birds with one stone’.

An hour later we left the school and walked to La Caballería. We saw a few pickup trucks passing us loaded with people who were heading to San Lorenzo to vote, a ‘service’ provided for free by the parties to guarantee that people will be able to vote.

‘What does your *comadre* have?’

¹⁶Officially, the terms *comadre* or *compadre*, literally ‘co-mother’ or ‘co-father’, refer to women or men who take the sponsorship role of godmother and godfather during the baptism of a child or of an adult convert to Christianity, but it is also used to refer a person who shares other ties with the family, such as a close friendship. It shows respect or love.

‘She went to the health center and was told that she has an infection. They gave her a prescription but she’s still ill. Maybe the doctor was wrong or maybe not, but the medicines are not working, or maybe something else is wrong’.

We climbed a hill to Cynthia’s house. We stood at the threshold of a cultivated corn field while Lude called for Cynthia, followed by barking dogs barking. The first two persons to come out were Cynthia’s children, aged 4 and 7.

‘Call your mom’, said Lude.

‘She’s inside, resting’, the boy told us. They stepped forward, touched Lude’s and my fingertips and then touched their foreheads as a sign of greeting, and ran back to the house. We followed them in.

Cynthia was lying in bed with her face covered by a towel. Lude came closer and whispered to her. Cynthia removed the towel and smiled at Lude. Cynthia explained to us that she was not feeling well last Sunday, a week before, after she took a bath in the *chuj*. ‘I felt numb, had a headache, and the next morning I started with fever’. On Monday she went to the health center in San Lorenzo and the doctor told her she had an infection.

‘What kind of examination did she do?’

‘She wanted to take a blood sample but I told her I didn’t want to because I was feeling really weak. A nurse measured my fever, asked me if I was pregnant and I told them I was not. She asked me other questions and then the doctor said it was probably an infection and gave me a prescription’.

A few days later Cynthia was still feeling ill, and her health did not improve after she took the medicines. After talking for a while, Lude said ‘I think it has to do with the *chuj*’s spirit’.

‘The *chuj*’s spirit? What is the *chuj*’s spirit?’ I asked.

‘All things have a soul or are “possessed” with energy, and if you don’t pay attention to it you can destabilize it and this leads to potential illnesses or conflicts. The *chuj*’s spirit sometimes gets “angry” if you don’t obey its rules. For example, you are not supposed to talk inside the *chuj* about bad things that can disturb it, or if you don’t pay it a tribute, or if you don’t make proper use of it’. Cynthia did not contradict Lude’s explanation and said she would ask for a ‘cleaning’ for the *chuj*.

The whole explanation about the *chuj* reinforced, rather than replaced, certain ideas related to the diagnosis Cynthia was given. Since the diagnosis provided by the physician remained unclear, Lude gave her another possibility for understanding why she was still feeling ill and explored the source of each symptom. How did she feel before? At what time did she go inside? For how long? What did she do afterwards? What did she eat? The possibility that some external force was making her ill became an organising lens. Lude recommended that Cynthia

perform a cleaning of the *chuj*, in which Cynthia would need to take out all the burned wood inside and put in fresh eucalyptus leaves. Lude also advised Cynthia not to use the *chuj* for at least two more weeks, and to drink some infusions of borage and chamomile that were described as ‘cold’.

There were some resemblances among the symptoms and attributes of Evil Eye, *fright* and the effects of the *chuj*'s spirit. Understanding the similarities is important for understanding their significance. Each of these illnesses is an ‘open’ system of attributes that permits the imposition of an internal structure on temporary internal chaos. Beliefs and taboos associated with folk illnesses guide people to avoid practices that can jeopardise someone’s health or well-being, but they also encourage mutual support within families and communities. Cynthia had experienced a series of misfortunes: her husband left, her two-year-old child fell chronically ill a few months earlier, and she and her family were worried about her brother, who was trying to cross the US border. When a person is afflicted with an illness, most of the traditional practices involve getting in contact with some member of the family and/or community. Even if this does not cure the patient directly, it can lead to increased care for the person who needs help. This phenomenon is linked to the understanding that the people of San Marcos have concerning illnesses. Illness, although it affects one individual’s body, always has a social component, not only in its nosology but also in connection with the patient’s struggles. Cynthia, for example, had been abandoned by her husband, and her economic situation had been difficult since then. Having a sick child added another burden to her situation. She was receiving support from her parents, who at the same time were hoping to receive support from Cynthia’s brother at some point. She did not want to add to the suffering of her relatives, so she avoided them as much as she could.

Lude did not contradict the physician’s diagnostic, but led Cynthia to ask herself what was behind her suffering, and most of all to get in contact with someone. This method of healing triggers support and enables people to share experiences to help them with their recovery. However, certain traditional practices can have a bad effect on people’s health. For example, some practices are not suitable for infants or pregnant women, such as the use of the *chuj*. Here we must also distinguish between ‘popular ideas’ (that is, a cultural construct of cause and the required therapy) and traditional knowledge. Healers and midwives are key to healing and curing practices because they understand the importance of traditional beliefs, ritual meanings and performances in healthcare, but they also often realise when certain practices can endanger people’s health. As a result, traditional practitioners allow biomedical and popular definitions to coexist within the

framework of both cultural systems. A visit to an experienced healer or midwife can therefore potentially obtain proper treatment or secure the required help in a socially approved fashion. It also emphasizes factors that may have been overlooked or excluded by the patient or physician, which can help to understand the illness process, consider therapies, and evaluate their potential effects.

Evil Eye in the Rural San Marcos Context

In rural Guatemala, Evil Eye is normally recognised as a condition that people suffer when their bodily balance is broken because of the intrusion of spirits and witchcraft, or most commonly, after another individual's voluntary or involuntary action of staring at them, with or without the intention to cause affliction (cf. Harris 1996; Leyn 1999; Rode 2000; Yukes 1997). This means a person is not considered 'evil', but can carry the potentially dangerous force that can transfer to another person. The result is a manifestation of symptoms of the illness that can appear suddenly, after a few hours, or even a number of days later. Thus it constitutes an 'autonomous' power that a person possesses, who may not be aware of the potential damage she/he can cause. Severina, a 25-year-old mother of three children struggling with the illness of Luis, her youngest child, explained how a woman from another town was to blame for her child suffering from Evil Eye.

"We had a meeting last week to discuss a celebration at church [in San Lorenzo]. A woman from Caballería was there; she was not taking part in the discussion, but she came since her sister now lives here. People call her 'the cat' because her eyes are greenish, like a cat. She starred at Luisito a couple of times because he was crying. That night Luisito couldn't sleep, he had a restless night. He was 'jumping' the whole time, as if he wanted to free himself from something. Next morning he started with diarrhoea. I instantly knew he had caught the Eye. This woman made him ill. Normally, when he falls ill with Eye, it takes just a few days to cure him, but this time he hasn't completely recovered. The Eye was too strong" (Caballería 2915-191)

The duration and intensity of the illness will depend on the Eye's force and the capacity of the afflicted child to 'fight' the Eye. The harm caused is perceived as the result of a powerful affective emotion evoked by envy, jealousy or unconstrained feelings of desire, but also as the involuntary effect that some people may have over others who are more sensitive and/or weak. Amulets can be used as a strategy to prevent harm, although they can only elude certain forms of contact, such as someone staring at or giving nice compliments to the wearer. Certain customs for avoiding the Eye are culturally shaped, validated by a general consensus but not

regarded as self-evident, for example, avoiding a visit to a newborn if a woman is menstruating, or avoiding any kind of contact if a person has been drinking alcohol or has been exposed for several hours to the sun. References to someone making ill a child were common, although frequently interpreted as involuntary. However some of the ideas that explained the condition of Evil Eye as a result of a broken social taboo were viewed as misguided practices within a relationship. Several interviews showed that in cases where caretakers ‘blamed’ a person from the same community for having causing the Eye to afflict their children, the caretakers directly questioned the person they believed to be responsible. However, in cases like Luis, the relief of symptoms was due to healings that did not involve the person accused, since in such cases social isolation or other collective practices would not be applied.

Rosario, a woman in her mid-forties from El Jícaro, Comitancillo, gave an example in which social taboos had possibly inflicted Evil Eye on a child, causing the supposed perpetrator to suffer a miscarriage.

“My neighbor had given birth to her baby so we all went to see her a few days later. At that time I was pregnant, close to my fourth month. While we were there [at my neighbor’s house], everyone praised how beautiful the baby was and held her tight. I had lost a baby a year ago, so many people said afterwards that I made her [newborn] ill, that she caught the Eye because I was jealous since I had lost my last baby. Doña Marielos came the next day and asked me to remove her child’s Eye, but I explained to her that I wasn’t jealous or desiring her baby, that I didn’t make her baby ill. But I was afraid people would get mad at me, that they would think that I was really resentful and that I went and casted the Eye. A week later I had a miscarriage. I think it was because I got the Eye inside me and gave it to my baby” (El Jícaro 04020-2648)

Women’s and caretakers’ concern to avoid encounters that were perceived as dangerous suggest distinct forms of social relationships focused on subjectivities that preserve and generate attributes and configurations among families and communities. Such arguments and behaviours are meaningful, since they concern interactions that lead to forms of solidarity or discord. In her narrative Rosario associated the power of normative concerns that mediate experiences with a causative capacity that could not only provide care and support to another, but could damage her own health. Thus, not only physiological but also social risks attached to the illness ambiguity; the inherent uncertainties of the situation provide an interpretative matrix through which an individual can understand and act on an affliction (e.g., the miscarriage), a useful resource for overcoming a personal struggle. As opposed to the Mediterranean context, where Evil Eye is based on conceptions

of good and evil (cf. Migliore 1997), the implications of Evil Eye in San Marcos are more closely related to the problems of interpersonal relationships and their environments (anxiety, hostility, envy, desire, imbalance). A highly sensitive and uncontrolled emotional state can injure others, with or without intention. This idea of suspecting bad feelings is closely related to the hypothesis of structural power relations explained by Appel (1976), Buonanno (1984) and Galt (1982) for Italian communities, and Reminick (1974) for Ethiopian communities. According to these authors, and similar to Elliot's idea (1990, 1991, 1992), a pervasive belief in Evil Eye is present where economic constraints and social or environmental interactions are in constant tension. Such a situation makes people feel vulnerable, as conspicuous consumption within an environment of scarcity may breed resentment (Foster 1972; Galt 1982; Shoek 1969).

In San Marcos, Evil Eye (*wutzb'aj*) is a disease (*yab'il*) that can be acquired in a variety of ways, including extrinsically-related (place; weather/environment), intrinsically-related (the individual strength associated with the person who transmits the Eye and the person who has been afflicted by it), and synergistic effects, which are coherence of symptoms (not all symptoms and signs are associated with Evil Eye, and not all the specific symptoms are necessarily exclusive to Evil Eye), and unambiguous response to the specific treatment. Synergistic aspects demonstrate why people are reluctant to make use of allopathic treatments during the first phases of the illness, but they also have additional significance as a criterion to label the seriousness of the illness and to classify it as a respiratory or diarrhoeal infection. The extrinsic and intrinsic features (place, environment and strength) develop simultaneously, which means that not all individuals present in a particular situation will get the Eye (not all individuals who are prone to catch the Eye get sick, nor do all the extrinsic features predispose all individuals).

Further, *wutzb'aj* refers not solely to an illness category but also to a state that could have been provoked by a disrupted event of daily life. This suggests that Evil Eye is not necessarily a state of illness, but also a condition of distress which can present symptoms that requires a special treatment, or an event that occurs within specific circumstances that requires ritual purification. When people relate symptoms of diarrhoea and respiratory infections to Evil Eye, the specific intent is to create a context that enables people to make a decision. From ethnographic data collected in Santa Catarina and Nahualá, Hawkins and Adams suggest that stressful situations, such as social uncertainties or monetary deprivation, trigger and shape behaviors in order to cope with, or give meaning to, experiences as a way to restrain emotions. They conclude that Evil Eye, among other folk illnesses, works as a cultural tool that helps individuals to canalise their worries as a common

source to explain certain symptoms, with the result that such illnesses will not only re-emerge but will also increase and persist over time (2007:215-235).

5.3 Understanding Evil Eye as an *Ambiguous Illness*

Although there is no set definition of Evil Eye *per se*, the biomedical symptoms of Evil Eye are not necessarily interpreted as a consequence of pulmonary or diarrhoeal infections, suggesting that the normative biomedical understanding of the illness is normally not met. Moreover, Evil Eye belongs to an ambiguous category. Some public health studies have demonstrated that in popular health culture, people consider Evil Eye as a possible cause for diarrhoea, fever, cough, vomiting, dizziness, headaches, etc., when the body has suffered a disruption of its balance (Gorter et al. 1995; Kendall 1990; Leyn 1999; Rivera & Wanderer 1986; Uribe et al. 2007). These physical symptoms to initiate the seeking of health treatment, conventionally organised around established traditional healers and therapies. These typically fall outside of the realm of biomedical intervention, shaping actions embedded in particular cultural dynamics, i.e., specific therapies and remedies that a biomedical treatment cannot effectively provide (Baer et al. 1993; Harris 1996: 28-39; Huber et al. 2001:155; Leyn 1999; Rubel 1960). Therefore, perceptions of Evil Eye affect or influence healthcare practices and attitudes based on the classification of its symptom. The symptoms of Evil Eye, diarrhoeal diseases and respiratory infections are often similar, but are viewed and treated differently by the rural population in San Marcos.

Diarrhoea caused by parasites is in general well-known, and is frequently appropriately treated in biomedical terms. Yet physical signs of most of the diseases known to mothers or caretakers are similar or identical. Only the progress of the disease and the response to a specific therapy can suggest the precise aetiology. Complications are therefore common when the early physical signs have not been promptly treated or have been wrongly treated. Diarrhoea also increases the risk of acute lower respiratory infections. The entwined symptoms render the recognition of a disease, and therefore the choice of specific treatments, difficult, since the rationality, beliefs and practices connected with a particular illness depend on its aetiology and symptoms. The term 'diarrhoea' (*ky'ilku'j*), for example, can be differentiated according to the characteristics or outcomes of a specific diarrhoea case, such as 'low pain', 'stomach pain' or 'itchy bottom' (pruritisani).

The different symptoms, types of pain, and durations of illness, among other fac-

tors, are translated into specific meanings that initiate the use of particular treatments. Therefore, a symptom may refer to a specific disease, may be only part of the ailment, or may be the result of climate changes or reactions to food poisoning, which are not necessarily seen as an illness. The abnormalities in the functionality of the organs, in biomedical terms, are therefore automatically correlated to people's perceptions about the body and how it reacts to specific environments or circumstances. While, for example, the use of the term 'worms' is a normal condition in children, and the 'disruption' of a child's state in this way means only that the winter has started or is about to start, the presence of parasites has other implications in biomedical terms. However, even though the presence of worms has this differentiated meaning, the treatment approach is usually the one expected by the biomedical standards. The cluster of illness narratives that associates Evil Eye with ARIs and ADDs show why illness experiences cannot be simply reduced to biological terms such as 'diarrhoea' or a 'respiratory infection', and therefore treated exclusively within an allopathic frame.

Pulmonary and diarrhoeal infections are not uncommon childhood illnesses, but when their symptoms intertwine with those of Evil Eye, health behaviours become ambiguous and rely on a more pluralistic model (Glei & Goldman 2000). The decision-making process used when symptoms appear is based on the perceived circumstances, which can support or challenge one or another interpretation of the aetiology and therefore affect decisions about healing practices (cf. Good 1994). In fact, local understandings of the complex system of symptoms and signs suggest that people seek treatments that require not only individual internalisation of the illness (the agency of *living* the ailment), but also a broader contextualisation within specific relationships of families and communities. Many cases related to illness ambiguity and its impact on an individual's health have been well documented: the use of specific or more general health systems, the interpretation of the cause (for example, witchcraft or 'germ theory'), and the use of natural and/or pharmaceutical treatments. These cases demonstrate that when biomedically defined illnesses overlap with local interpretations, they produce new aetiologies and concepts. Moreover, the same sickness episode may be simultaneously characterised by different interpretations of both the meaning and current status of efficacy (Waldram 2000:615).

A few poignant examples of this are Lewis' (1975) work in New Guinea, Janzen's (1978b) in Zaire, Greenwood's (1992) in Morocco, and Nichter's (1994) in the Philippines, which provided clear cases of practical healthcare and relational implications of what Nichter calls an *ambiguous illness category*, in which interpretations of closely interrelated illnesses (showing the same cluster of symptoms) influence

and shape perceptions of causality and treatment choices, as opposed to schematic categories where illnesses belong unambiguously to one or another cluster of symptomatology. For example, what Nichter named ‘weak lungs-tuberculosis complex’ is called ‘weak lungs’¹⁷ by people who suffer from symptoms of ARI, tuberculosis and probably lung cancer. As noted by Ryan (1998), people in rural Cameroon reduce the ambiguity of acute illnesses by assigning them to particular categories that require explicit health practices, as well as by delaying health-seeking, which provides a better understanding of the onset of the illness and therefore of its appropriate therapy management. In Kenya, however, the approach to treating certain common illnesses, which are narrowly defined by a cluster of symptoms, is to tackle the illness as soon as the first signs and symptoms appear (Nyamongo 2002), expecting the ailment will be overcome with home remedies as the first level of therapy. In a similar sense, Evil Eye encompasses a multiplicity of characteristics, the interpretation of which depends on how people perceive symptoms, the nature or source of the Eye (i.e., exposure to a specific condition), individual features and vulnerability, identification of danger signs, and treatment outcomes. For cases of Evil Eye, striking similarities between symptoms can therefore only be differentiated by a highly ritual diagnostic process.

Some of the problems of dealing with Evil Eye arise from its categorisation. The first is that its symptoms are seen from a biomedical perspective as superficial (misdiagnosed, superstitious and irrational), requiring ‘translation’ into correct diagnosis and treatments. Second, its ambiguous character makes it difficult for caretakers to make sense of the illness when dealing with healthcare facilities. When allopathic healthcare treats Evil Eye not as a complex phenomenon, but as a failure on the part of caretakers to use conventional assessing methods, it ignores the role of Evil Eye in addressing fears, uncertainties, distrust, doubts, and treatment failure among families and communities.

The following excerpts show through two different biomedical discourses how cultural healthcare practices, and specifically the Evil Eye category, are reflected as ‘ethnic boundaries’, and which aspects are considered an individual responsibility of best-care practices, rather than addressing structural-historical problems of allocation of resources or recognising illness categories as part of the dynamics and identities of communities. Further, social and economical conditions are not reflected within the context of the ‘production of illness’ but emphasised as

¹⁷ *Weak lungs* (1) identify a state of ill health associated with a variety of attributes ranging from failure to thrive among children and weakness in adults, to chest or back pain, low-grade fever or wheeze; (2) describe an ARI condition which is persistent or recurrent; (3) describe a state of perceived weakness or vulnerability; and (4) call attention to a state of ill health linked to tuberculosis while deflecting attention from the stigma of this disease (Nichter 1994).

a behavioural challenge, reproducing stereotypes and prejudices, regarding cultural practices as a disadvantage, causing children under five to remain a high-risk group for diarrhoeal and respiratory infections. As a result, from a biomedical perspective Evil Eye is considered a problematic behaviour.

“Let me show you something”. The medical doctor took me into her office and showed me the *National Vademecum of Medicinal Plants* that had been produced by the previous government. I sat on the chair while she stood in front of me and raised her voice. “Are we supposed to use this? For what?! Traditional medicine can be palliative in some cases, but you cannot tell me that these plants can save a child who comes in with clinical symptoms of acute diarrhoea or a pulmonary infection. What they need are antibiotics!! Even worse: People come here when it is too late and then complain about us. They go to see charlatans to cure Evil Eye, for example, and wait until the child shows danger signs. We [physicians] don’t need to be educated about plants, it’s the ignorance of people that the government should be aware of!” (Health Center in Comitancillo, San Marcos)

“Mothers come here with children who are malnourished, unclean. You have to tell them, ‘mama, please clean your child, clean his/her nose’. Children cannot even breathe properly because of their parents’ lack of hygienic practices. Daily we see cases of severe pneumonia or acute diarrhoea and although the aetiological range of the cases cannot be truly known, we always suspect bacterial infections because people live in very contaminated conditions. So when a mother comes into the clinic we try to understand that her worldview is different, that she believes in Evil Eye, but for us it is clear that we are dealing with endemic settings where children die because they suffer from acute infections. Vaccines have made it possible to save many children but we are still faced with the fact that there are many cultural barriers that have a bad impact on those children”. (Dr. Cifuentes, private clinic, Comitancillo)

However although symptoms of ARI and ADD refer to specific biomedical categories, these concepts are also sometimes enormously ambiguous, contributing to standardised practices of treatment that generate mistrust in the process of allopathic health-seeking, especially when treatments do not work. Not only do many people use rather vague words to describe symptoms, but the terms used by physicians are sometimes unhelpful and misleading for caretakers in identifying the source of the problem. By using terms such as ‘diarrhoea’ to make a diagnosis without further information, physicians use specific symptoms (e.g. pain, vomiting, fever) to identify a disease. Diarrhoea is a symptom complex or a diagnosis recognised by biomedical personnel but unhelpful for caretakers to understand a

disease or a disease process; it does not help them connect the symptoms with specific therapies and outcomes. Thus, symptoms of ARIs and ADDs, which can be imprecise and are associated with a wide range of disorders, can be interpreted differently in different circumstances, affecting the diagnostic process and subsequent healthcare behaviours.

The ambiguity results from the fact that caretakers could attribute symptoms to a variety of other possible causes, including Evil Eye. However, whereas illness ambiguity appears to generate confusion and distress in cases of ARI and ADD, Evil Eye's ambiguity has the effect of calling upon consistent practices in which the social understanding of the illness contributes helpful elements. In other words, when the biomedical diagnosis or treatments were not reliable, caretakers linked symptoms to Evil Eye or other more familiar illnesses that have a clearer case management. Examples of the problem of ambiguity and meaningful symptoms were usually expressed in terms of physiological and emotional implications:

Nuria: “The nurse at the post center said that Yobdin had an *infection* and then she gave me 4 sachets [of oral rehydration salts]. Two days later he was still sick with the same diarrhoea. A few weeks ago my oldest daughter had also diarrhoea and the man from the SIAS told her to buy a bottle of Pepto-Bismol® because it was probably an *infection*, that's why I gave Yobdin the same. I didn't worry when he started vomiting because when children have an infection their stomachs get scrambled”. (La Unión 29015-245)

Blanca: “The doctor at the health center said that Selena had pneumonia. We got a bottle of medicine and he said, “Your child will be cured with this”, but Selena was still ill a week later. That's why I got worried, because the doctor couldn't identify the illness. Then my husband said we had better get to the pharmacy. They gave us a bottle of Neo-Melubrina,¹⁸ but this medicine was too ‘hot’ for her because she had fever at night. That's why we make the effort to take her to a private clinic, because nothing seemed to work. When the fever is provoked by Evil Eye then you *know* which [medicinal] herbs work and how to cast the Eye. . . you *know* how to treat it, but not with other [types of] fever”. (Tuiquiac 04237-474)

In one of the most recent studies on Evil Eye, Migliore (1997) analyses the phenomenon in a Sicilian-Canadian community, linking Pirandello's and Wittgenstein's concepts of *meaning* derived from the perspective of ‘experiences’ and ‘con-

¹⁸Neo-Melubrina (metamizole or dipyrone) is a pyrazolone non-steroidal anti-inflammatory agent, an effective analgesic and antipyretic drug. It is widely used in Latin America but was banned in the United States by the Food and Drug Administration (FDA) in 1977 because of the risk of inducing agranulocytosis, a condition characterised by a dramatic decrease in white blood cells, affecting the immune system and making a person prone to bacterial infections. <http://pediatrics.aappublications.org/content/109/6/e98.full>

sciousness'. Migliore argues that 'ambiguity, vagueness, and variability are the essential ingredients that generate the type of flexibility necessary to allow people to make sense of their personal experience (or the experience of others), and to manipulate Evil Eye talk to create a potentially infinite set of alternative 'meanings' or 'messages'. [As a result] Evil Eye is open to interpretation, argument and negotiation within specific socio-cultural context' (Migliore 1997:12-13). Although not homogenous, this led to an understanding of Evil Eye in which people use the concept as an instrument to negotiate—or even influence—situations. Whether or not it is an instrumental concept, Evil Eye makes it possible for a community to develop strategies to overcome what the Eye represents as a threat in terms of health-seeking dynamics (cf. Harris 1996:36-41).

In a deprived environment where the available resources are scarce, people maintain a closer social control over goods and services and generate power relationships that constantly mediate among their families, neighbours and communities. Through these interactions, social relationships tend to be reinforced or restructured when (new) meanings are negotiated. The resulting imposed way of thinking implies artificial situations that can contradict or dispute normative behaviours. Biomedical positions and rationality normally do not allow room for negotiations or acceptance of people's beliefs and identities, since their discourse of 'objectivity' converts aetiologies and treatments into unquestioned resolutions. Consequently, illnesses are not only a fundamental healthcare relation but situational experiences that need decision-making based on an individual's significance within their socio-economic position. Healthcare services, provisions and policies—although usually well-intended, disease-related solutions—not only respond to 'specific' problems but confront individuals within their most private spheres. The problem is not the attempt to evade individuals' conceptions of diseases but rather the endeavour to impose practices that are assumed one-way processes where the disease becomes depersonalised and the patient a more or less standardised subject.

The semantics of the illness: “*He has a strong blood and she a powerful glance*”

Although Evil Eye has specific, yet broad, symptomatology, the illness is placed in an ambiguous condition amidst a pluralistic medical pluralistic system where caretakers have to reach consensus about the idea of *appropriateness* in defining the borders between attributes and healthcare practices entailed by the illness. While the biomedical setting tends to delegitimise Evil Eye's nosological entity, the illness involves experiences configured by both cultural and physiological manifestations important for caretakers. Notwithstanding the particularities of illness

experiences, Evil Eye is a point of reference to explain how illnesses and social conflicts emerge and develop in particular settings, rather than being a phenomenon that explains everything that happens to children (in terms of physiological effects). These interstices over the course of the illness's process have a powerful influence upon notions of assessment and seeking behaviours. Thus the semantic range of the Evil Eye concept covers not only healthcare for specific symptomatology but also to rather diffuse expressions of ill-being and social distress. The following case exemplifies some of these points of convergence and practices.

You have to know the name, surname and, if possible, some additional references that lead you to find the person you are looking for. There are no addresses, or numbers to identify the houses, but a tree, a crossroad, a local store, a church, or a specific sight of the volcano maybe sufficient; individual attributes are also of great importance. We were looking for 'the house where there lives a woman with a curly-haired girl', which is rare among the Mam population. I wanted to find this woman because, at the weekly visits from the ACCESS projects, she always reported that her daughter had been sick with Evil Eye, a kind of 'chronic Eye', but no visit from the nurse was required since none of the symptoms were labeled as danger signs or had been present for more than two weeks.

With the help of the Mam woman who not only helped me to translate Mam into Spanish, but also introduced me to the arts of 'knowing how' among the population, we found Rosa. At that time she was 31 years old, born in Tuixoquel, a small village of Tuilelén in Comitancillo. She has given birth to four children. Mauricio, her third child, died at the age of one year, a couple of years ago, due to renal insufficiency. Rosa greeted us by touching the very tips of our fingers together and then moving the same hand to her forehead with a slight bow, which is the traditional Mam greeting, invited us to come in and offered us seats close to the open fire. A dog and some chickens were outside the house. She was at that time living in Tuilelén with her nuclear family. The house was situated close to a cliff around 2,500 meters above sea level, protected by a wall. On both sides were corn fields. One belonged to them, she explained us, and the other one to one of her brothers-in-law.

When Rosa married she moved into her husband's parents' house but she had problems with her sister-in-law, who accused her of having an affair with a man from another community. When Maritza, the curly-haired daughter, was born, Rosa's husband hit her because the girl had light skin,¹⁹ and later her hair showed

¹⁹Similarly, according to Robert and Barbara Levine in western Kenya, people identified a malevolent power called *okobiriria*, which was transmitted through the eyes of some light-skinned Gusii tribes people, usually women, which caused small objects to cling to and burrow

signs of being slightly curled. Maritza also wore a bracelet to protect her against Evil Eye. ‘My father is white’, Rosa explained to us, ‘but because of the hard work under the sun over the years you couldn’t tell. But my husband doubted and we started to have problems: “That’s why you like to go out; my sister was right!” he yelled at me all the time; he also started to drink heavily. One day a healer from Tacaná passed by. I was washing clothes and when he saw me he approached and said, “You must be a suffering woman. I can tell you have been crying a lot”. I think he was a *brujo*! He told me that I was having problems with my husband, so he gave me some medicine to treat my *nerves*. He told me that I also had to pray more: “God will hear your prayers but you have to be strong”. He comes once a month to Tuilelén so we buy some medicine from him if my husband has money. His remedies are very strong, they are really good! When he doesn’t come, the doctors give me injections of Neurobion®. At the hospital they said I had a *derrame*.²⁰ I got *nervios*²¹ after I started to have problems with my sister-in-law and then problems with my husband from being mad at me and not believing me. But the man gives me medicine for me and Maritza. She is very prone to get the Eye because of the colour of her skin and her curly hair, but when I use the medicine he gives us she recovers quickly. My *comadre* cures Maritza once a week when she has the Eye because sometimes my husband comes home drunk and his blood makes her ill’. Rosa explained the various disruptive factors that caused her and her daughter to become ill. She showed us the panoply of medicines she was taking, which were of different types and from different sources. Pharmaceutical, natural and unknown treatments (those I was unable to classify as pharmaceutical or natural) were used for different purposes at different times.

The medicines provided by the *brujo* were produced in Mexico but they were not registered and it was unclear what they contained. There were also several packages of multi-vitamins and some empty bottles of what appeared to be powdered milk. Behind these was a picture of Rosa’s husband, looking directly at the camera, standing straight and with a rifle at his side in his military uniform. Close to this picture there were others of her children and family. In a golden frame there was an image of the Sacred Heart of Jesus. I asked her which medicines were specific

into the skin of light-skinned infants, killing them if not rubbed off quickly with clarified butter (Levine & Levine 1966).

²⁰People use the term *derrame* to refer to physiological and psychological symptoms that strike after they have been in a stressful situation. Literally, *derrame* means a stroke or a synovial fluid. The symptoms reported are very broad.

²¹*Nervios* is a culturally specific illness found in Latin American countries. This malady is interpreted as a depression-like disorder in western biomedical terms. Among Latinos *nervios* or *ataque de nervios* (attacks of nerves) has been referred as a ‘culturally meaningful way to express powerful emotions’ such as distress, anger, or deep sadness, or as the effect of a shocking event (Guarnaccia et al. 1989:47).

to treat the Eye. I was expecting the same herbs other people had shown me, but instead she gave me a little reddish pill wrapped in translucent plastic. ‘It’s called *pill of life*. You can buy these at the pharmacy as well but the ones the man gives us are much better’. Almost every child in the ACCESS project had been reported as having Evil Eye at least once. The peculiarity of Maritza, however, was that the symptoms her mother reported were always perceived as ‘severe’, but never confirmed as such by the nurse.



Figure 5.2: Tincture used to cast the Eye, which is said to have the same properties that the “pill of life” has, which can be acquired at some pharmacies.

The intimate space in which Rosa explained to us the source and consequences of her problems and sickness has also affected Rosa’s daily life. The problems with her husband prompted her to join an evangelical religious group and make monthly visits to a healer who treated her *nervios*. Her neighbor, who is part of the Alianz program, a non-profit rural community health project in Comitancillo founded and coordinated by a Canadian nurse, gave Rosa social support. Rosa’s constant fear of Maritza becoming sick and the fear of being accused by her husband are reflected in the multitude of treatments and patterns of seeking help from her neighbour, from health facilities and practitioners and from the church. When we asked her to describe Maritza’s symptoms of Evil Eye, her response clarified why she saw them as severe. Evil Eye is a common explanation for various manifestations of symptoms, but what differentiates it from ADD and ARI is that, while the public health system views the ailments as a result of inadequate hygiene practices, people’s perception of Evil Eye is that it is omnipresent and always related to forces that are inherent to the individual, not related to specific practices but part of their own *life world*, including the perception of a person’s own ‘strength’ and other attributes (e.g., weak, strong, prone to illness). This does not necessarily label Evil Eye as supernatural, but as a way to understand a person’s own fate within a particular environment. Maritza’s general state was severe because she is always at risk.

A good example of concept of the Eye was when Rosa told us briefly about Mauricio's death. "We took him to the national hospital, where they told us that he had some problems with his kidneys. He hadn't peed in days and then he was peeing blood. They put a [tracheal] tube in his throat and had another [catheter] tube inside his 'part' [penis]. We waited outside for hours until a doctor came to us and said, 'We're sorry, Mauricio's heart didn't make it'. (She weeps. Long silence.). The *tubes* drained his strength. He was often ill with Eye, he was weakened by it. . . If the doctors had not *drained* Mauricio's strength, then he could have survived his disease but he would have been always prone to falling ill".

While people tend to narrow down the outcomes of other ailments, Evil Eye illustrates the perception of a person's body. Evil Eye opens a continuum of endless potential problems, and is also an indicator of the state of social relations. To explain Mauricio's condition, Rosa employed the specific concept of Evil Eye to communicate that his weakened state was influenced by social constructs and interactions (family dynamics, healthcare facilities, therapies). With the help of a cultural illness category that portrays more clearly how organs (Mauricio's kidneys) are affected by the triggering processes (biomedical therapies perceived as invasive and dangerous), people create a cultural domain with the aim of not only providing healthcare, but also of comprehending an ambiguous condition. Children suffering from Evil Eye are perceived as neither healthy nor ill, but as prone to developing illnesses or chronic symptoms when entering the biomedical setting. This perception is especially strong in cases with tragic outcomes and cases involving troubled family dynamics.

The aetiology of the Eye always corresponds with those of ARI and ADD and suggests its own explanations and therapy managements. For this reason, for example, an episode of diarrhoea that has been the effect of Evil Eye can develop into another type of diarrhoea if the treatment for Eye has been provided. The perception of the seriousness of symptoms not related to the Eye therefore emphasises the effectiveness of the treatments, which would explain the delay in help-seeking and the use of multiple treatments. If the symptoms are from the Eye, then people expect that the afflicted individual will somehow fight it. In other words, while symptoms of ADD and ARI are the result of cause and effect, those of Evil Eye can encompass several different aetiologies and treatments. From this perspective, Evil Eye is not a state of defenselessness, but an attempt to circumvent the expectations of the national health discourse, an instrument that empowers women to mediate between public and private spheres with respect to their children's health and care. Before I leave, Rosa says to me, 'Please, *señor*, make a cross on her forehead, so she won't get sick with Eye".

As previously mentioned, the factors that cause illness after a person has been ‘exposed to’ or afflicted with Evil Eye are very diverse. The most common route is through the eyes, which may or may not be intentional. When intended, the glance is understood to be a feeling of desire, admiration or envy, which is then transferred to the individual. This desire can either be directly transmitted to the infant or given to the mother, who passes it to the child in a form of triangulation: the person who desires the child, the child’s mother (indirect subject of envy) and the child who receives the glance (subject of desire). According to many scholars, there is a constant fear of giving unrestrained praise to (or glances at) the beauty of children. Examples of how to avoid causing harm to the child, present in many cultures, include spells, gestures, and mock disparagement, such as spitting a bit of saliva on the child’s forehead, calling nice-looking sons ‘ugly and dark’ in Palestine or ‘flea’ or ‘dog’ in China, or refraining from complimenting the healthiness of a baby in Malaysia, among other customs (McCarteney 1992:17-33). Similarly, in the Turkish culture, people say ‘*mashállah*’ when seeing something attractive or recognising a positive quality or an achievement of another. A person might also say ‘ugly! ugly!’, when someone praises another’s beauty or talents (Serotte 2006:2), so that the person being praised cannot catch the negative energy of the Evil Eye. Thus, calling somebody ‘ugly’ may be a compliment in disguise.

Although envy is always despicable and dangerous, in this case the feeling of envy is not a form of disrespect (cf. Migliore 1997), since it does not convey contempt but is instead the result of an unavoidable disclosed emotion related to longing. Envy is regarded as an emotion that, although it always has the same effects and implications, has different cognitive representations. In Marizta’s case, her curly hair and light skin were a focus of attention and were therefore her weakness, yet the social determinants²² in which she and her family were living also explained the ‘cumulative’ effect of the *Eye*. Evil Eye also provides ways to deal with ‘abnormalities’ associated with the social and moral order. This is because Evil Eye’s ambiguity is systematically subjected to daily experiences shaped by the perception that specific symptoms—as distinct from biological disorders—can be treated in a more or less standardised way.

It is not that Evil Eye provides a way to interpret every symptom as a bodily response to the Eye, but its nature explicitly allows securing help when those symptoms are constant and represent a physical threat. Rosa’s words “but my husband didn’t believe [me] and we started to have problems” objectified and

²²‘Social determinants’ refer to the various conditions shaped by the broader economic, social and political circumstances in which people are born, grow up, live, work and age, and the systems put in place to deal with illnesses (WHO 2008a).

instrumentalised not only the source of her troubles but also the experiences of illnesses that she and her daughter Maritza were having. The experiences of distress and illness, normally overlaid with gender and family dynamics, were expressed in a socially accepted way, in which Evil Eye was used to communicate a constant problem that posed a permanent risk to their health. Even when Maritza was the one who suffered the illness, this insurmountable source of worry made Rosa ill. Hence, the ‘chronicity’ of the symptoms reported by Rosa was inseparable from the accusation of having cheated on her husband and the use of Maritza’s apparently unexplained light skin and curly hair as ‘evidence’. Chronic symptoms of Evil Eye turned attention to the risk Maritza was living in and the danger that lay in constantly mentioning Maritza’s hair or skin.

Maritza’s risk lay not only in her features themselves, but in their social significance and the assumptions behind that significance. Although Rosa did not mention the current status of her problems, we could assume that they continued (possibly in a lesser degree), since she and her daughter remained vulnerable. Thus, Evil Eye not only provided an explanation of certain symptoms but also became a social resource when Rosa turned to someone else for help (in this case, her neighbour). Instead of victimising herself after the accusations or just accepting her ‘fate’ of having a beautiful baby (which of course is also a source of happiness), the illness offered an intersubjective space to negotiate interpretations of her struggles. Rosa became part of an evangelical religious group from which she received support, received material help from her neighbour, and created an intimate space to communicate and negotiate with her husband over her presumed moral failure (her breach of his trust in supposedly having an affair), along with obtaining treatment for the symptoms of the illness. Evil Eye balances between a biological dysfunction and social relations based on embodied values, risks, social ties, obligations, self-images, and expectations.

5.4 Evil Eye as Social Behaviour

Since the variations of Evil Eye can be linked to intentionality and to unknown sources, the social aspects of Evil Eye involve not only symbolic frames but also social practices that are used to avoid the malady or its consequences. The notions of being afflicted or possessing the ‘power’ to cause harm suggest the existence of social boundaries and conventions for conceptions of *self* and *another*. In contexts in which social interactions occur, people are linked to each other in a particularly strong and intimate way, yet these links are limited by the viability threshold of relationships. In such encounters Evil Eye works as an intrusive force that is

always related to people's social context. The nature of Evil Eye implies that anyone can be afflicted with it or become the source of the ailment; hence some precautions, usually related to specific types of socialisation, must be observed. In this regard, an examination of the ethnographic notes and narratives displayed some behavioural patterns that reveal conceptions of social practices that are imperative with respect to the physical world and moral obligations. Although a few preventive methods and paraphernalia can be used as protection from Evil Eye, people avoid direct staring or physical closeness that might be understood as desire or envy.

The following case illustrates Evil Eye as an example of social behaviour and how this affects healthcare decisions. This narrative is about Doña Flora, a midwife from Chicajalaj, Comitancillo. The first time I met her, she told me to come back another day since Doña Flora's daughter-in-law, Irma, 24 years old, had just given birth to her second child the previous week and was 'making her diet', a period of time when the new mother is at rest. This case is typical of situations where (1) caretakers live within patrilineal extended families; (2) healthcare dynamics are shared and influenced by the nuclear family (i.e., mothers seek permission from their husbands or in-laws to take their children to a health facility); (3) the source of income in temporary work; (4) illnesses raise several issues, including aspects of 'risk' and 'recognition'; (5) therapy management includes different encounters with biomedical and traditional systems; and (6) Evil Eye overlaps with symptoms of ARI and ADD.

One of Flora's grandchildren, a son of Yuri and Marco, had died a few years earlier, only four months after his birth. The loss of the baby was a consequence of Evil Eye, Doña Flora explained to me. "I told Yuri that she shouldn't spend much time outside chatting with the other women, but she didn't listen to me. People are jealous of us because Marco sends us dollars every month. He's in the States. People are resentful that he could cross the border but they don't know how difficult it was for him and is for us now. But they just think we bathe in money [she laughs]. He sends us the money to build a better house".

Marco attended primary school and had worked as an unskilled worker in several places before. Around 11% of the total population from Guatemala lives outside the country. Of this, 10.5% is the population from San Marcos that has emigrated, primarily to the United States (UNICEF 2010). Marco is one of the millions of people who have migrated in order to find a job outside the country. Guatemala receives much more money through remittances than the Latin American average, 9.6% of GDP, making the country one of the top remittance-receiving countries

worldwide. The majority of the migrants go to Belize, Mexico and the United States.²³ However, in 2013 alone the Department of Homeland Security in the US deported almost 50,000 emigrants, about 10,000 more than in 2012. Families live in constant fear that their members who live in the US will be deported. According to the International Organisation for Migration (IOM), 86.1% of the Guatemalan immigrants send remittances to their families.²⁴ The phenomenon of migration is especially relevant for the San Marcos area, where external and internal migration takes place annually. Internal migration occurs periodically, since the productivity of almost all coffee²⁵ and sugar plantations in the coastal areas depends on seasonal work by men, women and even children. During the season, they are housed in shacks holding up to 50 or more people, or in open-air one-room buildings, working for a legal minimum wage of only \$2.85 per day (CEADEL 2007:12). However, temporary workers normally receive less than that since they are paid a fixed price for a quantity of coffee berries picked, which will depend on how many family members are involved in the activity.

A number of causes contribute to the phenomenon of emigration as a source of income: non-productive small landholding, lack of jobs, nonagricultural work in the same community, low agricultural production, increase in family size, and lack of agricultural technology and markets to sell the products (Camey 2002). Men in particular see migration as a way to overcome poverty or even as a rite of passage (Levitt 2003), leaving their families behind for months or years until they are deported or decide to come back to their homeland. Meanwhile, the non-migrant family members create an image of success and prosperity, even though the absence of the missing family member clearly involves a separation and private struggles that are not often visible to others. Socialisation and social networks are reshaped to respond to new needs and new forms of support, developing new roles that involve changed social boundaries of inclusion and exclusion. Marco got to know a man who had befriended one of his siblings, who told him that he was going to try to get to the States, where he already had some relatives. Marco decided to take the risk and go with him. For Marco his acquaintance became not only the

²³World Bank, Migration and Remittances Factbook 2011.

²⁴<http://www.migracion.gob.gt/index.php/root1/estadisticas.html>

²⁵The Guatemalan coffee sector employs a large number of people. In 2009 workers accounted for 7% to 11% of Guatemala's EAP (VARITE 2012:8-9). Coffee farms rely on three different types of labour. Much of the labour is provided by *voluntarios*, workers who live in communities close to the coffee plantations who seek casual labour on their own rather than through a registered labour contractor. *Mozos-colonos* are permanent coffee workers who live on the coffee plantations and take care of the whole process of farming and processing. Since there is not much work outside of the three-month harvest season, the coffee-plantation owners claim to reduce their costs for housing, food, education and other benefits by hiring *voluntarios* (VARITE 2012:9). During the harvest season coffee farms rely on a large number of migrant workers.

personification of an idea but also a key person who could help him once he had reached the border. But first Marco needed to pay a *coyote*, a smuggler who, for a high fee, helps people cross the Guatemalan/Mexican and Mexican/U.S. borders illegally²⁶.

Marco and his family contracted a debt with a *coyote* to cross the border in March 2007. In April they reached the border, and after a few weeks Marco was lucky enough to find relatively stable work as a gardener, from which he paid his debt and started to send remittances back home. Yuri was five months pregnant when Marco left. They were living with Marco's parents, sharing a small house with the rest of Marco's siblings and their children. Marco's father was in charge of the money he sent. Yuri and Flora developed different interpretations of the baby's death in order to deal with it, but also to deal with the absence of Marco and the conflict the money produced. Yuri believed she was entitled to the money her husband sent. Flora felt that it belonged to Marco's father, since they were still living under the same roof and her spouse was the head of the house.

Flora took care of Yuri's labour with no complications. The problems began later. Yuri said, "My sister gave birth at the health center once and at the [National] hospital another time. Her midwife told her that the baby's head wasn't in the right position so she would need a doctor. Then she got problems with her [blood] pressure (preeclampsia). She was afraid of giving birth outside home but it was a good decision". The maternal mortality rate in Guatemala is estimated at 120 deaths per 100,000 live births.²⁷ Approximately 60% of births nationwide, and over 90% in some rural areas, are attended by traditional midwives, who are required to register at the health center of their locality and are encouraged to refer women to the nearest health facility to receive prenatal checkups and give birth in a medical facility if there are signs of a risky pregnancy, in order to reduce maternal mortality rates (Replogle 2007:177-178).²⁸

"Yuri's water broke at night", continued Flora. "Young women are now so weak, they want to see a doctor for everything! She was insisting on going to the health

²⁶Transnational connections and networks with compatriots of the same ethnic identity or religion play an important role in migrants' lives, including the type of services they need to pay for in order to cross the border (cf. López 1998).

²⁷http://www.who.int/maternal_child_adolescent/epidemiology/profiles/maternal/gtm.pdf

²⁸This practice continues as part of a training programme launched by the WHO and other major health policymakers during the 1970s and 1980s that targeted the education of traditional midwives and other empirically-trained birth attendants, to help reduce high maternal mortality rates (Replogle 2007). The program was reduced in the 1990s. Presently the 'training program' of the national Ministry of Health for traditional birth attendants includes only general topics such as the importance of good hygiene, recognition of danger signs during pregnancy and the process of referrals to local medical facilities (Foster et al. 2011).

center but there was no need of it. I had received so many babies; some of them have been long labors. The pain [she told her] was normal. Yuri's baby was born in the morning, a boy, but he died before we could baptise him". Flora views the events of the death as a result of the jealousy people had, arguing that they were victims of intense feelings of envy since the money Marco sent has given them a new position in the community. She claimed that since Marco was not there, his baby was the repository of the contempt people were feeling but not explicitly saying. When people looked at Yuri—with resentment or admiration—the baby was weakened. Symbolically, as Galt suggests, some people are likely to claim they are envied by others as an unconscious strategy in the 'game' of stratification (1982:675). Nevertheless the accusations were not directly linked to any individual, but were ascribed to the community in general.

By local standards Flora's family was not only enjoying a privileged status, but also 'showing off' without 'sharing their wealth'. Their first investment was building a house adjoining the house they were living in. By the time I arrived, just one room was finished and the rest was an unfinished frame structure, which I supposed was intended for a second floor. Their wealth, however, did not provide a source of jobs for people from the same community. Instead they contracted people from Comitancillo to do the building work. Neighbors and acquaintances were resentful that they did not benefit from the redistribution of Flora's wealth. One of the greatest fears Flora's family had was being asked for money. Their refusal to lend money drew attention to the general poverty of the area, since the message of Marco's absence was that his effort and struggles were worth the sacrifice. The various opinions about the baby's death, Marco's absence, and family conflicts demonstrated the role of Evil Eye in establishing a reasonable and acceptable social boundary. Flora explained:

"I'm not saying people here are dishonest but it is undeniable that most of the men and women just use the money to get drunk. We can't give them a job! They would just buy *cuscha* (alcohol) and leave the work unfinished. . . But people like to gossip. My own sister-in-law got mad at us because we did not give the job to one of our nephews, but what would you do?! He has never put a brick in a wall [she laughs]. I just tell my daughters-in-law to avoid gossip and chatting with the other people, especially now that there was a baby. I needed to cure him every day in case he had contracted the Eye".

When I looked at the construction site, the room not only seemed unfinished but had started to fall apart. Some sacks of corn and firewood were heaped in one of the corners, while construction materials filled the rest of the space. Flora looked at the place in silence with me and offered me coffee in her kitchen. 'Rest, *ok*'

k'ojlala mesha ['white' or Latina person]', she told me. I was given a plastic chair while she poured a brown liquid into a plastic cup. Only then did I notice, behind a curtain that divided the kitchen from the bedroom, a silhouette that moved and stood up. A thin man in his sixties came out—Jeremías, Flora's husband. I greeted him, apologising for my intrusion, and offered him my chair. He waved his hand and sat at the edge of the bed.



Figure 5.3: Site construction of Marco's new house

I waited for him to say something, but when the silence became uncomfortable I clumsily told him that Doña Flora and I were talking about Marco and the house. In the kitchen were two women making some *tortillas*. One, I assumed, was Irma. 'I built the house' (*wu'ne xb'aj b'ant ja*), Jeremías explained to me. I did not know whether he meant the new construction or the shack we were in, so I asked him when it was. Jeremías is the father of ten children. Three of them died in different years from different causes. The extended family now lives in the same house, which has two extensions made of aluminum sheets, wood and mud. One serves as a kitchen and a bedroom, and the other one serves as a bedroom for Irma, Marco, and most of Jeremías's grandchildren and their respective parents. Flora and Jeremías have only two daughters, who are now married and live in Caballería and Comitancillo with their families. Marco is the only child who has left the country. He is now their most important source of income. Jeremías responded to my question about the house:

"This one and the new one, well with [the money] Marco [sends], but the new [construction] remains unfinished after I fell ill. I was about to harvest the maize field when I heard a big sound behind me and I saw that all the table frames from the new construction fell down!, *peng! tchjonte qman!!* [Thanks to our creator!!] It didn't hit me, but I got the illness (*ya'bil*), I got *fright*".

What seemed a story of happiness and success with Marco working in the United

States was shadowed with events that were correlated to his absence. Jeremías never questioned—he said—his son’s decision to leave his pregnant wife. “Young people just get drunk here and help with the harvest and other little jobs they find, but we have a lot of mouths to feed, that’s why he left, *nqo ximine tib’aj kychw in glal k’wal*’ [thinking about the children’s lives]”. The indigenous population is constantly marginalised and excluded, with fewer opportunities for secure employment. For many young people, this leads to family disintegration, because they see migration as the only path to overcome poverty and escape from structural violence²⁹ and drug trafficking. Behind the house they have a little land where they sow corn, potatoes, *güisquil* (*Sechium edule*), and beans. If the harvest has been good they can sell some at the local market, and keep the rest for their own consumption. Population growth and agricultural land expansion have increased considerably in the past few decades, concentrating small holdings mainly in marginal areas, where the land is better suited to forestry than to agriculture. Yet suitable lands for cultivation are monopolised for coffee, and for newer crops such as banana and palm oil. The extraction of silver, and the discovery of gold³⁰ in the past ten years, have posed severe problems in San Marcos, along with issues of land tenure and use, water scarcity and drug trafficking.

That year, extreme cold weather made the harvest poor. Jeremías felt that the effects on his well-being were because he was victim of *fright*. Headaches, pain in his joints, lack of strength, waking up at night, and sometimes feverish sweats were the symptoms he related to the illness. Jeremías started to treat it with herbs and pills. It was important to the family to acknowledge that Marco’s achievements came with a price. They did not suspect any kind of witchcraft around both events, (the baby’s death and Jeremías’s health problems) but the distressful situations suggested the effects of potentially dangerous emotions that had affected the well-being of the family. Since Evil Eye is recognised as a threat that can be delivered unintentionally, the correct behaviour was to avoid any kind of unnecessary encounters that could jeopardise the newborn and Jeremías. They both were more susceptible to Evil Eye and fright because they were in a naturally

²⁹Structural violence refers to the effects of institutionalised inequalities in wealth and power on those who are underprivileged.

³⁰Montana Exploradora, a subsidiary of a Canadian enterprise called Goldcorp, has been extracting gold in the highlands of San Marcos since 2005. The resulting air and water pollution have led to health problems. The surface water and groundwater used for human consumption and irrigation show high levels of aluminium, manganese, nitrates, arsenic and copper, making it unsuitable for human consumption. Other kinds of damage, such as houses deteriorating due to seismic activities related to mining, have also been reported. Moreover, the presence of the enterprise has generated severe conflicts between the communities who are in favour of the mining and those who are against it, increasing the levels of organised crime. <http://www.copaeguatemala.org/articulosCOPAE/Los%20Problemas%20creados%20por%20la%20mina%20Marlin.html>

weak physical state—the baby because he had not developed internal strength (cf. Migliore 2009:5), and the grandfather because of his position as the head of a family who had been in worrying situations.

From Yuri's point of view, the loss of her baby was linked to her physical pain and untreated symptoms of Eye. Yuri was not only more willing to give birth at a health facility, but also expected to be able to take her son to a private clinic, since she recognised that he was too small and fragile. In her narrative Yuri expressed an unshakable hope of obtaining a cure through the possibilities biotechnology and bioscience offer. She believed that these possibilities were guaranteed at private clinics and hospitals. Although in rural Guatemala pregnant women normally choose to give birth at home with a midwife,³¹ who also has taken care of her during their pregnancy, some women decide to give birth at a health facility that makes use of a program called Birth Attendance with Cultural Relevance. In this program, midwives and members of the family, including spouses, can be present, but most importantly, the woman can decide the position in which she wants to give birth.

Flora took care of Yuri's prenatal checkups and helped her with the birth. Flora also plays a role in the community as a healer, which is quite common among midwives in indigenous communities in Guatemala (cf. Ellsworth 1996). Yuri gave birth one morning. The contractions started at night. Flora reassured Yuri, telling her that even though she was a *primeriza* (first-time mother), everything would be fine. Flora could feel that the head of the baby was 'in the right position'. When her labor started, Yuri knelt and waited for the contractions that signified she was a few minutes away from the birth. In addition to Flora, Yuri's sisters-in-law and father-in-law were present, assisting Flora. Her own mother was not present and of course neither was Marco. When Yuri gave birth to the baby, Flora reassured her that there was nothing to worry about.

As a postpartum custom, women enter the *chuj*, which is a rather small sweat lodge, covered with a blanket at the entrance, located at the side of almost every house, with a stone fireplace at one side. People can either lie down on a wooden or stone 'bed', or sit if there are more people inside. These wood-fired steam baths

³¹When the delivery takes place at home, midwives take particular care in the delivery of the placenta, which needs special attention to secure the wellbeing of the mother (Cosminsky 1977a; 1994). After the delivery, the family buries the umbilical cord and the placenta together near their home. They are regarded as the companions of the newborn. This ritual plays an important role (Lefebber & Voorhoeve 1998:46-47), since the inability to bury it is associated with possible illness, harm or even death for the newborn (cf. Ellsworth 1996). This practice, along with the use of the *chuj*, which does not take place at healthcare facilities, are important reasons why many women prefer to deliver at home.

are used in rural highlands of Guatemala for bathing and purifying (i.e., healing purposes) (Rode 2000; Thompson et al. 2011a). During a postpartum period that lasts around four weeks, mothers and their newborns enter the *chuj* once or twice a day in order to restore their humoral balance (Foster 1994). Newborns are also placed near an open fire to keep them warm, which places them at high risk for increased exposure to carbon monoxide (CO). Pregnant women who have been exposed to significant levels of CO during their first and third trimesters also have an increased risk of low-birth-weight babies (Thompson et al. 2011b).

After about ten weeks, Yuri took her baby to be vaccinated. The medical personnel told Yuri that her baby was underweight. Back at home, they decided that they could afford to buy some vitamins and powdered milk to feed him. Yuri believed that the baby was underweight as a direct consequence of not having given birth at a health facility. In the following weeks, the baby's health deteriorated rapidly. He had a fever and was coughing most of the time. Yuri stated:

“It's not about the machines (referring to the medical equipment); it's about the comfort you and your baby get at those [health] facilities. I know there are certain things we don't get there, especially those related to our culture, but they could have done something for us, for my baby—give us some vitamins perhaps. They have special equipment to find out what the problem might have been... I think he was born with Eye, weakened by all the problems I went through... After a few days when we came back home he started with fever at night, only at night. His feet were cold though, really cold! Then he started coughing, a dry cough, so we gave him a few pills of Neo-Melubrina dissolved into herb teas for two days I think, I don't remember. ‘We'd better wait, at the health center they only give you medicine that doesn't work’ said my mother-in-law, which is true. You go there and they give you the same medicines, no matter what [the illness] is. We gave him herbal infusions with honey, but he was still ill. I think he needed ‘good medicine’ at some private doctor, but we waited and the Eye killed him”.

Evil Eye constitutes not only an illness category but also a cultural instrument and a strategy of communication. Social struggles, including illnesses, lead to conceptions of personhood, fate, suffering, feelings, ideas, symbols, practical knowledge and identities. Evil Eye has been transformed over time, yet it has remained a reasonably stable cognitive affirmation of experience to effectively communicate these concepts. Evil Eye also retains a relative ambiguity that assigns rather flexible meanings to particular social dynamics and interpersonal relationships, as well as a flexible notion of discomfort and illnesses. These factors provide important points of reference, or cultural patterns, for individuals and families, such

as the responsibilities of mothers or caretakers, health-seeking behaviours, home care practices, and other measures specific to a community, centering on cultural references that establish the responsibilities of health and care. Therefore Evil Eye adds stability to the many beliefs and behaviors connected with ambiguous symptoms and experiences of distress or discomfort. In Yuri's (and Flora's) case, the performance domain of Evil Eye included the overwhelming and unresolved stresses caused by the absence of Yuri's husband, family power dynamics, and the need to cope with vulnerability, uncertainty and death. Thus Evil Eye influences the community in favor of tradition, providing a continuing, although weakening, preference for in-home care as opposed to institutional public healthcare.

According to Harvey, Mayan curative practices are interactive and 'polyphonic', "co-opting multiple voices and pluralistic experiences in their composition [as opposed to] the sociolinguistic structure of the canonical Western medical interview [that] presupposes not communicative contributions of the family and companions but instead the participation of a *single* doctor and *single* patient" (Harvey 2013:90-94). As a result, Evil Eye has been adapted into local realities and amalgamated with biomedical concepts of infectious diseases, so that illnesses are not treated with specific, fixed interventions, while institutional public healthcare and resources normally just offer a specific diagnosis, without obtaining any contextual information from the patient or considering the interpersonal tensions inherent in the situation. Moreover, Evil Eye enhances and incorporates an efficient process of a social and 'healing imaginary' that not only provides a cure but also allows a continuum of intersubjective roles that determine treatment strategies and behavioural patterns associated with illness experiences.

5.5 Conclusions

It is probable that Evil Eye in Guatemala emerged from complex cultural encounters, incorporating components of Mayan practices and beliefs into the interpretation of illness aetiologies, primarily, although not exclusively, relying on traditional/folk medicine and which nowadays integrates elements of the allopathic healthcare system. Today, the concept refers to specific manifestations of symptoms that include fever, diarrhoea, cough, dizziness, among other. These are related to the ailments of body and/or psychological discomforts after harm has been directly or indirectly, intentionally or unintentionally inflicted through a powerful glance, either out of envy, jealousy or pure malice; when a person has been praised too much, received admiration or has specific phenotypic features. The illness can also be acquired when the body has suffered from an internal imbalance due to

environmental factors, thus not solely related to personal, but also environmental encounters or conditions. In rural San Marcos, Evil Eye is an illness of powerful meaning which mainly affects children, who are considered to be more vulnerable due to the negative energy the Eye possesses.

Concepts derived from Mayan cosmology have contributed to important aspects of folk illness categories. One of its valuable features is its explanation for the process of falling ill or becoming vulnerable, in terms of ideas such as ‘imbalance’ and *animas*. However, the objectification of these concepts as underlying and only related factors to understand illness aetiologies lack of explanations of daily and present collective dynamics that portrait a threat to health or are associated to illnesses, and therefore employed as references of social aspects that affect people and relationships. The idea of balance is of central importance in understanding treatments for Evil Eye, since it is connected to the ways in which people interpret the social and environmental conditions that shape the illness. These are precisely the socio-moral relations that guide the practices associated with Evil Eye. They lack homogenous categories, conceptualisations and labels, even though the literature reports remarkable similarities among groups that recognize Evil Eye. The illness is culturally constructed and therefore supremely subjective, intimately linked with the *significant others*, and therefore frequently associated with the allocation of responsibility for the illness. It allows for negotiation in the interpretation of the illness and the healthcare practices that address it. It demands dynamic illness trajectories (that is, a critical event that provokes the illness, followed by the onset of symptoms and then the treatment process) that affect not only the child’s condition but also societal approaches or responses.

Although Evil Eye shares many similarities among populations where this folk illness prevails, it also constitutes a culturally shaped explanation of symptoms that are experienced and explained differently. The conceptualisation of Evil Eye’s symptoms is dissimilar to the conceptualisation of other symptoms that resemble it. Evil Eye is linked to states such as ‘weakness’, ‘vulnerability’, and ‘destabilisation’ as a consequence of the actions of others, of environmental conditions, or of personal (but not controllable) factors that cause the illness. Evil Eye is disruptive not only because it affects an individual’s body but also because it encompasses a wide range of practices, responsibilities and relationships that become unstable and need to be renegotiated. Although symptoms such as diarrhoea, fever and cough, among others, are not excluded from being part of Evil Eye, the main diagnostic purpose of Evil Eye is to serve as a mechanism to understand, deal with, and overcome social conflicts, discuss or enforce the use of resources, relate ailments directly to a person’s health condition, or express dissatisfaction with one’s role or

position.

Thus, Evil Eye can serve as a cultural basis for effective (bio)medical and social practices. Theories of illness causation in rural San Marcos account for the perceptions and understandings indigenous people have of the material and spiritual world, a convergence of interpretative ideas of classificatory categories that recognise variability and attributes within the whole existing objects, subjects, etc. which when interaction occurs may produce changes in people's bodies. Rather than simply being an illness concept, Evil Eye provides a further understanding of how people organise their illness experiences in their cultural and social structures and how a *state* of illness offers a fundamental social relations outcome. Evil Eye is therefore a phenomenon of social production and reproduction with a particular meaning within local health values and practices. The phenomenon of Evil Eye as an epistemological predicament open to different systems of medical domains (biomedicine and traditional), linked together but also contained within several boundaries. Evil Eye is as an illness category; a contested practice of resistance; a process of healthcare management and a meaningful social construct of vulnerability and uncertainty.

Evil Eye is not only a 'fact'—that is, an illness definition—but a process of making visible certain pathologies and underlying social conflicts that affect children's lives as a combination of allopathic medicine and social factors. But it is precisely its ambiguous nature that allows satisfactory healing. Common symptoms of ARIs and ADDs are part of Evil Eye but not exclusive to it. Since diarrhoea and respiratory diseases present a hazard to children's life, but can require behaviours that are difficult to execute (taking a child to the hospital, following treatment instructions, paying for medical care), Evil Eye can assist the healing process since it is always 'shared' among families and communities. Thus, responsibility for the illness falls upon groups instead of individuals. Nevertheless, children's healthcare is largely considered to be a mother's task, with the result that a persistent debilitating symptom can be viewed as a consequent of negligent practices or 'wrong' behaviour.

Evil Eye is encoded in (1) aetiological understandings of how the body works and reacts; (2) cultural behavioral measures that include ideas of appropriateness regarding responsibilities and moral values; and (3) beliefs that are part of larger networks of relationships and environmental conditions, rather than isolated elements. Evil Eye therefore emphasizes its ambiguity by becoming an instrumentalised concept that inseparably connects physiological abnormalities and their interpretation. This interpretative task falls to mothers or caregivers, as well as to the nuclear and extended family or community. It works as a channel to communi-

cate the child's or the mother's need for attention or support. When symptoms are successfully treated, people receive two messages. One is that the cure provides with an objectified vulnerability to specific contexts (e.g. attributes attached to the environment or individual's features); in this way, illness and practices are bound together. The other is that the presence of the ailment is a straightforward biological event that requires a particular kind of attention in order to be cured. The complexity of the phenomenon is a result of the intertwining of these two aspects. The idea of moral or social responsibility towards neighbors and family is an important element in health-seeking and care responses, especially when specific required treatments do not succeed or are not available. Ties within communities and families are important for facing the social world outside the immediate circle. The impact of social networks is particularly significant among groups or individuals that lack specific resources to help those in need. This moral or social responsibility is also an effective strategy for generating and maintaining associations.

The next chapter will examine the healing processes applied by healers and caregivers in relation to Evil Eye. It shows how the process of treatment and cures an illness as well as a social representation. While ARIs and ADDs are regarded as 'pathologies', Evil Eye reflects not only a physical condition but is understood and treated as a 'social space' that connects bodies, spirits/souls and forces within the realm of a social world. In this sense, Evil Eye only makes sense when a sense of fear or danger is shared. Consequently, for the rural population in San Marcos the healing ritual represents an important factor for inclusion into a community. The various elements observed during the ritual of healing show how different symbolism and healing dynamics are continuous references that shape cultural identity and confront the everyday hazards of illness and uncertainty. People therefore define themselves not only through their health status and well-being but also through illnesses.

Evil Eye entails aspects that otherwise carry a stigma, such as being 'dirty', lazy or irresponsible. As a consequence, the ritual healing is a process of 'cleansing', or destigmatisation of negative symptoms. In terms of empowerment, it is also a symbolic device that allows individuals to take responsibility for the suffering of others by acknowledging the importance or seriousness of an individual's distress. By revealing the suspicion that Evil Eye is afflicting a child, the healing ritual offers a space of resilience for the caregivers. Many rural people, particularly among the young and those who have emigrated and then returned to their communities, have begun to display a reluctance to follow traditional practices, especially in healthcare. However, refusal to follow cultural patterns, especially

by young women living in a male-based family, implies an ‘otherness’ that would exclude them from relationships that are based on reciprocity and sharing. Thus, Evil Eye healing is a direct medium of communication and tie among families and their communities.

Healing and Relief

‘Although bodies have signs and symptoms, only people become sick’.

— Engel (1962)

Evil Eye displays different behaviours, not only associated with its symptomatology but also in its social experiences and manifestations. The treatment of Evil Eye’s symptoms mediates between a rationality of the biological or pathological dimension of the illness, and moral dimension attached to the responsibilities that validate Evil Eye as a precise category. In other words, Evil Eye is wrapped up in practices of care and social dynamics, the object of many mixed messages concerning perceived hazardous environments and improper behaviour. Evil Eye situates the afflicted person and caretakers in relation to underlying issues that claim authority to protect from or avoid illness, and that treat both the ‘material’ and the ‘social’ body. Thus, the apparent biomedical authority is confronted by social interactions and subjectivities that, despite the biomedical definitions of signs and symptoms, lose that authority through the language of *beliefs*, which are powerful and complex representations of symptomatology with cultural meaning (cf. Good & Delvecchio 1981). This can be illustrated by the following case, in which the polyphony of Evil Eye deploys such representations, which will be explained in depth in this chapter.

Celestina was a woman from Taltimiche, in her early twenties when I met her. She was experiencing distress after her husband was caught in Mexico and forced to return to Guatemala, after he had tried to cross the US border a year earlier. This left him in debt and also frustrated, resulting in aggressive behaviour towards Celestina, who felt insecure and saw her husband’s attitude as jeopardising herself and her son’s health. Marital conflicts among the poorest rural population rarely result in divorce or separation, even if there is physical aggression. A combination of factors, such as poverty, dependence on patriarchal relations and social structures concerning gender roles, determines embodied conflicts. When Evil Eye is allowed to ‘locate’ within an illness, its devastating effects on these problematic relations allow the sufferer to seek help. This illness is therefore a coherent concept of ideas, values, and behaviours from which it derives its meaning, oriented to the

purpose of securing support or help. Although symptoms of Evil Eye are limited to specific physiological outcomes, the illness experience is linked to meaningful actions that help to cope with or overcome the pervasive effects of ailments and social conflicts. Kleinman emphasised these aspects of illness and care within cultural systems by stressing that ‘healing occurs along a symbolic pathway of words, feelings, values, expectations, beliefs, and the like which connect cultural events and forms with affective and physiological events’ (1973:210).

Sebastián: “The other day I talked to my sister because she has been feeling constantly sick for the past two weeks. She looked pale and sad; it wasn’t *her*. But you cannot always talk directly, especially to women, so I just invited her to our house because my wife was there and women are more open to talk if there are other women around. Celestina [my sister] told Lidia [my wife] that her husband had started drinking and beating her again. He has been like that since he came back. He left four years ago to cross the [U.S.] border. When he came back he was angry. They had just been married for a couple of months when he left. He wanted to work for a year or more, so he could send money for the baby and her, and maybe start building a house. But when he came back he only came with a huge debt for the *coyote*. A neighbour was the one who noticed that Celestina was being beaten. She saw her crying, hiding in the grass. She [the neighbour] is Julian’s [the husband’s] aunt, but she has been helping her. Celestina says she casts the boy’s Eye every day in case he got it”. (Taltimiche)

Celestina: “He [Julian] wasn’t like this before, but after he came back from Mexico he started drinking. When we got the news that he was coming back I was happy and sad at the same time, but I was pregnant; that’s why I thought it was better that he had come back home. But when he came he spent most of the time at the shop drinking. His father told him he should take any job, but he didn’t. “It’s all hard work and badly paid”, he said. The day Mauricio [my child] was born, Julian wasn’t at home. Some people found him lying on a bench completely drunk. His mom died a couple of years ago and my mom is taking care of my younger siblings, but his aunt helped me during the first weeks. She and the midwife were here every day because I was *primeriza* [having my first baby]. . . That’s why Mauricio is prone to fall ill and get the Eye, because I was weak and afraid of being beaten and losing the baby while I was pregnant. But Doña Rosa is very good at curing children. If Julian comes home drunk I just take Mauricio and stay there for a while”. (Taltimiche)

Mayarí: “Can the Eye be so deeply hidden that you might overlook the symptoms?” I asked Doña Isabel, a midwife and healer from Paconché who I accompanied many times to observe how she cured Evil Eye and *fright*.

Doña Isabel: “No, you can always tell if a child has a hidden Eye, a *dumb* Eye. Of course you have to notice certain aspects to be aware of a hidden Eye. That’s why it is always very important that a woman tell you as much as she can about what happened during the day. But normally women seek help because they already suspect their children might have caught the Eye somewhere. You just listen and then during the healing we can prove that the Eye has been cured or not because the peppers carry the Eye with them. But sometimes mothers like to come as a precaution so their children won’t catch the Eye, so they come every day and talk to me. Sometimes they have problems and want to protect themselves and their children. If mothers are breastfeeding and they fall ill with *fright*, or don’t recognise a hidden Eye, they and their children get weaker. That’s why I always tell them, “Come and we will make sure you and your baby are safe” “. (Paconché)

6 HEALING (COLLECTIVE) BODIES

‘The intense view of these manifold contradictions and imperfections in human reason has so wrought upon me, and heated my brain, that I am ready to reject all belief and reasoning, and can look upon no opinion even as more probable or likely than another.’

— David Hume, *Treatise of Human Nature*, 1.4.7.8

6.1 Introduction

Healing/curing is normally understood as the process intended to provide relief and restore people’s health and well-being. Healing therefore is intrinsically concerned with the relationship of culture to diseases and communication between the patient and the health practitioner. As a result, healthcare services and practices have been examined at length in order to understand the effects of such relationships and encounters on people’s health, as well as to identify factors that reduce or encourage the use of health facilities.

This chapter deals with two aspects of the healing process based on empirical findings. The purpose of the first part is to provide insight into why caretakers of children suffering from Evil Eye prefer to make use of traditional healing. Healing does not only come from empirical verification that symptoms have been effectively treated. The efficacy of Evil Eye’s treatment, although not separated from its aetiology and symptomatology, depends on an agreement about the meaning of its symptoms. Hence, a symptom (fever, stomach ache, vomiting) is a communicative response consistent with a personal experience. A symptom embodies a direct ‘experience of the world’ that can only be valid in terms of the patient’s reality. If no agreement is reached about a plausible cause for the symptoms, individuals may reject or doubt that a specific illness, such as Evil Eye, is the cause of a particular symptom, since the necessary intervention depends on an ‘inclusive understanding’ of the symptoms (e.g., fever can be treated within the *chuj* if it is perceived as the result of the body’s heat loss, but not if it is a result of Evil Eye). This involves not

just a ‘cognitive’ understanding, but a personal judgement of how to deal with an illness. Hence, this communicative rationality is based on experiences that might differ from those of healthcare providers and caretakers. Although illnesses involve a theoretical frame (the biomedical explanation), they are also, to a large extent, rooted in individuals’ experiences and perceptions that may or may not correspond to the normative rationality. Consequently, the recognition of signs and symptoms that may or may not correspond to a particular illness regulates health-seeking strategies and healthcare patterns—the interpretation and the choice of practices that healthcare professionals and patients consider proper.

The second part of the chapter examines how the management of Evil Eye provides a social space where imprecise shared experiences (e.g., fear, insecurity, apprehension) emerge to give fragmented and incoherent incidents of ill-being a perspective or logic, increasing the resources available for social (or financial) support. Thus, in order to evaluate healing practices, we need to explore the experiences of individuals experiences in such encounters. Although the Evil Eye healing process is primarily concerned with providing a physical cure, it also involves the restoration of the ‘collective body’. Taking the concept from Scheper-Hughes and Lock (1987) of ‘social body’, as a symbol for thinking about relationships among society, culture and nature, where the body is used as metaphor for social processes in which illnesses can be understood as ‘social conflict’ and ‘disintegration’, the idea of ‘collective body’ suggests that Evil Eye embodies social forms of concerns that are considered perilous. In addressing or healing Evil Eye, there are implicit, regulated practices that redefine the moral norms of the group with reference to ideas of culture that operate or are assumed as moral values, locating the collective body in cultural identifications of everyday life. Furthermore, symptoms, according to Risor, ‘have specific social values, use and social consequences as circulating commodities. . . having particular trajectories and social potential’ (2011:22).

An important aspect of illness and healing experiences is precisely that their intimacy relies on a subjective dimension of sense-making that defines personal or group experiences. Atkinson, with respect to shamanism in Indonesia, suggested that ‘the relation between a ritual’s symbolic action and its therapeutic benefits may be neither obvious nor direct. . . The ritual under question simultaneously addresses patients and a wider audience as well’ (1987:353). Similarly, Evil Eye’s healing is part of a social domain that carries and reproduces ideas of the collective body through particular relations and practices that constitute social values that are part of a group. Within this process and encounter of healing, cultural beliefs are addressed and transferred as powerful images within a physical and social body, since *beliefs* are meaningful embodied experiences that include (in-

ter)subjective aspects (emotions, expectations, status, values, family and social dynamics) of individual and collective significance within the framework of illness. These experiences elicit not only awareness of and responses to the symptomatology of the illness, but also more complex dynamics.

6.2 Interpreting Signs and Symptoms

David Hume, who was born at the time when the debate about the nature of knowledge was active in Europe, formulated in his work *Treatise of Human Nature* (1739) the problem of knowledge and beliefs. Hume divides ‘facts’ into two phenomena: *impressions*, or direct perceptions, what he calls emotions, sensations and passions, and *ideas*, which are faded reproductions of our impressions (reflections, thoughts). This old debate introduces a discussion about the problem of reasoning and making sense of the world that continues to this day: knowledge in opposition to beliefs. His examination tackles the principles of ‘demonstrative’ and ‘probable’ statements. Demonstrative statements are known to be true or false *a priori*, or prior to experience. Probable statements, on the other hand, require empirical evidence. Between these two extremes lie relations of resemblance, contrariety, degrees of quality and proportions in quantity or number that depend only on the *ideas*. Hume’s revolutionary preposition leads to the conclusion of inductive reasoning, arguing that there is never any rational basis for inferring cause and effect. Uniformity (which follows repetition) and causal connection shape/form ‘constant conjunctions’ of occurrences; they are the essence of scientific knowledge that generates ‘laws’.

The problem, Hume argues, is that rationalism is guided by custom, which is ‘natural’—part of ‘human nature’. Through custom we are able to reliably draw causal inferences, creating knowledge and making inferences about possible occurrences, since custom is a form of reason. In this sense facts are, according to Hume, a form of beliefs, since these are only created by repetition and expectation. There are, however ‘degrees of beliefs’, which are inferred by cause and effect through repetition. Despite some philosophical debates and challenges of Hume’s reasoning about knowledge and beliefs, his ideas undermine dogmatism and open a space to debate the problem of practices that affect human action. The grounds for our knowledge and beliefs are the same, yet authoritative knowledge questions ideas or practices that are believed to rely on an inaccurate or erroneous line of argument.

Taking the argument of the validity of the foundation of scientific knowledge proposed by Hume, we can observe that one of the problems with observing or talking

about ‘facts’ concerns *perceptions*. Individuals are confronted with multiple factors (such as theoretical knowledge, previous experiences, social influences, expectations) that sometimes make it difficult to judge whether a perceived situation is a ‘rational’ (*idea*) or ‘emotional’ (*impression*) reflection. At the level of individual perceptions, both aspects are intertwined, and since we cannot detach ourselves from our own thoughts and experiences, everything is dependent and based on them. Judgements about situations are made on the basis of both aspects. This conceptual perspective views illness experiences as ‘entities’, and is concerned with questions of whether or not the illnesses are correctly diagnosed and treated, requiring a person to act according to explicit reasoning in which perceptions are critical in giving an illness a meaning and value tied to a goal-based behaviour (i.e., the help-seeking and healing process).

Conversely, illness categories are labelled in the biomedical perspective as a part of a disease’s materiality. A disease is an epistemological entity formulated in terms of symptoms and signs. From a biomedical approach therefore, pathologies are identified and organised, providing each disease with a specific biological process that shows particular signs and symptoms inherent to it. Even experiential (also described as mental or psychic), nonspecific (e.g. fatigue, weight loss, anxiety, irritability) and lack of symptoms¹ are recognised and sustained by what is account acknowledgeable and therefore limited to its own system of reproduction. Although the absence of signs is not equal to being ‘healthy’, symptoms that physicians cannot identify are labeled as ‘crockery or hypochondria’, inextricably linked to ideas of not ‘being real ill’ (Dumit 2006). As a result, although concepts of illness and healing experiences are considered crucial, they remain elusive. Frankenburg’s (1980) concept of the ‘making social of disease’ shows how fundamentally important this ‘rationality’ is, essential for creating a systematic and explicit understanding of diseases. A disease has to be ‘medically’ important to be included in biomedical frames so that health practitioners can engage with it. The separation between symptoms and signs, therefore, according to Singer & Baer (cf. 1995, 2007), has been a problem for biomedical conceptions of diseases, since it presupposes that disease categories are objective expressions of the body alone (cf. Gordon 1988). According to this idea, pathologies can be diagnosed, explained, classified and treated, following Hume’s principle of a ‘demonstrative statement’, in which truth or falsity appears as self-evident. Biomedical practices rely on the judgement of healthcare professionals who evaluate the ‘validity’ or plausibility of ‘objective symptoms’ as well as the solution for those symptoms that are considered functional disorders, based on the clinical findings of a patho-physiological

¹The main types of recognised symptoms are *chronic*, which are long lasting or recurrent; *relapsing* and *remitting*, when symptoms improve or disappear completely.

aetiology. Patients are then expected to ‘adapt’ their illness experiences (‘subjective symptoms’) into socially accepted events (cf. Sebeok 2001:46-48).

Physiological dysfunctions involving asymptomatic conditions, combined with clinically recognised deviant behaviours, are normally attributed to psychological or psychiatric disorders. Illnesses that are asymptomatic (normally at early stages of the condition), characterised by subclinical organic manifestations, are recognised as a particular risk, which is why routine checkups are advised when a person is considered to be in a higher-risk group for particular infections or illnesses. Any other conditions that presents similar symptoms but whose aetiology is believed to differ from standardised concepts are identified as ‘culturally defined syndromes’ and correlated with recognised disorders in order to be treated.² However, when patients are confronted with no clear patho-physiological diagnosis or effective treatment, initiate what Risor calls a ‘process of *symptomisation*³’ through negotiation in dominant social spaces, most importantly in clinical encounters (2011:22). Additionally, social and environmental factors considered as risk factors are perceived and handled differently. Further, attributions of meaning tied to the experience of illness give symptoms a particular oriented structure. Thus, social agreement about the significance of symptoms suggests a strong role of cultural construction of what constitutes a cluster of danger signs.

This process of rationalisation is, in general, followed by anyone, whatever the symptom: What could have caused this diarrhoea? What triggered this headache? At this primary stage, people immediately examine a symptom based on their previous experiences or their particular knowledge and beliefs. First, people associate the symptom with a specific element or fact that might trigger such a state (e.g., food poisoning, allergies, infections, stress). Second, by ‘identifying’ the cause, people can seek help more easily (from home therapies or self-medication to seeking help at health facilities). If a person is not able to identify the source of the symptom (or misdiagnoses it), or does not recognise some symptoms that might indicate a serious illness, this is perceived as increasing the risk of delayed or incorrect treatment. Third, although symptoms help to organise or categorise a disorder, a symptom can vary in its somatic outcome or process. The onset of some illnesses can be a sign, a symptom or both. Thus, symptoms are experienced (and perceived) differently by every person.

Although some physicians have acknowledged that signs and symptoms merely dif-

²See Chapter III.

³‘Symptomization’ refers to a process of ‘how bodily signs become symptoms and how these circulate, are exchanged and negotiated in social processes and settings. It is not equivalent to the use of the term as almost the same as somatization, which is often seen in psychosomatics and psychiatry’ (Risor 2011:22).

fer from their cause, most medical practitioners rely on different signs present during an illness (pathognomonic, anamnestic, diagnostic and prognostic signs). As a result, the ‘perceptions of signs and symptoms’, an expression used in biomedicine to define and objectively recognise an illness, are far from straightforward. Additionally, with the introduction of pharmaceutical treatments and self-medication, some symptoms are perceived and experienced differently, such as not requiring further diagnosis or check-ups, since a symptom can be linked to a specific condition, and thus to an effective treatment that requires no follow-up. Similarly, when a physician does not identify any sign indicating an illness, the condition can be recognised as cured. This brings us back to the problem of recognition and perceptions, as well as differences attached to symptoms and signs, as part of the sequence of experiences presented by an illness.

Therefore, people normally try to identify a symptom and decide what to do about it depending on their own idea of what is necessary and suitable. According to Fainzang, symptoms are social practices of ‘construction’ and ‘identification’ since ‘it involves acknowledging that the symptom has a real existence, independent of its medical reality. . . The process of construction-identification must be considered as a whole since it implies that, for the subject, the symptom exists in itself, at a given moment of his/her existence, and that is what induces the act of choosing to medicalise the sign perceived’ (2011:41-42). In this framework it is also important to observe that the way in which an illness is perceived depends largely on its symptoms, which are associated with particularities in both the biological and the social realms. In biomedical terms, the recognition of dangerous conditions in children suffering from ADDs or ARIs is based on the capacity of caretakers to recognise them and seek treatment. While signs are definite, symptoms are rather broader and subjective. Thus, symptoms need to be clinically recognised to become a sign (cf. Shands 1970) in terms of a ‘biomedical gaze’ (Foucault 1963). Parallel to the recognition of a symptom’s severity, another (biomedical) concern is the efficacy of treatment. Not only is the illness itself attached to specific values (meaning and levels of severity or disability), but the healing practice as well is characterised by diverse interpretations, which as signs a ‘status’ to the illness (in the process of being effectively cured, or actually cured).

The aetiology and classification of illnesses there becomes important, since their diagnostic category determines whether treatment is required. Clinicians normally focus on specific signs presented in children suffering from a respiratory or diarrhoeal infection, in order to rate the severity and provide them with treatment. Symptoms, in contrast, need to be identified by the patient and then correlated with the visible signs of the disease. Evidence of an illness is therefore a body-

focused perception that may result in different response behaviours. This ethnographic research has shown that caretakers often felt embarrassed or ashamed of their help-seeking practices when physicians complained about delayed treatment-seeking, stressing the importance of the diagnosis criteria, requiring referrals or frequent antibiotics. Hence clinical features or signs are important diagnostic validators, yet the inclusion of symptoms associated with a particular illness and the responses to it are culturally dependent, especially if the illness, such as Evil Eye, is consistent with the specific cultural content of the body as a place of suffering and social influences.

6.3 Diagnostic Criteria of Evil Eye's Symptomatology

In biomedical terms, symptoms and signs are two different manifestations of an illness or condition. Whereas symptoms are conceived as subjective, apparent only to the patient, signs are regarded as objective evidence, important to recognise and treat in order to prevent disability or death. However, signs can be misunderstood or difficult for caretakers to recognise, especially in small children or babies. Symptoms, for their part, always lack general consensus since these are largely based on personal experiences. Additionally, the presence of common signs and symptoms can be due to a variety of illnesses (such as sepsis, which can be caused by meningitis, pneumonia and diarrhoea). This uncertainty can make it difficult to recognise danger signs in infants and seek the appropriate level of care, which in turn can have adverse effects. The symptoms reported by caregivers, as well as their interpretations, cover a broad range and are quite variable. Consequently, the Integrated Management of Childhood Illnesses (IMCI)⁴ framework has attempted to provide a standard case definition to recognise infant illnesses, based on clinical findings, in order to reduce morbidity and mortality from these diseases in developing countries. Yet a caretaker's perspectives (including those of health workers) and household practices do not necessarily correspond to standard biomedical case management behaviours. In addition, potential risk conditions or factors are usually perspective dependent or are assigned a different significance by different observers.

The difficulties of sign and symptom recognition and case reporting (which implies healthcare seeking at any level of biomedical care) can be illustrated by the definition and evaluation of respiratory illnesses. Although some countries require mandatory reporting of pneumonia cases (Simoes et al. 2006), the death rates

⁴See chapter VIII.

from ARIs are uncertain. The reasons include unreported cases, deaths at home, lack of official death certifications, non-uniform definitions of respiratory diseases, and under-recognition of the diseases due to nonspecific symptoms. Furthermore, several diseases, especially infectious diseases, pose tracking difficulties due to the presence of new strains and possible alternative transmission methods (cf. IOM 2007). Since 1951 (with a few slight amendments made in 1969,) some communicable diseases such as yellow fever, plague and cholera have mandatory reporting requirements at the World Health Organisation (WHO). Since then, other diseases, such as dengue fever, haemorrhagic fever, influenza, African trypanosomiasis, HIV/AIDS, leishmaniasis and leishmania/HIV co-infection have been added to the list.⁵ Since 1993 the Division of Vaccines and Immunisation of the Pan American Health Organisation (PAHO) has been promoting epidemiological surveillance of bacterial pneumonias and meningitis, with the aim of supporting public health decisions about conjugated vaccines.⁶ In 2001 a WHO working group developed definitions for radiological pneumonia as a standardised method of identification with a strictly epidemiological purpose, in order to evaluate the impact of interventions to control the disease (WHO 2001; Lagos et al. 2003; Lanata et al. 2004).

In 2007 the Integrated Community Watch Program (Programa de Vigilancia Integrada Comunitaria, ViCo) was implemented in Guatemala at the National Hospital of Cuilapa, in the Department of Santa Rosa, and two years later in the cities of Xela, Quetzaltenango, and Guatemala. ViCo was created by the Global Disease Detection Initiative of the Coordinating Office of Global Health at the U.S. Centers for Disease Control and Prevention (CDC), with the collaboration of the Ministry of Public Health and Universidad del Valle de Guatemala (UVG). Its purpose is to develop an integrated surveillance system to provide information for rational decision making, information collation about the aetiologies of certain syndromes, risk factor identification, support for the development of priority healthcare initiatives, and evaluation of the impact of public health programmes for four particular acute infectious illnesses, including diarrhoeal diseases and respiratory infections.⁷ Another objective of the system is to establish a methodology that allows standardising X-ray evidence of pneumonia in order to reduce the variability between radiographic interpretations and thus compare the effects and interventions of other studies. When cases are identified more quickly, a better therapeutic approach could be adopted, reducing for example, the use of unnecessary antibiotics. The surveillance system is an integrated baseline of services (hospitals, health posts

⁵WHO, Global Alert and Response <http://www.who.int/csr/en/>

⁶http://www.paho.org/hq/index.php?option=com_content&view=category&layout=blog&id=956&Itemid=358&lang=en

⁷<http://portal.mspas.gob.gt/index.php/en/mspas/noticias/450-proyecto-de-vigilancia-comunitaria.html>

and health centers), syndromes (diarrhoeal, respiratory, neurological and febrile), data (aetiological, epidemiological and clinical), and demographic data (Contreras 2011). Cases of respiratory diseases, such as pediatric pneumonia, are identified through the use of radiological images of alveolar consolidation as a confirmatory criterion for a presumptively bacterial or viral pneumonia; however, there is still considerable variability among physicians in the interpretation of chest radiographs.

These examples demonstrate the difficulties in defining signs and symptoms for the diagnosis of acute diseases. Laboratory tests (e.g., sputum, urine and blood samples), pulse oximetry, X-rays and CT scans, among other clinical examinations, need to be interpreted consistently in order to confirm an illness. Only through standardised methodologies and definitions of syndromes (and symptoms) can certain diseases be identified, i.e., determining which signs and symptoms indicate a specific pathology. However, these methods are not easy to develop or use.

Within this biomedical framework, the diagnostic criteria for Evil Eye are significant, since a diagnosis of Evil Eye can considerably improve a child's health by suggesting a pathology or a treatment. When symptoms of Evil Eye are classified as a separate illness, the treatments required can be sought at biomedical facilities. Evil Eye is almost always considered when a child falls ill, since this illness is perceived as common and recurrent. However, the diagnosis of Evil Eye can sometimes be inaccurate, explaining why caretakers and healers⁸ are more concerned with treatments than with the actual diagnosis. However, the Eye is sometimes perceived as 'hidden', which may lead to delay in seeking biomedical care.

The wide range of possible interpretations for warning signs and states demonstrates how varied the perceptions of illness, well-being, or ways people talk about the experience and embodiment of illness can be. Even an apparently unambiguous symptom can be described and classified differently. Thus, to neglect the importance of how the symptoms and signs are referred to (or felt) by the patient is to overlook what people are communicating. When clinical encounters address the importance of a specific (clinical) profile—i.e. certain symptoms and signs—this tends to narrow the interpretation of a symptom to a single condition when in fact it can have a broader range (cf. Wagner 2001:6). The clinical practitioner needs to be aware of this, and to ask about the use of traditional or folk therapies and their outcomes. Unfortunately, the privileged institutionalised biomedicine has typically failed to notice that other ways of knowing and insights can convey

⁸The term 'healer' in the context of Evil Eye refers to any lay person who can perform the healing, not necessarily a shaman or diviner. However for difficult cases of Evil Eye or other illnesses that require special knowledge and powers, traditional healers are sought out.

alternative diagnostics and treatments, as well as help to improve the understanding of what may be called ‘personal or cultural barriers’ with respect to specific diseases.

General criteria for Evil Eye

As explained at length in chapter V, some children are believed to be inherently weak, since their blood is perceived as being feeble, a natural condition that no one can change or influence (cf. Migliore 1997:34-36). People generally consider infants and children under five years old as typically more susceptible to diseases because their bodies are less mature and lack strength. For this reason people explain why children over five who suffer from Evil Eye cannot easily die as a result. There are no gender differences in vulnerability to the Eye; more important are the person’s age and perceived personal strength. Consequently, the possibility of being affected by Evil Eye and developing symptoms is correlated with these two features. The younger and weaker a person is, the more chronic and dangerous the illness symptoms. Lack of intrinsic force or strength is partly a function of being young, but is also related to being prone to illnesses if a person’s blood is perceived as frail. Thus, exposure to pathogens does not solely determine the origin of the ailment; the individual’s vulnerability is also considered important.

Caretakers who reported children with Evil Eye mentioned at least one of the following symptoms: fever, cough, diarrhoea, sore throat, chest pain, sunken eyes, loss of appetite, irritability, unusual lethargy or uneasy sleep, vomiting, nasal flaring, shortness of breath or difficulty breathing, and stuffy nose. However, these symptoms are not specific to Evil Eye, but also are reported when children become ill with a diarrhoeal and/or a respiratory infection. Exclusive symptoms of Evil Eye are normally greenish stool, fever located in the chest with coolness in the extremities, persistent vomiting, and a dry cough (*nxwisen*). An illness is diagnosed as a diarrhoeal infection if it persists for 14 days or more, with presence of blood in stools (dysentery). Symptoms of respiratory infections include cyanosis, constant sneezing, rattling sound in the chest due to phlegm (*nloquin*), wheeze (*ntzo’lin*) and tachypnea (*njaw txew*). Yet even these specific symptoms are reported by means of several different terms distinguished by intensity and frequency. A cough (*tzjo’l*), for example, can be classified as sturdy cough (*tzjo’l mani’tz*), mild cough with phlegm (*tzjo’l b’unin*), dry cough (*nxwisen*), moist cough (*tzjo’l ak’iyin*), just phlegm (*xlo’q*), severe cough (*ntzojen*), persistent cough (*tzoj’l chq’al*), upper chest noises when coughing (*ntzo’lin*), lower chest noises (*nloqin*), and so on, each one associated with a specific illness.

Mam terminology for symptoms and illnesses is rather complex. Some symptoms are distinguished by their location in parts of the body, which cannot be precisely translated into Spanish or English terms for specific respiratory or diarrhoeal signs and symptoms. Furthermore, some terms refer not only to a symptom but also to a part of the body, such as the concept *tqul'*, which can be understood as a cough or phlegm but can also refer to the throat and neck (Thompson et al. 2007). An implication of this flexibility in meaning is that it allows for explanations care management in ways that address the specific needs of the patient and achieve the desired outcome.

Specific criteria for Evil Eye

In the majority of cases of Evil Eye, the critical point was reached when people recognised the degree of seriousness, which they defined as '*normal* ill' or '*very* ill'. One form of Evil Eye will delay healthcare attention, whilst others require urgent treatment. The initial cure needs to come from traditional healing, but only as long as the illness is believed to be caused by the cultural environment. Yet perceptions of the severity of the illness may vary widely among caretakers. Duration of the symptoms, for example, was not necessarily an indication of severity. A case was perceived as severe only if treatment failed over a period of time considered permissible. This period of time was determined by the type of Eye, the child's condition, treatments provided and the person who treated the child. Thus, the severity of Evil Eye was difficult to assess, since it was self-rated, regardless of the aetiology of the illness.

Perceptions of severity did influence behavioural responses on the basis of persistent somatic symptoms. For example, if caretakers perceived that the child had a strong Eye, and the child was identified as fragile, this could indicate potentially negative outcomes if not treated promptly, but precisely because of the Eye's intensity, the curing could take longer than in children who were considered to have a strong blood. In such a case, the rate of healing was the criterion of the severity (e.g., no changes in the symptoms, or deterioration of the child's condition). A specific symptom could also influence the perception of severity and play a role in treatment and care-seeking. Thus, classification of severity, although significant in relation to healthcare-seeking behaviours, was dependent on multiple factors that could vary greatly.

Evil Eye is not considered infectious (perceived to be transmitted from person to person), but it can be transferred from mother to child, as a result of transferring feelings or emotions to their infants through breastfeeding or while pregnant (cf.

Neilsen et al. 2001), in particular during stressful situations and states of vulnerability that increases the risk to the child. Under normal circumstances of health, people are considered to be in a state of inner balance. Often, however, when a mother's equilibrium is disturbed, she can disrupt the stability of her children, changing the child's body temperature. This can occur when, for example, the mother has walked for a long period of time in the sun carrying the child on her back. The temporary change in the mother's temperature is transferred to the child, who is incapable of regulating his own body temperature, leading to sickness. Although infrequent, people other than the mother who are related to the child can also endanger the child's health. This suggests an intimate perception of susceptibility and intersubjectivity that mediates between the body and the shared world of experience.⁹ Pregnant women are also considered to be potential transmitters of Evil Eye, since they could evoke natural desires,¹⁰ particularly due to uncertainty regarding her own pregnancy (e.g. conditions that threaten women's lives in pregnancy and childbirth). An unintentional glance at a child, entirely unpremeditated and frequently by intoxicated individuals, can also transmit Evil Eye, as the altered blood state causes the child's internal fluids to lose their normal temperature, initiating an internal disruption. Therefore Evil Eye is seen as being transmitted via two channels, one organic and one spiritual. This is similar to forms of *fright*, discussed in the studies of Rubel et al. (1985). The Eye is understood to be animate and is not separated from either the victim or its source. It possesses its own force that can grow, and change its repository. *Fluidity* and its meanings as part of a 'triad' in indigenous communities in Guatemala is of great importance. For example, according to Harvey, Mayan therapeutic healing "can be seen as a trinity, involving a movement from an enfolded illness experience (alterity) to an unfolding sickness experience (ipseity), passing through empathy until participants together arrive at sympathy (community) to experience healing" (2006:903).

In the San Marcos area two types of Evil Eye are found. One is called 'dumb eye' (*ojo sonso*), in which children cry (*xwach'il*) and display a constant fatigue caused by asymptomatic internal discomfort. The second is called 'sharp eye'

⁹ With respect to 'determining the patient' and the 'locus of healing', Waldram explains that 'many traditional medical systems contain etiological explanations that situate the genesis of sickness within the social realm, in the relation among people, animals, animated objects, and the cosmos. It is common for sickness to be differentiated into two distinct (though often related) treatable realms, etiology and symptomatology; understandings of etiology in particular often require treatment that extend beyond the individual and into the "social body"' (2000:612).

¹⁰ 'Natural desires' are sensations and feelings that are intrinsically part of the human being which appear to be 'natural' to specific genders or social contexts. This idea of 'natural desires' is also understood as a 'purpose of being'. For a pregnant woman this 'natural desire' will be a child she is looking at.

(*ojo agudo*), normally presenting symptoms of diarrhoea (*chk'Eyeky'ilku'j*), fever (*kyaq*) and cough (*tzjolorsjo'l*). These symptoms can externalise simultaneously, or one of them can be absent without changing the aetiological perception of Evil Eye. Both types of Eye are perceived as equally dangerous, even fatal, if not correctly treated. Diarrhoea caused by Evil Eye has specific characteristics which distinguish it from parasitic diarrhoea and shigellosis.¹¹ Diarrhoea caused by Evil Eye is recognised by its greenish-yellow colour and a specific odour, and is described as 'egg-shaped diarrhoea'. Since the use of laboratory tests is uncommon in rural areas,¹² bacterial diarrhoeas are not recognised as such, but people use the terms 'bacteria', 'germs' and 'microbes' to refer infectious agents that cause various diseases. Fever resulting from Evil Eye is mainly located in the head and chest, while the legs remain cold. Cough as a symptom of Evil Eye is dry without phlegm, which distinguishes it from acute lower respiratory tract infections. Hence people recognise (1) an asymptomatic Evil Eye, (2) Evil Eye with symptoms of respiratory infections, (3) Evil Eye with symptoms of diarrhoea, and (4) Evil Eye with symptoms of diarrhoea and respiratory infection. Other symptoms are summarised as follows:

¹¹Shigellosis is a global human health problem. Four species of *Shigella*, i.e., *S. dysenteriae*, *S. flexneri*, *S. boydii* and *S. sonnei*, are able to cause the disease... The symptoms of shigellosis include diarrhoea and/or dysentery with frequent mucoid bloody stools, abdominal cramps and tenesmus. *Shigella* spp. causes dysentery by invading the colonic mucosa. *Shigella* bacteria multiply within colonic epithelial cells, cause cell death and spread laterally to infect and kill adjacent epithelial cells, causing mucosal ulceration, inflammation and bleeding. Transmission usually occurs via contaminated food and water or through person-to-person contact". PubMed 2005 Apr. 43(2):133-43, <http://www.ncbi.nlm.nih.gov/pubmed/15880088>

¹²Laboratory tests are performed in San Marcos City or at Comitancillo if required. However, since the tests are rather expensive, they are not often prescribed. This leads, however, to the use of broad-spectrum antibiotics such as ampicillin.

Symptom	Evil Eye	ARI	ADD
Fever	•	•	•
Aching limbs	•	•	•
Sunken eyes	•	•	•
Vomiting	•	-	•
Diarrhoea	•	-	•
Spasm pains in the abdomen	•	-	•
Cough	•	•	-
Irritability or lethargy	•	-	-
Weakness	•	-	-
Headache	•	-	-
Tachypnea	-	•	-
Breathlessness	(•)	•	-
Severe cough	-	•	-
Thoracic indrawings ¹³	-	•	-

Symptoms of Evil Eye are described with highly elaborate explanations. In order to identify the type of Evil Eye, people combine a range of factors, from those that are seen as a ‘natural condition’ of children to ‘external circumstances’ with internal effects. Emerging symptoms can be identified as Evil Eye if they are the result of a strong Eye that has debilitated the whole body. In cases where the appearance of symptoms is not directly related to Evil Eye but has developed simultaneously, these symptoms are biomedically defined and can be treated as diarrhoea or as a pulmonary infection; yet only after the Eye has been ‘removed’ or cast away are people able to identify which symptoms are not part of Evil Eye.

As mentioned earlier, the concept of Evil Eye comprises several aspects that extend throughout the perception of the body’s condition. Thus, Evil Eye’s illness process connects inherent personal features which are part of the physiological body, such as an ‘internal strength’ (*fuorza*) or personality (subject to different affective behaviours), which influence or predispose a person to fall ill. These features, believed to maintain a state of equilibrium, are of a physiological order which can put a person at risk, or they can provide adaptive bodily reactions—for example, if the body loses its capacity to regulate its temperature, a person will experience

¹³Numerous studies have documented that the practice of overwrapping the child in several layers of clothing reduces the chances of detecting fast breathing or chest indrawing associated with severe pneumonia (Berman & McIntosh 1985; Khan et al. 1993). This practice is observed in many rural areas of Guatemala, such as San Marcos.

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a form of collapse, since the ‘internal strength’ has been unable to preserve the normal physiological condition. In this case an organic dysfunction affects the individual’s strength. The variations of the Eye (i.e., dumb Eye, sharp Eye) therefore exist in relation to an internal condition caused by specific external encounters. ‘Tuning’ or controlling a person’s strength in response to external stressors is considered impossible. No complete model for understanding this process has yet been developed, but the logic of lack of strength as a cause of Evil Eye is nevertheless integrated into the specific illness experiences and provides consistent and replicable solutions. Whether or not an external stressor or environmental factor contributes to specific somatic reactions, the precise definition or measure of an individual’s level of strength (by which Evil Eye is explained) operates as a variable that increases people’s vulnerability and therefore their predisposition to any kind of disease. Thus, potential risk factors, preventive measures, the ability to afford or obtain the right treatment, and the perceived or actual personal coping resources can only be evaluated if the aspects of (ab)normality affecting a child’s life are properly identified. This is not to suggest that the phenomenon of Evil Eye is a metaphor of misfortune for coping with illnesses, but rather a selective choice of environmental and social influences specific to a culture of a belief system and the available treatments.

A symptom that remains after the main symptoms have been eliminated does not have the same significance as a symptom that is part of the original cluster. For example, if a child starts with diarrhoea and fever, which are identified as a result of the Eye, and subsequently symptoms of ARI appear, like cough and a runny nose, these can be (a) secondary symptoms of Evil Eye, or (b) associated with another illness, i.e. a respiratory infection. The interpretation will depend on the length of time the secondary symptoms persist after the main symptoms disappear. The first signs of the effectiveness of the cure would be, in this case, the disappearance of diarrhoea and fever. If the cough continues after a few days, the interpretation might be that the child is also suffering from flu (case a) as a result of the body being weakened by the Eye. In cases like these, parents do not report their children as having been sick with a diarrhoeal infection, since diarrhoea is a common symptom of Evil Eye. Only in cases when symptoms do not disappear after the traditional healing, or when the remaining symptoms become more serious and last over a period of two weeks, will people consider another aetiology for the symptoms (case b). The difficulty arises when danger signs are perceived as ‘sudden’ onsets, a consequence of the primary signs of Evil Eye. For example, if a child has difficulty breathing or loses consciousness and was suffering from Evil Eye before, the symptoms of cough and fever will not be viewed as

primary signs of a lung infection, since cough and fever can also be part of the Eye.

Symptoms of diarrhoea as diagnostic factors

Diarrhoea is the most common symptom of Evil Eye (cf. Weller et al. 2014). Its presence does not imply that the illness is more dangerous or severe. Nevertheless, the response to treatment for this type of diarrhoea is considered important, because effective treatment communicates to caretakers that the Eye has been removed. As previously mentioned, diarrhoea is identified as a symptom of Evil Eye if it has a particular shape, colour and consistency. A study carried out in Peru showed a similar belief: “The moment diarrhoea stops, it is thought to be ‘cut’ or ‘cured’, if it returns, it is thought to be a different illness, perhaps a ‘stronger’ diarrhoea, which requires a more powerful drug” (Rivera & Wanderer 1986:1268). Diarrhoeas with different aetiologies signify different types of illnesses, for which different types of treatment are appropriate. The term ‘egg-shaped’ is widely used to describe the specific diarrhoea caused by Evil Eye. This categorisation includes several types of diarrhoea that present small amounts of greenish, sometimes yellowish, sponge-like clusters in the stools. The presence of blood clots or worms in the stools (whether or not they are accompanied by any other symptom) is seen as requiring another type of treatment, eliminating the possibility of Evil Eye as a source of the diarrhoea. Some caretakers also mentioned peristaltic (bowel) sounds as a sign of a gastrointestinal infection not related to the presence of the Eye. Although people talk about the Eye as an ‘active entity’, stomach activities are not associated with the illness.

Whereas WHO guidelines stress the use of oral rehydration therapy (ORT) in the management of diarrhoeal diseases to prevent dehydration, caretakers are more concerned about the aetiology of the illness than about the symptom, i.e., the diarrhoea itself. This means that people consider frequent stools normal when children ‘hold’ the Eye inside their bodies and no specific treatment is required. This does not mean that the Eye does not require treatment unless some other type of symptom appears. Diarrhoea is perceived as effectively treated only if the Eye has been removed by the healing process. In general, this implies the cessation of diarrhoeal episodes or, in some cases, a change in the stools. If the diarrhoea disappears or diminishes after the second day of the healing, the child is considered to be responding well to the treatment, or else the Eye is weak; if it persists after three days or more, this is interpreted as the child being afflicted by a powerful Eye or the treatment not being effective. Thus, the severity of the Eye is measured by the occurrence of diarrhoea episodes and the response to the

treatment. The choice of the healer is considered relevant. Midwives (*yoq'el*) and healers (*ajq'anil*) who are considered powerful because of their experiences and reputation are preferred for severe cases of Evil Eye. In cases where the signs of Evil Eye are perceived as being very strong, people seek help from midwives or healers from farther away, a practice that is also common in other areas of Guatemala (cf. Eder & García2002).

Symptoms of respiratory infections as diagnostic factors

Cases where Evil Eye presents symptoms of ARI are more difficult than those related to diarrhoeal infections. Signs of discomfort observed in a child trigger practices that can be counterproductive for a child's health according to biomedical practitioners. An example is the use of the *chuj*, when a symptom is perceived as the effect of an abrupt change in a child's temperature, calling for action to regulate the child's internal (balance) heat. Part of the difficulty in treating symptoms of ARI and Evil Eye is the dissimilarity of meanings or significance given to the same symptoms. The symptoms of ARI and Evil Eye are not necessarily mutually exclusive but the interpretations of the symptoms are; they depend on the situational context, i.e., inclusion and exclusion criteria.

For cases of Evil Eye the categories are derived from daily experiences such as social context, vulnerability, excessive exposure to a particular environment, and the effects of specific situations, while ARI's categories reflect mainly biophysical characteristics. However, the treatment for symptoms of ARI, in contrast to ADD, is dialogical rather than based solely on the aetiology of the symptoms, an ambiguity that allows room to discuss an adequate and appropriate therapy management. Conversely, the key clinical signs for case management of ARI, such as respiratory rate and lower chest wall in drawing (WHO 1991b), are not readily identified as ARI by parents or caregivers, since there are a number of different ways in which these signs of Evil Eye can be explained. One is that the Evil Eye, especially if caused by another person (intentionally or not), provokes in the child's body a reaction to 'fetch out' the Eye, increasing their respiratory rate. Another difficulty is that babies and toddlers are wrapped in blankets and held on their mother's back in such a way that people cannot easily observe respiratory changes that might be symptoms of ARI. Identifying and addressing these differences in interpreting symptoms is therefore critical to treating the illnesses.

6.4 The Knowledge Domain and the Healing Process of Evil Eye

A good relationship between the healer and the person who seeks help is seen as essential to performing the healing. Asking and being asked becomes an embodied value expressed via this process. The therapeutic work in the pragmatic context of the healing encounter uncovers an ongoing sequence of acknowledgment and acceptance rather than just a provision of diagnosis and care. This dynamic shifts vectors of social interactions, solidarity, negotiations, and local knowledge suggesting power relationships that unfold between families, communities, and traditional health providers, based on therapeutic judgment, which may lead to a collision between ideologies, gender dynamics, and public health discourses. Consequently the effect of the normative practices on anticipated outcomes greatly influences the decisions people make. There are some apparent expected-utility decisions that affect perceptions and health-seeking behaviours and that are important in adjusting anticipations to reality, which include emotions and rationality. Emotions of empathy and the rationality of efficacy are closely related to the reluctance people sometimes feel during encounters with the health post or health center, when, for example, a health facilitator is perceived as unpleasant or untrustworthy, or when an illness is ascribed to negligent care at home. Csordas has suggested that religious or symbolic healing systems “[do] not necessarily include removal of symptoms, but change in the meaning the patient attributes to the illness, or an alteration of the patient’s lifestyle” (1983:334). This aspect is of great importance, since it is not only about receiving the (right) treatment but looks at what the procedure and attention emanating from a *significant other* mean to individuals. It also expresses multiple levels of perceptions and representations that stem not only from facts, but also from effects, bringing about a *symbolic healing* that reduces the anxiety, fear, or distress of the caretakers.

A person who is considered an expert in removing the Eye is not necessarily the same person who can identify it, with the exception of healers or midwives, who are recognised as having special abilities to diagnose and treat the illness. Unlike other regions where Evil Eye is almost entirely treated by healers from other areas (Adams & Hawkings 2007; Leyn 1999), in this area of San Marcos it is usually people from the same community who perform the healing. As previously discussed, infants suffering from Evil Eye cannot be cured by their own mothers, as this will cause the Eye to remain inside the mother’s body and consequently it could be transmitted again through breastfeeding or (spiritual) energy; someone outside of the home is usually sought to cure the Eye (as long as it is not a lactating woman). Although some individuals are considered experts in removing

the Eye, people usually just determine the Eye's type and level of danger through family and/or community agreement, with the aim of providing the most suitable healthcare. This process is important in avoiding a misdiagnosis due to the complexities of the Eye's specificities. Thus approaching a healer is particularly important, because this encounter is not only a place to treat the physical complaints of the afflicted child, but it is also relevant for immediate and long-term medical outcomes associated with ARIs and ADDs.

The identification process is also important because the resulting label may determine whether the patients (both mother and child) needs a specific type of support or care, since Evil Eye is a kind of somatic mode of receptiveness that also afflicts the mother. In these terms it could be said that Evil Eye developed into an adaptive system of illness which influences social behaviours and extends to cultural rules about avoidance of things that are part of the social environment but threaten the social order. Evil Eye therefore embodies not only what the social environment produces in terms of illness, but also the cultural mechanisms to overcome illness.

In the context of healing, the illness develops into a shared experience with other members of the family or community. In this sense, according to Waldram, 'deceptively simple at first glance, identifying and naming the scourge is an essential step in healing and identifies the healer as one with the 'power to establish order' within the disordered context of sickness' (2000:605). As a result, healing amidst the community is quite common in removing the Eye. In effect, it is an informal way to consider everybody a 'healer' who is expected to assist when required, while only the 'significant others' are entrusted with the actual healing process. This encourages the mother or caretaker to seek healthcare within her immediate social network, which stimulates social support. The socialisation in connection with Evil Eye also helps people to recognise other possible sources of illnesses, misfortune or death. When a child falls ill with Evil Eye and particular social events are involved (normally events that lead to *fright*), community-based social support is important to initiate healing, a powerful and significant effect that helps people to understand the illness and seek a (more) effective or appropriate therapy to alleviate or cure it.

Children may be born in a weakened condition because of events that happened to the mother during her pregnancy, or such a condition may signal an existential suffering, such as the woman feeling anxious, afraid or vulnerable in her home or community during her pregnancy or afterwards. Identifying the actual causes is difficult but important, since children who are prone to catching the Eye, or who

are suffering from a dangerous type, are less likely to respond to the treatment. The social context is therefore very important because Evil Eye permeates emotional and environmental encounters, which are not separated from personal and social structures and which affect the physical and psychological integrity of an individual.

In practice, when a mother suspects that her child's symptoms are a consequence of Evil Eye, she seeks help during the first days, if possible, from someone who is recognised as a good healer or midwife. This is not only to secure help to treat the Eye but also to erase the suspicion of another illness and to establish the legitimacy of her concern. Biomedical personnel are believed to be unable to recognise and successfully treat Evil Eye because they do not understand how the illness is acquired, what it does to the body, and how to remove it. Further, many people prefer to avoid the national hospitals, mainly due to (1) the necessity for mothers to stay with their children during the time of hospitalisation, which is usually from six days to two weeks, leaving them unable to care for their other children, (2) the costs of hospitalisation and transportation, (3) dislike of the way the hospital staff treats them, and (4) the possibility of death. This does not imply a rejection of institutional medicine, but rather explains the appeal of parallel models of care (cf. Agbor & Naidoo 2011; Fleuriet 2007; Makundi et al. 2006; Young 1980), as well as showing some of implications of using national healthcare facilities. This attitude is based on the view of biomedicine as a model that treats biological conditions almost exclusively, while traditional medicine offers holistic care that goes beyond the biological focus. Because of this narrow focus, the exclusive use of biomedical treatments is not considered as a possibility in rural or indigenous communities. This reflects in part certain aspects of marginality, inequality and cultural identity embodied in a physical and social order of daily life, such as gender relationships and emotional responses to distressful situations, since 'illness labeling and symptom reporting are invested with meaning and emotion [as well as] strategy' (Nichter 1996:120).

Removing the Eye

Since Evil Eye is considered so pervasive, mothers normally maintain at home most of the items needed to perform the cure, or can acquire them quite easily from neighbours and local shops. The person who is performing the cure does not primarily focus on the symptoms of Evil Eye but rather on the *efficacy* of the healing itself. In this regard McGuire notes that 'participants have a sense that their healing system "works" when a sickness episode is consistent with their expectations... Insofar as these alternative healing systems adequately match adherents'

expectations with their experiences, they “work” (1991:189). In cases where the child shows no response, the healer decides whether the Eye is camouflaged with other symptoms or still too weak to show its presence. According to Etkin, this is connected with the understanding of traditional medicine that healing is a *process* and not necessarily the effect of treating a particular symptom (1988). The *efficacy* of the treatment therefore varies according to the specificities of the illness; the presence or absence of physical signs is not the only determinant of it. Different types of Eye, as well as differences between individual children affected, may call for more frequent application of the cure. However, since the cure is seen as a means of increasing the temperature of the body, healers try not to exceed three curing performances in a day.



Figure 6.1: Displayed components used to remove the Eye

Only slight variations in the healing process and expected outcomes can be observed. The ritual is rather structured and straightforward despite the many potential sources of the ailment. The efficacy of the treatment is not doubted, and the ambiguity of the symptoms does not affect the healing ritual. Consequently, the capability of a person to cure the ailment and the immanent power of the Eye are two closely linked variables. If the healer cannot remove the Eye, he or she will suggest searching for someone with more experience or power. This change of authority is important, since the new healer may end up referring the child to a health facility. While from a biomedical perspective this delay in seeking

biomedical advice is of great concern, I propose that Evil Eye could be regarded as a form of triage to bridge the gap between local care and the health centre. As Waldram points out, '*failure* also exists as a test of physician/healer skill, allowing for the emergence of specialisations and hierarchy of practitioners in which some are known to be more successful for specific problems than others, and in which notions of incompetence and malpractice can be developed' (2000:610). Although the healing process may differ slightly from one healer to another, their diagnoses tend to be quite similar, contributing to the stability of belief in the diagnosis and the associated health-seeking behavior.

There are significant differences between the way Evil Eye is treated when people fully agree on the diagnosis and the way it is treated when the people who are supposed to recognise and heal it are in disagreement. On the practical level, not only are important differences attributed to the 'character', or type, of Eye, but the actions undertaken as a consequence become fragmented or disjunctive. The result is a conflict not only over power between individuals, but also about the effects of the Eye and the significance of other symptoms, especially in connection with important health-related decisions. In such cases, mothers tend to privilege one or another explanation according to their social and economic situation, but they also favor responses that are more culturally accepted in terms of the system of health beliefs that explains the cause of the illness and who should be involved in the process of treating it. The following two cases provide examples of Evil Eye as a concept that expands the scope of illness and healthcare, creating a culturally appropriate knowledge domain of Evil Eye. These stories also show the underlying reasons for the high underreporting of ARI and ADD, as well as potentially life-threatening aspects of symptoms such as fever and diarrhoea, that can lead to death if not managed effectively at home. The extent to which people perceive the illness as having cultural relevance has a profound effect on their willingness to use one or another type of diagnosis and treatment. Cultural recognition therefore plays a major role in case management compliance. The first case shows how caretakers made considerable efforts to comply with therapy, but in a manner consistent with their underlying understanding of how the body and treatments work. It also shows the importance of family and community participation in the treatment of Evil Eye, playing an important role in the healthcare system amidst structural and social factors.

Rosario Rosario was a woman in her late thirties from Tuizacaja, Comitancillo. Three of her eight children had died at an early age. Sergio was one of them. He was one and a half when he died. The family had been celebrating 'Lord of Esquipulas, the Black Christ', a Catholic veneration of a crucifix found in the

municipality of Esquipulas, located in the department of Chiquimula in eastern Guatemala; this crucifix is considered miraculous. The celebration takes place on January 15, beginning with a mass and then continuing with music and food. Rosario and her family participated in the celebration during the four days of the festivities.

“We were celebrating the Lord of Esquipulas at the church. We once traveled to Esquipulas Palo Gordo, but that was a few years ago. Some people organised a trip there once, but normally we celebrate it here. Here is better because you can participate in the whole celebration during the four days that it lasts. During those first two days Sergio was fine. He played and ate as he did every day. But on the second day at night he started crying. He didn’t want to eat or take my breast. He complained about his stomach aching and also had fever; that’s why we thought it might have been Evil Eye. There were some drunken people at the feast, so maybe someone might have seen him, or maybe it was because we also walked under the sun. Normally Sergio recovered after the cures of Evil Eye, but that night he didn’t. I took him to a neighbor who quite often cures my children when they catch the Eye. “Maybe it is because we are too hot to remove the Eye”, said my husband, so we asked our neighbour to remove it. He said we should take Sergio to Comitancillo because he had fever in his whole body: “It might be something else”, he said. My husband said that [doctors] at Comitancillo wouldn’t be able to do anything, so we waited. Sergio had a strong blood but because he smiled a lot people were always praising him. This made him weak at times but at the end he got better. The next morning Sergio was healthy again. We bought some candles to pray to the Lord of Esquipulas for Sergio’s health. We asked the priest to give Sergio his blessing too. But an hour later, after we had arrived at the church, he vomited his whole breakfast and was feverish. . .

. . . We went to the pharmacy. The person who sold us the medicines told us, “I can inject him to reduce his fever”, but I explained to him that Sergio might have Eye and it hadn’t been properly removed, and this could be dangerous. “Give him this [saline] solution with this medicine”, the man then said. I don’t know what it was, but he said it was special to cure the Eye. He gave me a few of those packages to put in water and more medicine for the Eye. The rest of the day Sergio felt much better. “Maybe it was just indigestion” my husband said. I told him that I should go back home and take care of Sergio in case more people could make him more ill. I thought of buying something more at the pharmacy that could be much stronger, but when I asked at the pharmacy the man said that a bottle of the medicine that could help cost Q.70. . .

. . . That night my husband came home drunk. I got agitated because when he

drinks he gets violent. [That's why] I didn't want to breastfeed Sergio, [since] I could make him ill, so I wanted to take Sergio to Doña Patty, but my husband said "Better not", that Doña Patty only likes to gossip. I didn't know what to do but my oldest daughter decided to ask Doña Patty to come anyway. When she saw Sergio she advised us to take him to the hospital next morning: "Even if it is Eye he needs to be seen". Doña Patty worked a few years in Guatemala City and that's why she might not always believe in certain things we do, or tell people to do things we are not used to. That's why she has problems with some of the people who live here, because she acts different. But because she has a strong personality she's very good at removing the Eye. Sergio was feverish and his eyes turned white. She insisted on taking Sergio to some doctor. "She doesn't know", said my husband, "she only talks about people but knows nothing". He didn't want us to go. Because we were not going to go, Doña Patty came back with some Bebetinas[®] for Sergio's fever. I was relieved that these worked because I thought the Eye was finally leaving Sergio's body. It probably was a dumb Eye. Sergio had received only one cure for Eye, so the Eye probably just grew stronger. Because of the festivities many people were not at home, or were too hot or drunk to be asked to remove the Eye. He might have had a strong dumb Eye because he seemed to be okay at times. It was only the fever that we couldn't control...

...The next day Doña Patty came home and asked me if I wanted her to come with me to take Sergio to the health center in Comitancillo. Don Eduardo [the community health worker] was at his home when we got there with Jairo [my husband]. We explained to him how Sergio got ill and that we thought it might be indigestion and Eye. Jairo was still not sure about going to the health center so we wanted to see if he could give us some medicines for Sergio. "Does he have diarrhoea?" "No". "Does he have cough?" "No". Don Eduardo didn't know what it was, either. We told him about the fever. He gave us a bottle of Sulfa(prim) for Sergio but when we tried to give it to him he just vomited it. The things [symptoms] he had were serious but with every different thing we gave him, even if it was just a bit of it, he seemed to get better. Before midday my husband and I took Sergio to [the health center at] Comitancillo. While we were waiting for the doctor to see Sergio he started with yellowish diarrhoea. The doctor said that he was seriously dehydrated: "Don't stop breastfeeding him; also, he needs to be rehydrated", she said, but Sergio didn't want to eat or drink anything, I explained to her. She said Sergio needed to be taken to the hospital but my husband didn't want to. We explained to her that Sergio had been having fever and that we also gave him [saline] solutions. "So he has been like this for how long?" "Just recently", my husband said. The ambulance had left so we would have to take a taxi or go

on the bus. Jairo was about to leave soon for the coffee plantation, so he said we should go to a pharmacy instead. The problem was that Sergio vomited the medicines that should have worked. He wasn't part of the Mi Familia Progresá programme so we didn't have to take him to the hospital. We told the attendant that Sergio was dehydrated. He gave us some medicines and a few bottles of Gatorade. But we never used these. When we came back home Sergio was not breathing anymore." (Tuizacaja_2322)

The key to the prevention of adverse consequences associated with ARIs and ADDs among children under five years is appropriate primary care management, usually given by the mother. This example shows, however, that adequate case management is a more multi-factored social domain. We can see that it is not necessarily the recognition of symptoms or the management of Evil Eye that prevents an effective treatment. Rather, it shows the importance of knowing the causes and the development of illnesses and the appropriate interventions, and reveals the expectations of caretakers when antibiotics, antipyretics, oral rehydration solutions, and other biomedical treatments are used.

Although the responses of the various healthcare workers indicate how symptoms like Sergio's are generally treated, the treatments vary depending what is considered 'adequate' management at the moment in the course of the illness when the intervention takes place. Thus, perceptions and practices related to management of symptoms are constantly influenced by decision points that can assist or hinder this process. In Sergio's case, the illness was labeled first as 'non uncommon' for the child's situation (elevated body temperature for several hours that became uncontrolled). The responses were first to acknowledge the illness and consider how serious it was. These two points—the effect of excessive heat and the body's response to it—answered the questions 'What caused the symptoms?' and 'What is considered an appropriate response to this cause?' The conflicting interactions were therefore not the result of ambiguity of the symptoms, but the way in which the subjectivities of the illness were negotiated (such as the ability to negotiate healthcare practices, and the space for dialogue between healthcare systems). Evil Eye is therefore a 'bodily event', not only in its biological aspect but also in its social dimensions. However, it is not always possible to clearly differentiate between the biological and the social dimensions, nor is it possible to reduce the illness to one or the other; it encompasses material, physical, social and biological entities. Since the concept of Evil Eye is a cultural construct and does not exist outside its own realm, the capacity to negotiate healthcare practices develops into a central dimension to mediate between healthcare systems and gender or family dynamics. Evil Eye becomes an embodiment of the illness as a site of social struggles and

the possibility of negotiating strategic healthcare practices. The ambiguity of the illness allows the actors to ‘manipulate’ and acknowledge the symptoms (taking them and their outcomes more or less seriously), showing how the ‘ill body’ creates practices of knowledge production. As a result, Evil Eye’s social embodiment turns into a place of control and discourse strategies that deal with authoritative discourses (of health) and roles. Upon this basis of diverse possibilities of how the symptoms might develop, caretakers open channels that can socially and materially help them to overcome the problem of how to deal with the illness, taking into account the ever-present variability and dynamics of the Evil Eye.

Healthcare behaviours and treatment adherence are interwoven strongly with gender roles. During the ethnographic research, there were frequent comments from women who could not make decisions without first asking their husbands, or who did not have the money to make a decision that required economic resources. Some women mentioned that they had borrowed money from someone, but this practice was kept secret, especially because they would need their husband’s consent or the man would be upset at the implication that he could not care for his family. Although the patriarchal system acknowledges women who have many children, women experience a burden in seeking healthcare when they lack the capacity to make decision. During illnesses, only ‘serious’ conditions are considered legitimate reasons for accessing formal healthcare. However, the decision of whether a child is seriously ill or not, and hence the decisions about where to take the child or whether to provide money to buy medicines, are considered the responsibility of men, which delays access to healthcare. Even though women are the primary caretakers for ill children and are the first to seek healthcare for them, the rationality and power in the situation belong to men. In the case of Evil Eye, however, female caretakers can break this role of authority by making use of social resources, in the way that Rosario sought help from Patty. Rosario knew that her husband did not want her to ask her neighbour for help, but she was concerned because she considered the Evil Eye symptoms severe. Rosario was able to take control over the health-seeking process by insisting that Sergio’s symptoms required treatment. Women can influence or manipulate healthcare behaviours for Evil Eye by labeling the illness as dangerous.

Elvira Elvira was 27 years old when I met her sitting outside the RENAP¹⁴ in Comitancillo. She gave birth to her seventh child, Jonathan, in a private hospital. Jonathan was perceived as having been born weak and therefore prone to catch the Eye. The process of treating him was never straightforward, but involved different approaches and outcomes. While she remembered and talked

¹⁴National Registry of Persons.

about the circumstances and settings in which her babies were born and the conditions that surrounded their deliveries, the experience of Evil Eye emerged several times amidst her personal calamities and suffering. Although Evil Eye's symptoms are usually regarded as unambiguous, sometimes the boundaries between this and other illness becomes blurred, allowing mothers or caretakers to negotiate in order to avoid specific healthcare behaviours that make them feel vulnerable or that expose them and their children to negative effects.

“In the third month [of my last pregnancy] I started with vomiting and headaches. I stopped eating for almost two months. I lost my appetite. One day while I was at home cooking I just lost consciousness. My husband found me on the floor! And then he took me to see Douglas (a private doctor in Comitancillo). He said that it was my heart and gave me *neurotropas*. He measured my pulse, put a cold thing on my heart and said my heart was weak. A couple of days later I went to the health center for my prenatal checkup and explained what had happened to me. The doctors gave me vitamins and some injections until the last month of my pregnancy. The day I started with contractions my midwife came home around 2am. She stayed with me until late in the morning and told me I was too weak to give birth at home so my husband took me to Douglas. I was afraid of having a child again on my own. The last baby I had before Jonathan was born [at the national hospital] in San Marcos. I remember they gave me only a hospital gown to wear. I was completely naked and had a hemorrhage. The nurses were mad at me because I had stained the sheets several times. “We don't have enough sheets! Tell your husband to bring your own or stand up!” they told me, but I was feeling dizzy. So I didn't want to be at the hospital again. But my husband decided to take me there and the midwife also said it was the best. When Jonathan was born I only spent two days [at the hospital]. It wasn't so bad, it was even like staying in a hotel [she laughs], but because I couldn't go to the *chuj* and I didn't have enough breast milk we both remained weak. Since I had my twins, I get ill while I'm pregnant. My midwife says that's why I lost consciousness. The twins were born at home but one was born dead and the other one died a week after.

... Once people knew I was pregnant with twins, some got very jealous, which made them [the babies] weak. I didn't know that children could get the Eye while the mother is pregnant. I had diarrhoea the whole time, which is a symptom of the Eye, but that's just supposed to affect babies [directly]. So now if my children or I fall ill I go to see a healer because it might be an illness that you know but can't recognise. But they explain to you why the illness is different. There are people who are very sensitive, she told me. But at the health center, for example, they only gave me vitamins. I had a lower [abdominal] pain the whole time but

they said nothing. Apparently the twins were fine. I never fully recovered after the twins, so my body gets weak when I become pregnant. When my other children were born, all of them became ill with Eye. I have learned now that the way Evil Eye affects the children can be different even if they are still in your belly! My husband is of the opinion to have our children at the hospital because I get weak, but my midwife knows better so I prefer to see her. When I'm pregnant she also massages my belly, and this helps me and the baby. I don't like much to go to the health center anyway. You go there and you are always afraid they might say something you don't understand or tell you to do something you cannot do. If my children don't recover I seek help at the pharmacy or with a healer...

... [Nowadays] there are nurses who speak Mam, but they don't believe in our customs any more, or at least that's what they say, so they ignore the fact that there are some [symptoms] that need another treatment... So it's not easy to reach the same opinion, especially if every person you know or lives with you has a different opinion. The doctors' opinions are always different. They do not approve the use of the *chuj* or of giving birth at home. But when you give birth at your home everybody is there to assist you and help you with the baby. My mom stays for a few days or comes everyday if necessary. If you give birth at the hospital they leave you there alone, and if you are tired you cannot see if the baby needs something, and when you come back home people think that because you gave birth there and are back you are feeling good so they don't come to help you. It was good that Jonathan and I only spent two days at Douglas because then the midwife was able to remove the Eye he might have had and my family came to help me". (San Pablo_1135).

Evil Eye can work as an instrumental approach to emotional conflicts that arise when some healthcare practices are seen as inappropriate. Although Evil Eye plays a central role in healing practices for children, it is also a platform that helps caretakers to cope or overcome unsupportive encounters with healthcare systems or families, in which they experience disrespect or neglect. The particular relationship with healers or midwives, for example, encourages women to negotiate their wishes in an ongoing process against pressures imposed by biomedical encounters, where patients may be subjected to negative sanctions or feelings of shame, such as Elvira's story of the nurses complaining about the sheets being stained with blood. Thus, in addition to allowing mothers to follow practices they find more suitable, and that provide an understandable structure of (illness) experiences, Evil Eye is also a social orientation action that unfolds forms of collective healthcare management. Caretakers feel free to seek help from close neighbors or friends, an accepted way of transgressing the normative behavioural patterns. Hence, Evil Eye reflects

the long-term effects of sanctions that influences healthcare practices, but more importantly, it provides a base for different types of *generalised reciprocity*, which, according to Sahlins (1965, 1968), constitute a mode of exchange in which the expectation is placed on the social relationship between individuals rather than on an exchange obligation of material support. This support comprises significant and indefinite ties sustained among families, neighbors and communities that provide cultural explanations of Evil Eye as well as the solutions for the problems it represents (cf. Migliore 1997:54-61).

There is still a huge deficit in the treatment of children for symptoms that do not correspond to those of Evil Eye. The ways in which caretakers view and categorise illnesses are crucial for the appropriate and consistent application of both traditional and biomedical healthcare behaviours. With respect to ARIs and ADDs, caretakers engage with healthcare practices more actively when informal or traditional healthcare form part of the intervention measures. This study also showed that gender plays a crucial role in the patterns of health behaviours and intervention practices, regardless of the symptomatology. This does not imply that social relations are always a hindrance or a potential barrier to access biomedical care. Yet, this research showed that Evil Eye plays a crucial role in the patterns of healthcare and behaviours. When other members of the family or community were included in the process, interventions were often more timely, following socio-cultural dynamics, since women could utilise a pluralistic model of care (public or private, allopathic or traditional) depending on the perception of Evil Eye's severity, which they are considered to be in a position to judge. Certain healthcare practices also raised questions about the power of language in terms of interpreting signs and symptoms and the different outcomes that can result from these different interpretations. For ARIs and ADDs, in contrast to Evil Eye, the severity of the disease, the type of treatment required and the use of healthcare facilities depends strongly on the healthcare practitioners, whose authority to label signs and symptoms controls access to healthcare facilities and treatments. This certainly has severe repercussions on symptoms assessment. Results of this research showed, for example, that the symptoms of children suffering from ARIs or ADDs were reported less frequently for healthcare seeking than symptoms of Evil Eye, suggesting the difficulties for caretakers to recognise appropriate and timely care for these prevalent diseases.

6.5 The Role of Divination in the Healing of Evil Eye

Divination, always practiced in private, is strongly associated with the healing process of Evil Eye. Healers can access the 'hidden Eye' when they use divination. The divination process consists of ascertaining where the Eye is placed and measuring its strength using specific herbal remedies. This will determine the number of cures and the procedure required to cure a child completely. The question of who has made the child ill only arises in rare cases. If someone is believed to have unintentionally made the child ill, he or she may be asked to perform the healing herself/himself. Sometimes this accusation works as a way of disciplining a social body that is displaying forms of behaviour that are considered inadequate or intolerable. The most common of these cases are drunken individuals. They are never directly criticised, but people demonstrate their concern or antipathy in a private, direct manner without open censure. If a person is suspected, but not sufficiently well-known or trusted to be asked to perform the healing, the caretakers will only mention their suspicion to the healer, who needs this information because the source of the Eye can greatly influence its strength. Failure to remove the Eye is normally never attributed to an incorrect diagnosis or lack of trust in the healer's powers, but rather to the Eye's strength and/or the patient's fragility. When the Eye is perceived as too strong, renowned healers or midwives are sought out. Strathern suggests that 'social control, the integration of groups, and the promotion of sociability are central in ceremonial exchange', as is shown in the Evil Eye healing ritual (1988:3).

Whyte states that, from an anthropological perspective, the ritual process of healing and divination is frequently turned to as a response to crisis, which helps to re-establish order, on either an individual or a social level. The problem with this approach, he argues, is that the 'intention' may be incorrectly taken for its 'results', and the role of the problem solving and formation of meaning is overrated (cf. Reynolds 1997:81). This critique draws explicitly on the aspect of *beliefs* attached to healing efficacy, which is commonly found when approaching (spiritual) healing and which is what healing divination is about. Divination, however, is still an important part of the therapeutic mechanism in health-seeking in general, an essential source that combines coded ideas, values and social structures shared within a group, yet devoid of authoritative statements. For this reason the effects of divination and healing should not be dismissed or explained in merely 'cognitive' terms.

Although caretakers can suspect or identify the Eye, the healing ritual specifically

determines whether the symptoms are all related to Evil Eye or associated with some other illness. The main symptoms need to change after the first few cures in order to ensure that the healing is having the predictable or expected results. The method of divination for Evil Eye makes use of the symbolism of *anima*-heat and its relation to spirituality.¹⁵ In this framework the Eye corresponds to the idea of a powerful, living entity with a physical form that communicates through fire. From an emic perspective, however, the Evil Eye is not symbolic but is a real, intelligible and recognizable element. Since the Eye is an animate entity, language, i.e., communication, is very important. The healer ‘talks’ to the Eye and uses medicinal plants as a vehicle of communication. The communication constitutes an effective step in the healing process.

To ensure that Evil Eye is properly treated, a therapeutic intention with two emotional variables is required: a specific condition of care, where the healer prepares her/himself and the child for the healing, entering into a state of relaxation; and an emic perception of the child that is being treated, where the person who is performing the healing needs to recognise the severity of the Eye. For this the healer needs to open her/his channels of consciousness in order to become aware of the presence of the Eye, since the central purpose is to be able to remove its bad energy from the body. Healers need to prepare before the healing begins. A healer who has been working and feels her/his body is too hot, or charged with negative energy, will not only provide an ineffective healing but could also endanger the patient. It is essential therefore, in the first step of healing, that the healer feels in a state of balance. Certain hours of the day, when this balance is more easily reached, are preferred for conducting the healing, in order to increase the efficacy of the cure.

In this research, healing practices to remove the Eye did not significantly vary and included three components. First, *cleaning* was important to identify the child’s state, as a part of the healer’s assessment of the patient. Second, *purification* enabled the categorisation of the type of Eye, crucial for removing it. This phase is considered to depend on the healer’s *don*, or power, which will make it easier or more difficult to remove the Eye. Third, *removal* is the process of measuring the Eye’s strength and deciding whether the child has been cured, and possibly to provide another diagnosis, in which the symptoms could be classified as part of a diarrhoeal or respiratory infection.

¹⁵See Chapter V.

First Phase: Cleaning

The ritual for casting out the Eye is not seen as strictly a ‘woman’s ritual’, but as a practice that can also be performed by men. It is not related to any kind of ‘obligation’ or special kin relationship; rather, it is attached to a personal attribute of someone that can drive her/his power to cure. In this sense, natural and social attributes are part of the same representation and not two separate elements. A midwife or a healer therefore accepts the petitions of people to help them, since their function becomes their community responsibility. Normally the healer or midwife pays a visit to the house to perform the healing. However, in cases where the child is believed to have a powerful Eye, healers or midwives of great reputation from other communities are sought, to whom the child needs to be taken. However, there is no such figure as a ‘specialist’ for removing the Eye.

Since the mother has previously been at the healer’s house to make an appointment for a consultation, there is no a big prelude before the healing takes place. However, the place and space become an important therapeutic area, where normative practices are observed. The people who live in the house welcome the healer and the space becomes a therapeutic space for the duration of the ritual. If other members of the family are present, they are allowed to remain, but are required to keep their distance from the healer and patient. The healing always takes place in the kitchen or somewhere close to a stove or open fire. There are preferred hours in which to carry out the healing, in particular during the morning and in the evening, thus avoiding the hottest part of the day that would increase the temperature of the healer’s body. If a person is physically or emotionally fatigued—that is, in an imbalanced state—a healing cannot be performed.

Sitting close to a fire or stove, the healer carefully arranges on a table all the remedies that will be used to remove the Eye. In order to obtain a more precise understanding of the patient’s state of health and the measures required, the healer converses with the mother while placing the therapeutic mixture on the table. After everything has been prepared, the healer sits on a bench or chair and starts the procedure. For this stage, peppercorns (*Piper nigrum*) are always used, wrapped in a piece of blanket, making a little sack that is passed along the whole body of the child, from the top of the head to the feet. Vital spots that need to be touched are the head, heart, stomach, arms, legs and feet. The person performing the ritual normally holds the baby on her/his lap, but some prefer to have the mother hold the baby to prevent discomfort in the child. The only clothes that are removed in some cases are socks, and the hat if the baby is wearing one. The healer passes the little sack under the baby’s shirt, rubbing her/his chest and back several times. The number of peppercorns is always twenty-seven, divided into



Figure 6.2: Doña Isabela preparing the therapeutic mixture

three groups of nine. Peppers are used as a vehicle to transport the Eye outside the child's body. After the rubbing they are discarded into the fire in order to destroy the Eye by burning.

Although caretakers and midwives could not explain the reason for always using numbers that are multiples of three, a few healers stated that the numbers 3, 9 and 27 represent a 'balance'. However, their attributes and meanings varied among the healers. Some associated the number 3 with the Holy Trinity, others to points of opposition and convergence. The only shaman interviewed provided a more elaborate explanation, stating that 9 describes the cosmic levels, a rationalisation of ritual calendars and galactic cycles. Nonetheless, even when people could not explain the use of these numbers, procedures or objects used for the healing were never an arbitrary number, but quite consistent.¹⁶

Some healers also made use of aromatic smoke (*sahumerios*) and whispered a

¹⁶Firestone (1962) described the same ritual performance of Evil Eye for Sephardic Jewish children living in Seattle. The healer passed some spices over the head, around the face and across the chest while a spell to cast out the Eye was recited three times. Just as in rural San Marcos, the spices were thrown into a fire, where they crackled and sparked. In this ritual, the patient, not the healer, sips a mixture which is also rubbed on the same places mentioned above.

special secret prayer. ‘Eye, leave this body’, the healer said while the peppers were burned, calling out the name of the baby in a chanting tone. This action would be repeated three times until all the peppers were burned. In severe cases, the healing could not ensure that the Eye was no longer in the baby’s body. It was only by observation over the next few hours (or day, depending the symptoms) that the child’s condition could be confirmed. There was no divinatory ritual to identify the source of the Eye, but mothers tended to mention various events in order to determine the place and time where the child might have gotten the Eye.

Second Phase: Purification

The purification phase makes use of ‘agua ardiente’ (inexpensive cane alcohol with between 20% and 60% ethyl alcohol), pepper and ruda (*Ruta graveolens*). No specific brand of alcohol was required, but normally a cheaper one was used for this purpose. The hot property of *agua ardiente* cleans, and purifies the child’s body, channeling the Eye out of it. It represents water, blood and other fluids. Its purpose is to decontaminate the child’s body, but it also serves as a protection to retain the child’s strength. The peppers are first chewed by the healer, and then she/he takes a sip of the drink and spits it all over the child’s body as forcefully as possible, in order to scare the Eye and make it leave the body. This is repeated three times.



Figure 6.3: Channeling the eye out of the body

During this process, the healer enters into communication with the patient by calling the child’s name. The calling creates a connection between healer and patient, helping the child to stop the force of the Eye. The purpose of calling the child’s name is to help her/him to leave the threshold of liminality, a condition that will help the child to regain her/his strength. It is believed that the relationship between the patient and the illness is determined by the energy forces between them. The type and severity of the connection depend on their locations in the

body, but the Eye is believed to an almost immediate organic dysfunction no matter where it is located, since there are parts of the body where it can remain without difficulty and provoke an effect of pain, discomfort or imbalance. The force and size of the Eye determine the frequency of the healing performance.

Third Phase: Removal

In some cases, healers use chicken eggs. A raw egg is swept all over the body of the child along with pepper and *ruda*. These steps are repeated at least three times in the same cure, depending on the strength of the symptoms. The egg is then placed overnight under the bed where the child sleeps. The next day the egg must be broken into a glass to verify whether the Eye has been transmitted into it. The egg yolk must show a black spot in the form of an eye, proving that it has left the child's body and been absorbed by the egg. In severe cases this procedure needs to be repeated for at least three days. The peppers that have been passed over the whole body are burned over hot coals. The peppers must explode when they are thrown into the fire, signifying that the Eye has been absorbed into them and they have become the repository for the force. As long the peppers continue bursting, the healing process is taking place. If the peppers do not explode, the reason can be either than the symptoms are not from Evil Eye, or that the Eye was not very powerful.



Figure 6.4: Process of burning peppers over hot coals

At the end of the healing the plants are also burned. If after three days of uninterrupted healings the child is still ill, or some symptoms have worsened or not improved, Evil Eye is rejected as the source of the remaining symptoms. Similarly, Galt's work on the practices of diagnosis and treatment in Pantelleria shows that the Eye needs to manifest itself in a way that makes it clear to the healer (and the

patient) that it has been cured or cast out. A bowl with fresh water and salt is held in front of the afflicted person while the healer touches the patient's chest with his/her finger while praying, invoking the holy power. At the end of the prayer, the sign of the cross is made over the bowl and some drops of oil are placed in it. If the patient remains afflicted by the malady, the water and oil will mix. This elaborate oracle is used in order to account for the origin of the Eye, to indicate its power and source, or to dismiss Evil Eye as the source of the symptoms (Galt 1982:673-674).

The *healing imaginary*, as opposed to the *medical imaginary* (cf. DelVecchio 2010),¹⁷ draws attention to the way in which the social and physical world is constructed around the therapy management in a more private, face-to-face sphere. The specificity of the diagnosis and therapy appear to be significant in initiating affective behaviours inherent to the process of healing and relief which differs from biomedical interventions. Thus, the differences in the symptomatology lie not solely in the structure of cognition (differentiation of types of diarrhoea, recognition of danger signs, etc.) but also in content (a more structural cognitive mapping of meaning and outcomes). While the healing of Evil Eye cannot necessarily provide the cure, it contributes to reducing the anxiety of the mother, as opposed to 'hope' in the curative measures provided by the health facility, with their high expectation of therapeutic efficacy. Waldran notes that healing 'can be directed toward alleviating physical pain and suffering but often also concerns itself with repairing the emotional state, possibly even leaving the pathology itself unaltered. . . In this sense, healing becomes a means of coping with disease, distress, disability, and recovery' (2000:606).

While biomedicine normally approaches a problem by using pharmaceutical treatments, which do not necessary provide the cure but may have some placebo effect, folk explanations of the illness offer other elements that can develop into strategies and care management. For example, since people recognise many aspects of social or environmental exposure as predictably and potentially dangerous for acquiring the Eye, some parents choose to leave their children at home with relatives when possible, since they are afraid children will fall sick if they are taken outside. Some use protective amulets in the form of a red string, a bracelet or a necklace with a gold pendant to protect children from harm and repel undesired feelings or energies. However, this practice is no longer very common; it is used only in cases where the child is prone to contracting the Eye, or when a child may be exposed to external conditions for a longer period of time which is perceived as

¹⁷The *medical imaginary* is constituted by the subjective experience of patients who embrace biotechnology, the political economy of hope, and the clinical narrative' (DelVecchio 2010:272).

risky. Wearing an amulet is regarded as not very effective offering some additional protection. Nonetheless, it is common to see children wearing jewellery that has a religious or spiritual meaning, such as charms or figure pendants portraying the crucifix, the Sacred Heart of Jesus or the Virgin, but these are used for general protection and not exclusively to avoid being afflicted by the Evil Eye. Since the effectiveness of an Evil Eye amulet is considered to be uncertain, this practice is combined with the use of some drugs and herbal infusions, what Waldram calls 'the biomedicalisation of traditional medicine' (2000:607). The most frequently used substances are medicinal herbs in the form of infusions, specific to treating the Eye, and a drug called *pill of life*.¹⁸ These are complementary to the ritual healing and not used as a replacement for it.

Social encounters during the treatment also play an important role in the healing strategy. People acknowledge that the social environment can influence the way they feel. Children are also susceptible to this influence. Illnesses, misfortune, marital or family problems, community distress, and other difficulties that disturb people's well-being are sometimes seen as diffuse expressions of such relations. People normally do not talk openly about such problems, which prevents them from dealing with them. In the context of Evil Eye, these troubles cease to be marginalised and instead become located within a social context, in which everyday problems can be handled. In this way, the Eye becomes a powerful symbol of suffering (cf. Migliore 1997:112-113). Caretakers may obtain help or support from relatives when facing a severe crisis, not only because Evil Eye signals distress and affliction, but also because the healing leads to therapeutic encounters where mothers are assured of support and understanding, bringing some order into the disrupted life world of their everyday experience.

6.6 Evil Eye's Social Conception

In people's narratives, the concept of Evil Eye is placed within different experiences that include aspects that can be explained or influenced by its presence. This possibility of including the concept in the powerful discourses employed by health services, or by members of the family or community, transforms the illness conception into a *language of argument* that creates alternative, but conflicting, lines of reasoning (Migliore 1997:90). Attitudes, social perceptions and emotions

¹⁸Most of the pharmacies in rural San Marcos sell these pills in little plastic blisters. They are believed to help the body remove the Eye and restore its balance. They are sold in the form of little pink-red tablets, easy to dissolve or swallow. However, these pills are of unknown composition, probably originating from illicit drug sales. At the time of the research, no study had been done to identify the chemical composition of these drugs. However, the use of them to treat the Eye is quite common.

concerning Evil Eye involve continual representations and translations of bodily states and collective participation, since the illness refers not only to the physiological condition of the afflicted child but a social system of action—that is, both the illness and the recovery are social. Several narratives from caretakers of children afflicted by the Eye recount episodes in which mothers perceived disapproval in the attitudes of other people, and linked this disapproval to their children's illness. These cases, like many others, display Evil Eye as both a powerful premise and a deductive argument, conveying important social and physiological connections that develop into healing strategies and forms of relations:

Sonia: “When we came back from the post center Ronaldo had fever. We went there because he had a cough I couldn't alleviate with infusions and a syrup the nurse gave me for him last week. I think the nurse made him ill because she reproached us when I told her I couldn't take Ronaldo to the health center in San Lorenzo after she said that she couldn't do anything more for him and I needed to take him to the health center. My mother-in-law told me that she could take care of my other two children if wanted to go to town, but only because she needed something. She said the fever Ronaldo had was something that needed to be seen by the doctors, but why did he only start with fever after the nurse said she couldn't give us any medicines? Doña Lupe [my neighbour] was very kind to cure Ronaldo; she cast the Eye away so he got better. I decided I would only take him to the health center if the fever wasn't [the result of] Evil Eye”. (Caballería)

Cipriana: “Carmela came by during the morning and asked me if I could lend her some cooking oil. I was about to leave and told her to come back later, but she probably thought that I didn't want to give her any oil. She always comes once a week and asks for something. She doesn't have a husband; he died in a road accident a year ago, and left her with four children, so she's always asking the people in the community for money or things. When I came back [my daughter] Celeste told me that [my son] Pedro Luis was vomiting. I left my children at home because I was just going to Santa Rosa to see my sister. They were outside playing when I left. I think Carmela made him ill, probably because I didn't give her the oil, so when I came I asked her to remove the Eye. ‘I don't have time’, she told me. ‘Here is the oil’, I said. She came to our house that evening and removed the Eye but Pedro Luis didn't get better, probably because she was still mad at me. That's why when she asks for something I'm afraid to say no”. (San Lorenzo)

Evil Eye's permeability is not necessarily correlated with biomedically defined symptoms, but also comprises several local terms that allocate and communicate moral ideas, danger and distress, developing in a rather widely varying approach

(cf. Migliore 1997:113). Evil Eye is therefore not a rigid or exclusive concept, but a flexible term that can convey different messages and discourses as a means of altering personal relations. The messages implicit in Evil Eye reflect the fact that perceptions and practices help to shape individuals' attitudes, and that Evil Eye has the capacity to influence social relations regulate behaviours in the form of expectations that could result in negative sanctions for both parties, i.e. the caretaker and the caster of the Eye.

In the realm of the caretaker's interpersonal relationships, Evil Eye reflects important aspects of the social image of mother's behaviours. The fact the Evil Eye affects mostly children shows the significance of looking at the role of women's embodiment or agency in dealing with illnesses, treatments, or coping strategies. Women not only 'transmit' or 'carry' the ailment, but also embody and signal certain healthcare patterns, a metaphor or form of moral order that includes significant others. Negative attitudes, vicious gossip, lack of support and contempt can also have long-term consequences to the child when attitudes towards caretakers' beliefs and behaviours are subjected to disrespect or disapproval:

Magdalena: "Ligia [my sister-in-law] didn't want to take Jeremías to remove the Eye. She said the Eye didn't exist. Ligia said that Jeremías was *really* ill, and that we just believe in the Eye because we are afraid of going to the hospital. She and my brother don't have children yet. They married a couple of months ago. She says that when she gives birth she wants to go to the hospital... But then when she saw that my son wasn't getting better even after the medicines we got at the health center, she didn't say anything when we all took Jeremías to remove the Eye. Because she didn't believe in the Eye she was making him *more* ill. But my mum finally convinced her and she agreed to also cure Jeremías to remove the Eye too, so he got better". (Talquichó)

Marta: "I was feeling ill, *really* ill. I had headaches, my body and throat hurt, and I felt tired most of the time. When [my son] Ignacio fell ill with the Eye... he was only sleeping, his eyes were sunken, and then he had a dry cough. I told Sebastian [my husband], "Ask Señor Tere to see if he got the Eye so she can remove it", but he said I was just being lazy, that I didn't want to do anything. Sebas was resentful because he had asked me to tell my brother to lend us some money because we were building a house but then we ran out of money. I didn't ask my brother for money because once I did and he said that I have a husband... Sebas thought I didn't want to ask my brother [to lend us money] and said to me, "You are not ill, you are just lazy, you take Ignacio to Señor Tere". Ignacio and I were really ill and by the end of the week my mom had to come and help me. Ignacio had a *dumb eye* she cured. I went to the health center in Comitancillo on Saturday

and the doctor said I had a virus...My mom told Sebastian, "You can't let an Eye grow, because if it explodes Ignacio could die" ". (Los Bujes)

To describe and explain all the possible conflicts within families and communities are beyond the scope of my analysis, but Evil Eye appears as a possible source or influence across a wide range of behaviours, with a variety of effects on social environments and health. The many aspects of Evil Eye not only serve as an explanation of a child's state but also—directly or indirectly—provide a number of powerful ideas about physical and emotional suffering or distress in a caretaker's life in attempt to control or influence the behaviours of others to act according to Evil Eye's belief, i.e. expectations and social support. Ligia's and Sebastian's lack of support are examples of this dynamic. As a result, a general social consensus is needed to determine whether or not the child has Evil Eye, and what type it might be, in order to decide what treatment is needed, and to whom they should turn to confirm the moral or social reference—that is, the language of argument (cf. Migliore 1997:99-113). Midwives' opinions concerning Evil Eye are regarded as accurate, yet generally the decision to take the child to a medical institution (post, health center, hospital, and private clinic) on the advice of a midwife largely depends on the opinion of husbands, parents, and parents-in-laws of the mother. As stated by Weiss, 'local cultural context underwrites family judgments about help-seeking, treatment and evaluations of whether care (including biomedicine) is acceptable or successful. Local power relationships in the social network maybe a stronger determinant behavior than the recommendations of healthcare providers' (Weiss 1988:6). This is a key to understanding Evil Eye as a dynamic entity, since it is continually being shaped and reconstructed in the course of the illness and the associated social engagement, in which it becomes collectivised, mediating between symptoms and intersubjective experiences.

Most of the caretakers described the events that triggered the Evil Eye as disruptive occurrences in their own lives, events that are regarded as plausible reasons for the illness. As a result, Evil Eye can also increase the risk of deterioration of the child's health if acknowledgment of the illness is delayed or the necessary social support is not offered. From this point of view, if the mother feels peripheral to the problem, treatment for Evil Eye would merely require treatment for the manifested symptoms. On the contrary, Evil Eye does not cease to exist if a therapist or physician does not find anything pathological, since its recognition is based largely on a social consensus about who can be a healer capable of curing the Eye. Therefore, the malady becomes a (treatable) illness only when it is acknowledged by the community, which identifies the criteria for illness as an objectification of suffering. The fact that mothers can identify isolated incidents

perceived as disruptive, but that these opinions need to be validated by members of their family or community, suggests that social or family networks constitute an important part of the healing process. Accordingly, Kleinman suggests that 'illness idioms crystallize out of the dynamic dialectic between bodily processes and cultural categories, between experience and meaning' (1988:14).

The emphasis on 'otherness', in connection with Evil Eye, thus becomes an articulation of self-affirmation and the acknowledgment of others. Evil Eye is thus a social dynamic process that not only exists as a form of individual illness, but depends on external recognition (which is flexible and situational) of relations between groups or individuals. In this sense Evil Eye becomes at times an over-employed term because of its permeability or ambiguity with respect to expectations of 'neglect' and 'attachment' or care. Evil Eye is therefore a social form of 'neglected actions' translated into care relations (attachment) crucial to restore health and well-being. Similarly, Migliore suggests that 'the implication of *mal'uocchio*. . . helps people to condense and concretize their idiosyncratic feelings, and transform them into a culturally recognizable expression of distress' (1997:68). Just as a disease has to be medically relevant to be included in biomedical frames and for health practitioners to engage with it, the effects (or outcomes) of Evil Eye cannot remain socially marginalised, since its validity depends upon inter-group relations. Further, not providing help to a caretaker in need would also jeopardize social relationships with larger consequences within communities (idem, pp.74-98).

Illness is a 'mark of the *lifeworld*'. It marks the 'body' (with symptoms, scars, stigmas, and ways of contact with technologies, health facilities and providers) and articulates social relationships around the ill. An illness therefore communicates and becomes an active part of the 'collective body'. For this reason, an ill person turns into a moral responsibility, displaying specific behaviours of avoidance or attachment between patients and those who feel or are responsible for the ill. Accordingly, Turner states that 'at the everyday level, social experiences of illnesses are equally shaped and constructed by cultural assumptions and social relationships. At this level of lay beliefs, there is a continuing tendency to see illness experiences within a moral framework of blame and responsibility, a framework that attempts to help individuals, in predominantly secular environment, to answer questions about life and death' (2000:22). The most fundamental characteristic of Evil Eye is that it is a way to make visible certain cultural aspects that, although perceived as 'natural' and 'common', are signs of social deviance, marginality and encoded forms of suffering. The illness concept results in differences in form and correlations, which can be redefined according to their implications. Caretakers, for example, take Evil Eye as a 'measure' of a weakened state of children regarded

as prone to illnesses. It ‘marks’ the body not only biologically but also within a vast range of particular practices that are considered necessary to gain strength or obtain protection, including the caretaker or family of which the child is a part. Since the concept is not an absolute idea or notion of illness, stable and delimited, but is flexible and situational, it only gains *form* through its cultural meaning and recognition. This is to say that if Evil Eye were only ambiguous or vague in its outcomes without social acknowledgment, the illness would just become a personal abstract feeling, without logic, closer to the idea of bad luck and always open to personal interpretations.

In this sense Tapias says that ‘the body and its ailments communicate polysemous messages of disappointment, neglect, economic scarcity, marital, or household conflict. Many of these messages are imbued with moral value. Furthermore, these ailments and symptoms may help structure social obligations, social roles, and the relationship between people. In evoking a particular illness category, people might receive greater empathy and support from those around them’ (Tapias 2015:75). Yet despite Evil Eye’s ambiguity and variability, the representation of *doubt* with regard to its pervasive dangers serves as a reflexive social interaction that maintains a form of social protection and reciprocal exchanges. Thus, although symptoms determine healing and caring practices, cultural explanations of Evil Eye are also relevant since the effects at the social level, as rationalisation of the cause of the illness, are culturally axiomatic. The moral responses to Evil Eye are encoded sociocultural references associated with diverse practices which guide or influence people’s health-seeking and care behaviours (from either the caretakers, family, or community). However, since the features and effects of the illness prompt proximal or distal actions, it also means that the illness is marked by uncertainty, not only in terms of its symptoms and outcomes, but also the degree to which individuals share ideas of how the variability of the symptoms can be assessed and what the anticipated or expected responsibilities should be, which may create problematic social interactions.

6.7 Conclusions

While the biomedical paradigm classifies biological disorders in terms of signs and symptoms to identify a ‘real’ pathology, patients and caretakers code such experiences with the help of their own perceptions and knowledge (cf. Good 1994), expressing pain and suffering within a different framework because they have profound implications for understanding an illness and its course. The actors involved in the process of diagnosing an illness and translating the ‘traditional’ and ‘biomed-

ical' explanations to each other therefore become central in the process of establishing social relations and their effects on people's lives. The importance of this translation process, and the use of the Evil Eye concept, can favour or disadvantage one explanation compared to another. The importance of the 'biological' in the realm of healthcare is that symptoms and signs constitute 'proof' of a pathology that triggers specific health-seeking behaviours. Yet illness not only mobilises actions around the ill but also gives the patient (or caretaker) an orientation point to deal with the underlying social and cultural aspects. In this sense, Evil Eye depends not only on its symptomatology for the recognition of its importance, but on the invariability of the life situations that provoke such symptoms. Although Evil Eye can be found in many places, the cultural category and its symptoms is deeply embedded with the life context of poverty and exposure to cases of diarrhoea and respiratory infections. Evil Eye embodies several aspects of illness that are not only health-seeking but also social-support oriented. Since the symptoms are enfolded within a social referential (not only the social environment, but the fact that it can only be cured by specific persons), the illness frames important references that are common to everybody.

The clinical handling of diarrhoea and respiratory infections is always limited to the provision of treatments that are often linked to conflictive interactions between healthcare providers and caretakers. From the perspective of the healthcare providers, these illnesses are the result of lack of hygiene, non-recognition of symptoms, and non-compliance with expected health-seeking behaviours. Caretakers, however, see the symptoms as part of Evil Eye, a result of shared subjectivities of notions of suffering and the caretakers' agency to provide care without being considered 'negligent' or 'ignorant'. Evil Eye is not always coherent. It is precisely its capacity to be *both* vague and unambiguous, and to arise within a variety of experiences, that makes it necessarily a case for negotiation. This fragmented but meaningful experience for giving structure to the illness provides caretakers with instruments of healthcare that otherwise would not be possible. Having a child constantly ill with diarrhoea framed in reference to neglected practices is not the same thing as having symptoms that are the result of societal and natural influences or practices. The difference permeates and challenges healthcare practices that raise concerns about the role of caretakers and inappropriate behaviours that jeopardize their children. To this end, Evil Eye is a strategy for a less stigmatised treatment approach that reinforces the perception of living within a hazardous environment but also including a meaningful response to symptoms with both biological and social efficacy. Moreover, Evil Eye is a necessary notion to engage with biomedical paradigms, entailing aspects of imperative relevance

within the conflictual perspectives of ‘modernity’ and ‘traditional’ health-care systems. Thus, Evil Eye comprises many contradictions and ambiguities; it works as a centripetal force to explain symptoms alike, turning the biomedical discourse and practices that are seen/felt/lived as controlling biological mechanisms into a more social element with an on-going and open-end process. This means the illness, although essentially a dysfunctional biological condition is primarily socially (inter)relational. Evil Eye as an illness concept contains indivisible conditions (individual/community/environmental) that create an unifying aetiology concept that becomes a recipient of traditions, beliefs and dialectical knowledge, which works as a regulatory catalyst of indivisible cultural and health practices. Behavioural aspects of Evil Eye are a standpoint that draws attention not only to underlying cultural logics but also to chronic inequity, economical, political and ecological contexts.

The next chapter examines the cultural meaning and consensus on healthcare practices concerning Evil Eye in the San Marcos context. In particular, I analyze the mutual influence of Evil Eye and public-health services on symptoms of diarrhoeas and respiratory infections. I draw on small-scale ethnographic research to examine how mothers’ and caregivers’ practices of healthcare promote or decrease the utilisation rate of public health services or health programmes launched to treat these diseases. I examine what practices of care and treatment among the Mam and Ladino populations disclose particular spaces where Evil Eye becomes a cultural bias with respect to ‘globalised illnesses’ and approaches. Some of these practices, including lay knowledge of medicinal plants, are perceived as *barriers* by global health initiatives and national health campaigns. By examining the Evil Eye’s rationale we can understand better the limitations presupposed by biomedical healthcare, as well as the ways in which cultural competence can address an effective but disregarded folk treatment.

I will explain how people understand and create healthcare paths concerning symptoms of Evil Eye to give a better insight of local realities and knowledge and to turn attention to the importance of such practices, questioning the universality of biomedical models and discourse that leave out important aspects of a moral logic and emotionality that are central to health behaviours. Using Gold’s and Clapp’s concept of *healthscape* to describe ‘an individual’s subjective vision of a landscape’s medical resources and institutions, limited by cost and accessibility and shaped by the uneasy coexistence of Western and indigenous medical systems’ (2011:1), I examine certain practices that reveal that the various barriers within the situation of Evil Eye are not stratified but constantly interact and are entangled, disclosing spaces where struggles, negotiations, and possibilities take place. Decision-making

involves values, preferences, judgements, knowledge and subjectivities, which may render behaviours difficult to grasp and which can be understood as either standardised or deviant, depending on the perspective. Yet the failure to understand health-seeking patterns is normally a consequence of attempting to simplify each aspect and assigning it a value specific to limited criteria, rather than examining the cultural or social ‘proxy’ factors that influence behaviour. Hence the following section is about understanding, opinions, interpretations, differences, strategies, negotiations, choices, (inchoate) feelings, distress and possibilities concerning Evil Eye among the indigenous Mam and Ladino population in San Marcos, Guatemala.

Structural Factors and Political Economy of Healthcare Interactions

From a biomedical perspective, standardised practices improve prevention, treatment compliance and outcomes. Thus, when biomedical healthcare practitioners are confronted with cultural perceptions and attitudes, which play a role in patient's treatment choices that may diverge from the biomedical rationale, cultural features become (implicitly or explicitly) a principled barrier in healthcare interventions. As a result, culture and beliefs are grouped together with inadequate or limited access to healthcare facilities, lack of economic resources, and poor literacy in explaining health disparities, incorrect treatment choices and risky practices.

This idea presupposes that culture and beliefs can become deviant behaviours that exacerbate a patient's reluctance to rely on biomedical therapies. Thus, the role of culture and beliefs in the provision of biomedical healthcare is based on the assumption that, by applying standardised principles as rules for appropriateness and *good* (right) practices, allopathic therapies become successful (cf. Galanti 2008). Culture and beliefs are important references of social relations, with the capability to frame and organise conventional knowledge so that it can appropriately and objectively respond to and assess healthcare responses according to social values (cf. Napier et al. 2014). Therefore, in order to maintain relations that are meaningful (i.e., collaborative and intentional), people need to share the information that characterises their ways of thinking and acting. Culture provides the elements that shape an individual's frame of reference and engagement. Beliefs are objective understandings that guide intentional rational outcomes, and they therefore constitute an oriented choice of action. Napier and colleagues expressed this more acerbically: 'an implicit assumption within biomedicine, therefore, needs challenging—namely, that doctors have knowledge, and patients have beliefs' (2014:1626).

When explaining folk illness and therapy management it is important to distinguish what researchers mean by culture, how culture is understood among individuals

and how the concept is used within public health discourses. Accordingly, concepts of culture and beliefs need to be clarified in order to avoid expressions that could automatically be overloaded with categories that are misunderstood, simplified or labeled as a disadvantage. Moreover, concerns about deviant practices have blurred issues related to cultural awareness and social dynamics that are crucial to the provision of healthcare, especially among families or communities. It sometimes seems that the concepts of ‘beliefs’ and ‘culture’ in the context of healthcare are applied to everything that might explain incorrect and risky treatment choices and behaviours, and as barriers to the provision of biomedical care. When used in public health discourses, the concepts of ‘beliefs’ and ‘culture’ are distorted and subjected to unclear social constructs. The placement of diseases within an apparently objective and scientific realm allows culture and beliefs to be explicitly located as a rather conflictive arena, which tends to legitimise standardised knowledge and processes of healthcare. According to Napier and colleagues, this view of culture associates scientific practices with macrocultures and large societies as a universal frame, while defining small-scale microcultures as *cultural*, i.e., a set of subjective presumptions (Napier et al. 2014:1607). Therefore health practices regarded as ‘cultural’ pose a challenge strategies based on the allopathic rationale.

Consequently, it is easy to find a large amount of published work that focuses on specific characteristics of minority groups (e.g., migration, ethnic and racial groups, religious affiliation) as almost exclusive principles that exclude other forms of rationality and knowledge—specifically, the principle of biomedical rational functionality as the only valid form of knowledge and action. In other words, ideas and practices that differ from those corresponding to ‘universal principles’ are believed to be unconnected to principles of rationality, and ineffective in improving health outcomes. They are not clearly defined and lead to negative results. The effect of assuming these essentialised categories of culture and beliefs is a failure to recognise the ways in which these categories interact with scientific knowledge and biomedical standards. The two types of knowledge are sometimes even viewed as completely incompatible, especially when certain practices seem to interfere with the provision of biomedical healthcare. Yet ‘we all participate in locally defined forms of behaviour that not only produce social cohesion, but that limit our ability to see the subjective nature of our values, our perceived responsibilities, and our assumptions about objective knowledge’ (Napier et al. 2014:1608).

The following narrative depicts how, from the perspective of a biomedical healthcare facilitator, the concepts ‘culture’ and ‘beliefs’ are equivalent to healthcare barriers that problematise ideas and values considered unsuitable for compliance with a biomedical process. Eduardo, a traveling nurse from San Marcos City,

working in an NGO for the provision of primary healthcare in Comitancillo, expressed the difficulties they have encountered in the association, in spite of the prevalence of disease in the area. He was sponsored by an international NGO to study nursing. When offered a job at Txolja¹⁹, he hesitated at first, because it would mean a long trip to work and back home. When we met he had been working at Txolja for over almost five years. I visited this institution a few times in order to observe the participation of NGOs in national healthcare programmes, such as vaccination and educational courses for caretakers; Txolja is an important healthcare location for the rural areas of Comitancillo. Eduardo's opinion was common among biomedical practitioners, since people in the rural area of San Marcos maintain traditional healthcare practices as an important form of illness management and social relations. Like Eduardo, healthcare practitioners not only provide care, but also promote provider-patient (or provider-caretaker) interactions, mediate between understandings of healthcare, and help to decide upon and implement strategies that are considered appropriate by both healthcare models. The use of the concepts of 'culture' and 'beliefs' within a public health frame is, in this case, a strategy to support the use of biomedical approaches, and also explains conflictive relationships that have a negative effect on people's health and well-being.

Eduardo: "At Txolja we work with four basic packages of health services: women's care, child care, ARIs/ADDs, and environment. Each month we visit the convergence centres. We gave people a schedule in advance, so they know when we are coming. We provide primary healthcare—preventive medicine, not curative—and we are in charge of the immunisation programme. We keep track of the children's vaccinations, we schedule home visits if necessary, but many people just refuse to vaccinate their children. They have a few myths, such as children becoming sterile or children not being able to bear children later if they get vaccinated now, especially girls, or people also think we are going to inject their children with something bad or 'evil'. Rural areas are undeveloped; people tend to think that children can be healthy without being vaccinated. *That's their culture.* We have a monthly meeting with community leaders or health facilitators and through them we work out a schedule for the following monthly visit. At the present we cover 23 communities; this selection was made by the CODI and CAP. They cover the

¹⁹ Asociación de Padres de Familia del Proyecto Txolja is a private entity created in 1992 with the aim of helping children who live in extremely poverty, in cooperation with Hogar de Niños de San Francisco de Asis and Fundación de Niños Cristianos. Txolja comprises programmes that address aspects of health and education. Communities and families may choose to enroll in them. In 2012 Txolja became part of the PEC for the provision of primary healthcare for more than 23,000 inhabitants in Comitancillo. Its personnel includes traveling nurses, health guardians (who serves mostly as a point person for referrals to higher-level Ministry of Health facilities), and midwives.

rest of the areas. Our team is made up of a traveling nurse, an auxiliary nurse, and a teacher whose role is to be the educator of health programmes. During the home visits or consultations we try to educate people. The problem we have with the educational plans is that the materials are developed by the SIAS, and they just give it to us, but these are not always suitable for the community needs. Also programmes such as AIEPI are not taught, there is no training for them. We have to be very self-sufficient and learn by our own way. For example, we have the huge problem of the topic of ‘hygiene’. Most cases of diarrhoea are the result of lack of hygiene. There are months where the morbidity is really high, plus this also has to do with environmental aspects. For example, we even have to explain to people that if a child drops a candy it has to be washed before he puts it back in his mouth again”.

When healthcare workers find it difficult to explain the negative effects of biological pathologies, they consider it a ‘cultural’ problem. However, Eduardo’s comments on the medical system illustrate how national healthcare programmes have failed to incorporate cultural values and identity, as the Peace Accords stipulated. Household and community health behaviours are more than mere cultural practices and beliefs; they are the result of structural societal factors that mediate between state economies, policies and legal frames (cf. Napier et al. 2014:1607). Eduardo’s reference to *local* cultural practices points to national cultural dimensions that directly influence both medical systems. Yet these are not defined as ‘cultural’, but as a common perception of how national health structures are formed, which limits the degree to which healthcare practitioners can negotiate and act based on social agreement and culturally specific frames.

Mayarí: “Is the participation of Txolja always bound to the terms of national programmes?”

Eduardo: “There is no collaboration between the health centre of Comitancillo and Txolja, but this is a problem that originates from above, from the Ministry of Health. They only send few resources or nothing for us to work with. For example, we work with a technical programme that has been already selected and scheduled, so we cannot influence or decide when to give these talks or trainings. When May comes and the rain starts and with it the cases of diarrhoea, or in November and December with cases of ARIs, we would like to address topics or aspects of importance so people can be aware of the relationship between seasons and contexts, but the information sheet does not allow this. If the topic is “family planning” we need to stick to the plan and teach people this, even if it’s in May where the topic of diarrhoeas would be more important. The coordinator of the ‘extended coverage plan’ would have to speak with the Department of Health (Área

de Salud) in order to change this, but there are too many problems inside that organisation that makes this impossible to even think about it. The exception is when we have an epidemic of diarrhoea, for example. Then we can be a little more proactive and decide on issues that we consider to have a priority”.

In assessing the concept of culture and beliefs in the provision of healthcare within the context of abject poverty, it is imperative to examine the motivations for people’s actions. Healthcare practices are extended to the realm of culture as long as individuals associate them with ideas of well-being and healthcare. Although both household resources and the national economy limit the provision of biomedical healthcare, the practitioners involved in primary healthcare try to identify the responsibilities of the respective parties in order to shape behaviours. Napier and his colleagues criticise this approach: ‘Under restricted and pressured conditions, behavioural variables that affect biological outcomes are dismissed as merely sociocultural, rather than medical. Especially when money is short, or when institutions claim to have discharged fully their public health obligations, blame for ill health can be projected onto those who are already disadvantaged’ (2014:1607).

Mayarí: “At the local level, what problems does the NGO deal with?”

Eduardo: “A problem we have at the community level is that when we arrive at the communities people come to us expecting to receive medicines, even if their children are not ill. If they come to us and we don’t give them anything, then their perception is that coming is just a waste of time. But sometimes we do have the problem that we cannot really help, even if people need it. For example, this month we no longer have any drugs left, so when mothers arrive with their children who are very ill but we cannot provide them with medicines they say, “I come here because I don’t have money. If I had money, then I would take my child to a private doctor”. We can only give them a referral to the health centre. This causes a loss of confidence. People don’t like to go to the CAP precisely because of this, because we cannot offer practical help. We are the first level of attention, [therefore] our focus is more preventive, but if people come to us it is because they need medicines. . .

. . . I can give you another example of *cultural barrier* with the following example. We observed that every time we made our periodical visits, a certain woman never took her youngest child for his vaccinations at the convergence centre. We looked up the child’s vaccination’s file and noticed that the child hadn’t received the MMR vaccine. We paid her a visit at her home and she told us she didn’t want us to vaccinate her child because the last time we did the child’s body got too hot and he also had a high fever afterwards. Besides this, her husband was there and

he had told his wife not to go to the CAP because we were forcing her to stop having children with the family planning programme. Here in these communities if the husband says ‘no’, then women can’t do anything, even if someone is dying. Women cannot take action if they don’t have their husbands’ support. They would say, “My husband is not at home”, “What will my husband say if he comes home and finds out we’re not here?”, or women say that their husbands are going to be very upset if they do something without their authorisation. [Thus], we have this *cultural difficulty*, a reason why many children have died, because mothers do not react promptly. We have women that are 24 years old with six children already, 24 years! with many years of fertility ahead. At that age they can still have a dozen children at least. A woman we recently saw had a caesarean. The husband *believes* that the woman will no longer be able to bear any children; therefore he doesn’t see a reason for her to attend the talks concerning family planning. We tried to explain to him that she is still able to have children, and since she had a cesarean the importance of such talks is even greater because it would be a risk for her and the baby if she gets pregnant again soon. But he wouldn’t listen to us”.

Eduardo, like most of the healthcare facilitators, was confronted with complex and conflictive contexts that illustrate how a combination of diverse factors affects people’s approaches to illness, health, risk and case management. Although these factors suggest that culture and beliefs shape health systems, these are also affected by political circumstances, economic viability and environmental frames. An ‘illness’ emerges as a ‘clause discourse’ that includes values and ideas (e.g. interpretations, therapies, interactions) as an attempt to legitimise arbitrary practices. Consequently, according to Napier, ‘many thinkers in health-care provision across disciplines attribute poor health-care outcomes to factors that are beyond the control of care providers—namely, on peculiar, individual, or largely inaccessible cultural systems of value’ (idem, p.1607).

Mayarí: “What role do illnesses such as Evil Eye and *fright* play in the provision of healthcare?”

Eduardo: “*Cultural ideas constantly clash* with health practices we try to establish or employ. During vaccination campaigns a lot of women just don’ts how up because they say their children are ill with Evil Eye and if we inject them they could die. On the other hand, parents will allow their children to die before following instructions: “My child wasn’t born to live”, they would say. That’s why we need the support of the midwives in their communities. They are given incentives such as toothpaste, towels, hand soaps...so they can feel motivated to help us. With them we have to work the subject of awareness, because they are the link

between our health programmes and health impacts in their communities. They know a lot about birth attendance but the approach of danger signs is still an unresolved issue, very delicate, because people have the idea that if someone dies in childbirth, either the mother or the baby, this is inevitable, it is the way it should be. That's why we try to emphasise the need to avoid such fatal cases, like cases of preeclampsia. What we try to do is to convince midwives to convince women to give birth outside their homes, at health facilities. Midwives are an important link between traditional and modern medicine. When we are making visits in the communities, midwives are there with us. They pay attention to which medicines we give or prescribe, so now they are adopting this knowledge. But there still many other problems...

... For example, with the use of ferrous sulfate and folic acid, pregnant women say, "Oh no, I don't want to take that because my baby will grow too much and it will be more difficult to give birth, the baby will not come out easily and I'll have to be taken to the hospital and get operated on", so we usually find these treatments in their homes, not being used. But sometimes there are other reasons. There are some health guards, for example, who give women amoxicillin and acetaminophen without explaining the doses. Amoxicillin, for example, comes in powder, and for that reason you have to explain very well how it needs to get dissolved, the right doses, at what times it should be given, for how many days. We explain to the mothers that the treatment should be given for seven days, even if their children look healthy again, to prevent them from becoming resistant to such drugs. There are children that get sick every three or four months, but among the poorest families we see that the incidence is higher, and they come each month looking for medicines. These families happen to be also the most numerous, with thirteen children, and six of them are still little. This increases the conditions of poverty, poor health and diseases. Because they are too many they do not seek help at any health facility because they cannot take that many children with them or leave them at home. Another aspect is that the majority work in their fields, they leave early and come back late at night; that's why they cannot attend activities such as vaccination campaigns or go to Comitancillo if their children are referred. However, food security programmes that exist at Comitancillo are helping to resolve some of the problems that are related to diseases. Almost 90% of the children here in Comitancillo have problems of malnutrition, which makes them more vulnerable".

What at times are considered cultural practices and beliefs are actually circumstances caused by socio-economic deprivation, originating in the political dimensions of inequality and poverty. It is clear that healthcare practices are not limited to cultural understandings and values but are also influenced by a particular moral

economy, a form of political suffering in terms of the specificities of the national structural frame, which compromises people's health and well-being (cf. Farmer 2003). As a result 'economic limitations dictate what is feasible, socioeconomic status produces its own cultures of security and insecurity that cut across nationality, ethnic background, gender orientation, age, and political persuasion' (Napier et al. 2014:1607).

Mayarí: "What other related problems do you frequently encounter that makes the work of Txolja more difficult?"

Eduardo: "There are so many problems that make the issues more complex. *In addition to the problem of cultural beliefs* we also found serious drinking problems. We have seen children who had started drinking alcohol at the age of seven. They get these *values* from their parents. Comitancillo has no recreational places for children, but there are more than 64 stores in the central area alone that sell alcohol illegally. When we speak to the authorities, they just say, "It's because people *don't understand*, it's better to leave them to continue doing what they do". We are also concerned to see that people have the custom of marrying girls quite young, as young as 13. The girls see this as an opportunity to escape the violence they suffer from their parents, who hit them when they are drunk, but then these girls are later hit by their own husbands. These girls live in poverty, discrimination, exclusion, injustice, violence, without any opportunities. There is a woman only fifteen years old whom we saw recently. She comes from a very large family. When her father comes home drunk he hits everybody in the house, including this girl. She met a young man when she was thirteen and married him. After three months he started to cheat on her. Fearing that he might be violent as her dad is, she decided to say nothing, but after a year of marriage she didn't get pregnant. Her husband told her, "You are not a real woman because you can't bear children". The situation escalated to physical violence. She decided to search for a job, but first asked her husband if she could work somewhere outside home. He first agreed, but then he started assaulting her, saying that she just wanted to be away from home to have sex with other men. There was never a day when he did not come home drunk and argue with her. In desperation she spoke with her mother-in-law, who told her, "You are the one to blame for everything, even that he's an alcoholic, because you don't know how to be a woman". The first time she came seeking help at Txolja was when her husband had threatened to kill her with a machete. The only thing we could tell her was to advise her to report her husband, but this only had the consequence that the husband's entire family got mad at her and she got in trouble. Once he hit her so badly that she decided to report the incident to the police. The man was summoned to the

police station, was taken to prison in Comitancillo for one day, and the day he was about to be moved to San Marcos he paid a judge a “bite” (bribe) and he was released. We encounter such cases and even worse. *Culturally* it is not seen as proper that a woman goes out to work—this is considered shameful—or let women decide or plan how many children they want to have. We know that when we give a prescription because we don’t have drugs left, women don’t buy the medicines because they don’t have any money and are afraid of asking their husbands for any. Men are the ones who have and manage the financial resources, but it’s not infrequent that families have nothing because men have drunk the whole money in *cushas* (illegal home-made alcohol). This *has become cultural*, which complicates our work. Paradoxically many seek help in evangelical churches. They give up the drinking, but other problems are aggravated, such as the perception of children’s life and death being God’s will”.

7 THE CONFLICT BETWEEN INDIGENOUS AND BIOMEDICAL CONCEPTIONS OF ILLNESS

‘If the role of cultural systems of value in health is ignored, biological wellness can be focused on as the sole measure of wellbeing, and the potential for culture to become a key component in health maintenance and promotion can be eroded... especially where resources are scarce or absent.’

— Napier et al. (2014:1607)

7.1 Introduction

During the 1990s, many efforts were made to improve the provision of primary healthcare. These new public health policies highlight mothers and caregivers as the most important factor in preventing morbidity and mortality among children under five years old (cf. Pérez-Cuevas et al. 1996). These high mortality rates are usually explained by health illiteracy—attitudes and beliefs about illness aetiologies that contribute to complications in the care of children with acute diarrhoeas or respiratory infections, such as the limited use of oral Rehydration Salts (ORS’s) and breast-feeding, as well as erroneous nutritional practices and lack of hygiene (cf. Bentley 1988; Guerrant et al. 2003; Fewtrell et al. 2005).

National health discourses portray some cultural behaviors as serious obstacles that prevent the cure of some illnesses that are of public health concern. Not only is there a general institutional indifference towards folk practices concerning healthcare, but also medical understandings of ‘risk’ are made visible when they clash with a caretaker’s conceptualisations and behaviours connected with illness. Aspects and practices surrounding beliefs perceived as ‘risky’ are met

with disapproval and sanctions, such as the use of control cards to keep a record of consultations at the health facilities in order to provide a conditional money transfer.¹The cultural beliefs of national or international health communities are also characterised by behaviours, discourses and policies shaped by their particular economies, social structures and belief systems as they are applied to their health facilities (Napier et al. 2014:1618). These can become factors in healthcare disparities, contributing to the creation of boundaries drawn around notions of cultural relatedness. In this frame, Evil Eye allows people to express ideas and behaviors in a way that avoids dependence on the pervasive and discriminatory national model of healthcare, shaping healing trajectories and combining different therapeutic resources. As a result, Evil Eye is simultaneously a necessary notion for formulating preferred healthcare practices and a mechanism to ‘draw near’ to biomedical paradigms.

7.2 The impact of Illness Beliefs

The concept of *beliefs* is used extensively in referring to traditional healthcare practices and the work of healers. It is considered especially important when the national healthcare services are deficient or almost nonexistent, explaining why global health programmes have sought to include traditional systems in the delivery of primary healthcare (cf. Agbor et al. 2011; Birhan et al. 2011; Bodeker et al. 2002; Foster et al. 2011). However, *beliefs* are also considered to be factors that contribute to delay in biomedical care or non-adherence to allopathic treatments (cf. Okeke et al. 2006; Replogle 2007; WHO 2013a). The concept of ‘beliefs’ has therefore been essentialised and considered a fixed and pervasive element of culture, which, from a biomedical perspective, promotes harmful practices (cf. Santiago-Irizarry 2001). This view of beliefs is based on the idea that perceptions and practices that derive from beliefs are a rigid false axiom of choice, endangering people’s behaviours. Beliefs that contribute to health disparities are therefore considered limitations and sources of risk that constrain people’s choices, instead of a ‘dynamic and changing system of value’ (Napier et al. 2014:1607).

When illness beliefs are part of a culture, ‘culture and health’ are accepted as relevant parts of illness and health processes. In attempting to interpret health outcomes, health studies ‘routinely attribute positive, negative, or neutral health-outcomes in ethnic minorities to traditional culture acting as a source of dysfunction or as a therapeutic panacea’ (Hunt 2005:617). Belief and culture attributes are, however, dynamic and diverse, and have different impacts on people’s percep-

¹See Chapter IV.

tions and behaviours. In terms of relations among factors that influence health, some behaviours depend on socio-cultural references that contain a specific function. Thus, beliefs are functionary variables applied and expressed within people's perceptions, choices and practices that can strengthen or weaken other functionary variables. This system of belief expression forms a substantial part of a group identity, and may therefore be influenced by a variety of factors, including illness aetiologies, ideas of health and well-being, social bonds, and attempts to provide specific forms of healthcare.

Despite the progress made in the recognition of indigenous identity after the peace agreement in Guatemala in the late 1990s, many indigenous cultural practices, including healthcare, are still perceived as an expression of underdevelopment or even a threat to well-being, especially when it comes to the treatment of infectious diseases. Success in obtaining standardised, i.e., expected, responses from caretakers often depends on longstanding and comprehensive social relations between community biomedical personnel and traditional health providers in the treatment of diarrhoeas and respiratory infections, as well as in care for Evil Eye.

Ethnographic research among caretakers has revealed how healthcare decisions based on the pervasive uncertainty of illnesses lead to an apparent common-sense approach to 'appropriate care'. Healthcare behaviours reveal that such attitudes are not only concerned with the pathologies or maladies themselves, but also with expressions of social distress within families, relationships among healthcare professionals and intentional practices directed toward desirable outcomes. These are attached to biological and social consequences and influenced by belief-based perceptions. *Beliefs* bring into focus how cultural practices associated with illness perceptions influence health programmes or strategies that can apparently become ineffective or inaccessible, due to the gap between actual and expected behaviours that arises from the discrepancy between the biomedical rationale and the experiences patients have of their illnesses. Thus, cultural beliefs actively explain illnesses, become a possible risk, develop (efficient) strategies and become a physical (embodied) and social construct amidst public health strategies and programmes; they can support or challenge biomedical aetiologies.

The risks of acute diarrhoeas and respiratory infections share risks with Evil Eye, yet Evil Eye operates in two directions that can either interfere with, or contribute to, the accessing of biomedically appropriate treatments. First, there is sometimes an undisclosed concern that biomedical treatments will not be obtainable if required, which is resolved by the occasional use of traditional drugs as part of the healing ritual. This fear expresses the problem of *efficacy* of drugs, their possible misuse, and decisions about 'right choices', which generally reveals an inclination

to use medicines. Second, the pervasiveness of the illness has created effective healing mechanisms that are perceived as ‘visible’ and involve a number of everyday practices. These mechanisms help caretakers to negotiate healthcare decisions that are embedded in relationships that have an impact on the choice and use of treatments.

I draw on some responses of health providers, and of mothers of children with diarrheas and respiratory infections, to explore why and how these ‘generic’ concepts are still intertwined with Evil Eye and models of treatment. I examine how the normative knowledge and the occasional impossibility of applying standardised treatments promote an ‘illness adjustment’—a changed interpretation of an illness provoked by similar symptoms. Since, in general, illness experiences differ in significance, certain signs, symptoms, and effects of ailments are perceived and experienced differently among different individuals and groups. Healthcare practices become ‘natural responses’ based on cultural references of specific ideas, perceptions and discourses (cf. Nielsen et al.2001).

The simultaneous occurrence of Evil Eye’s symptoms with ARIs and ADDs may correspond to both the decline of exclusive traditional healthcare practices and the unreliable provision of biomedical care. This phenomenon legitimates the use of multiple models of treatment, not only to improve the health status of infants and children, but also to confirm social practices and negotiate power relationships among caretakers and health providers. Nationalhealth services remain precarious and sometimes inaccessible, which weakens the healthcare model and management if used in isolation, but Evil Eye allows mediation between individuals, community health providers and facilities, contributing to the development of a network of knowledge, practices, and aetiologies that indicate points of struggles, resistance and engagement. Thus, an illness adjustment is a pragmatic contestation as well a social process through which diverse healthcare practices unfold and can be redirected.

Diseases therefore, on the one hand, have a relatively consistent definition in biological terms, and on the other they are contextualised and dependent, involving several different aspects integrated into the process of illness and healthcare. The cultural perspective in health underlines the fact that the health care dimension is read through multiple lenses at once. At the level of socio-cultural groups, culture establishes what will be considered appropriate in terms of the way in which health and illness are viewed (cf. Fietje & Stein 2015). Culture also establishes the ontological field in which perceptions and behaviours are given legitimate acceptance. Health professionals who understand local concepts and aetiologies are

better able to communicate with their patients, since the biomedical system is full of jargon and unfamiliar approaches that contribute to the tension between traditional and biomedical systems. However, it is precisely the implications of culture that create tension between the health systems. Culture comprises a conflation of contextual factors and significations that define limits and the possibilities for action. Cultural beliefs, religious values, and social constraints therefore influence therapeutic decision-making. However, the focus on ADDs, ARIs, and Evil Eye shows that ‘culture’ is not a fixed or closed system, but a broader setting in which healthcare decision-making and negotiations among individuals take place. Evil Eye as a cultural concept might therefore be linked to healthcare practices in terms of the disjuncture between biomedical and folk aetiologies, but it is not a concept that should be used as pre-defined indicator to predict healthcare outcomes.

Culture is, in a sense, a kaleidoscope, containing innumerable mixtures of many loose pieces that assume different shapes when integrated or separated, forming significant patterns or scenes that constantly change. In this allegory, Evil Eye is one of those loose pieces inside of this ‘culture vault’. Viewing it through different lights and combinations produces different forms or shapes in healthcare practices. Even when the causes of infectious diseases might be visible and reasonably straight forward (perhaps with the exception of emerging infectious diseases), the dynamic responses to them are rather complex. Consequently, standardised biomedical knowledge aims to reduce behavioural responses to predicted outcomes by eliciting aetiologies, risk practices, standards of care and methods. Evil Eye serves as an integrating and differentiating healthcare mechanism that influences and mediates between health systems, disrupting and contesting concepts that are apparently stable.

This chapter seeks to understand the conflicting relationship between standardised healthcare models and cultural practices and settings, when individuals encounter choices regarding the recognition and treatment of symptoms of Evil Eye. The factual features and aspects of this folk illness show that, although the care management is apparently simple, many of the possible diagnoses and treatments are far removed from being ‘easy’ or affordable. Which health-seeking practices have persisted over time that indicate erroneous assessment of Evil Eye in terms of obligatory cultural practices? What are the underlying considerations that affect peoples’ choices and help them make specific healthcare decisions? How is the cultural framework of healthcare—its coherence and continuity—extended to mothers’ agency? How do health providers confront perceptions and practices that are considered to be cultural? The understanding of the specificities of illnesses should also include awareness of the use of drugs, since not only the biological def-

initions and features of the symptoms, but also people's ideas of the effectiveness of treatments, influence directly the processes and outcomes of the diseases. The introduction of drugs has dramatically increased, and thus the acceptance and reliance upon medical “*technoscapes*”, resulting in useful practical measures but also altering the understanding of illnesses. Here I make use of the term *healthscape*,² a term coined by Gold and Clapp, who borrowed from Appadurai's concept *ethnoscape*.³ It refers to the biophysical and social space as well as relationships in which illness occurs in everyday practices (Gold & Clapp 2011). It comprises the biomedical and socio-ecological conditions and interactions occurring in a place, population or system that have an effect on people's health capacity or strategies, with the aim of reducing vulnerability.

7.3 A Cultural Understanding of the Evil Eye's Nosology

Kleinman defined a cultural system as embodying symbolic meanings fixed in patterns of interpersonal interaction and social institutions (1980:24). Culture, i.e., the collective setting that includes “not only habits and beliefs about perceived wellbeing, but also political, economic, legal, ethical, and moral practices and values” (Napier et al. 2014:1607), shapes and brings together specific life contexts such as gender, ethnicity, social position, roles, and age, in which each individual experiences illnesses differently, due on one hand to the imposed societal context, and on the other by the ‘contingency of individual life’ (Kleinman & Seeman 2000:234-235). Illness interplays between a local and global cultural framework, in

²Similarly, Hörbst and Wolf coined the term *medicoscape*, which refers to an analytical concept to help observe and scrutinise complex entangled local, national, and global ongoing relations, taking into account the diversities, inequities and gaps among the different actors, practices, ideologies and dynamics that outline illness experiences and outcomes. *Medicoscapes* comprise ‘globally dispersed landscapes of individuals; national, transnational, and international organisations and institutions as well as heterogeneous practices, artifacts, and things, which are connected to different policies, power relations and regimes of medical knowledge, treatments, and healing. While concentrated in certain localities, medicoscapes connect locations, persons, and institutions via multiple and partially contradicting aims, practices, and policies’ (Hörbst & Wolf 2014:184).

³The landscape of persons who constitute the shifting world in which we live: tourists, immigrants, refugees, exiles, guest workers, and other moving groups and individuals constitute an essential feature of the world and appear to affect the politics of (and between) nations to a hitherto unprecedented degree. . . This is not to say that there are no relatively stable communities and networks of kinship, friendship, work, and leisure, as well as of birth, residence, and other filial terms. But it is to say that the warp of these stabilities is everywhere shot through with the woof of human motion, as more persons and groups deal with the realities of having to move or the fantasies of wanting to move. . . And as international capital shifts its needs, as production and technology generate different needs, as nation-states shift their policies on refugee populations, these moving groups can never afford to let their imaginations rest too long, even if they wish to.’ Appadurai (1990:295).

which ideas and practices can be redefined (although not always without conflict) since both frames are fluid dynamics subject to change. This phenomenological idea of culture, according to Kleinman, underpins the encounters of ‘disease’ or ‘illness’ that allows better articulation of aspects (including problems) that are part of a culture, as well those more subtle parts that normally remain invisible to healthcare providers (such as feelings of being stigmatised, fear, hope, etc.). Therefore each culture develops explicit principles that explain signs and symptoms which are integrated into a system of treatment, therapy or process of healing (Comaroff 1982; Lock 1988; Nichter 1988).

The concept of culture is extremely problematic, however, not only because there are hundreds of definitions (cf. Apte 1994), but also because there is no agreement regarding what determines and becomes part of a culture. Existing concepts of culture, such as Tylor’s evolutionary concept, described in *Primitive Culture* (1870), which defines culture as ‘a complex whole which includes knowledge, belief, art, morals, law, custom, and any other capabilities and habits acquired by man as member of a society’, are still of enormous heuristic significance, even if they are sometimes controversial. Similarly, Redfield’s definition of culture as ‘conventional understandings, manifest in act and artifact’ (1994:132) focuses on people’s behaviours that are based on meaningful ideas which are maintained and reproduced because they underline societal functions of ‘being and belonging’. Thus, cultural practices are distinctive among groups that, even when they share certain characteristics, perceive things differently, provide a different meaning (or no meaning at all) to specific socio-cultural manifestations, and draw differentiated cognitive maps of social relationships and knowledge (cf. Napier et al. 2014:1609). Yet these explanations leave unresolved the problem of behaviour that appears to be of an unconscious nature. Also problematic is the correlation of aspects that can be part of a culture but are quite often used as a synonym for culture, in particular the concept of ethnicity (cf. Kleinman & Benson 2006). Precarious health conditions can be caused by a wide range of factors (including biological determinants and social inequality), yet ethnicity is considered a dummy variable for poor health. Thus, the concept of culture as a generalised notion of practices, tradition and beliefs produces a conflation of the concepts of cultural behaviours, ethnicity and even biology. Although many ethnic groups report worse health conditions, the explanation is related to experiences of discrimination and prejudice rather than behaviours or beliefs that are part of a culture, since ‘despite the laudably flexible criteria for indigenous status, at the local level. . . the criteria for indigenous status tend to become ontologically saturated with essentialist and primordialist concepts of culture’ (Sylvain 2002:1075).

Sociocultural factors intertwine with socioeconomic status and accessibility to health services to sometimes situate ethnicity as a ‘cultural barrier’ or a ‘risk’ factor. In this regard, Stephens et al. point out that ‘at a national level, many countries do not break down their data in a way that reveals ethnic differences in health or socioeconomic conditions’ (2006:2021). The implication of a normative perception of ethnicity and culture is that it creates a (biomedical) discourse that situates the incidence of particular diseases in a macro-level. Although health promotion and programmes should be ‘culturally pertinent’ and reflect the special needs and features of a particular group, campaigns and policies tend to have unidirectional implementations that do not account for specific settings. Although community-based health programmes have emphasised lay participation and knowledge, and acknowledged their *culture* in order to empower communities to promote and deliver healthcare more efficiently (cf. Stacy 1994), the decisions have always been of a vertical structure, from ‘bottom-up’ to ‘top-down’, inspired by international healthcare planning. Another public health concern is the ‘partial compliance’ that delays treatment-seeking and leads to worse outcomes, because mothers’ decisions also rely on their social relations; yet ‘agency is inevitably structured, although not always structurally established. People’s everyday lives and the restrictions on their decision making are, in part, shaped for them by external and internal structures’ (Napier et al. 2014:1623).

The rationale of a biomedical discourse, also included in the Millennium Development Goals, is grounded on health indicators for which allopathic interventions work as an axis while ‘indigenous knowledge’ and systems are only partially tolerated because of people’s demand for their medicinal plants and natural resources. The plethora of studies and programmes exploring the concept of culture has obscured our understanding of which actions and symbolisms are *culturally* dependant and significant, and which are methods to deal with a determinative social and personal context devoid of preconceived cultural categories. Inadequate measurements that do not reflect specific cultural frameworks such as health beliefs and attitudes can generate doubts and rejections of some of the procedures offered by particular clinics or hospitals. Personal barriers therefore do not fall under the general concept of culture’, but constitute strategies of normative endeavours within conventional healthcare. This *healthscape* produce narratives of the social and material world, a fluid encounter of discourses and practices as an expression of patterns or rationality, cultural values and identity (Miles 2003:110).

Therefore, to understand Evil Eye in the rural San Marcos context and to determine what underlies the specific behaviour patterns, it is imperative to examine the values and meanings that are manifested through the illness process, how in-

dividuals perceive risks, how they feel about the state of illness in general, and what they think of their particular condition. These aspects are included in Kroeber and Kluckhohn's definition of culture, which 'consists of patterns, explicit and implicit, of and for behaviour acquired and transmitted by symbols, constituting the distinctive achievements of human groups, including their embodiment in artifacts; the essential core of culture consist of traditional (i.e. historically derived and selected) ideas and especially their attached values; culture systems may, on the one hand, be considered as products of action, on the other, as conditional elements of future action' (1952:181). The emphasis on 'future action' or expectations is of striking importance, since it amplifies the argument that healthcare practices are not only situational in the face of the immediate fear, but subject to behaviours that seek specific outcomes that fulfil ideas that 'make sense' within a social group and therefore are culturally relevant and accepted. In the same manner, Jezewski (1990) defines culture as a learned and shared framework for decision-making (perceiving and interpreting) and behavioural strategies (interactional experiences). There are of course individual-level variations among groups, since culture is not uniformly distributed, homogenous or static. Since culture is an explanatory and not an evaluative concept, abrupt or gradual changes that take place within the system need to be organised and integrated in order to make sense in specific contexts. This understanding creates particular dynamics in a state of order that can be accepted or rejected to different degrees by different members of the group.

While the *culturally visible level* of Evil Eye is easy to examine, the underlying logic of this particular behaviour remains concealed. Responses that shape the peculiarities of the illness—and therefore differ from the categories of ADD and ARI—rely for their expression on an internalised idea of sickness and health. In other words, Evil Eye is a *shared* cultural phenomenon that has created an adaptive behaviour that engages a general consensus. In hindsight, however, behaviours regarding Evil Eye are not so much a cultural category as a *maladaptive cultural response* (cf. Edgerton 1992) when the results are a deteriorated health state of a child, and increased morbidity and mortality rates. One problem that requires an understanding of Evil Eye is the debate as to whether the illness experiences result in an acceptable resolution of taking the 'right decision' after considering the gravity of the symptoms. The public-health discourse gives special attention to the awareness mothers or caregivers need to have in order to identify danger signs, and expects the resulting healthcare attention to meet the biomedical standards. In this sense the biomedical aetiology and pathogenesis are not employed the public-health discourse, but are focused only on the physiological dysfunctions

that generate the debate about cultural barriers to health services, even when ‘the idea that biomedicine is able to address the ills of the world is... a fundamentally cultural notion’ (Napier et al. 2014:1618).

However, increased rates of diarrhoeal and pulmonary infections are not only the result of behaviours related to illness practices. Abject poverty undoubtedly exacerbates the problems associated with exposure to pathogens or detrimental environments, but another major factor is the fact that national health programs and budgets are deficient and inappropriate, despite the existing legislation that guarantees access to primary healthcare services. In this sense, ‘information systems (e.g., online appointment and treatment management programmes) establish non-negotiable terms through which a patient’s wellbeing must be negotiated. At the same time, the easy flow of information shifts responsibility for care from the caregiver to the individual, who can now be blamed for not accessing what is on offer even if he or she might be incapable of participating in such processes’ (Napier et al. 2014:1626). Hence, healthcare behaviours examined only from their negative outcomes influence the idea of people *maladaptively* making decisions about diarrhoeal and respiratory illnesses, addressing Evil Eye as the most influential practice within this process.

Early studies and analysis of folk illnesses—especially during the 1960s and 1970s—drew attention to the coexistence of other medical models of care, parallel to the critiques of the public health discourse that were brought up not only in political debate, but by applied anthropologists. Since then the focus on folk illnesses has postulated that the distribution of health, social disparity, and dominant political practices emerge from the medical process itself rather than within the communities (Good 1997:25-28). Yet, Evil Eye underpins the fact that some folk concepts are tied to cultural ideas that are difficult to understand. The subjectiveness of the Evil Eye phenomenon suggests an unconscious behaviour based on a customary application of cultural configurations. As a *syndrome of experience* (Good 1977:27),⁴ Evil Eye is diverse and is linked to more than one explicit setting—the private context, the community framework, the health-facilities environment, etc.—that prove that the attributes of the phenomenon are not misconceptions or lack of awareness.

The observed decision-making behaviours in connection with Evil Eye usually give the perception of an apparently irrational practice that can ultimately end in the death of a child if not treated in time. The problem of (seemingly) irrational

⁴A set of words, experiences, and feelings which typically ‘run together’ for members of a society’ (Good 1977:27)

beliefs, poor understanding, and health-seeking patterns represents—not only in medical anthropology but in biomedical examination as well—an ‘epistemological hypochondria’ (Geertz 1988),⁵ where concern with the ‘truth’ and the question of ‘evidence’ claims a specific authorised knowledge. Yet ‘the status of rejected knowledge’, Laguerre suggests, “relies more on questions of power than on standards of truth and effectiveness” (1987:11). If the recognition of symptoms should include specific conscious health patterns, then Evil Eye also becomes an evidence of motivated behaviour. The cultural practices in relation to illnesses are not only connected to the idea of well-being in terms of *relief* but also upon the conception of a shared adaptation model of health and care. In this sense, according to Fabrega, ‘illness, for example, offers an additional opportunity to study how behaviour is structured and organised by underlying cultural rules. Culture by definition represents a “man-made”, socially relevant, experientially derived set of rules for living’ (Fabrega 1974:3).

Culture is therefore not only a symbolic-capital system of reference held by individuals, but also a capital that comprises a variety of ways in which people participate according to their choices, values and decisions with reference to other systems of significance and identification, which in turn contributes to an individual’s knowledge, allocating and demonstrating a person’s membership in their community or society (cf. Dilger 2010:7). This system of reference can also constrain relationships and networks, which has an impact on people’s motivations to act in the interest of their understanding, beliefs, and well-being. According to Napier’s definition of culture, this is concerned with ‘the shared, overt and covert understandings that constitute conventions and practices, and the ideas, symbols, and concrete artifacts that sustain conventions and practices, and make them meaningful’ (2014:1610). Consequently, behaviours within cultural systems are constantly negotiated (and therefore not necessarily fixed in patterns as Kleinman’s concept suggests) and modified through a process of legitimation of practices. A person can address, influence or act within his/her group, producing multiple responses that reinforce ideas of cultural relevance (e.g., identity, values, gender roles, family structures) and responsibility.

⁵Clifford Geertz raises the concern about the problem that produces the examination of other rationalities and their representations, and how the interpretation of those realities are not just a fractional or distorted of the *Self*, i.e., ‘how one can know that anything one says about the other forms of life is as a matter of fact so’ (1988:71).

7.4 Evil Eye as a Melting Category

Diarrohoeal and respiratory infections are frequently associated with poverty, poor hygiene and malnutrition. Since preventive and curative measures are considered inexpensive and effective, much emphasis is still put on the cultural and social context in which these diseases occur (Vecchiato 1997). As a result, public health education concentrates on practices and behaviours that are incorrect or constitute a hazard by biomedical standards. However, some of the recommendations are not accepted by mothers or caretakers because they clash with local beliefs. For example, while biomedical healthcare providers encourage people to attend vaccination campaigns or make use of injectable solutions or antibiotics when needed, needles are feared since people believe these practices could endanger a child's life. The belief that certain organs can 'explode', as can happen in Evil Eye, or that blood cannot be 'replaced', make it difficult for caretakers to fully accept available biomedical services or treatments. At the local level, health facilitators put emphasis on seeking help at health facilities, partly so as to recognise difficult cases that might require the use of specific drugs, but also in order to avoid seeking help with traditional healers. All of the health facilitators I encountered were undoubtedly concerned for their communities; yet they exerted a strong influence on approaches and behaviours that address global health challenges.

Therefore behavioural change is, without doubt, one of the main concerns in improving health outcomes. The opinion of Ramón, a health facilitator from the community of San Pablo, concerning treatment adherence and household practices in the provision of healthcare, showed how the preferred practices for care training, health programmes, and procedures are drawn solely from the global system of biomedicine rather than from integrated health knowledge and practices, despite the reluctance of caretakers to follow them. Health promoters often talked about folk illnesses or practices that seemed to be incompatible with the biomedical prevention and treatment of diseases:

“Children's living conditions are definitely one of the aspects involved in diseases they get. When we visit some households we try to educate people about how important is to keep the place clean. But sometimes we visit houses that are in fact tidy and clean so we have to explain [to the mothers] that *microbes* are everywhere, and are easy to get if you are a baby or a little child. These [microbes] take advantage of children's bad conditions. That's why we also explain to mothers that nutrition helps to reduce frequent infections. When we receive training the doctors explain to us that, because of the environment and people's ideas, some diseases are more frequent than others. We have to give families the message that prevention is a key concept, but most of the time there are things you cannot

control, like, for example, what options do people have when their harvest is poor? How can you control the weather? During the rainy season we do see an increase in cases of pulmonary infection, and it is difficult to tell someone ‘You need to feed your children better’ when you see they have nothing to eat. So we have to see the differences between personal responsibilities and external aspects where there is *no one to blame*. But we also know that people’s beliefs affect treatments. They alternate practices. They first seek help with healers, for example, and then they decide to seek help at the convergence centre. Mothers now are not clueless. They come and say, ‘I need a bottle of tetracycline’ and they know why. They come to us looking for treatments when they see that the herbs didn’t help. We cannot change that, so we only try to encourage people to make use of the [health] facilities”.

Community health workers (CHWs) who possess these insights are very important, because their cultural awareness (i.e., the examination of their own biases towards their own practices and beliefs) provides them with the necessary skills to navigate among health-related beliefs and the practices of the allopathic healthcare model. However, CHWs, are just one of the several stakeholders in the provision of healthcare. As part of the biomedical healthcare system, CHWs embraced biomedical approaches and responses that legitimise their work. This medical imaginary of effective therapies provided by allopathic treatments produces optimistic stories of biomedical effectiveness, which influence peoples’ health-seeking responses. From the first signs of Evil Eye until the cure, there is an ongoing process not limited to an allopathic or traditional scope which appears rather linear. One of the challenges is the understanding of cultural knowledge, i.e., the social construction of practices and ideas with a particular value. Whereas from a biomedical healthcare model some health-related beliefs and practices are *culturally* shaped, the process of curing or treating specific symptoms of ARIs or ADDs is depicted as straightforward, and ‘culture’ could arrive at a wrong assessment. Thus, the concept of culture becomes blurred with the ideas of competence, reliability and validity. In the course of identifying causes or determinants of ‘bad’ practices in connection with ADDs and ARIs, people create strategies that encompass practices that are encouraged by public health promotion. Such practices suggest mixed ideas of treatments that are not specifically ‘culturally appropriate’, but rather culturally contextualised. This means that the healthcare landscape has now been influenced by scientific knowledge and practices, in which the idea of ‘correct’ treatment is mixed with normative knowledge and cultural ideas.

As a result, not only mothers and caretakers reported a selective use of specific drugs to ensure an effective treatment, but also some midwives, who play a key role

as CHWs and/or healers in their communities. Some of these healthcare providers have set up little dispensaries at their homes, offering some drugs in addition to traditional healing. Because of this availability, most visits to an official healthcare facility were delayed several days by biomedical standards. Rather than ignoring or not recognising danger signs, mothers were afraid their children would be diagnosed with an illness that required special care. However, women acknowledged the danger of delay in seeking help. Many of them reacted promptly after symptoms appeared, normally by making use of the drugs that can be obtained at little shops or local pharmacies and that are given with medicinal herbs. Similarly, in a study carried out in Pakistan by Cody, mothers reported the use of different antibiotics in a short period of time after they saw no improvement in their children's health, not only spending a great deal of money in treatments but also using different drugs, posing a public health concern when children became resistant to the antibiotics (Cody et al. 1997:331-372; Nichter 1996:267-279).

Emergent treatment paths

Since the medical equipment at the primary and secondary levels is rather spartan, the degree of assertiveness in diagnosing children's ailments depends greatly on the experience of the medical staff. Although national health programmes place great emphasis on diarrhoeal and respiratory infections because of their high prevalence, the majority of the pharmaceutical treatments for these diseases are not readily available in sufficient quantities to treat all cases. For the same reason, recurrent cases are normally not treated free of charge. The failure to make an adequate diagnosis and provide appropriate treatment to cases of acute diarrhea or respiratory infections creates for the health personnel, especially at convergence centres, the impression of a system that cannot reliably provide effective and rapid cures. The popular perception that there is a hierarchical preference in providing treatments occasionally results in the avoidance of the primary healthcare service in favor of alternative cures from healers or midwives. This observation is asserted by Waldram, who argues that 'failure is an essential component of the empiricism inherent in all medical systems: it can be rationalised in a way that deflects a challenge to the legitimacy of the system itself, and it can also lead to a refinement of understandings of disease and illness, as well as specific medical practices' (2000:610).

The following of Carmelita, a health guard in her mid-fifties from Piedras Negras, shows how health behaviours are negotiated among health providers and healthcare seekers, whose practices correspond to important ideas of aetiologies, overall lifestyle and healthcare. Within the concept of *healthscapewe* we can observe how the

general principles of treatment choices mask subtle differences among the many specificities of illness causation, symptoms and common views of health, which complicate caretakers' understanding of the role of treatments within the underlying cultural model. When community health providers encounter perceptions and practices that are considered to be cultural, sometimes healthcare delivery is more dynamic, and not necessarily in conflict with the biomedical standard.

The people involved in the processes of seeking and providing healthcare do not make treatment decisions solely with regard to aetiology, but also within the variability of their *healthscape* mosaics. This is important because it shows that beliefs do not automatically transform behaviours into apparently neglected expressions of illness and health but constantly supports the reevaluation of aetiologies and practices, varying across encounters with healers, midwives, and health guards, whose knowledge and experiences also affect diagnosis and treatments. Thus, beliefs help to create an 'illness adjustment', since ideas, perceptions and understandings which are part of these beliefs allow a process of transfiguration that supersedes normative practices and knowledge. This adjustment is a model of acting in which disadvantages (e.g., social environments, lack of resources, congenital disabilities) lead to strategies that support such needs, not as coping strategies, but as a model of caring or acting, developing new skills (cf. Napier et al. 2014:1633). This logic operates on the assumption that the belief in Evil Eye is based not only on its pathological outcome but is configured by experience, i.e., it is not just 'there' but is created through commitment, support, and social needs. Normative knowledge and practices, as opposed to beliefs, are constrained to a specific rationality that is separate from social conditions and constructs. It then becomes clear that Evil Eye cannot simply be in constant conflict with ARI and ADD but in regular negotiation, being a salient cultural assessment rather than a cultural bias.

Carmelita Ramírez lives in Chicajalaj. Her home consists of two adjoining rooms. One of these is her 'office', where a shelf holds medicines that she sells to patients who need them. It is also probably a bedroom at night, but she explains the presence of a bed by saying that this is where she sees her patients. From aspirins to antibiotics, Carmelita proudly shows me all the drugs she can recommend, which implies that she can diagnose and treat different illnesses. I came to visit her because people referred her to me as a 'healer', others as a 'midwife' or 'health guardian', who had seen many children afflicted not only by Evil Eye but by ARIs and ADDs. I was interested in knowing how her role as a health provider, in the context of a medical pluralism, influences caretaker dynamics. While healers usually attribute their curing talents to a prolonged illness, skills learned from elders or a "supernatural call", Carmelita was trained in a formal school, which has

deeply influenced her activities as a health guard in her community. In addition to her title as a health provider given by the SIASs he also refers to herself as a healer, yet she didn't explain why. In her case, it is clear that the view and practices of health provision combine the allopathic and traditional systems, alternating not only forms of treatment but also illness aetiologies. We can see that her situation is completely different from that of Eduardo, who works at Txolja as an auxiliary nurse. Eduardo's socio-cultural background is different: he is from San Marcos City, where people discourage the use of traditional medicine and see it as "quackery" or simply part of the indigenous culture and rural areas, considered "undeveloped". This is a prevalent form of thinking among people from the cities and the Ladino population:

Carmelita: "My father sent me to Tejutla (San Marcos) when I was young, where I took a one-year course. They taught us how to give injections, how to knit a sweater and other stuff. It was a woman from Belgium, Marlene was her name, who taught us many things. I really liked the healthcare topics. I also learned which drugs were good to treat diarrhoea, fever, nausea, headaches, different kind of pains. . . many illnesses! But this is what many people do: if you go to the little shops (*tiendas*) you can find some medicine for diarrhoea or fever because people know about medicines, what to take themselves or give to their children. Now I'm a health guardian in Piedras Negras, that's why I keep learning about illnesses and medicines. When I'm ill and seek help with some doctor in San Marcos I keep the prescriptions they give me. So I also learn from my own symptoms: what they are, how I feel, and what's good to treat such illnesses. I write down the prescriptions' [contents] and keep these in my own archive. Then I buy the medicines whenever I can so I can use them when people are seeking help here at my home. People trust me because I can give injections if is something urgent, so I can not only provide them with medicines they need but also give them fast relief if needed. But all of these [medicines] are just pure chemicals. I also know lots about herbs. People come to see me more often because of this. For diarrhoea, for example, I use *epazote*, *altamisa*, chamomile, garlic. . . I boil these and give my patients [an infusion]. But it depends. If the diarrhoea is severe you need other things. There are different types of diarrhoea for which you need specific treatments"

"Mothers, especially younger mothers, bring me their children who have caught the Eye. Sometimes these children are in really bad shape. They think that because I'm a health guardian and a healer I can heal their children faster. But I need to explain to these younger mothers, not every diarrhoea is a sign of Eye, and also that symptoms of Evil Eye need to be treated as fast as you can. Recently, a mother came with her son. He had been ill with diarrhoea for fifteen days. "Give



Figure 7.1: Over-the-counter drugs sales of rural San Marcos

him an injection”, the woman told me. “I gave him some pills but didn’t get better, he needs something stronger”. “I need first to see what kind of diarrhoea he has”, I told her. You need to see how the diarrhoea is, the color, the frequency... his diarrhoea was white, like foam. “No, *Seño*, I can’t inject him, he has worms. How long has he been ill?” “Just a few days”, she told me. “No, that’s not possible. He has probably been ill like this for a week or much longer”. The boy was screaming “Ayy! It hurts!” and flew to the latrine! He was already six years old, that’s why I gave him an infusion. He told us how long he had been like that. I gave him several bottles with [medicinal] herbs for him to drink for seven days. That’s good for worms or amoebas. In three days the boy was healthy again. If is a fever and cough then I use eucalyptus, borage, rosemary, verbena... When people have colic I use aloe, horsetail, artemisa, valerian... So there are people who come and say, “I want a natural treatment” or “I want medicines” or “I want an injection”, so I have them all here. Some take both. If the illness is too strong then I give them an injection but first I need to see the patient. Some women come here pregnant but they don’t know it yet, so they come complaining they have some pain, nausea, or feel extremely tired. I tell them “Let me make sure first that you are not pregnant”, because if they are I can’t give them some kinds of medicine or herbs. If I do, without knowing, these women could have a miscarriage. I advise people to go to their health centres or post centres because doctors have special devices for examining a patient. But sometimes people just say, “I would rather wait to see if what you gave me works, because *I trust you*”.

The underlying assumption that traditional health practices and folk aetiologies only delay seeking help in cases like this pose the question of who is qualified to recognise diseases and provide healthcare, rather than only focusing on the issue of danger signs recognition by caretakers or the use of biomedical facilities. Folk

illnesses, such as Evil Eye, are used as a reason for immediate contact with a health provider (or other person outside the household), but they also constitute a channel to adequate treatments, since the illness launches dynamic processes. It is recognised as complex, contingent and the result of any one of a number of possible social and pathological causes. In other words, one does not seek the same kind of help if a child is diagnosed with ‘diarrhoea’ or if the diarrhoea is a result of Evil Eye, since this is not just a therapy decision.

The apparently insignificant difference between the two types of illness actually transforms a symptom, giving it another meaning, since the understanding of the illness relates to the way in which values, practices and representations associated with the illness are produced and shared. The brief account of Carmelita’s patient shows that caretakers tend to simplify their ideas of how to treat clinically defined cases of diarrhoea when they are not seen in a context of social relationships. This does not imply that Evil Eye explicitly provides adequate explanations for the cause of an illness or the right path to treat the symptoms; instead, the possibility of the coexistence of Evil Eye and other illness makes people more alert to the possibility that the symptoms may be dangerous; since the symptoms are linked but not related by cause. Evil Eye evolves because it is adaptive. Yet a large number of cases of children with symptoms of ARI or ADD were classified by physicians or biomedical facilitators as ‘delay in seeking care’, when in fact, from the caretaker’s point of view, they sought help promptly. The contact with a biomedical healthcare provider was late only by biomedical standards, revealing a major cultural disconnection in regard to therapy management. Healthcare should therefore be seen not only as a process of therapy but as a cultural value involving mediations between healthcare practices (cf. Napier et al. 2014.:627).

Health providers such as Carmelita can guide or redirect treatments (or health-seeking behaviours) by making use of allopathic and medicinal herbs and provide people with a choice, although she is limited to what is permissible or advisable. Because she can treat various illnesses with different treatments, patients or caretakers are likely to assume that the practices of health providers such as Carmelita, who can navigate between systems of healthcare and find suitable compromises, as “correct”. This is primarily because, as opposed to the biomedical perspective that denies Evil Eye as an illness category, people are not worried that health providers who treat folk illnesses will misidentify the illness or try to suppress the belief (and hence the knowledge and practices attached to it). Consequently, according to Napier et al., ‘intercultural health communication is not only about language translation, but also situated beliefs and practices about causation, local views on what constitutes effective provision of health care, and attitudes about agency and

advocacy [and] health care competence is about creation and growth of meaningful relationships' (2014:1614).

Any person who take on the role of healing an afflicted child is confronted with the possibility of not being able to cure the Eye. This responsibility can damage relationships (leading to loss of trust or avoidance) rather than strengthening them, if a healer renounces responsibility and does not redirect a caretaker's behaviours after failing to identify or remove the Eye. Thus, the nature of Evil Eye allows the healer to avoid risks (such as worsening or uncontrollable symptoms) beyond a certain point by taking into account the outcome of treatment, which is influenced by the social consequences. Evil Eye case management draws attention to the way in which social dynamics can present an opportunity to provide healthcare, but also limit the healer's efforts by acknowledging the point at which the Eye becomes a (true) threat to the afflicted and child and to the healer who has the responsibility of casting it out. In these circumstances, a healer might rather encourage caretakers to seek help from health facilities or midwives.

Is the symptom a result or a cause?

One of the chief concerns of caretakers with respect to Evil Eye is to conceive the responses to treatments that will demonstrate that the symptomatology correspond to a specific aetiology. Whereas Evil Eye's aetiology is related to perceptions of the 'self' (blood, vulnerability), biomedically defined diseases correspond automatically to treatments available for the 'body'. In other words, a diagnosis of Evil Eye permits different approaches that have a large number of available responses to overcome the illness, since physiological symptomatology is only one part of the illness process. By contrast, ARIs and ADDs are fixed categories that correspond to standardised treatments for particular symptoms. If these treatments fail, caretakers cannot easily incorporate *new* categories (different 'types of Eye') that Evil Eye allows.⁶

The following excerpts, from two different caretakers, explain this. They illustrate how convoluted health-seeking strategies became when illness categories corresponding to ARIs and ADDs could not be explained or effectively accessed, precisely because the notions of 'medical knowledge' place the emphasis on drugs to treat the symptoms, rather than on the cause. Conversely, Evil Eye is an illness where many symptoms converge. The complication is that only one symptom is perceived as intrinsic part of the illness,⁷ which provides a new pattern in the provision of healthcare.

⁶See Chapter VI, section 'Specific Criteria for Evil Eye'.

⁷See Chapter VI, section 'Diagnostic Criteria of Evil Eye's Symptomatology'.

“You can use the same medicines”

Otilia was a mother of three children from Tuilelén. We met her at the SIAS facilities, while I was visiting a vaccination campaign. I was interested in understanding caretakers’ perceptions of primary care services, since these are seen by the government as the ‘magic bullet’ for improving health outcomes, especially for ARIs and ADDs. This explains why people are encouraged to assist; especially those who were not receiving any conditional cash transfer from ‘Mi Familia Progresá’. However, Otilia’s opinion was a common example of ideas and attitudes towards primary healthcare programmes, which led to a slight improvement in behavioural care management since aspects, such as lack of capacity to provide adequate or sufficient treatments and the inefficient system structure, made the inflexible standardised assessment insufficient or inadequate.

Otilia: “We live down the hill close to the river. We get a notification when people from the SIAS are coming to the village so I come here [to the SIAS facilities] and wait with the other women to be seen. Last time my youngest daughter got sick. The doctor examined her, heard her heart [beats] looked into her ears, and gave me at the end a bottle of Enteroguanil for her. A couple of weeks ago Santiago also got sick and the health guard told me I should wait for the health community facilitator. During those days it was raining and I cannot take my three children with me when is raining like that, so I just took my daughter and went to see if Don Ricardo was at home but he wasn’t. His wife told me she would tell him I was looking for him. I decided to try treating Santiago with some medicines that I use for Evil Eye. I thought that this medicine would help because sometimes when children fall ill with Eye they also have diarrhoea, so you can use this [medicine] even if the Eye hasn’t been expelled. The next day Don Ricardo came by, saw Santiago, and told me to see him the following day. I just told him about the diarrhoea and he gave me a bottle of Enteroguanil! So I think if every time my children get sick and they always give me the same medicine, why just not get it at the pharmacy? Those are the same medicines we already use! You don’t save money but you save time and your child doesn’t get sicker. The medicines for the Eye worked for a week or so. Then Santiago fell ill again but the symptoms were of the Eye”.

Evil Eye symptoms influence not only the path of health-seeking behaviours but also the provision of treatments. Even if the pharmaceutical drugs provided might not be adequate, it is possible to suggest that caretakers use them when they suspect Evil Eye, since the Evil Eye symptoms are the same as those of ARIs and ADDs. However, this practice raises the question of access to pharmaceutical drugs and their functions in communities and societies, as they can easily be overused

or used inappropriately. This is a particular problem in rural areas where the prevalence and morbidity of ARIs and ADDs are high, food insecurity is common, and economic resources are limited.

“The difference is that you will know . . .”

Fidelia, a mother of four children, lived in Tuixoquel and was part of the ACCESS programme. Her youngest child, Nacho, was the one who participated in the study. Some of the weekly surveys reported that Nacho had symptoms of diarrhoea, but she did not report help-seeking at the primary or secondary level of care, since the symptom was always reported as ‘cured’. Fidelia’s account described not only how Evil Eye produced strategies to overcome symptoms, but also how the illness itself was a strategy for securing help. Biomedical conceptualisations do not allow this kind of flexibility, since disease categories are organised primarily around the symptoms and their recognised allopathic treatments, with no room for adjusting caretakers’ behaviours. Instead of waiting for gradual change in the symptoms while the treatments take effect, or seeking help at other levels, the caretakers focus on quick outcomes.

Fidelia: “Sometimes I found difficult to know if I should go to the health centre or not if Nacho falls ill. When it’s Evil Eye it’s easier to know and decide what to do because you ask someone to remove the Eye. Then if the diarrhoea or fever stops you know that the Eye is gone, or if he’s still ill then you can ask someone else to see if the Eye is too strong or is something else. But when he has diarrhoea and it’s not from Evil Eye then you expect to get the medicines for this at the health centre, but quite often these don’t work or just work for a short period of time”

Mayarí: “So when Nacho falls ill with, let’s say, a ‘cold’ and he gets treatments from the health centre in Comitancillo and these don’t work, what do you normally do, if you have been told or you identified yourself that it is in fact a cold?”

Fidelia: “Well, the difference is that you will know that the treatments were not good so you need to try with other medicines that are stronger for the same illness. You can find good medicines at the pharmacy; the problem is that these are expensive”

Mayarí: “In the case of your example, when you mentioned diarrhoea, what would be the difference then?”

Fidelia: “That you don’t know what made him ill, because diarrhoeas are not supposed to last longer than the doctors say. They give you, for example, a bottle of albendazole or metronidazole, so you know these are for diarrhoea, but sometimes they don’t work so you have to get them at the pharmacy”

Mayarí: “So now that Nacho has recently been ill, what happened? Why did he have diarrhoea?”

Fidelia: “Nacho started with diarrhoea and the stools were greenish, eye-shaped, so I knew it was the Eye. We cured him at home and he got better. But two days later he had diarrhoea again but it was different, it was like foam and white. We took him to Comitancillo and the doctors gave us a prescription, but it would have cost Q. 200!! (around €20). The next day Nacho was still ill so we took him to San Pedro. Our neighbor drives every day to San Marcos, so he took us. There is a person there who is very good at removing the Eye and treating many other illnesses. Cipriano [the man who cured Nacho] told us that the Eye left him so frail that he had started with diarrhoea that was not part of the Eye. He told us to get a bottle of medicine for Nacho’s diarrhoea and recommended [infusions of] apazote and pericón with panela. With these things Nacho got better, and we only spent Q.50”

Mayarí: “So, do you prefer not going to the health centre?”

Fidelia: “Well, if the diarrhoea or fever is not part of the Eye then you need to go there in case you don’t know what it is and ask which medicines are good for that”.

Differences between beliefs and the role of ‘appropriation of knowledge’ with respect to diagnosis and treatments are not only contradictory at times, but also have long-term health consequences. The various causes of Evil Eye (biological, behavioural, chemical, psychological) allow a large, flexible deployment for the ‘Evil Eye’ label, which delivers solutions that depend on the perceptions and requirements of the situation. This results in differentiations within treatment patterns of symptoms of ARIs, ADDs and Evil Eye delineated by different domains, such as the variability in beliefs, social roles, and composition of the community healthcare frame.

‘Might have been just a bad cold’: Deflection of illness amidst uncertainties

The cultural model for the perception of, and responses to, Evil Eye symptoms, and the factors underlying health-seeking behaviours at health facilities, reveal mothers’ strategies according to their perception of the gravity of the symptoms, strategies which play a role in possible subsequent misdiagnosis and treatment delay. Since Evil Eye is associated with a multiplicity of factors that go beyond physiological symptoms, the cultural perceptions and meanings attached to Evil Eye are particularly important. As a result, some signs are unnoticed or ignored. Whereas the seasonality of ARIs and ADDs limits the likelihood of their presence,

diagnoses of Evil Eye abound, since is not attached to winter or summer, although there are links between the body's temperature and susceptibility to the illness. One long-held belief is that specific viruses and bacteria (what the local people call *microbes*) are more likely to appear during the rainy season or in low temperatures, triggering an onset of diarrhoea and respiratory symptoms. The general perception is that such 'microbes' are 'activated' when cold air is inhaled or when the body becomes cold. This explains why mothers are more aware of ARIs or ADDs and recognise the onset of the diseases more quickly during seasons when these specific infections can be expected. However, since the presentation of Evil Eye is more complex, there is a process for classifying the symptoms. This is intrinsically connected with the perception of time and severity of the symptoms, which elicits (or fails to elicit) the desired behaviour. The presence of cough, for example, can be a sign of many different illnesses. If the coughs last for a few days and changes (coughing attacks, lethargy, breathing difficulty), this will affect the perceived level of danger, and also make the illness easier to interpret.

Drawing on ideas or models of cultural consonance to approach an illness creates a cultural domain of a community's *healthscapes*. These include required treatments (drugs, herbs, etc.); institutional and social support (a person or a group who provides assistance); family dynamics (the characteristics and structure of the family, including gender dynamics, that make it possible to provide a patient with the necessary treatment); and identity (the sense of belonging to a group and therefore compliance with specific practices). Within this frame, perceptions and experiences of physical discomfort determine how health and well-being are understood and negotiated. However, once a child is in a state of illness, the progress of the disease becomes more difficult to assess. Within this process, different forces shape and value the illness state, since healthcare practices are not autonomous but are shared responsibilities among caretakers and health providers. Part of the explanation for why certain erroneous assessments in Evil Eye have persisted over time, becoming 'adjusted cultural practices', has to do with the analysis of overt expressions of the belief. Although Evil Eye frequently affects the perception of other illnesses with similar symptoms, it is clear that Evil Eye is an explicit and independent concept, because it legitimates the provision of healthcare when the biomedical systems fail. Local treatment practices are immersed within the paradox of expecting individuals to objectively examine subjective understandings and effects when a child falls ill.

Rosmary, a thirty-seven-year-old woman who lived in Ixmoco, Comitancillo, with her husband and four children, illustrates a full range of the aforementioned factors that shape the utilisation of healthcare facilities and healthcare resources. Mothers

and caretakers have specific views and knowledge about illnesses that help them to create a cultural model or schema to organise and structure the different elements that are found within an illness process. This provides a variety of references that allow caretakers to act on their own beliefs, knowledge and understanding; these actions become behavioural references.

Rosmery: “Graciela had fever but just in her heart and head. That’s why at first I thought she had caught the Eye. I cure her almost every day in case she has been afflicted by the Eye, but maybe that day it was too strong. Well, that’s what I thought, because after the healing she still had fever and started coughing. That’s why I decide to give her an infusion of *taltimisa* (artemisa) and rue. ‘It may be Eye, though, a strong one’, I told myself, but since you shouldn’t make too many cures in one day I waited until the next morning to do another cure of Eye. I prepared another tea but with *borraje* (*Borago officinalis*) and *limonchun*. But she still was feverish and was whooping a lot, so Linita [my oldest daughter] went to the convergence centre, to the SIAS, where Don Pablo [the health guardian] gave her acetaminophen for Graciela’s fever. But after three or four days she was still coughing and had fever, so I went to the health centre, where the doctor gave me amoxicillin. I gave it to her for a couple of days but she didn’t get better. I didn’t want to come back again so I decide to buy something at the pharmacy. I didn’t want to get the same medicine, or get a referral to the hospital in San Marcos, or a prescription, because I already had one”.

First, mothers are confronted with the concrete situation of recognising symptoms (e.g., in the case of diarrhoea the shape and consistency of stools, an increase in the number of bowel movements, etc.). Second, mothers need to understand and classify the origin of these symptoms. Here the situation is more critical because it assigns a value to symptoms and possible outcomes (e.g., the presence of blood in stools is a sign of a more dangerous infection because the person is ‘bleeding’ or ‘losing blood’; thus not treating it with drugs will only endanger the person afflicted). Finally, the strategies to comply with or refrain from expected biomedical practices are shaped by personal and sociocultural factors based on perceptions of risk and danger (e.g., death from dysentery is a severe hazard, but it is also a very small danger because, although the risk is high, there is a general perception that it can be effectively cured if promptly treated with specific drugs).

A common difficulty mothers have is to make sense of certain symptoms and communicate them accurately to the health practitioners. If a symptom is not perceived as a hazard even if a treatment provided did not work, people might not report it; thus the illness is only partially reported, possibly making it seem

less significant than it actually is. Healthcare providers might therefore not be able to identify an illness if a group of associated symptoms is not reported. Some treatment failures stem from the fact that treatments are recommended based on the most common illnesses or on specific symptoms. The opposite occurs when a mother considers a symptom dangerous, in which case the failed treatment is explicitly evaluated as ineffective. Efficacy, therefore, is a major determinant for perceptions of danger and consequently for behaviours. The effectiveness can be relational to a particular drug or a symptom source (e.g., diarrhoea due to rain). If a symptom was recognised as severe by mothers (even if the health personnel disagreed), people would focus on the provision of what they perceived as efficient treatments for severe cases of diarrhoea or respiratory infections.

Rosmary: “My other son, Mauricio, is very prone to colds. The doctor said once he had pneumonia and gave me a prescription that I kept, so I thought of buying “amo” [amoxicillin] and “clavu” [clavulanic acid] at the pharmacy, the same medicines I used to cure him. I don’t know if these medicines have really *killed* the disease or not because Mauricio is often sick with colds but he got well after he took these. When I went to the pharmacy I told [the pharmacist] that Graciela had high fever and was coughing, so he said it would be better to give her an injection instead. When Mauricio was sick he got an injection of that medicine, the “amo”, but Graciela is still a baby and, like I’ve said, I have to cure her almost every day to cast away the Eye, so I wasn’t sure if this was good or not. My sister was with me and she advised me to not inject Graciela, only if the fever got worse. My sister lost a baby because of it. He was only five months old when he died. My sister and her husband were having problems, so their son was born *weak* because they were fighting all the time because [my sister’s husband] wanted to go north [to the USA]; she suffered from *nervios* but never got a treatment. When her baby was born he fell sick all the time with Eye. He was very *fragile*. One night he had a terrible fever and my sister didn’t have any experience, so they took their son to the pharmacy and they injected the baby, but he died a couple of hours later. He probably had a big *dumb Eye* which exploded with the injection. So she was afraid that this would happen to Graciela too. But the man said I could give Graciela the “amo” in little spoons. The next day she seemed happier. Her eyes were not closed all the time. In a couple of days she was *completely* recovered. I still have some of the medicine in case she gets sick again. It might have been a terrible cold because Graciela lost weight during those days and she still has a runny nose. But I cannot run to the health centre every time my children get ill. When I bring my children to the health centre I’m afraid they will tell me my children are too ill and I need to go to the hospital at San Marcos. Sometimes they tell us to go

because they don't know either what the children might have, or just don't want to have many patients at the centre. It is always full of people. But going to the hospital is not something I can do just like that. My husband would first need to ask permission to leave his work and the *patrones* [bosses] get angry. If you tell them, "My child has diarrhoea or gripe" they would just say, "Get something at the pharmacy".

When symptoms are perceived as easy to treat, these cases show a more consistent use of specific drugs and approaches. This means that a detailed knowledge of symptoms, based on experiences and perceptions, ultimately influences the care-seeking process: how long people wait to seek help outside the household, where they go first, what types of treatments are preferred. This cannot be looked upon as simply an individual response, but as a process of 'cultural consonance', which is the degree to which individuals, based on their own beliefs and attitudes, converge on prototypes for belief and behaviour encoded in shared or derived cultural models (Dressler 2007). In this view, Evil Eye is an important 'illness catalyst' for symptoms of ARIs and ADDs. However, the set of health behaviours is not based exclusively on beliefs and illness experiences. As shown in the last example, health practices also reflect the ways in which the political economy permeates and determines healthcare relations, shaping outcomes by inducing caretakers to weigh the possibilities and priorities in terms of reducing risk and improving outcomes. The socio-political and socio-economic relations are therefore key dimensions of healthcare and illness, driving social relations in the realm of healthcare-seeking. One of these dynamics applies to the 'patronal labor-power relations' common in Guatemala. These tend to exist in temporary-labor markets where workers are not protected by any legislation, and the payments and other entitlements are based on productivity. It also shows how closely health resources and the availability of care are associated with gender and social relationships. Family structures have a massive impact on the provision of care and use of healthcare facilities or pharmaceutical treatments. Access to healthcare is a social experience that affects diagnoses, interventions, and the resources used for case management.

7.5 Caretakers within Healthscapes

Evil Eye's capacity to 'adjust' its symptoms and healthcare strategies creates a significant space and process in which power relations become interdependent and embedded within complex healthscapes. As showed by Price (2003) in the context of treating *fright* among wealthy families in Quito, social networks play a key role in healthcare decisions, in which mothers can assert (or decrease) their power and

strengthen relationships by collaborating with their extended family. Healthcare decisions normally depend on fathers, not only because they control the family finances, but also because, within this dynamic, men's ideas are considered not opinions but final decisions, undermining women's assessments. Price illustrates the process of negotiation that takes place between husband and wife, which allows the mother to take the child afflicted with *fright* to a traditional healer after the father's grandmother insists on this diagnosis. The illness adjustment, i.e., the possibility of alternating between healthcare models and treatments and identifying the meaning of the illness, allows women to uphold a form of authority within the domestic frame and outside the household. Similarly, Evil Eye empowers women to ignore men's decisions concerning treatments, since it is the mother who normally recognises when an infant or child is afflicted with the illness and seeks help. As Price explains, 'women's roles in healing the family are reinforced and celebrated through alternative healing in a way that is not possible through biomedical healing. This is partly because biomedicine often dismisses the role of mothers in illness management, appropriating all credit for cure' (2003:218). The following two quotes exemplify responses to Evil Eye symptoms shaped by limited access to resources, responses that become dynamic by the process of adjustment in response to healthscape dynamics:

"In my experience I always have been able to cure my children when they fall ill with the Eye. But sometimes the diarrhoea or the fever is not part of the Eye. "Go to the SIAS", says my husband, and that's what we [women] normally do, but the people at SIAS complain that we want too many medicines. "Go to the pharmacy or the health centre", they say. Sometimes I have a little bit of money that I can use for medicines, but my husband doesn't give me much. That's for food and soap... But Doña Amalia lives nearby. She's an auxiliary nurse and her mum is a midwife. If I don't have money I go to see them. "No, that's not Eye" Doña Amalia sometimes says, "your son has an infection". I tell her I don't have money and she helps us". (Rocío, Tuichilipe)

"Sometimes you do know that your child doesn't have Eye but I cannot ask for money. We are still living with my father-in-law and Don Seba doesn't like it when Julio gives me money. "You are supposed to save [money]", he tells him, because he wants to buy a pick-up so he can sell vegetables and fruits... We have two children and if it's not one it's the other who is ill. But Doña Esmeralda [Julian's grandmother] tells him, "If you don't buy something now you will have to pay a hospital later". He listens to her, so when Cristina or Gabriel falls ill I pay a visit to Doña Esmeralda, and she can either cure them of Eye or tell Julio to buy something. But I can't just ask for medicines. "What have you done with

the money I gave you?” he would say. So I ask Doña Esmeralda to make cures of the Eye in case they have caught it, but I can also tell Julian: “See, it’s not Eye that they have”. (Clarita, Piedras Negras)

It is important to note that the model of primary healthcare programmes locate the decisions of mothers as paramount for the recognition of danger signs and treatment decisions, yet women’s agency is marginal not only within their households but also when they enter the public health system seeking long-term action, such as an adequate provision of pharmaceuticals or referrals to the secondary level of care or hospitals. Evil Eye’s daily threat requires prevention and treatment encounters performed outside the home, where the healing process can still be negotiated and the necessary remedies circulate among caretakers. This ‘debt’ or trade-off not only creates a possibility to provide a cure even if the caretakers cannot buy the remedies, but also generates bonds among relatives and neighbours. Women’s activities outside the household are normally just related to their duties as caretakers and wife, but Evil Eye necessarily involves contact with other community or family members where the healing is performed, navigating power dynamics for women in the act of seeking care (cf. Gold & Clapp 2011).

“But I don’t like to ask the same person all the time to do the cures or give me her [his] opinion. That would just upset her [him]. You ask for a favor and then you wait for this person to come to you asking for help so you can “repay the favor”. Sometimes they need sugar, some peppers to cure the Eye, or if you are not breastfeeding you can do the healing. [By doing so] you get in contact with people of the community you haven’t talked to before... You get to know more people who could help you, even people you didn’t know are good healers”. (Rocío, Tuichilipe)

The gap of interactions between biomedicine and folk/traditional healing was more evident in other illnesses. When women mentioned cases of *puj* or *fright* I could observe that the process of diagnosing and treating relied heavily on experienced healers, rather than being a multi-sided exchange. Here there are few or no interactional choices, similar to the diagnosis and treatment of ARIs and ADDs. Evil Eye’s adjustment reconciles, if not aetiologies, the interactions that provide a more flexible and interactive exchange of knowledge and practices that are more accessible for women. Evil Eye has the capacity to influence behaviours and opinions that otherwise would not be easily acceptable in their local landscape, yet the illness sustains a space for other relationships involved in the process of diagnosis and healing. The fluidity in the meaning of Evil Eye in different contexts and symptomatology provides a constellation of relationships and practices. These

are not necessarily regarded as part of a 'traditional model domain' because of the interrelation of symptoms between Evil Eye and biomedically defined illnesses, but they allow for contradictions and variant practices in which women, in their role of healthcare-seekers, can participate more actively.

The dominance of men's opinions is seen as culturally appropriate, although this does not preclude silenced frictions that can eventually materialise. Yet Evil Eye's narratives comprise a multifaceted description in which mothers are paramount, since the therapeutic interactions, more specifically the retelling of the process of the illness, is an important part of the curing. Mothers elicit (from the healers they consult, their own experience with the illness, etc.) information about the possible source of the illness, opening a channel that allows them to dispute authoritarian relationships. The threshold of decision making is a space for women to decide for themselves how to manage the illness, not limited to the opinions of others, since Evil Eye does not draw a line that compromises women's opinions or perceptions but leads to an iterative process of healthcare. Furthermore, these encounters establish networks—relationships of trust, solidarity, exchange of knowledge and goods—that create social capital for women and actively circulate within the community. The Evil Eye's capacity for adjustment is based on its ambiguity, offering caretakers the possibility of choice inherent in the pluralistic healthscape.

7.6 Evil Eye's ethnophysiology. The intentionality of including diverse meanings

Health-seeking behaviours for Evil Eye follow distinctive, structured steps and employ sequential perceptions that result in elaborated, predictable outcomes. To choose a treatment, people first determine the origin of the ailment, which also has an effect on the perception of the gravity of the illness. The origin of the ailment also determines the correctness of the treatment, as opposed to the treatment of illnesses of a biomedical order, for which aspects of 'faith or confidence in biomedicine [are] strong and belief in biomedical fixes extends beyond cure to prevention' (Nichter 1994:287). However, an ineffective treatment can lead to many other interventions to reduce the symptoms or eliminate the ailment. The underlying logic unites health and illness to climate, food consumption, particular features and state of the body, and natural and social events. Interpretations of the symptoms are therefore constantly changing as a result of treatment failure or adverse outcomes. However, a relatively large number of people referred to their socio-economic condition or financial assets as the genesis of most of their

ailments, including Evil Eye, in a very contradictory way.

For example, many acknowledged that malnutrition and child mortality from acute respiratory and diarrheal diseases increase when there is a significant lack of resources, but the cultural image of the presence of ailments such as Evil Eye are a daily threat to children's lives and health. Yet explanations of the nature of Evil Eye are inconsistent with this understanding, since Evil Eye can supposedly be successfully treated if it is promptly recognised, regardless of the patient's economic circumstances or nutritional state. Consequently, the criteria for diagnosis are highly ambiguous and its therapy is dependent upon the surrounding circumstances. Children with Evil Eye are seen as having a 'vivid' personality and a 'desirable' look, and the interpretation of how a child becomes ill is subject to many assumptions that amount to a dysfunction in the body's balance.⁸ However, although the aetiology of Evil Eye is not related to biomedical explanations (pathogenesis), the treatments interweave or overlap.

Blanca's views, explanations and practices include some of these aspects, key components of Evil Eye's ethnophysiological dynamics, whereby Evil Eye leads to healthcare utilisation for a range of symptoms, increasing in some instances the use of allopathic treatments and biomedical healthcare facilitators, since the illness mediates between aetiologies and beliefs in relation to the efficacy of treatments. It also illustrates how healthcare dynamics derive from consensus and variation in knowledge (belief) between caretakers. Symptoms of Evil Eye and biomedical illness alike also reveal the uncertainty of access to treatments and use of national healthcare facilities. That is, the outcomes of public health interventions that people fear are produced by the very structure of healthcare programmes and policies.

Mayarí: "When did Marvin get ill?"

Blanca: "He has been ill for the last two weeks. First with Eye, then he started coughing."

Mayarí: "Is the cough part of Evil Eye?"

Blanca: "I thought so. That's why I was giving him this bottle to alleviate his cough [showing me a bottle of an antibiotic called Lincomycin®]"

Mayarí: "But you told me before that you can't take a child with Evil Eye to the health centre or give them pharmaceutical medicines because the doctors can't treat it"

Blanca: "Oh, yes, but the thing is that I've been taking Marvin to the healer to treat the Eye a few times and also to the health centre because he has an

⁸See Chapters V and VI.

awful cough and other symptoms. That's why I also decided to take him to the pharmacy"

Mayarí: "So, you are not sure if it is Eye or not?"

Blanca: "No, it's not. Those symptoms are because Marvin has very poor lungs [she hesitates] hmm, but also he has Evil Eye. The Eye can make you ill, but if you are strong then it just gets inside you. So you can have Eye without getting too ill"

Mayarí: "So how can you recognise—if the symptoms appear to be so similar—that a symptom is not part of Evil Eye or that you need to treat it differently?"

Blanca: "Hmm. . . well, some people can recognise it, but I don't have the experience. That's why I seek help from the healer, because she knows better. She also advises me about what to do regarding Marvin's health and recommends natural medicine for me"

Mayarí: "So now you have given him the natural treatment, the medicines from the health centre and those of the pharmacy? Is it not bad [counter-productive] to give Marvin different treatments?"

Blanca: "Not if you know what to give. Besides, when you go to the health centre they always give you the same treatments no matter what the child has, or even worse, you end up going to the hospital for at least two weeks or more, and that we can't afford, so better try all you can first, you know? Something will work"

Mothers perceived that traditional healing of Evil Eye was frequently effective, but their most important goal was to find an effective strategy to (1) secure social resources, i.e. a reliable guide to help people with low incomes, especially women, to make self-reliant decisions in the midst of multiple ambiguities, such as the uncertainties of the symptoms and outcomes of ADDs and ARIs; (2) make sense of their particular experiences, regardless of the illness; and (3) to express conflict, uncertainty, concerns and negotiations within the context of the household and community. According to Unschuld (1975), people use medicine as a primary strategy in order to get access to secondary resources, especially where diverse resources exist and the choice between them becomes politically and socially significant. A socially desirable effect of this strategy can be to disclose a suspicion or information, and thereby 'share' the consequences of the illness or reflect upon its threatening possibilities, rendering community-oriented healing an important part of the therapy management for Evil Eye.

Mayarí: "And what happened next? Why did you end up taking Marvin to a private clinic?"

Blanca: "Because Marvin started with fever and I was afraid I couldn't control it [mumbling]. . . the Eye Marvin has is very strong. He probably got ill on the

Sunday when we went to town. I dressed him really nice! My aunt gave him very nice clothes for his birthday and I dressed him in those clothes that day, and you know how people can get very jealous of you when they don't have something you have. . . probably someone saw him and thought he was looking really nice" [she laughs]

Mayarí: "So, someone made him ill?"

Blanca: "Yes, I think so, but unintentionally, I mean, it's not like witchcraft! But that's why Marvin got so ill, and because he has very poor lungs his state deteriorated really quickly. Marvin has been ill since he was born. He's very prone to get ill and that's also why I need to take him very often to remove a potential Eye. I always take him with me when I go to the market [she paused]. . . sometimes it's the sun, or a drunken person, or if I get cold and breastfeed him [long pause]. . . My husband is never at home and I have problems with my mother-in-law. . . I'm just saying that there are so many reasons why Marvin gets sick"

Mayarí: "And what do you mean by that, I mean, by telling me you are having problems with. . .?"

Blanca: "Ah! well, it's not like we have fights! It's only because she is very insistent on taking Marvin to a private doctor, but I don't have the money. Besides, I also have another daughter, so if I get angry I transfer my worries to Marvin and he gets sick"

Mayarí: "So Evil Eye is the result of anger as well?"

Blanca: "No, the anger is inside me and I make him ill. But since he's already weak his own Eye grows".

When seeking help for children afflicted with a malady, people try to contextualise and 'name' the illness, identifying the symptoms so that the treatment will be more efficient (cf. Waldram 2000:607-608). Thus, the preliminary contact with other members of the family or community is to confirm the aetiology of the symptoms. Corresponding to 'laboratory tests', a 'social laboratory' is set in motion in order to drive actions, since there is more than a simple use of medication at stake: responsibilities, resources, specific forms of care and healing. In this regard Waldram suggests that 'other individuals may also participate in the determination of efficacy, these may be members of the patient's family, friends, other members of the treatment team, or even the whole community. . . grounded in the quotidian experience of the sickness' (2000:6130). A study in Tanzania that examined the problem of distinguishing between an ordinary fever and malaria fever demonstrated how *illness identities* were constantly questioned and susceptible to reconsideration of a new diagnosis, including the identification of onset symptoms or through judgement provided by relatives and health personnel (Kamat 2006:2951). Likewise,

Castle (1994) explains this process of understanding fatal cases of illnesses among children in rural Mali, involving communities rather than only individuals, which indicates the importance of sharing healthcare trajectories when facing illnesses and possible serious outcomes.

In this sense the social components of Evil Eye fit the definition of *rituals* as 'conventional acts of display through which one or more participants transmit information concerning their physiological, psychological, or sociological states either to themselves or to one or more of their participants' (Rappaport 1971:25 in Galt 1982:674). Nevertheless, despite what the 'decision model' contains (i.e., the selection of a specific behavioural choice that elicits a decision criterion), there is a negotiated cultural consensus about therapy management which always includes the individual's own perceptions as well as those of others. An initial failure to recognise a symptom or illness can therefore be resolved by socialising the ailment. The pool of information not only improves access to healthcare but also signals an essential role that leads to the emergence of the illness. Since caretakers are confronted by many interacting determinants of health and risks, illnesses reveal the extent to which anticipated social interactions generate consensus in the face of uncertainty. For example, linking Evil Eye to socio-ecological variables, evokes behaviour as a resilience strategy to identify feasible and effective measurements. Thus, cultural competence or collective knowledge is of great importance, since through these encounters people improve or learn about their local natural and social resources, enabling them to resolve problems, reach decisions and measure the probability of receiving support. The likelihood of following advice or agreeing on the possible ways to tackle the problem is increased when it comes from an elder or from someone else who is highly competent in a particular cultural domain. When intracultural variations occur, individuals may defer to the supposedly more competent person. However, gender and gender roles produce different effects. In cases involving children, elder women are seen as more competent and therefore have more influence within their community. Yet their statements consistently stressed the influence of men's opinions on their own views, especially for treatments that require economic resources and utilisation of national hospitals.

The complexity of the phenomenon of Evil Eye cannot be applied to a general context, yet it suggests a broader problematic that shapes the concepts of vulnerability and social agency, regardless of health practices. Several situations proved how the concept of Evil Eye allowed women to cope better with uncertainty and the lack of economic resources (cf. Crandon-Malamud 1993). When a child becomes ill with Evil Eye, women display self-sufficient behaviors. Furthermore, Evil Eye is fundamental in communicating other concerns attached to the illness.

What was an apparently highly ritualised process of curing an ailment become an assemblage of meanings and strategies that are used to obtain practicable solutions. In this sense, even when the illness seemed homogenous from an outsider's perspective, the understanding of the aetiology and treatment of Evil Eye remains fragmented and unfixed because it articulates individual lived experiences. Accordingly, 'patients are much more willing to burden their suffering when that suffering has shared meaning. For this reason, health cannot be separated from culture' (Napier et al. 2014:1628). Hence, negotiation of knowledge, perceptions, and resources is part of the decision-taking dynamics, and does not necessarily signal an underlying incoherent 'system of beliefs'. In practice, 'if we examine beliefs about a particular disease, measure need associated with that disease, and observe the services received to deal specifically with the disease, the relationships will probably be much stronger than if we try to relate general health beliefs to global measures of need and a summary measure of all services received in a period of time' (Andersen 1995:2).

Individuals are confronted by many interacting determinants of health and ecological hazards (e.g., air pollution, climate change, extensive mining operations, creation of crop and grazing lands in nutrient-poor soils). These alterations bring changes in social interactions and affect populations, causing diseases and increasing people's vulnerability. Evil Eye has the ability to evolve and comprise different aspects that help people examine the implications of these changes. Its permeability allows people to manage multiple interacting issues and point out problems. Unanticipated consequences of socio-ecological changes, as well as socio-ecological threats that are well-known, can be channeled through people's *healthscape*. Evil Eye is a reference concept within that space that forces an explanation of why certain symptoms appear or change, even if the symptoms or outcomes are not ultimately the result of Evil Eye. This means that the mere suspicion that someone is afflicted by Evil Eye increases the ability to look for strategies, thereby enhancing the ability to cope with negative life events. In other words, Evil Eye's permeability and dynamism render visible previously invisible factors in a variety of contexts and circumstances, where multiple symptoms are recognised and addressed.

7.7 Articulating Experiences of Illness

Mothers' and caretakers' health-seeking experiences consistently showed how critical stances defined 'illness communicability' when they were struggling to provide healthcare out of fragmented or inadequate solutions. Illness-communicability de-

scribes the individual's *healthscape*, relationships of power amidst levels of care, economic possibilities and social agency to decide on measures in terms of a network-like structure. The most significant determinants of this network structure are the conflicting processes of identifying the illness and its severity, the conceptualisation of mother- or parenthood (i.e., responsibility and possibility to react), and the intention to achieve specific outcomes. In the face of this network, the dynamics of healthcare at national facilities, as well as within family dynamics, can be quite difficult.

On a normative level, women are assumed to bear the responsibility of care for their family members. This practice is strongly bonded to kin relations that structure expectations of care. This structure is embedded in the context of a patriarchal system in which women, in their role as 'carers', are also expected to recognise the many signs and symptoms that repeatedly afflict children, and act accordingly. However, women frequently lack the economic capacity to transfer these 'practices of care' into 'practices of curing'. The care obligations illustrate the great degree to which the status position of women is dependent on the economic resources and accessibility of some other relative's resources, or on the possibility of negotiating with their partner's specific healthcare patterns (e.g., having prescriptions filled, or seeking help at private physicians or clinics). Women who live near family members or have close relationships with their neighbours may have a better chance of securing healthcare. Asking openly for money is socially unacceptable, but in general people will ask closer relatives or friends, which allows women to access resources. Thus, women who are not highly dependent on their husbands to obtain resources, or who are able to negotiate help-seeking strategies, may be able to secure help in spite of the overall difficulty of obtaining healthcare.

From an analytical framework, healthscapes are therefore positioned between two related rationales: on one side, a rationale between social dynamics, including healthcare facilities, and on the other, a rationale based on aetiologies and symptomatology. The two aspects converge, which can either facilitate or interfere with processes of health-seeking and treatment behaviours. These points of convergence produce a timeframe for the recognition of symptoms, actions to secure help, treatment practices and the possibility of integrating different types of interventions, embedded in relational perceptions and practices. This also shows how illnesses are flexible in terms of outcomes, since caring and healing are idioms and practices of power that can either engage or ignore biological and social dimensions of illness and are not restricted to one or the aspect ('the family' or the 'disease').

Case One: “If your baby didn’t die during the first eight days he can now wait another two days to be seen”

When Fredy, the youngest son of Maria Cruz Temaj from Talquichó, got sick, she received help from the Roman Catholic Congregation of the Franciscan Sisters, known as Las Hermanitas, who are located in San Lorenzo and have provided primary healthcare and medicines since 1998. Maria had known about the Hermanitas because her family had bought some medicines for her mother-in-law many times before at their dispensary. But when Fredy got sick with diarrhoea and fever she first sought help at the health centre.

Maria Cruz Temaj is one of the many people who have taken advantage of the presence of low-cost charity organisations. However, under a pluralistic model the quandary of ‘making sense’ of the illness and the decision of where to seek help becomes contextually troublesome when the wellness-seeker mediates between services and facilities that differ in nature and therapies. This also means obtaining different diagnoses, different therapies from a variety of providers including self-therapy, and making individuals into active consumers of health services rather than passive patients. Maria Cruz’s first encounter was at the health centre in San Lorenzo, around 1.5 kilometers from her village, the day she went to buy some things at the market. Maria speaks Mam and fluent Spanish, and she is very self-confident. Her mother-in-law lives close to them with her youngest brother-in-law and his family. Marta’s father-in-law passed away a few years ago. During the coffee-picking season, between August and November, Marta’s husband, Julian, works in a coffee plantation, afterwards returning home to Talquichó to harvest their own corn crop. Marta and Julian met in the capital city of Guatemala. She was working as a domestic employee in a private house, while Julian was driving for a private taxicab company. Marta lived in the city around five years and Julian three.

“Julian said to me that we would be better if we came back to San Marcos. We had some savings and could get married and live in our own house, no matter how little. I came first and Julian a couple of months later. I stayed at my sister’s before we got married. It was a good decision to come back, as things in the city are getting worse and worse, and you have to pay for everything! I was working in San Pedro (one of the 30 municipalities of San Marcos) as a lunch lady in a restaurant before I got pregnant with Amalia, the one who was in the project.⁹ We have healthy children, but occasionally they get sick, especially if it is too cold

⁹The reference is to the RESPIRE project conducted in San Marcos, addressing acute lower respiratory infections and indoor air pollution; <http://www.who.int/bulletin/volumes/85/7/06-035832/en/>

or has been raining a lot. Amalia used to get Eye very easily because she always smiled and everybody was always telling her how sweet she was—well, that’s what my mother-in-law says. I’m not sure if there is such a thing! I mean, in the city you never hear of children getting Eye, but my mother-in-law says that that’s why children are often ill, because people can’t identify it. I listen to her because she is old. . . Fredy had diarrhoea a couple of times before but not like this, so I thought, “Why not? It may be true”. I thought maybe it was Evil Eye because of the color and shape [the feces had], so we treated [him] for a couple of days with Doña Martita until it stopped. But on Sunday he started [with diarrhoea] again”.

One significant feature of these networks was observed. Positive experiences and the agency to act resulted in a cluster of responses that differed from the responses of women who could not engage in the dynamics of health decisions. When women could not make a decision without the consent of their husbands or elders, or were reprimanded by healthcare practitioners, behaviours were deeply influenced by normative restrictions on what counts as acceptable or desirable. These norms locate women within spaces that are shaped by expressions of relationships, which are definitive with respect to other people. In such cases, healthcare practices were determined by kin or social relations, rather than organised around the presumed gravity of the illness. Thus, a caretaker’s agency in healthcare consists not only in recognising danger signs but also in her capacity to articulate, integrate or change imposed models and dynamics of care. The process of recognising symptoms is undeniably crucial for securing help, yet the inability to take an active role in decision-making may affect the outcome. For this reason, illnesses cannot be reduced to an apparently objective realm of care when they are subject to the cultural configurations of social hierarchies.

“This time it was different, so on Monday I took him to the health centre. “We’d better go to see the doctors to give him his medicine”, said Julian, so we went to San Lorenzo, but the doctors were having a meeting in San Marcos. The auxiliary nurse said, “What’s the problem, nana?” I told her that Fredy had diarrhoea for a couple of days. “Okay, when did he start?” “He started a week ago but we cured the Eye. We gave him infusions of eucalyptus, pepper, and some aspirins as well, then he started again on Sunday”. “So he has been sick for a week now?” “No, it stopped on Thursday”. I asked her if she could give me something for him, but she said, “The doctors are not here and we don’t have any medicine left. If your baby didn’t die during the first eight days he can now wait another one or two days to be seen”. We then decided to buy some medicine at the pharmacy. They gave us Enteroguanil but Fredy kept on being sick, so on Wednesday we decided to go to see El Campesino (a Mam private medical doctor who studied in Cuba

and has a private clinic and a pharmacy in San Lorenzo). He told us, “You did the right thing to cure him of the Eye, but now it is an intestinal infection that he has”, so we bought some medicine and gave it to Fredy for two days but he kept being really sick. His diarrhoea didn’t stop and he still had fever. On Friday my mother-in-law and I went to Las Hermanitas to get her medicine, and I asked them if they could give me something. They told me that the infection Fredy had was probably bacterial and gave me two bottles of a different medicine”.

The conditions and environment under which health personnel normally work, sometimes waiting months to be paid, increases a mother’s frustration and fears. During this research, encounters between health-seekers and medical personnel were likely to end in frustration for both parties. For example, varying levels of reliability and uncertainty were important determinants for subsequent approaches in the network system described above. This rather fragile system of care manifests mothers’ distress over health behaviors, and affects the number of ‘behavioural stages’ that can be found not only for ‘intentions’ to cure but also in estimates of the probability of obtaining an effective treatment within a specific period of time. Mothers who attended a first level of care and found help or felt they were heard were more likely to follow the advice of medical personnel than were mothers who met with delays or perceived indifference towards the patient. These experiences tended to increase the possibility that the mother would resort to ‘risky’ behaviours, such as seeking help from healers.

Like Maria, many women who received effective care or felt that their concerns were acknowledged would normally simplify the definition of Evil Eye, i.e., narrow its symptoms and outcomes, instead of prolonging the time to secure a cure. Maria, for example, effectively conceived a series of stages specific to symptoms and care. When a ‘behavioural stage’ did not provide a cure (whether it was her mother-in-law or a doctor who suggested it), Maria went looking for a better solution. In both cases Maria’s responses were neither rejected nor specifically endorsed by others, but were integrated into the process of healing. These cases are examples of the importance of the dimension of ‘culture’ in the process of illness definition and the detection of danger signs. However, a behavioural stage that involves the use of health services suggest that resorting to standardised healthcare or treatments as an expected behaviour is only possible when the mother’s level of agency allows her to follow this course.

Cultural consonance is defined as the extent or degree to which individuals can achieve a specific goal that responds to cultural measures or practices. While other illnesses tend to be more ‘isolated’ or ‘individualistic’, Evil Eye is embedded

in networks that are internally differentiated, and are as likely to lead to fragmentation and uncertainty as to an unequivocal decision. Thus, the illness tends to be collectively defined and acknowledged, which is profoundly important since it relies on the authoritativeness or judgement of more than one person. This not only suggests that Evil Eye can be defined and treated solely by shared cultural models, but also offers the possibility of changing roles (and functions). This may allow a mother to engage in what might be called a ‘deviant accepted behaviour’: the possibility of opening interactions between healthcare models and members of the community, including healthcare providers, and making use of family resources. Thus, labeling an illness as Evil Eye provides a ‘sense of coherence’¹⁰ which is strongly influenced by the caretakers’ roles. Even when they need the approval of men—for example, to take a child to the hospital—they are permitted to negotiate judgements between socially recognised individuals such as midwives, healers, and other family members as well as considering their own opinions.

Case Two: “When a child catches the Eye it’s just like any other illness”

The most critical problem in diagnosing an illness is identifying the severity of any symptom as a condition that needs to be treated within a certain time and by a certain method. What is essential in any illness, therefore, is awareness of the implications of the dysfunction. Prior conceptions and experiences need to be taken into account by physicians in order to provide an efficient, clinically-oriented outcome. The difficulty in defining the problem from the family’s perspective shows that the so-called ‘barriers’ have a broader social and political dimension. Patients’ narratives reveal that the problem is not just identifying and treating a specific symptom, but how far removed the medical discourse is from the actual context of the problem.

This final case shows how public health interventions and the national healthcare system have distorted a model of healthcare that cannot provide sufficient care or guarantee entitlement to treatment. This fragmented system transforms

¹⁰Although the majority of caretakers will identify symptoms of diarrhoea, fever, cough and dizziness, among others, as part of Evil Eye, depending mainly on traditional medicines and healing, it should be noted that these are not reasons to avoid biomedical healthcare facilities. Nor is limited household income a complete barrier to allopathic treatments, even at private medical facilities. Caretakers benefit from help-seeking behaviours that are supported by their social networks. Therefore, Evil Eye, on one hand, requires the recognition of others to provide a specific form of healing/care, and on the other hand is constantly challenged by its own imperative attribute of ‘sense of coherence’. Cases where healers advised against treating (or continuing to treat) symptoms as part of Evil Eye were reported when caretakers described the symptoms as part of ARIs or ADDs or when the child’s state was rapidly deteriorating after treatments failed, as described in chapter VI.

caretakers' healthscapes into a chain of illness categories, treatments and interventions that cannot be relied upon because of the political economy of healthcare. The importance of this case lies in the idea that beliefs and cultural healthcare practices are not a simple matter of recognition, classification and treatment compliance, but the result of constant interpretations, possibilities and negotiations within families, social networks and national healthcare structures.

In 2008 Carola gave birth to her first baby, Jordie. Carola looked like a forty-year-old woman but was only twenty-six, as is true for most of the people in this area who live in poverty. In the beginning her baby did not present any sign of being weakened by the external conditions that normally make babies ill and are explained by Evil Eye. She joked about that, saying that perhaps her baby was not "as pretty as his dad" but more like her. One day she approached us while we were interviewing a mother whose child had been sick with symptoms of ARI. She was part of the study but lived in a community nearby where she was visiting her sister, so her regular weekly visit had taken place a few days before. She came to us and explained that Jordie began with what she thought was a normal cold, but after several treatments Jordie's health deteriorated. She and her son later came to the clinic of the project, where the physician listened to his chest and recommended that she go to the health centre. Before she left she came to me and asked my opinion. I told her I was not a physician so I could not provide her with the type of help she needed. Her response was, "I don't mean the treatment, but what to do?" I asked for the weekly report to see if she had reported some symptoms or signs related to ARI, but nothing had been written down, meaning the child was apparently healthy the day of the visit.

Three weeks later the person in charge of the project told us that Jordie had died. We could not believe it and were shocked by the news. A few of the project's personnel went to visit her a few days later. Her house was located at the bottom of a mountain, approximately a twenty-minute drive from San Lorenzo and only ten minutes' walking distance from the main street of the settlement, except when the rain makes the road and the path down the mountain almost impenetrable. It took us more than an hour to get to her house. Carola's husband asked us who we were and what we wanted. I said we wanted to see Carola and tell her that we were sorry about her loss. "She's at her sister; she has been there for the last few days". We all said nothing. First a drizzle and then a heavy rain started to pour down. We tried to get some shelter at the threshold of the door until the rain had passed. I noticed that the whole place felt damp, with no windows and an improvised ceiling made of laminates. An unbearable cold came from outside the walls. Carola's husband let us stand in the doorway, where a smell of burnt

wood came from within, probably from the open fire. There was no electric light, only a candle flickering inside the room. We saw on our way to the town that one of the lampposts had been washed away, so there was no electricity around the area, although only the major's office, the *salon municipal*, the church and a few business and houses had electricity at that time anyway.

"So you all are doctors?" he asked. "No, none of us is. He's an agronomist, she's a fieldworker, and I'm a social scientist". "Ah, you are a social worker?" "No, something different". "So what do you do?" followed by some jokes from the fieldworkers. Then the man continued, "You know, my son was part of the program, that health program you are part of, but it didn't make any difference. No one did anything for my son". "Would you mind telling me what happened?" I asked "We don't know. The doctors said that we didn't treat him properly but we gave him all the things they told us. We still have some of the things here at home because he died before he could even finish it. One day he was fine, the next day he couldn't breathe properly and turned blue".

Carola's husband continued: "Jordie was a very healthy boy; he only suffered from the normal colds and illnesses that attack children, but nothing serious. He had received all his vaccinations and vitamins. He had a strong blood". "Did he never suffer from Evil Eye?" "No, not really. I mean, we cured him in case he had caught the Eye, or when he had some symptoms, but he never fell seriously ill". "So what do you think was different this time that he got ill with a bad cold?" "Well, the winter has been pretty bad. We all were having symptoms of a cold but they were never too bad or lasted for many days. A few weeks ago we all fell ill in the house. We bought some medicines at the pharmacy for the five of us. After two days we all were healthy again, even Jordie, we all were cured". "Carola told us that Jordie started with symptoms of a cold. Were they the same symptoms all of you had?" "Maybe, I don't know. When Jordie started with the cold, then he had fever and we got worried, but because of the heavy rain we couldn't leave the house. Then the following day Carola went to the health centre in San Lorenzo but they sent them back home and told her that we belong to Comitancillo and that we should seek help there although we are closer to San Lorenzo. So Carola just bought something at the pharmacy and came back home. I think the medicines worked a bit because Jordie's cough wasn't too bad anymore. . .

. . . After the fever stopped we took him into the *chuj*; perhaps he was only cold and his body couldn't get warm. But on Sunday, the market day at Comitancillo [when many people from the surrounding villages come down to sell or buy merchandise], we went with Carola to the health centre. The doctor said that Jordie's lungs

seemed to be full [of phlegm]. He gave us some bottles of medicines and we left. Then we went to town [inaudible]. At lunchtime Jordie turned blue and we went back to the health centre. Another doctor was there and told us that Jordie needed to be taken to the hospital, but the ambulance had just left so we would need to pay a taxi. I didn't have much money with me and it took me a while to locate my brother-in-law and borrow some money from him. When we finally got to the hospital Jordie was unconscious. We left around six in the afternoon and got there at night around eight or so".

"Did Jordie die at the hospital?" "No, he and Carola stayed a week at the hospital. My brother-in-law helped me out and brought her coffee and lunch every day. After five days the doctors released him and they came back home. He was fine but then he started again with the cough. I went to see if I could find the health promoter. I told him that Jordie had a cough again and maybe needed more medicine. But he said that they were short of the medicines and there were not enough because at the time many other children were also sick. "Go back to the health centre", he said to me, but what could they possibly have done again? Send him and Carola back to the hospital? So I went to the pharmacy and bought some medicines. But Jordie didn't receive anymore. He stopped eating and at night he died". "What does the death certificate say?" "I think they wrote pneumonia. Maybe it was that, but I don't know. He never had been sick with it before and like I said he received all his vaccines. With Evil Eye or *puj* it's different, you know? When children get sick with it you know what to expect, and if you don't recognise the symptoms then someone with more experience will. If you don't get the right treatment, then someone can provide you with the right one. If something [unexpected] happens then there is always someone who says, "Ah, that happened to Fulanito or Menganito", so you can ask them what they did or where they went, but with other illnesses it is different. Jordie was always cured when symptoms of Evil Eye appeared. It was just one day that he didn't have any symptoms of Evil Eye and got ill with something else". "But what happens when the symptoms are just alike and you cannot tell the difference?" "A man might not be sure, or even mothers who are not so experienced. Carola kept going to her sister to be sure Jordie didn't have the Eye, because her sister has [experience with her] four children". "Let me rephrase my question. What if, for example, my child starts with a cough and I think it is *only* a cold and...". "If it's a cold you can use the *chuj*" "No, but what if it's not, what if the cough is because of something else?" "When a child catches the Eye it's just like any other illness. You treat it and if he doesn't get better then it's something else. But with Jordie nobody could identify what it was. They said it was pneumonia, but if he was cured at the hospital,

then why did he die?"

Decline in the health status of children is a direct consequence of poor basic conditions such as a lack of potable water, sewerage and disposal facilities. The introduction and promotion of antibiotics and therapies such as ORT suggests that these interventions have a significant impact on disadvantaged socioeconomic groups. However, it is precisely this deprived state that makes children susceptible to frequent infections. The local understanding is that symptoms such as those of respiratory infections are experienced as a constant bodily disorder, affecting a broad range of social practices but usually appearing in more or less controlled patterns. Although the information provided by the health authorities about recognition of symptoms and danger signs, along with access to health facilities and health management, have improved in recent decades (cf. Sastry & Burgard 2010), the population continues to be exposed to perilous conditions that increase the need for care management at home.

Peoples responses to interventions portray a development of strategies of a healthcare-network management that reduces the dependence on doctors and medical supplies when these are scarce, insufficient or inefficient after required use of treatments. Consequently, endemic diarrhoeal and respiratory infections have been integrated into the understanding and practices that characterise the local health-decision processes, yet important factors such as environment, living conditions and nutrition are not necessarily included in this decision network. Although the links and evidence may be clear, the fact that unfavorable social and economic conditions cause serious and constant health problems can only be seen as a general, structural problem, rather than a specific personal or family behaviour.

The resulting sense of loss and distress is defined and managed by the shared cultural model that forms the foundation of the belief in Evil Eye. When mothers or caretakers were not able to achieve a goal such as an effective cure, it provoked a social distress that needed to be understood in order to be accepted. In this way, the belief in Evil Eye is explicitly placed among relationships and practices, with the notion that detrimental community attitudes, including healthcare provision, contribute to the emergence of illnesses and negative outcomes. Although Evil Eye is perceived as an ominous threat of death, I only encountered a few cases where caretakers actually explained the death of their children as a direct result of the Eye. Evil Eye has been instrumentalised as a mediating mechanism to address the implications of using only biomedical facilities, due to a general lack of confidence in the biomedical healthcare system, and also as an adaptive long-term response to emotionally arousing experiences in ways that reduce the costly emotional burden

of the high prevalence of diarrhoeal and respiratory infections. This pluralistic medical model is an area of overlap that ‘does not necessarily change people’s beliefs about health and illness. It indicates they seek a solution for their health needs, not a change in ideology’ (Gold & Clapp 2011:96).

In order to make this shift, caretakers also talked about their own feelings of insecurity and susceptibility, establishing a direct link between their own health status and that of their children. Paradoxically, this state was self-reflected not as a state of vulnerability but associated with harmful social relationships or effects that had a negative influence on the whole family. Caretakers stressed not symptoms, but feelings, to demonstrate detrimental health outcomes when cultural patterns were not adopted (e.g., non-compliance with social norms, feelings associated with envy, the implications of not being able to convey beliefs about illness causation), an understanding that corresponds with ideas of illness aetiologies among indigenous groups, and the impossibility of separating emotions from biological health and well-being. Family and social frictions also increased cases of Evil Eye. The caretaker’s socioeconomic status indicated the likelihood of access to treatments, but more important was their social capital, which affected their dissemination of healthcare information, i.e., management.

7.8 Conclusions

It has often been asserted that culture and beliefs influence health-seeking delays or automatically pose a threat to assessment and treatment compliance. Biomedical personnel working in various levels of healthcare in rural San Marcos often expressed their frustration at seeing patients whose health state had apparently deteriorated for these reasons. However, caretakers do not necessarily follow what has been prescribed, recommended or expected, not as a result of ‘cultural barriers’—i.e., unwillingness or refusal to follow biomedical advice as a result illness beliefs—but due to several factors that people encounter in the process of healthcare seeking and delivery. Thus, Evil Eye does not account for the overall burden of diarrhoeal and respiratory infections. Points of orientation or reference are, however, a matter of cultural conflict. An apparently standardised biomedical culture is based upon a rationality that is deprived of values and personal/family dynamics, in which the medical personnel expect that caretakers or patients will assume a specific role in order to achieve the biomedical goal. However, illnesses are not only the result of pathologies but of a complex relationship among family and other social networks in which illnesses are organised, resulting in entangled dynamics and processes. Therefore, diseases cannot solely be perceived as biomedical concepts, focused on

the biological malfunction at the expense of understanding problems associated with the illness experiences (cf. Kleinman 1997), but as cultural phenomenon a built and organised outside the ‘body’. This selective process creates healthscapes in which people navigate among diseases, institutions, and diverse social networks.

Behaviours addressing Evil Eye do not automatically constitute a hindrance against biomedical conceptualisations or practices, despite the similarity to symptoms of diarrhoeas and respiratory infections. Evil Eye facilitates the caretaker’s self-efficacy while providing affordable, available, and efficacious treatments to attain the goal of curing through customary practices and values, or by adapting the illness to more efficient treatments when necessary through social participation. ARIs and ADDs, on the other hand, are depersonalised and tailored to meet biomedical expectations, rather than being integrated into people’s realities, which are limited by lack of options, difficulty of treatment compliance, and the role that caretakers can reasonably play in such dynamics. Evil Eye matters because it is organised around social dynamics and networks that link multiple aspects (environmental, social, and personal vulnerability), which consequently mediate between systems of care and healthcare providers. Evil Eye’s capacity to adjust depends upon the ways the illness creates and structures new opportunities (or models of care), providing access to certain treatments. Thus, the illness plays an important role in providing new meanings, thereby ensuring access to healthcare and permitting more dynamic patterns of healthcare. As a result, cases and experiences of Evil Eye differ. While some examples displayed patterns that increased the use of healthcare systems, precisely due to the different ways in which Evil Eye can engage with different aetiologies and care strategies, other examples showed that the delay of appropriate care was influenced by insistence on standardised procedures, when the formal health model disregarded the patient’s or caretaker’s perception of causes, and focused only on symptoms and the policy of ‘access to care’.

Health workers who developed ways to provide access to treatments without relying strictly on the biomedical perspective proved to be more effective, since treatment adherence is largely based on trust and recognition. Family and community are important social actors in the provision of healthcare in rural San Marcos, emphasizing the extent to which illness concepts include emotional commitment that can lead to rejection or adherence of treatments, not necessarily based on biological considerations. In this sense ‘culture is not something that irrationally limits science, but is the very basis for value systems on which the effectiveness of science depends’ (Napier et al. 2014:1630).

However, Evil Eye is continually challenged because the beliefs and values that influence the evaluation of illness aetiologies and treatments play a major role in

developing strategies of healthcare and support. Thus, Evil Eye has been transformed over time and will continue to adjust, since it underpins different attitudes towards healthcare dynamics: support, provision of treatments, and strengthened ties of solidarity among families and communities, despite being in constant conflict with public health discourses. Nonetheless, Evil Eye's symptoms, and those of illnesses with similar symptomatology, tend to worsen as the illnesses progress when not treated promptly or adequately, to the point where interventions may become ineffective and complications develop. These problems are not due exclusively to a failure to seek biomedical attention or provide (adequate) allopathic treatments. What makes intervention plans difficult to implement are the manifold overlapping symptoms of these diseases, which come into play when biomedical concepts and outcomes interact with cultural factors but cannot be prevented or effectively dealt with. Thus, despite innovative ways of delivering healthcare, affordable and more effective treatments, and improvements in nutrition and maternal education, these initiatives have not always been sustainable or helped to reduce the morbidity and mortality of ARIs and ADDs. Public healthcare facilities in the rural area of San Marcos often suffer from staff shortages and lack of equipment and supplies, which weakens the public healthcare system in both the short and the long term.

It is important to recall insights of Evil Eye's belief and healthcare practices to understand its role upon health-seeking behaviours and case management due to its perceived pervasiveness, which impacts cases of acute respiratory infections and diarrhoeas among children. However public health endeavours to identify, diagnose and treat these infectious diseases have demonstrated that not only caretakers, but also biomedical personnel and facilitators have sometimes failed in this process. Consequently, the impact of some of these diseases in specific contexts and environments expresses and exposes health conditions that call into question people's behaviours and the barriers they encounter, as well as the role of public health efforts (cf. Moran-Thomas 2013). The difficulty of assessing the symptoms of ARIs and ADDs demonstrates that low treatment-compliance rates for diarrhoeal and respiratory infections is the result of disjointed public health interventions that have not provided accurate diagnosis, appropriate referral or adequate treatments, often resulting in an increased use of generic drugs, an approach that has appeared frequently within the dynamics of the Guatemalan healthcare system.

Deficiencies in various parts of the public health sector seriously affect the delivery of some services, which is one of the root causes for the widespread deficiencies in care. For example, not only is basic training for volunteer health personnel deficient, but approaches to manage ARIs and ADDs, based on global and national guidelines, have not met the required standards. However, it is precisely this

process of standardisation as a strategy to identify cases by using ‘simple’ signs-and-symptoms charts, viewed as the key to the diagnosis and treatment of minor cases of such infections within the household and referring more severe cases to a higher level of care, that has generated a detrimental dependence on antibiotics and inappropriate and ineffective health interventions. Furthermore, environmental factors such as nutritional status (feeding practices, complementary food/liquids), household sanitation facilities (toilet, latrine), and drinking water quality have a direct impact on health tend to negate the progress that has already been made in fighting preventable childhood diseases, especially pneumonia and diarrhoea.

When the global biomedical sector and the community base intersect, it becomes clear that explanations of the nature and causes of diseases may differ, along with the expected methods of treatment and care. As a result, global rates of morbidity and mortality for children under 5 are still below the Millennium Development Goal (target 4). The final chapter of this dissertation discusses these aspects with respect to diarrhoea and pneumonia, but, more importantly, discusses how difficult these generic concepts¹¹ are to assess, and shows that they can be linked to many potential aetiologies as a cause of illness in such an inadequate healthcare system. Exploring the entanglements that characterise illnesses is of particular importance to recognise the effect of global health policies on culturally specific illness categories, as well as to reflect upon the models and programs of large-scale health interventions when they are applied to micro-scale communities.

¹¹*Generic concepts* refer to concepts with similar features or nature, classified as part of a category, such as diarrhoea and respiratory infections, which are non-specific terms that refer to a large range of differentiated pathologies.

Stumbling on (Mis)diagnosis

‘In a world where most sickness manifests via invisible pathogens and ambiguous symptoms, the dramatic appearance of this [Guinea worm] affliction has contributed greatly to the charged meaning ascribed to it.’

— Moran-Thomas (2013:211)

Although not generally a cause of mortality, intestinal helminthiasis is one of the most common diseases worldwide, occurring in the poorest and most deprived areas (WHO 2014b), and it remains largely neglected. Helminths¹² have been human parasites prior to recorded history, found in mummified human feces; yet only four drugs are available to treat helminthiasis, due to lack of pharmaceutical interest in the commercial development of therapies (cf. Hotez 2006, 2008). Most of these afflictions could be easily eradicated through improved water supplies, healthy environments and sanitary services (cf. Moran-Thomas 2013). In Guatemala, however, poverty, economic inequality and uneven health coverage are common in populations living in vulnerable settings, where children are especially susceptible to intestinal helminthiasis infections.

Intestinal helminthiasis refers to infections of the intestinal tract by one or more soil-transmitted helminths (STH), including hookworms, *Ascaris lumbricoides*, *Trichuris trichiura*, and *Strongyloides stercoralis*. Platyhelminth tapeworms and STH are highly prevalent throughout Latin America, especially in rural areas (Hotez 2011). *Ascaris lumbricoides*, an intestinal nematode (roundworm), is the most common STH infection, affecting around one billion people worldwide, particularly children (Brooker 2010; Hotez et al. 2006), and contributing to malnutrition, iron-deficiency anemia, growth stunting and cognitive deficits (Gupta et al. 2012; Hadidjaja et al. 1998). Morbidity from STH infections is related to the number of worms harboured. People infected by *A. lumbricoides* may or may not present symptoms, depending on the type of parasite and which part

¹²Included among helminthiasis infections are *filarial nematodes* (classified according to host organ in which they inhabit), which cause illnesses such as onchocerciasis, drancunculiasis and lymphatic filariasis; *platyhelminths* (flatworms), which consist of several types of flukes (trematodes), causing schistosomes; and *tapeworms* (cestodes), such as the pork tapeworm that causes cysticercosis (Hotez 2011).

of the body is affected. People with light-intensity infections generally have no overt symptoms, and diagnosis of infection must rely on microscopy-based testing to detect the parasites in the stool. Heavier infections, however, can cause a range of health effects, including intestinal symptoms (diarrhoea, abdominal pain), malaise, weakness, diminished growth, compromised cognitive development, and impaired immune responses (Albonico et al. 2008). Larger numbers of eggs may provoke pneumonitis during migration of larvae through the lungs, causing persistent cough, wheezing, and shortness of breath. Adult worms in the intestines can provoke abdominal pain, nausea, vomiting, diarrhoea or bloody stools. A severe intestinal infestation can also cause weight loss, fatigue and presence of worms in stool or vomit (Cruz et al. 1994; Ghenghesh et al. 2008).

Guatemala has more cases of *Ascaris*, *Trichuris*, and hookworm infection than any other country in Central America. An estimated 3.2 million pre-school and school-age children are infected with STH, and 8.3 million children are at risk, require periodic deworming treatments with a single dose of albendazole or mebendazole (Hotez et al. 2014). As a result, a vast majority of the Guatemalan population, especially children, face serious health burdens, including the highest number of STH infections and the highest prevalence of chronic malnutrition. STH infections and recurring diarrhoea can contribute to malnutrition in young children, increasing the risk of death from diarrhoea and pneumonia. Diarrhoea, acute respiratory illness, STH infections, and malnutrition are all closely entwined as the foremost challenges to child survival in Guatemala. Their prevalence and incidence are linked to ecological, behavioural, immunological and demographic determinants (Vecchiato 1997:242). However, helminthic infections are more often associated with inadequate sanitary conditions and household hygiene practices. Since the 1960s, WHO public health interventions have launched control strategies using mass distribution of antihelminthic drugs at least 2-3 times per year among children in areas with high prevalence, and once a year in areas of lower transmission (WHO 1967; Jamison et al. 2006:473).

Although helminth infections are common, interventions to control and eliminate these diseases are inadequate. Conditions such as political instability, lack of continuity or monitoring of programmes, and poor involvement of key community members all contribute to the failure of control measures, such as promoting oral rehydration solution (ORS) for diarrhoea management. Twenty countries have been unsuccessful in promoting the use of ORS (Wilson et al. 2013). At the community level, the direct sources of contamination for helminthic infections are normally visible. However, ideas of contagion, pollution and hygiene are understood differently. Consequently, caretakers' responses to diarrhoeas and respiratory in-

fections reflect norms and values that define the range of acceptable behaviours and interactions, which do not necessarily coincide with the standardised, effective measures promoted by the WHO. The result has been an integration of perceptions and responses that include a wide range of cultural explanations as to how infections are acquired and the reasons that biomedical treatment remains largely ineffective.

Several cases from the fieldwork show how child deaths from acute respiratory infections (ARIs) and acute diarrhoea diseases (ADDs) could be prevented, and how the poorest are at higher risk of death from pneumonia and diarrhoeal infections. The following case provides an example of different perceptions and responses of healthcare in a case of diarrhoea caused by parasitic helminths. It reveals different understandings of the concept of diarrhoea, but more importantly, it illustrates the extent to which generic concepts are difficult to assess and can be linked to many potential aetiologies as a cause of illness. On one hand, generic illness concepts help to provide a context of attributes that relate to the symptoms; and on the other, these concepts encourage the development of more systematic strategies within a caretaker's social and structural relationships. In addition, the interpretation of generic concepts can lead to an increase or decrease of treatment awareness as well as drug dependence.

After a day in Comitancillo, Rocío and her family returned home on a Sunday afternoon. 'That day was especially hot. I dressed my sons nicely because we went to church there. That's why they may have been wearing too many [items of] clothes, so when we arrived we all were sweaty and pretty hot. Mauricio (her eldest son, 7 years old) was thirsty, so we bought a soda for him and one for Alejandro (her youngest son, 3 years old) when we arrived. After mass, we went to the marketplace. Sometimes we stay longer [in Comitancillo] and eat something there, like we did that day. We had grilled corn and some hotdogs. The park was full and the children were playing, so they didn't want to leave, but a few hours later Julio [my husband] decided we should come back home because there is a microbus that goes to our village in Chicajalaj. The next morning Alejandro was saying, "My belly hurts", and he wasn't hungry. I gave him [a tea of] chamomile but later that day, after lunch, he started vomiting. That's why I thought he must have caught the Eye. My neighbor cured him, but at night Alejandro didn't stop vomiting. We all were fine so I couldn't think [of what it could have been], since we all ate the same food the day before. . .

. . . He cried a lot and I could see that his belly was inflated. Julio decided to take

him to the clinic of San Vicente,¹³ but that day there was just a woman at the pharmacy and no doctor was coming. We still had a bottle of Pepto (Bismol) at home that we gave to him. He was better for one or two days, he even started eating again, but his stomach was still making funny noises. When I thought he was cured he started with fever and at night his nose was bleeding. I got nervous because I didn't know why he was bleeding, he wasn't hurt. Julio went out to call the health promoter but because it was late he said that the best we could do was to take him to the health center in Comitancillo, but it was 8pm! So we had to pay a pick-up. They charged us 40 quetzales to take all of us there. When we arrived, Alejandro was feverish and the bleeding hadn't stopped. The doctor asked, "What does he have?" Julio explained that Alejandro had been bleeding for almost two hours. Then the doctor gave him an injection. "He's too skinny", she said. "Does he have diarrhoea?", she asked. "No", I said. [She replied,] "The ambulance hasn't come back from San Marcos yet, so if you want to have him hospitalised you have to pay a car". But Julio and I thought it wasn't necessary, and I was relieved Julio said so because I don't like hospitals. We waited until the bleeding stopped and we left. The next couple of days went on pretty normally, but one morning after breakfast Alejandro was vomiting again. "Ay no!" I said, "What does this boy have?!" I was so worried because he always seemed to get sick all of a sudden. I got so worried I even thought someone was making him ill. But then he had this diarrhoea that scared me! I went back to the clinic of San Vicente. I told the woman what happened and she said, "The doctor is not coming until tomorrow; you can bring him around 2pm. Until then you can give him this". It was a bottle of some medicine. The medicine was good because it cured Alejandro. That's why Julio said, "Why take him to the clinic?" so I didn't. I think the medicine really cured him because for a week or so Alejandro was healthy. I went to wash clothes one day. The sky was "charged with rain". When we arrived at home a heavy storm hit the village. The day after I saw that Alejandro's diaper had a worm!! I almost fainted. Alejandro had been playing with mud. When it rains, the smell of earth "agitates" the worms and sometimes they come out. When Julio came back I told him what I saw. The next day he went to the pharmacy and got a bottle of albendazole. My mom told me that Alejandro's stomach was fragile; that's why he had been having so many and different types of diarrhoeas. When the worms stopped coming [in his stools] I took him into the *chuj* to re-establish his strength. But since that day he is always catching something, but nobody seems to know what it is, or maybe there are too many things"

¹³Chicajalaj is located about 15 kilometers from Comitancillo, with a population of about 3500 habitants. Thanks to the Society of San Vicente de Paúl Zaragoza, Spain, Chicajalaj has had a 'social clinic and pharmacy' since 2000, that sees patients twice a week and provides medicines at low cost.

Mayarí: “Do you think all the symptoms Alejandro had were part of the same illness?”

Rocío: “No, I don’t think so. Alejandro had different things. When he started vomiting I thought it was because he got too hot the day before, so his body was affected; or he might have eaten something cold and his body just “lost control”; or maybe it was just because he is still a little child he’s prone to get sick, and that’s why his brother didn’t get sick [although] both were playing under the sun, and ate and drank the same things. [Since] his body was fragile I think that’s why his nose was bleeding. But then children also catch the Eye easily... then it started raining”

Mayarí: “At the times you took Alejandro to see a doctor or at the clinic, did they make a physical examination?”

Rocío: “The doctor at the health center undressed him on the top to hear his heart [beats], took his temperature and weighed him too. She asked about the diarrhoea but Alejandro wasn’t ill from diarrhoea. Sometimes he does more [stools] in a day, but that’s only when he catches the Eye or has eaten something raw or “bad”. But those stools are green and watery. When I saw the worm his stools were yellowish and I could hear his stomach making noises because the worms were awake. They smelled earth and wanted to go out. I can recognise dysentery but it wasn’t that because there was no blood in his stools”

Mayarí: “Have you heard about deworming medications? Did anyone advise you to give Alejandro some?”

Rocío: “Yes, Mauricio receives Yodochlorina® every year since he’s going to school, because they eat things that may have “microbes”, but Alejandro is still too young to get those [microbes] too. These were other types of worms”.

Public health programmes have constantly addressed the importance of caretakers recognising danger signs in children suffering from any acute illness in order to seek help and receive the right treatment in time. The assessment of the gravity of the symptoms, together with the understanding of coendemicity with other illnesses, is necessary in order to effectively control or eradicate specific infections. Rocío detected some symptoms but there was nothing that clearly indicated what the source or the seriousness of the symptoms might be. To identify a diarrhoeal or respiratory infection and to judge its seriousness requires an understanding of prodromal symptoms (a symptom or group of symptoms that appears before an illness breaks out). Specific strategies to treat or cure an illness frequently depend on what is perceived as the determinant symptom.

Diarrhoeal diseases and respiratory infections account for the majority of deaths among children under 5, and are the most common illnesses worldwide (Bruce et

al. 2014). However, they are not always clearly defined. Respiratory infection, for example, is a non-specific term used to refer an acute infection of the upper or lower respiratory system, and is normally treated as a common cold. Diarrhoea can be related to different aetiologies, and its visible aspects (e.g., stool colour, shape, size, odour, consistency) play an important role in the caretaker's evaluation, since the judgement is based largely on observable symptoms rather than on a clinician's diagnosis. However the presence of pathogens has been 'naturalised' and incorporated into illness experiences, suggesting that notions of illness are to some extent indeterminate, allowing a space for negotiation in dealing with them and with the problems they create (cf. Moran-Thomas 2013). Additionally, the complexity and ambiguity of these illnesses, along with the similarities between their symptoms and those of Evil Eye, contribute to low compliance rates for diarrhoeal and respiratory infections. Other factors include the financial and operational fragmentation of the public health services, resulting in inappropriate diagnosis and inadequate treatments. Healthcare providers resort to overuse of generic treatments for ARIs and ADDs, focusing on cures rather than prevention.

8 SIMPLE TERMS, DIFFERENT UNDERSTANDINGS AND THE TRANSLATION OF MEDICAL CONCEPTS INTO CULTURAL PRACTICES

‘Often, outcome “measurables” are seen as the end product of the intervention as much as the health outcomes themselves’.

— Adams (2013:68)

International health institutions, particularly the World Health Organisation (WHO), have contributed to the development, introduction and promotion of the regulation, implementation and provision of maternal and child healthcare. However, various factors have hampered improvement of health services and children’s health. For those with access to treatment, the provision of pharmaceuticals has brought dramatic changes in the way people perceive and treat acute illnesses such as diarrhoeas and respiratory infections. Availability and provision of treatments is one of the elements of achieving the Millennium Development Goal 4 to reduce child mortality. However, lack of information about the causes of certain diseases (e.g., virus, bacteria, fungus), and the misuse of drugs, play an important role in the understanding, transmission, and treatment of diarrhoea and respiratory infections.

The complexity of beliefs and practices concerning illness such as Evil Eye grappled with early emerging global public health endeavors contribute to problematical healthcare decisions and at sometimes improper use of treatments. Recognising these entanglements is of particular importance in assessing the effect of global health policies on culturally specific illness categories, and in evaluating the concepts involved in large-scale health interventions as they are applied to micro-scale communities. In this regard ‘there are profound discrepancies between how global

health policies and campaigns are envisaged to work and the concrete ways in which they are actually implemented or received by target populations that are routinely facing multiple morbidities and economic insecurity' (Biehl & Petryna 2013:10).

Global policies placed into local realities, and theoretical understandings of health-related practices (specific terminus, objectification of care, use of biomedical resources), are not always grounded in particular localities, and have not taken seriously concerns such as Evil Eye (cf. Nichter 1994; Luby 2013). In this chapter I draw attention to the complexity and heterogeneity of categories and symptoms that can be part of diarrhoeal diseases and respiratory infections, which make it difficult to create guidelines that incorporate the caretaker's perceptions of the illness. Thus, 'generic' illness concepts are useful to draw attention to the debate regarding the application of standardised procedures to treat cases of diarrhoea or respiratory infections.

In addition, although international standards provide standardised definitions of diarrhoea and respiratory infections, at a local level the definitions of these diseases are variable and inconsistent. As a result, the Integrated Management of Childhood Illnesses (IMCI) approach to improving child healthcare in developing countries is occasionally inefficient. Thus, in specific contexts and environments these health conditions involve people's behaviours and local barriers to healthcare, as well as the role of public health efforts (cf. Moran-Thomas 2013). When the global biomedical sector and the community base entwine, it becomes inevitable that explanations of the nature and causes of diseases may diverge, along with the expected methods of treatment and care. In Luby's view, 'epidemiologists often assume an underlying model that the community is ignorant of certain vital information, and that if we identify this lack of knowledge and develop an educational intervention to improve knowledge, then community practices and health will improve' (2013:45). Some examples of this are found in the global policies and behavioral risk factors for diarrhoea infections and respiratory diseases discussed in chapter I.

Since the 1980s an increased global awareness of ARIs and ADDs has led to increased attention on programs and interventions aimed at decreasing the morbidity and mortality rate among children under five years of age, as well as the wider at-risk population. The global under-five mortality rate has fallen by 49%, from 90 deaths per 1,000 live births in 1990 to 46 per 1,000 in 2013¹, yet many of the successful initiatives have not been incorporated into national policies or strategies

¹http://www.who.int/gho/child_health/mortality/mortality_under_five_text/en/

even though both diseases are largely preventable and methods of intervention can be easily applied (Sastry & Burgard 2010).

Following the process by which ARIs and ADDs attained global and national attention, I intend to discuss the practicality of the methods and therapies recommended by global and national health agendas, as these diseases are intrinsically related to symptoms of Evil Eye and therefore tend to constrain standardised treatments. By examining global health dynamics we can observe, for example, how the international and national initiatives have enforced a reliance on antibiotic treatments and hospital referrals instead of strengthening health education and providing solutions for causal factors such as unsafe drinking water, poor sanitary facilities and malnutrition (cf. Gill et al. 2013:1490). According to the most recent report issued by the United Nations Children's Fund (UNICEF) and United Nations World Food Programme, the prevalence of chronic malnutrition among Guatemalan children under 5 years of age is the highest in Latin America and the fourth highest in the world (UNICEF 2012c; 2013c). Almost 50% of Guatemalan children in this age group are chronically malnourished, especially in areas with predominantly indigenous and rural populations, who are more likely to live in extreme poverty (Martorell 2012). Among families living on just a dollar or two a day, the percentage of children suffering from malnutrition increases to 69%.² The association between malnutrition and diarrhoea is also bi-directional. Not only does diarrhoea contribute to malnutrition, but undernourished children are at higher risk of death from diarrhoea and pneumonia (UNICEF 2013c). These factors have an impact on attitudes, beliefs and systemic factors regarding ARIs and ADDs, which is crucial to understanding the aspects of accessibility and acceptability of selective treatment measures, especially for children referred by health workers to secondary or tertiary levels of healthcare where, for example, caretakers frequently do not follow international health recommendations. Although such practices are simple to apply, they are not always practical or easily followed in the rural Guatemalan context.

8.1 Introduction

In developing countries infectious diseases are a significant direct cause of death and disability³ (Rice et al. 2000), and are among the leading causes of disability-

²World Food Programme, <https://www.wfp.org/content/country-programme-guatemala>

³This definition of this concept has changed over time. Until the nineteenth century disability was a defining social status, stressing not only lack of health but also a social marginalisation. With the emergence of allopathic medicine the concept shifted to an understanding of abnormalities of a biological order. While in industrialised countries the concept includes illnesses

adjusted life years⁴ (DALYs) (Murray & López 1997; Murray et al. 2013). According to WHO, the official reports of mortality rates from ARIs⁵ (especially due to pneumonia) and ADDs shows that children have often been taken to a hospital too late or not at all (Mulholland et al. 2008). Evidence from a study in Guatemala during the 1990s by Goldman and Heuveline suggests that the uptake of health-care, particularly in rural areas, was and remains very poor, with about two-thirds of the population not seeking any formal, qualified health care for acute respiratory infections and diarrhoea (Goldman & Heuveline 2000). A study of care-seeking for pneumonia and diarrhoea, based on the 1995 Guatemalan Survey of Family Health, described a range of influencing factors, i.e., a ‘probability multinomial logit model’,⁶ that delay formal help seeking; among these, poverty was a serious limitation, while education and ethnicity were found to be less important (cf. Goldman et al. 2002; Owen et al. 2010). Nevertheless, education and ethnicity are considered to be historical determinants of inequity, putting at risk the most vulnerable population (cf. Gragnolati & Marini 2003; Mayer-Foulkes & Larrea 2005).

In rural areas, concerns such as ‘symptoms associated with the illness, mother’s beliefs about the illness causes’ (Goldman et al. 2002:1702-1703) and ‘perceived severity, duration of the illness, and time missed at work’ were the most frequently cited causes for failing to comply with a healthcare referral, and were also factors in the selection of healthcare resources (Weller et al. 1997:237-238). In 1997 the Integrated System for Health Care (Sistema Integrado de Atención en Salud) began a to provide basic services to the impoverished population in rural areas, with the aim of reducing maternal and infant mortality rates in places where diseases such as ARIs and ADDs among children normally overlap and constitute the major causes of infant deaths.⁷ Other conditions included in the study were chronic malnutrition, malaria and measles. However, published studies show that between 1997 and 2005 the morbidity rate of ARIs and ADDs did not change

such as spinal cord injury, deafness, multiple sclerosis, diabetes, and mental health conditions, among others, disabling conditions in developing countries still including diarrhoeal diseases, respiratory infections, tuberculosis and malaria (cf. Albrecht & Verbrugge 2000).

⁴Nichter offers a serious critique of this concept, which is designed to measure the impact of illness and disability on a community in order to help prioritise investments in health interventions, with reference to ‘quality of life’ based on a quantitative scale (cf. Adams 2013:72).

⁵Based on the WHO, ARI is responsible for about 20% of all deaths in children under 5 years, and 90% of these deaths are caused by pneumonia; http://www.who.int/fch/depts/cah/resp_infections/en/

⁶This expression refers to a multinomial/conditional model that arises from different assumptions of distinguishing characteristics.

⁷Boletín Epidemiológico Ministerio de Salud Pública y Asistencia Social de Guatemala (MSPAS), <http://epidemiologia.mspas.gob.gt/publicaciones/BOLETIN22.pdf> (accessed on 05.11.2010)

(MSPAS 2012). Treatments for pneumonia and acute diarrhoea (antibiotics, oral rehydration solutions, and zinc) are safe, effective and inexpensive if they are manufactured and acquired off-patent (cf. Gill et al. 2013). However, barely 31% of children with pneumonia are provided (correct) antibiotics, and only 35% with diarrhoea receive oral rehydration therapy (ORT) (UNICEF & WHO 2013:5).

The non-recognition of warning or danger signs, misclassification of the illness, exclusively symptom-clinical based approach, inappropriate prescription of medications, delay and discontinuity of treatments, and antibiotic resistance are factors that increase the risk of death in children suffering from both diseases (cf. Boonstra et al. 2005). For instance, several studies have shown antibiotic resistance among enteric pathogens such as *Escherichia coli*, *Salmonella*, *Vibrio cholerae*, and *Shigella*, among other common bacterial infections (Kariuki 2010:177). To introduce improved management standards, the WHO and UNICEF developed the IMCI in 1992, to provide guidelines for preventing, or promoting early detection of, the most important causes of childhood deaths: ARIs, ADDs, measles, malaria and malnutrition (Patwari & Raina 2002; WHO 2000b). This strategy promotes a holistic approach which includes a range of interventions to prevent and to manage childhood diseases both at home and at health facilities, without expensive laboratory tests or prolonged medical training, through practical procedures (Lejnef & Bailey 2000; Rudan et al. 2004; WHO 2008b). IMCI is built upon effective interventions like ORT, immunisations, management of ARIs and improved diet and feeding practices. It encompasses algorithms for syndromic management of acute respiratory infection and a diarrhoeal control programme, as well as child-related aspects of malaria control, nutritional interventions, immunisation, and essential drug programmes (cf. Patwari & Raina 2002; Tulchinsky 2010; Tulloch 1999).

Some physicians, especially private practitioners, agree that changes in health-seeking behaviours favoring only biomedical healthcare would be safer and more effective when treating diarrhoea and respiratory infections, yet they question the use of medicines acquired at the pharmacy without prescription. They view this as a threat to their medical authority, rather than a problem of overuse of drugs, efficacy and side effects:

“People go to the pharmacies expecting that the person who works there is like us [physicians] and can provide a *correct* diagnosis. But *our* role is of great responsibility. We *know* what a patient needs, but handing people medicines over the counter is widely practiced here. People who work at pharmacies don’t know if the medicines they are giving are suitable for the patient’s condition, or people just ask for a medicine because someone told them it was good” (El Campesino, Private Clinic, San Lorenzo)



Figure 8.1: Private Clinic “El Campesino”

These perspectives emphasise the importance of understanding the prevailing family and community practices in relation to the poor utilisation of the existing health care facilities for ARI and ADD in children. Most deaths of children under the age of 5 from these diseases result from a failure to recognise danger signs or from inappropriate management at the primary healthcare level. Although it is difficult to distinguish between bacterial and viral causes of ARIs or ADDs, in order to identify an appropriate treatment, it is important to increase awareness of the need to take children promptly to a health facility, without first resorting to antibiotics. Yet, it has been noted that health workers are more likely to recommend the use of medical treatments than are medical doctors (cf. Goldman & Heuveline 2000). “A woman came asking for some medicines for her baby who had still diarrhoea after a week. I knew that if I referred her to the health center she wouldn’t go because she has two more little children, so I gave her another bottle of albendazole because this was better than giving her nothing”, explained a health promoter to me. Lack of resources to conduct laboratory or clinical examinations also limits provision of appropriate treatments. Therefore, preventive measures, including parental recognition and early involvement of the local health workers, are extremely important. However, the allopathic care model has focused on the provision of wide-spectrum drugs rather than improvement of the environmental conditions of the population, and strengthened health education programmes for prevention. Furthermore, educational materials are provided in Spanish, which is inadequate for mothers or caretakers who speak only Mam or another language.

8.2 Junction between Illnesses

Assessing the international perspective of diseases and healthcare

Initiatives to overcome health-related problems have been put into action worldwide since the Renaissance. These initiatives date from the appearance of the bubonic plague, or 'Black Death', caused by the bacterium *Yersinia pestis*, which swept through Europe and the Near East and reduced the population by almost a quarter between 1347 and 1351 (Cipolla 1976). This epidemic precipitated three principal contributions to public health: the organisation of boards of health, the promulgation of a theory of contagion, and the introduction of health statistics (Rosen 1993). Epidemics became more frequent when the population of cities increased and sanitary conditions were deficient or non-existent. Exposure to diseases became more frequent, often to new diseases for which individuals lacked immunity (Porter 1999). In the Americas, smallpox, tuberculosis, measles and malaria are examples of disease epidemics associated with the arrival of colonists, which resulted in the decimation of native populations (Ujvari 2003). This encounter also became a threat to the colonisers, who died of communicable diseases they had never encountered before (Leng 1982). Thus, eighteenth- and nineteenth-century colonialism marked the origin of international development efforts in which public health became an instrument in service of the interests of the colonial powers (Arnold 1988:1-26; El-Mehairy 1984:11; Farmer 2009; Leng 1982). In this regard, Farmer points out that 'although historians of public health will reach back to maritime trade and efforts, usually fruitless, to contain plagues, colonial aspirations were often the crucible of transregional efforts to improve health in order to reach other, usually extractive, goals' (Farmer 2009).

In 1851, 12 European nations held the first International Sanitary Conference in order to standardise international quarantine regulations (King 2002:765). Subsequently, the occurrences of epidemics and pandemics have been responsible for the institution of policies worldwide to confront disease. In 1920 the term 'public health' was used for the first time by Charles Edward Winslow, who defined it as 'the science and art of preventing disease, prolonging life, and promoting physical health and efficiency through organised community efforts for the sanitation of the environment, the control of community infections, the education of the individual in principles of personal hygiene, the organisation of medical and nursing service for the early diagnosis and preventive treatment of disease, and the development of the social machinery which will ensure to every individual in the community a standard of living adequate for the maintenance of health' (Winslow 1920:53).

The beginning of the twentieth century set a precedent for international interest in public health regulations with the establishment of the oldest public health organisation, in connection with the construction of the Panama Canal (Cueto 2007). During the construction of the canal, health measures were undertaken to prevent malaria and yellow fever, the high incidence of which threatened its successful construction (Minna 2005).

In 1902 President Theodore Roosevelt established the International Sanitary Bureau, located in Washington, D.C., whose purpose was to gather information on health conditions in the American republics in order to formulate public health standards such as the requirements for quarantine—one of the most widespread public health strategies to reduce the outbreaks of epidemics—to facilitate commerce, and to improve sanitary conditions in seaports through improved sewage disposal and the eradication of disease vectors such as the *Aedes aegypti* mosquito (Farmer 2009; Mellander 1971). With respect to these public efforts, King notes that ‘although often characterised as a humanitarian activity, modern public health as practiced in the United States and other Western industrialised nations has long been closely associated with the needs of national security and international commerce’ (King 2002:763).

In 1903 the International Sanitary Bureau was transformed into the Pan American Sanitary Bureau, an international institution whose membership included 21 states. In 1949, the Pan American Sanitary Conference signed an agreement with the WHO and became the Regional Office for the Americas of the WHO. In 1958 it was renamed the Pan American Health Organisation (PAHO). Since then, the concept of *international health* has been used by health policy planners to refer to ‘the flow of advice, health professionals, and health technology from the wealthier nations to the poorer’ (Lane et al.1996:397). Under this concept, models for prevention and treatment are introduced and results are evaluated.

International conferences at Viña del Mar, Chile in 1954 and at Tehuacán, Mexico in 1955 promoted new public health strategies, such as the inclusion of a more community-based approach through ‘social and preventive medicine’ within the curricula of medical and public health schools. The absence of public health services in rural areas was a major concern, and resulted in the construction of regional hospital systems to provide health care (Murray et. al 2013). During the administration of President John Kennedy in the 1960s, the United States initiated intervention programs referred to as ‘humanitarian assistance programs’. The International Cooperation Administration, a precursor of the United States Agency for International Development (USAID), together with the WHO and other organisations, initiated global health programs designed to eradicate epidemics and

strengthen national health plans, focusing principally on poor countries. This was part of the Alliance for Progress, a 10-year, multibillion-dollar aid program for Latin America, which targeted assistance to support community cooperatives and improve development strategies (Streeter 2006), ‘superficially committed to social transformation as a path away from communism’ (Fischer 1996 In: Rohloff et al. 2011). In Guatemala, these efforts focused on the rural areas, where they formed part of a plan to strengthen national programs through focused support for housing, education, community development, and public health (Ibid 2011:143) as an effort to ‘change the negative attitudes of our people for favorable attitudes’ (Diario Centro América 1956:15).

In the 1970s, growing international interest focused on public health policies implemented in Cuba and the People’s Republic of China. In Cuba, the Ministry of Health focused on providing professional medical personnel and facilities—hospitals, polyclinics, ambulatory medicine—to the entire population (Fernandez 1975; Mason et al. 2010; Navarro 1972; Rifkin 1981; Rohde 1983). In China the Communist Party initiated the programme “Barefoot Doctors”, in which peasants were selected for an intensive course of medical training, including instruction in anatomy, bacteriology, disease diagnosis, acupuncture, prescription of traditional and Western medicines, birth control and maternal and infant care (Sidel 1973; Rifkin 1981; Rohde 1983). Diseases such as cholera, typhoid and scarlet fever were greatly reduced through this initiative. As a result, the WHO and some of the developing countries began to consider China’s and Cuba’s programmes as alternatives to the biomedical health care model. In 1972, the WHO commissioned a study to develop proposals on how to improve and ensure effective health care in developing countries. The results of this study, presented a year later, formulated the principles of the new strategy of public health care. It was not until the late 1970s, however, that *health* was stressed as a fundamental component for national development. Also during this period, social science research increasingly stressed the importance of social development and other conditions that influence primary health care (PHC). Ironically, these studies were often considered subversive (cf. García 1994). Halfdan Mahler, then general director of the WHO, advocated a political rather than a technical approach to health problems, whereby health systems could serve as a ‘strategy for social change’ (Mahler 1979).

Global Health Strategies

A global conference, sponsored by the WHO and UNICEF and held in Alma Ata (then in the USSR) in 1978, produced a set of guiding principles for social development and health care. These principals focused on the provision of accessible

health care, especially for women, infants and children.⁸ Yet the Alma-Ata initiative did not address the problem of poverty, which is directly related to the predicament of inequality of health care services, although the conference did underline the importance of socio-political factors. Thus, the focus on barriers to care was a general statement of health outcomes rather than a focus on service availability as the measure of adequate access (cf. IOM 1993). It proposed universal accessibility and provision of care with emphasis on disease prevention and health promotion, self-sufficiency, community involvement, and intersectional support. The programme identified principles for the organisation and coverage of health services, and a range of approaches to address priority health needs for the fundamental ‘determinants of health’,⁹ as a global agreement on the health sector reforms of the twentieth century. This agreement on health rights forms the ideological basis of WHO and UNICEF, under which nations pledged to carry out the program Health for All by the Year 2000 (Mahler 1981). Strategies for an integrated health system were undertaken within the programmes, especially in multi-ethnic states characterised by medical pluralism. Yet this strategy, implemented in countries such as Guatemala, suggested that traditional medical models were sometimes not only insufficient but problematic. Furthermore, even when the health promoters were part of the same community, this did not guarantee a comprehensive framework for implementing healthcare interventions.

Subsequently, international (multilateral) organisations such as the WHO, UNICEF and financial organisations, including the World Bank (WB) and International Monetary Fund (IMF), have approved enormous amounts of credit to pay for programs of primary health care in various countries. Many of these included aspects of health education, control of endemic diseases, immunisation, nutrition programs, maternal and child care, drug delivery and basic sanitation, emphasising the close relationship between health and basic living conditions, i.e., economic and social development. However, the PHC model had an uneven worldwide implementation. Both international and domestic agencies carried out the programs without structural adjustments spreading hegemonic biomedical models of care without taking into account community participation, which was a key aspect identified in the agreement. This approach accelerated a process of what Talcott Parson

⁸The WHO identified five main aspects for achieving that goal: (1) reducing exclusion and social disparities in health (universal coverage reforms); (2) organising health services around people’s needs and expectations (service delivery reforms); (3) integrating health into all sectors (public policy reforms); (4) pursuing collaborative models of policy dialogue (leadership reforms); and (5) increasing stakeholder participation. Declaration of Alma-Ata, International Conference on Primary Health Care, Alma-Ata, USSR, September 1978.

⁹This includes the social and economic environment, the physical environment, and the person’s individual characteristics, i.e., the conditions in which people are born, grow, live, work, and age; these are shaped by the distribution of money and resources as well as by people’s behaviours <http://www.who.int/hia/evidence/doh/en/>



Figure 8.2: Pursuing collaborative models of policy dialogue

called *medicalisation* of illness, that is, viewing illness and care in terms of medical control. Since the early 1970s, perspectives in the sociology of medicine have emphasised the concept of medicalisation,¹⁰ understood as ‘a process by which

¹⁰Nowadays, according to Singer and Baer, *medicalisation* means ‘giving a condition or behaviour a medical label, defining the problem in medical terms, and using a medical intervention to treat it’ (2007:93), while Sobo refers to it as the ‘extension of medicine’s authority into what were once nonmedical realms and the conversion of what were once normal human ailments or social problems into medical diseases, and the (resulting) regulation of everyday life’ (2009:67).

nonmedical problems become defined and treated as medical problems, usually in terms of illnesses or disorders' (Conrad 1992:209), such as homosexuality. The concept was further developed in studies by Irving Zola and Ivan Illich (1972), among other scholars (cf. Conrad 1992; Lock 2003).

Medicalisation originates from a model where medical authority prevails. It also blurs the fact that perceptions, meanings and treatments for illnesses are social phenomena that emerge between the biomedical and social domains. The importance of this trend is that illness attributes are transformed through biomedical approaches, and diseases or specific syndromes are therefore seen as definitively treatable or curable. This perspective also transforms the implications and meanings of diseases, underlining the idea of 'risk' labeled in biomedical terms as well as the stigmatisation attached to mishandling of a disease (e.g., the idea of negligence, for example, if a child's state is considered treatable from the biomedical point of view, but caregivers decide against such interventions).

According to Foster, international health policies are based on the assumption that allopathic models are a prototype of healthcare programmes and actions to treat or eradicate diseases, especially in poorer, dependent countries (cf. Foster 1987a, 1987b). These programs frequently fail when cultural beliefs and political circumstances are not taken into account (cf. Engel 1977; Justice 1986). Parallel to this, international and national events, such as the oil crisis, global recession, civil wars, introduction of other programmes that shift national budgets away from health and other social services, the emergence of new pandemics (especially AIDS/HIV), and the reappearance of diseases such as malaria and dengue, moved the focus of international public health away from broad-based programmes and toward the management of high-mortality emergencies (cf. Chan 2008).

PAHO identified in its 2008-2009 strategic work plan the necessity to fortify the capacity of the health sector to develop improved gender- and ethnic-specific approaches to health care and to develop the capacity to detect and respond to emerging and reemerging diseases, and to strengthen institutional and community capacity to identify, prevent, assess and/or control environmental factors that affect health, with emphasis on the most vulnerable populations¹¹ (PAHO 2009:55-

¹¹In its final report, the PAHO stated: 'The concerns regarding funding targets were reiterated, and the importance of community-based participatory research, particularly research that would promote the participation of indigenous people and the use of traditional knowledge was highlighted. . . Many delegates [of the Council] also emphasised the need to ensure universal access to and coverage of health care services. It was pointed out that community health programs should apply an intercultural approach that took into account the differing needs of different ethnic groups and cultures, with due regard for indigenous populations and their traditional medicine. . . Several delegates highlighted the need for an integrated, comprehensive, and multidisciplinary approach to family and community health services' (Pan American Health Organisation; World Health Organisation CD49 2009:16-21).

77). In 2000, the United Nations adopted the Millennium Declaration, with eight goals and 21 targets, three of them directly related to healthcare and its provision. Childhood mortality is highlighted as an area of great importance in Goal 4 of the UN's Millennium Development Goals (MDG), which seeks to reduce the mortality rate of children under 5 years old by two-thirds (United Nations 2010). Childhood mortality rates are still extremely high in developing countries due to infectious diseases, particularly acute respiratory infections and diarrhoeas. According to WHO and UNICEF, there are approximately two billion cases of diarrhoeal disease annually worldwide, killing around 1.5 million children under 5 years of age, principally in developing countries, where a child under 5 has an average of three episodes of acute diarrhoea per annum.¹²

Pneumonia accounts for a similarly high number of deaths each year (UNICEF & WHO 2013). Childhood pneumonia, the most serious form of acute lower respiratory infection (ALRI), is the leading single cause of mortality (19% of all deaths) in children aged less than five years, followed by diarrhoea (17%).¹³ In addition, 37% of deaths among under-fives occur during the neonatal period, a significant proportion of which are also due to ALRI (Bryce et al. 2005; CDC 2006). Reasons for this high incidence are widespread poor living conditions, lack of proper sanitation service, contaminated sources of water, and poor hygiene. Interventions to reduce the risk have been directed towards programmes of exclusive breastfeeding¹⁴ (which prevents diarrhoea) and improved sanitary arrangements, along with use of vaccines and visits to healthcare centers.

8.3 Development of ARI Control Programmes

In 1976, during its 29th Assembly, the WHO launched a special programme to address the worldwide problem of ARIs, for which the management or 'key practices' constitutes a fundamental aspect of primary health care programmes. The Sixth General Programme of Work of the WHO (1978-1983) recommended extension of the programme for control of tuberculosis to include control of other communicable diseases of the respiratory tract (WHO 1976:94). As a result, in 1979 the 32nd World Health Assembly approved a resolution 'to stimulate and to intensify the involvement of Member States in the control of respiratory diseases' and 'to ac-

¹²www.who.int/healthinfo/statistics/mortality/en/ (accessed on 21.03.2013).

¹³UN Inter-Agency Group for Child Mortality Estimation (2010), 'Levels and Trends in Child Mortality', UNICEF, WHO, WB, UN.

¹⁴*Exclusive breastfeeding* is when a child receives exclusively breastmilk without any other kind of liquids or solids, apart from some vitamins, mineral supplements, or medicines. Partial breastfeeding implies the child receives some breastmilk together with other liquids and foods (León-Cava 2002:52).

cord high priority to research activities for the development of simple and effective methods for the prevention [and control] of acute and chronic respiratory diseases' (WHO 1982a:12). This led to a review of the extant aetiological knowledge, processes for diagnosis, and approaches to clinical management, control measures, and examination of ARI epidemiology in order to make recommendations for clinical management, employment of rapid laboratory techniques for viral and bacterial diagnosis, and general guidelines for operational research on ARI worldwide (Heiby 1998; WHO 1998).

In 1982 the WHO approved the Seventh General Programme of Work (1984-1989), which included ARI control as a part of the seventeen programmes contained within the segment on 'disease prevention and control'. The purpose was to identify strategies for intervention at the community level to reduce mortality rates, particularly for children, and to introduce or increase the availability of PHC services for the control and treatment of ARI cases through national healthcare programmes, as a part of an integrated maternal and child care program (WHO 1982a). These uniform and structured strategies, implemented by WHO and NGOs and summarised in basic protocols designed for collection of national epidemiological data by community-based workers, provided operational data for surveillance of ARI.

In the same year the twenty-fourth session of the Advisory Committee on Medical Research (ACMR) and the UNICEF/WHO Inter-Secretariat Meeting also discussed and highlighted the importance of national efforts to undertake prevention measures in particularly high-risk areas, through better case management of ARI at the PHC. Special importance was placed on community participation for the 'development and evaluation of improved child care practices' and other factors called *behavioural determinants* of ARI (cf. WHO 2010:17-21). After the development of protocols for first-level care facilities, pilot community-based programmes followed. However, pneumonia (as well as diarrhoea) has been neglected in many countries, where efforts have been focused on the control and prevention of HIV/AIDS,¹⁵ tuberculosis and malaria, even though such efforts have only reduced childhood deaths from these latter diseases by about 13% (cf. Gill et al. 2013:1496; PATH 1988; The Global Fund 2010). Along with issues such as pluralistic positions regarding suitable intervention strategies, the inclusion of case management into the IMCI plan from 1989 shifted to *facility-based training*, the complexity of an 'evidence-based' approach to establish the aetiologies of the various diseases, and the difficulties of reaching the 'target group' (Greenwood 2008).

¹⁵In 2008, US\$13.7 billion dollars went to HIV/AIDS programmes in low- and middle-income countries, while pneumonia and diarrhoea programmes were not allocated even half of this



Figure 8.3: National Hospital in San Marcos

Consequently, in 2008 the Global Action Plan for the Prevention and Control of Pneumonia (GAPP) was established to decrease pneumonia deaths and achieve Goal 4 of the Millennium Development Goals—specifically, to reduce the child mortality rate by 65% by 2015 as compared to 2000 levels (WHO 2009a:2), and to decrease by 25% the incidence of severe pneumonia in children under five years old (UNICEF & WHO 2013). Unlike the case management of ADD with sugar-salt solutions to prevent dehydration, the control of ARI morbidity and mortality relies largely on antimicrobial treatment and hospital referral. This requires a more active management outside the household and therefore becomes more health-community dependent (cf. Bhattacharya 1997:219-220). For this purpose, UNICEF and the WHO in 2003 outlined a Joint Statement to support programmes at the community level, advocating for the distribution of antibiotics by community workers, parallel to malaria campaigns. In developing countries one concern still endures, namely the reduced accessibility of technology and infrastructure in the PHC services. The quality of PHC management and home care is thus considered determinant but insufficient, based on the WHO guidelines (Nicoll 2000; WHO 1990).

Acute Respiratory Infections (ARIs)

“Doña Rosario brought Ismael to the health center two times. The child had a swollen testicle and persistent diarrhoea; he was also undernourished. We gave her a treatment of Trimethoprim, Sulfaprim and acetaminophen, which it seems she also got from the SIAS before. The last time we saw Ismael he presented onset of pneumonia, with febrile seizures and tachypnea, that’s why we referred

amount (Gill et al. 2013:1496).

him to the hospital. But Doña Rosario said she couldn't go because her husband was working in the Pacific coast. Despite improved measures now that we can see patients 24/7, mortality is still common. Mothers expect miracles at the health center but we cannot treat severe cases here". (Health Center, Comitancillo)

ARIs are a leading cause for seeking treatment at health facilities, and also a leading cause of death, in both developed and developing countries (cf. Wainwright 2010; Wardlaw et al. 2006:5; WHO 2001; 2011). ARIs in low-income countries account for many of the mortality cases in old people and infants, with increased risk during the first six months of life (Gill et al. 2013; Schlipkötter & Flahault 2010:97). Globally, pneumonia and diarrhoea account for 29% of all child deaths, with nearly 90% of the fatal cases in sub-Saharan Africa and South Asia (UNICEF & WHO 2013:10). Children are more vulnerable to respiratory infections since their lungs are not completely developed until the age of 2, through proliferation of pulmonary alveoli and capillaries (AAP 2003). Vulnerability is further increased by the fact that children inhale more pollutants per kilogram of body weight than adults, and also because their airways are narrower, which can lead to airway obstruction (Moya 2004). Compared to adults, children's bronchioles are much smaller, allowing intraluminal debris to cause proportionally greater obstruction. In addition, infants have relatively larger mucous glands, which increase secretions and cases of oedema (dropsy) since their airway mucosa is less firmly adherent (Bar-on & Zanga 1996). During the first five years of life a child living in a city has an annual average of between 5 and 8 episodes of respiratory infections, including infections of the upper respiratory system, many of them mild or moderate¹⁶ (ibid). Children living in poor conditions show a significantly higher risk (cf. Berman Smith et al. 2000). However, notifiable respiratory infections are not always reported, so that the 'real' total of cases among the whole population is understated to an unknown degree (Cash & Narasimhan 2000).

Data from a few community-based longitudinal studies show that respiratory infections are very common worldwide (cf. Selwyn 1990; WHO & UNICEF 2004). However, while the overall incidences of ARI are similar in urban areas of developed and developing countries, the relative incidence and severity of lower respiratory tract infections, in particular pneumonia, are vastly different (Rudan et al. 2004). Although in developing countries the lack of reliable data makes it difficult to provide accurate numbers of cases, it is often considered to be between 10 and 50 times higher than in developed countries (cf. Chatterjee 2006; Pio 2003). Further, in developing countries respiratory infections are frequently a contributing cause of death in other illnesses, in particular as a complication of pertussis, measles and

¹⁶Mild and moderate upper respiratory infections include colds and coughs.

HIV/AIDS, despite significant reductions in the mortality rates for these diseases (Wardlaw et al. 2006:26).

Diseases of the respiratory system are categorised by the WHO in the International Classification of Diseases (ICD) according to whether they affect the upper or lower part of the respiratory system, for purposes of standardised diagnosis and management (WHO 2009b). Upper respiratory infections (URI) affect the nose, sinuses, middle ear, larynx and pharynx; lower respiratory infections (LRI) affect the trachea, bronchi and lungs (cf. Lanata et al. 2004; Montasser et al. 2012), although there is no definitive criterion to characterise LRI among children (Lanata et al. 2004). Additionally, respiratory diseases are grouped according to whether they are chronic (lasting usually longer than 3 months), and acute (lasting a short time) (Simoes et al. 2006). Comprising a diverse cluster of circumstances, acute respiratory infections involve over 300 antigenic types of viruses and bacteria (WHO 1983) that affect the airway below the epiglottis (Rudan et al. 2004:896; Welsh Medicines Resource Centre 1999). The aetiology of LRIs, in particular pneumonia, is difficult to identify (Mulholland 2007). LRIs include more serious illnesses such as influenza, bronchiolitis (usually caused by a virus), tuberculosis, and pneumonia, which are the primary causes of ARI mortality (AAP 2006; Bellos et al. 2010; Scott et al. 2008). LRIs, similar to upper respiratory tract infections, present a prompt onset with symptoms that can be dangerous and which last normally for up to a week but less than three months (Welsh Medicines Resource Centre 1999). A physician from the health center at San Lorenzo explained, “The problem we face in rural areas is that caregivers don’t seek appropriate care for children with symptoms of acute respiratory infection. That’s why we normally treat those symptoms, cough with fast or difficult breathing due to a chest-related problem, as “suspected pneumonia”. I think almost every child in these areas has had a treatment of Sulfaprim and Trimethoprim at least three times by the age of two”.

Both the upper and lower respiratory tracts are often affected at the same time, or successively, and there are also undefined conditions such as the influenza syndrome (ILI) (Rudan et al. 2004:896). Additionally, a viral URI can develop into a more severe LRI by colonising bacteria (Galobardes et al. 2008). URI infections frequently occur during the colder months of the year and are a common cause of visits to post or health centres. ARIs are generally caused by viral infections but can develop into secondary bacterial infections (Berman 1991; Purushothama & Chien 1996). The more frequent respiratory syndromes in infants are acute laryngitis and pneumonia. Bacterial pneumonia (including bronchopneumonia) as a primary infection, or as a complication of a viral infection, constitutes the main



Figure 8.4: Patient with pneumonia treated at the secondary healthcare system

cause of death among toddlers and infants (Bartoloni & Gotuzzo 2010:200; Simoes et al. 2006). Bacterial infections are also associated with malnutrition and immune impairment in children, and also with inadequate coverage of immunisation programmes, low levels of parental education, low utilisation of health facilities, poor hygienic practices, lack of sanitary conditions, and the lack of early health care or of any care at all (cf. Barreto et al. 2007; Cairncross & Valdmanis 2006; Feachem 1986; Tulchinsky 2010; WHO 2006).

Concerning morbidity, the last national population-based survey in 2008–2009 suggested that 20% of children under 5 years of age in Guatemala had suffered from acute respiratory tract infections (cough with rapid breathing) and 23% had had diarrhoea in the previous 2 weeks (MSPAS 2009). Some of the aetiological agents causing infectious diarrhoea and respiratory disease in Guatemala are known (Benoit et al. 2014; Verani et al. 2013), but, as in most developing countries, less is known about the aetiology of disease in communities with limited access to or utilisation of the healthcare system, in addition to the lack of data on the prevalence of diarrhoea and respiratory infections. Inconsistent case definitions, limited availability of diagnostic testing, and limited survey data contribute to the poor state of knowledge regarding two of the most important infectious disease syndromes in Guatemala.

Pneumonia

“According to the father the patient was treated with azithromycin a few weeks before... When the child was seen his vital signs were fever of 39.5°C, pulse 130 beats per minute, respiratory rate 35 breaths per minute. Auscultation of his lungs revealed rhonchi in the left lower lobe. We conducted chest X-ray and blood tests which *confirmed* a ‘common’ pneumonia caused by streptococcus... We urge health workers to conduct better diagnosis and provision of recommended treatments to avoid contraindications or severe cases of pneumonia due to delayed management. In this case we advised hospitalization to the father, based on risk”. (National Hospital of San Marcos)

Pneumonia consists of inflammation of one or both lungs caused by virus, bacteria, fungi or parasitic agents, with bacterial and viral pneumonia the most frequent (Galobardes et al. 2008). Common symptoms of pneumonia are chills, loss of appetite, cough with phlegm, chest pain, headaches, fever, and rapid or difficult breathing (Purushothama & Chien 1996). Pneumonia accounts for 19% of all under-five deaths and is one of the major obstacles to attaining the Millennium Development Goal (MDG 4) of reducing the 1990 mortality rate among children under five by two-thirds by 2015 (WHO 2004b; WHO 2013). Nearly one-fifth of child deaths worldwide between 1 and 59 months are the result of pneumonia, which normally appears along with other illnesses such as diarrhoea, malaria, malnutrition, and measles, increasing the risk of death (Berman 1991; Sosa et al. 2010; UNICEF & WHO 2013).

According to the UNICEF, only about half of the children suffering from pneumonia obtain appropriate medical care and less than 20 per cent are given suitable antibiotics (UNICEF 2012a). One of the most common causes of community-acquired pneumonia (CAP)¹⁷ is a Gram-positive bacterial infection (most commonly *Staphylococcus aureus* and *Streptococcus pneumoniae*, also known as pneumococcal disease), responsible for 1.6 million deaths per annum, of which half are children under 5 years old (WHO 2007). *Streptococcus pneumoniae* and *Haemophilus influenzae* type b (Hib) are the most common causes of severe pneumonia among children in the developing world (cf. Smyth 2002; Wardlaw et al. 2006:27). Pneumonias can be recognised by lower chest wall in drawing and rapid breathing¹⁸ (≥ 50 breaths per minute for children from 2 to 12 months and ≥ 40 from 12 months up to

¹⁷CAP is defined as a pneumonia acquired outside of hospitals or other healthcare facilities.

¹⁸The lungs are composed of thousands of tubes (*bronchi*) that subdivide into smaller airways (*bronchioles*), which end in small sacs (*alveoli*). The alveoli contain capillaries where oxygen is added to the blood and carbon dioxide is removed. When a person has pneumonia, pus and fluid fill the alveoli in one or both lungs, which interferes with oxygen absorption, making breathing difficult’ (Wardlaw et al. 2006:6).

5 years) (WHO 2007). However, fast breathing is difficult to recognise in malnourished children, who may be too weak to breathe harder (Seidel 2005:120). Most cases of pneumonia are only mild, and for this reason, the recognition of symptoms is considered crucial to prevent delayed medical care. Consequently, during the 1980s, public health physicians and pediatricians emphasised the importance of identifying cases of pneumonia to improve case management by healthcare community workers (HCWs). HCWs must be able to recognise the symptoms and the clinical characteristics that require the use of antibiotics to treat children at primary health facilities and therefore prevent the need for referral to secondary and tertiary health services (Scott et al. 2012).

Since the introduction of the IMCI in 1992 by the WHO and UNICEF, these globally accepted criteria and strategy protocol have been the basis for HCWs' approach to children's health, including detection and treatment of pneumonia in developing countries; they have become 'key behaviours for ARI care-seeking and management' (cf. Goldman et al. 2002:1709). Since 95% of children with pneumonia present cough, one of the WHO recommendations has therefore been to educate mothers and caregivers in order to identify symptoms and signs of danger with the algorithm 'cough *or* difficult breathing',¹⁹ rather than 'cough *and* difficult breathing', while also taking into account the *specificity* and *sensitivity*²⁰ of the illness, which include fever, raised respiratory rate, lower chest wall indrawing, history of cough or breathlessness, inability to feed, and tachycardia (Scott et al. 2008, 2012; Weber et al. 1997; WHO 1991b, 1991c, 2002a). Key behavioural practices also include symptom recognition and parental response to danger signs, compliance with the advice given for homecare, and adequate provision of treatments and instructions.

Of primary importance in proper treatment are access to affordable drugs and instruction in the importance of completing the dose, as well as (breast)feeding practices. It is well known that even when caretakers recognise symptoms, there is still a delay in seeking help from local providers. Furthermore, several studies have showed that neither HCWs nor caretakers always follow referral recommendations (Cervantes et al. 2003:1). As a result, a series of Focused Ethnographic Studies (FESs) since the 1990s have been undertaken as part of the Programme for the Control of Acute Respiratory Infections, with the objective of reducing pneumonia

¹⁹Children presenting convulsions with one of these two symptoms are classified as suffering from a 'very severe pneumonia'.

²⁰*Sensitivity* is the proportion of those with the disease who are correctly identified by sign. It measures how sensitive the sign is in detecting the disease. *Specificity*, on the other hand, is defined as the proportion of those without the disease who are correctly called free of the disease by using the sign. http://www.who.int/maternal_child_adolescent/documents/pdfs/cah_01_10_tsslides_ari.pdf

morbidity and mortality rates by considering household and cultural behaviours. The compilation relied on anthropological theory and methods, i.e., pile sorts, free listening, hypothetical scenarios, paired comparisons and narratives of current and past ARI episodes (cf. Bhattacharyya 1997:218-219; Gove & Pelto 1994, Nichter 1994; Sáenz de Tejada 1997). The purpose of these studies was to provide support and assistance to improve national ARI programmes based on WHO recommendations regarding household care, and adapt the terminology used with mothers and caregivers to clarify and strengthen local therapy management. These include care-seeking aspects such as who makes the decisions, whom people consult and in what order (cf. Seidel 2005:116).

Etiological agents

“Doctor Douglas told us they needed to run blood, urine and other tests the next day, but we decided to wait a few more days because for the blood test they use a needle and Luis had also Eye. During those days Luis finished [at home] the medicines we got at the pharmacy to reduce his fever and cough. When we took him back to the clinic Luis stayed [hospitalised] for 4 days. The first day they only [ran] test[s]. We got a bill of almost 2000 quetzales! Then my husband saw that the medicines they gave to Luis were the same we were using but they wrote *intravenous* and made it sound more expensive. You can buy these at the pharmacy but we didn’t know that”. (Matilde, Chamaque)

Viral agents account for most of the cases of community-acquired acute infections of the upper respiratory tract and many of the lower respiratory tract cases (Purushothama & Chien; Scott et al. 2008, 2012). Yet a viral origin can be complicated by (or co-occur with) a bacterial infection. Respiratory viral infections predispose to bacterial pathogens (ibid. 1996). The most common viral agents of lower respiratory tract illnesses in infants and children are the respiratory syncytial viruses (RSV), rhinovirus (RV), and influenza A and B viruses (Tregoning & Schwarze 2010). Some agents are more frequently linked with a specific syndrome, e.g., RSV with bronchiolitis and para-influenza viruses; however, the same syndrome can be caused by different agents, and the same agent might cause an extensive variety of different syndromes (cf. Maffey 2008).

New evidence has shown that bacterial pathogens play a greater role as a primary or secondary cause of LRI in developing countries (cf. UNICEF & WHO 2006:7-14). In malaria-endemic areas, the symptoms of malaria substantially overlap with the clinical symptoms of pneumonia (cf. Källander et al. 2004; WHO 1991b, 1991c). Consequently, the use of anti-microbial drugs, although crucial,

is often carried out incorrectly at the PHC level: improper drug, wrong dosage (e.g., confusing the measures of teaspoons and tablespoons) and wrong length of therapy (cf. Sosa et al. 2010). In addition, in some developing countries antibiotic resistance is an increasing problem.²¹ At a clinical level the antimicrobial therapy of ARI management depends on data about existing bacterial pathogens; techniques to identify pathogens; responses/sensitivity of bacterial to specific drugs; policies regarding the use of antimicrobials and of intramuscular injection by the PHC facilitators; acceptability of the way in which drugs are administered (syrups, injections, tablets), price of treatment, and the availability of referral to higher levels of care (cf. Pio 2003; WHO 1982a). This research also documented a large use of injections, which were actively desired as a ‘better’ choice to treat illnesses. In some cases, long-acting oral penicillin is also considered a suitable option for ARI case management (WHO 2004b). Benzylpenicillin (also known as penicillin G) is usually given parenterally during the initial treatment because of its high effectiveness and low cost. The choice of the initial drug treatment is more difficult when the PHC worker is not capable of or is not authorised to give injections. Caretakers generally perceive parenteral treatments as highly effective, and they are preferred in order to avoid referrals to hospitals. However, when children are afflicted by illnesses such as Evil Eye, caretakers are afraid to use injections.

Prevention and intervention

“With the programme “Mi Familia Progresá” it was easy to motivate caretakers to bring their children to the vaccination campaigns and health checkups. We also saw an increase of visits to the post and health centers. But the problem is that there is not always money to support this [type of interventions]. When we had our last quartile evaluation we could see that children that weren’t part of MIFAPRO were often ill. Beneficiary families also receive other incentives such as beans, sugar or other types of food. Children from such families are healthier and seldom severely ill”. (Jairo, health promoter)

Improvements in socio-economic conditions, such as better sanitary arrangements, reduced exposure to air pollution, and less crowded sleeping areas, directly reduce mortality in ARI mortality cases (cf. Smith et al. 2000; UNICEF 2012a). According to the results obtained by the ‘National Survey of Living Conditions’ (ENCOVI) in 2011, there were approximately 4.91 residents per house in Guatemala. An estimated 51% of households were overcrowded; in San Marcos the figure was 61%. Other factors that contribute to the prevalence of bacterial infections are low

²¹WHO (2015): “Antimicrobial resistance”; Fact sheet No. 194, <http://www.who.int/mediacentre/factsheets/fs194/en/>

levels of education, low utilisation of health facilities, poor hygienic practices, lack of early health care or of any care at all, malnutrition and immune impairment in children (cf. Barreto et al.2007; Cairncross & V aldmanis 2006; Feachem 1986; Tulchinsky 2010).

Adequate protein-energy nutrition is of crucial importance for children's immune system. So is the Expanded Program of Immunisation (EPI) (CDC 2006) against measles, pertussis, pneumococcus and Hib²². In Guatemala, respiratory infections and diarrhoeal diseases are directly linked with malnutrition. Currently 43.4% of children under five nationwide are affected by growth retardation (MSAPS 2012:30-31). The usual diet, which consists mostly of maize, interferes with zinc absorption, a micronutrient vital to preventing diarrhoeal and respiratory infections, and Guatemala has some of the highest levels of zinc deficiency in Latin America. Low birth weights, zinc deficiency, concomitant diseases, and parental smoking are likely risk factors that increase cases of ARI and death during infancy (Brooks 2004; Jackson et al. 2013). Breastfeeding during the first six months of life is associated with a reduced incidence of pneumonia and bronchiolitis compared to those who were not breastfed or had non-exclusive breastfeeding (cf. Watkins et al. 1979). Exclusive breastfeeding during the first six months of life is one of the priorities included within GAPP and many other global recommendations to prevent respiratory and diarrhoeal diseases, especially in settings with high mortality rates due to pneumonia.²³ However, rates of exclusive breastfeeding are extremely low. The provision of other fluids and some food during the child's first six months of life is a common practice among rural women in San Marcos. In Guatemala, only 50% of mothers practice exclusive breastfeeding during the first six months of life (USAID 2010:12).

Along with low birth weight (associated with maternal undernutrition during pregnancy), poor complementary nutritional practices, chronic malnutrition due to insufficient food intake, lack of nutritional knowledge, and chronic repeated infectious diseases, incorrect or misused drugs are also factors associated with morbidity and mortality in children under 5 (Stachel & Dean 2006). Children with ARI who suffer from chronic malnutrition can have difficulty breathing and sucking due to blocked airways. When rehydration and feeding of infants during an acute respiratory infection is inadequate, the result may be only partial recovery and consecutive reoccurrences of ARI, with outcomes such as severe malnutrition or death. For this reason, public health interventions stress the importance of the mother's education and autonomy (cf. Cody et al. 1997:333).

²²WHO, Nov. 2013 Fact sheet Nr.331.

²³<http://www.who.int/bulletin/volumes/86/5/07-048769/en/> (accessed on 28.03.2013)

A major concern has been the identification of important signs and symptoms for the assessment of a child with ARI, since the recommended antimicrobial treatment for bacterial pneumonia is antibiotics (cf. Qazi et al. 1996; Sosa et al. 2010; WHO 2001). The significance of the aetiology is that bacterial infections constitute the main cause of mortality from severe acute LRI. Therefore, an inappropriate antibiotic prescription would increase the risk of death (cf. Sosa et al. 2010:30-33; Wardlaw et al. 2006:25-27). Moreover, self-prescribed treatments, or incorrect treatments by clinicians, for viral infections or other ailments with wide-spectrum antibiotics leads to drug resistance (Sosa et al. 2010:8-9). Thus, UNICEF/WHO guidelines for appropriate diagnosis (distinguishing between severe pneumonia, non-severe pneumonia and other respiratory illness) and treatments (i.e., appropriate use of antibiotics in community settings in developing countries (WHO 2004b)) are an essential tool. This also includes instructions for when ARIs overlap with other common childhood illnesses, such as malaria. Antibiotic resistance has complicated treatment of these illnesses (cf. Sosa et al. 2010).

An emphasis on vaccination has substantially reduced morbidity and mortality rates. In 1977 the Revolving Fund (RF) of the EPI of the PAHO was established, and a mechanism for immunisation programs in the Americas was launched two years later, in 1979. Through this program, on behalf of the 41 participating member states and countries, PAHO buys large quantities of vaccines, syringes, and related medical supplies, guaranteeing high-quality vaccines at the lowest price, for which the member states provide only 3.5% of the purchase price (cf. Carrasco et al. 1983). A line of credit allows a member state to pay back the RF within 60 days after the arrival of the supplies. Annually, the RF prepares a public notice, the Joint Report Form on Immunisation, based on the consolidated annual demand, i.e., the epidemiological profile of the participating member states. Among other benefits of the fund are training and advice for national immunisation programmes, a constant supply of vaccines, and the introduction of new vaccines (cf. De Roeck et al. 2006; WHO 1983b). To become part of the Revolving Fund, countries must meet at least three requirements: (1) have a five-year action plan for their immunisation programme, (2) have a national budget for the purchase of vaccines, syringes and supplies, and (3) have at least one professional responsible for the programme. Based on annual demand, the RF consolidates the requirements of all member states. This creates a single regional demand for each product, allowing them to be obtained at lower prices through economies of scale. This enables the participating countries to maximise the use of national budgets to purchase vaccines, covering over 95% of vaccination costs in some countries.

This fund has been vital to the success of immunisation programs in the Americas,

including the elimination of polio, measles and rubella. Guatemala began acquiring vaccines through this fund in 1984. Currently the vaccines purchased are BCG or bacilli Calmette-Guerin (against severe forms of TB); Hepatitis B (adult and child); OPV (oral polio vaccine); pentavalent (diphtheria, tetanus, pertussis, hepatitis B and Haemophilus influenza type b (Hib)); rotavirus;²⁴ MMR (measles, mumps and rubella); DPT (diphtheria, pertussis, tetanus); TD (tetanus and diphtheria); and influenza. Hib was introduced into the immunisation schedule in 2005, yet the pneumococcal conjugate vaccine only became part of the programme in 2012.²⁵ While some countries in the Americas have improved their vaccination coverage more than others, certain countries, such as Guatemala, are considered ‘not especially poor’, which prevents the acquisition of some vaccines at a reduced price through the fund. This poses a major problem of sustainable financing for national immunisation coverage.

Consequently, Guatemala, along with Peru and Brazil, has only recently begun vaccination in certain specific geographical areas or populations considered at risk (cf. Asturias et al. 2003; Barrera et al. 2014). The introduction of mass vaccine campaigns and acquisition of vaccinations through the fund has prevented thousands of deaths and morbidity cases globally. One such example is the Hib vaccine in the Americas, which was introduced between 1996 and 2006 (cf. Barrera et al. 2014; Sosa 2010:481). Hib causes approximately 400,000 deaths annually worldwide among children who suffering from pneumonia or meningitis caused by that bacillus (Barrera et al. 2014). In Guatemala the average vaccination coverage for 2011, according to the latest ENCOVI survey, was 96.77% for TB, 89.97% for DPT, and 77.71% for measles, compared to only an 18% vaccination rate in 1987 (UNICEF 2012b:4). If rotavirus vaccine could reach the same proportion of the population as DPT vaccines, around 2.6 million child deaths could be prevented in a 20-year period worldwide (Gill et al. 2013:1496).

Case management of ARI

“One of the problems we had at the health center is that we couldn’t provide a much better case management, especially for neonatal pneumonia, when we needed to make use of oxygen since they are at higher risk of hypoxaemia and apnea. [Nowadays] we have improved our resources, but we are still facing a large

²⁴Rotavirus-related deaths worldwide are about 600,000 cases each year and represent approximately 40% of hospitalisations for diarrhoea in children under five years old. These cases provide a large caseload for health centers. In developing countries the highest rate of infection occurs between 3 and 11 months of life. http://www.paho.org/hq/index.php?option=com_content&view=article&id=1861&Itemid=1621&lang=es

²⁵UNICEF/WHO (2013): ‘Immunization Summary. A statistical reference containing data through 2011’, http://www.who.int/immunization_monitoring/data/en/

proportion of pneumonia deaths because these cases overlap with unfavourable conditions. Many of the children are severely malnourished. That's why we need not only specific diagnostic tests but also other type of antibiotics we still cannot provide". (Dr. Cali, Health Center in San Lorenzo)

Since the mid-1980s the WHO control program for ARIs has largely focused on case management by health workers for early detection and treatment (WHO 1984). Thus, the recognition of danger signs of acute respiratory infections has been regarded as key for the decision-making process (cf. WHO 1991b, 1991c). Currently, Guatemala's Ministry of Health focuses on preventive services including vaccination, and initiatives related to food and nutritional security, which are part of Programa de Extensión de Cobertura (PEC)²⁶ at the PHC level to increase child survival rates. The PHC approach stresses the importance of educating families in simple case management through the dynamic participation of primary healthcare workers. The goal of the training is to increase the caretaker's ability to recognise mild and severe ARI, give supportive care, and take children to a health facility where trained health workers provide counselling and referral (WHO 2003; 2004b). Flow charts are used to help health facilitators at the PHC and at referral levels to easily recognise symptoms and signs in order to provide antibiotics/antimicrobials, and to refer cases to another level of care if needed (WHO 1995). Thus, global and national policies and programmes have focused on securing help at the first-level facilities, strengthened by better-trained community health workers. Behavioural change and communication strategies are also considered central parts of these programs (cf. Seidel 2005).

One of the constraints is that, in some areas, ARI constitutes an endemic problem, which increases the amount of antibiotics/antimicrobials required for the daily caseload at the health units. WHO advises two doses of amoxicillin per day for three days in settings with low HIV prevalence and five days in settings with high HIV prevalence (UNICEF 2012a:25; UNICEF & WHO 2009b, 2013). Regular monitoring of diagnoses and prescribing behaviour is essential to effective case management. Accurate differential diagnosis²⁷ of LRI and URI is important, since the latter does not require the use of antimicrobials (Bennish & Khan 2010:46). Therefore a rationalised use of pharmaceutical treatments is encouraged, which depends on accurate diagnoses. However, it is difficult to provide suitable training to illiterate or semi-literate caretakers and CHWs. The WHO initially launched small controlled pilot studies and subsequently employed other strategies to strengthen

²⁶See Chapter IV.

²⁷*Differential diagnosis* refers to the process of determining the probability of one disease being the cause of the observed symptoms, eliminating the possibility of other diseases that present similar signs and symptoms.

national programs by improving the capacity of CHWs, traditional healers and community health volunteers to recognise ARI and give advice to caregivers who seek help.

In cases of LRI, the WHO recommends children should be taken to a health facility within the first day, and in severe cases within the first hours. If children do not respond to the initial PHC treatment, a referral to a hospital is required, with access to oxygen therapy and intravenous antibiotics.²⁸ Although referrals are important, people do not always accept the recommendations of the PHC workers. Thus, health education has been the Achilles' heel of ARI programs, since efficient case management depends on the information the community possesses and uses. In this regard Amalia, a mother of three children from Cerro Grande, San Lorenzo, explained to me: "The nurses think they own the medicines. When we seek help at the post center they say, "Go to San Lorenzo, we don't have any more medicines". They just look at the babies and then send us to the health center if we need medicines. Now in San Lorenzo the health center is always open, they tell us that there is no excuse not to bring our children because there are always nurses and a doctor, but how do you get there at night? You walk at least an hour and a half, or more if you are taking more than one child".

Another problem with ARI is that aetiological, clinical and epidemiological data that could lead to improved case-management strategies are not available. This lack of standardised case management can lead to ineffective treatments. Further, without access to X-rays, blood tests and sputum tests for pneumonia diagnosis, the disease is treated based only on symptoms and physical examination according to IMCI, in which respiratory rate constitutes the classificatory criterion. For such cases, children are given a 'full course of effective antibiotics', on the presumption that most of the severe cases are bacterial.

8.4 Development of ADD Control Programmes

It was not until the mid-1920s that diarrhoea could be successfully treated with intravenous fluids, blood transfusions and fasting. This course of treatment prevailed until the 1950s, when physicians suggested the ingestion of carob flour and dehydrated bananas as a non-invasive treatment that could be administered outside a hospital (Ruxin 1994:366-367). During the late 1970s, around 5 million deaths per year resulted from approximately 500 million annual episodes of diarrhoea in children and infants (UNICEF & WHO 2009a; WHO 1978a). Programs launched

²⁸Handbook IMCI, UNICEF 2005.

during the 1970s and 1980s by the WHO resulted in reduced mortality by focusing on the introduction of oral rehydration therapy (ORT). Initiated by the International Centre for Diarrhoeal Disease Research in Bangladesh in 1969, ORT became the core of diarrhoea treatment programmes, reducing the under-5 mortality rate by 75%, from 193 per 1000 to 49 per 1000, between 1980 and 2011 (Gill et al. 2013:1488). Although the provision of ORT and zinc could prevent around 75% of diarrhoeal deaths, reducing the total rate of mortality among children under 5 years to 20% (Gill et al. 2013:1496), only 66 countries around the world currently have direct national policies to treat childhood diarrhoea with ORT (UNICEF 2009:26). On average, between 2006 and 2011, just one-third of children with diarrhoea in developing countries received ORT; children in the poorest areas often receive no oral rehydration at all (UNICEF & WHO 2009a).

ORTs are simple solutions of water, salt and sugar, which makes them low-cost and readily available at home. However, the quantities of the required ingredients could result in a potentially fatal mixture for a child; also, the solution is less effective if not prepared or dissolved as recommended.²⁹ The solution also needs to be kept covered to prevent contamination, and discarded after 24 hours. ORT provides sodium and glucose to the small intestine, increasing the concentration of sodium in the intestines, improving water absorption and preventing dehydration. However, treatment recommendations have changed over time (cf. Sukkary-Stolba 1990). ORT was first distributed in developing countries in the form of one-liter dry powder packages (specifically low-osmolarity oral rehydration salts). Later, the IMCI guidelines called for it to be distributed over the counter, without requiring a prescription (idem). When ORT packages are not accessible, caregivers and CHWs are advised to provide other fluids to maintain the child's nutritional status and ability to fight infections. For example, 'recommended home-made fluids' (RHF) are readily available and have low-cost ingredients (for example, cereal-based drinks from grain or root crops). However once children have become dehydrated the provision of any type of fluids is no longer effective (UNICEF & WHO 2009a:15). Currently, just 33% of children with diarrhoea in developing countries receive ORT (Idem 24). In Guatemala this figure ranges from 11 to 22% for children under five (cf. CDC 2008).

Since the 1980s several studies have been conducted to determine the knowledge, attitudes and practices of mothers and healthcare providers regarding immunisa-

²⁹When a person ingests a higher concentration of salt or sugar than the body needs, water osmotically leaves the body and enters the intestinal lumen (in order to maintain isotonicity), resulting in dehydration as well as higher salt concentrations in the body. The WHO changed its recommended formulation in 2002 by reducing the concentrations of salt and glucose: <http://rehydrate.org/ors/who-unicef-statement.html>

tion and diarrhoeal disease, and to gather data on the effectiveness of rural health promoters, the value and appropriateness of their training, and the problems encountered at the community level (cf. Bentley 1988; Green 1989; Nichter 1988; Scrimshaw & Hurtado 1988). These studies have provided valuable information for use in the design of training curricula for MSPAS personnel and the planning of promotional strategies. Volunteer health promoters became valuable players in the expansion of immunisation coverage, in promoting ORT, and in convincing mothers to give these to their children. However, inappropriate public health messages on how to make use of ORTs, confusion caused by multiple healthcare campaigns, unsuitable marketing of ORTs, and lack of attention to healthcare culture have often impeded the effectiveness of these programs (cf. Nielsen et al. 2001; Nichter 1988). Furthermore, vague educational programmes for diarrhoeal case management and administration of fluids, including ORT, have been one of the constant problems identified in promoters' training manuals. For several decades, the MSPAS normative manuals were ambiguous in their instructions. For example, the difference between 'continuing' and 'increasing' breastfeeding/fluids/feeding was vague, and it was discovered that many health promoters were recommending a 'reduction in' or 'withholding of' breast milk, other fluids or food during and/or following an episode of diarrhoea (cf. IDRC 1989; WGO 2012). The same research found that some promoters recommended intermittent administration of ORT, thus increasing the risk of dehydration. Some EPI and ORT interventions are still inadequate in terms of support and supervision, affecting the administration and effectiveness of treatments provided at the primary healthcare services.

Evidence from a two-town study in Santa Rosa and Quetzaltenango in Guatemala in 2010 revealed a rate of ORT use of 32% among children under five, of which only 61% were properly prepared. This study also showed that when caretakers received ORTs without adequate instruction the result was frequently improper preparation (Masterson 2010:v). This is troubling, since ORTs are inexpensive, easy to prepare, and readily available at local shops (*tiendas*) or pharmacies. As a result, several studies among rural populations worldwide have recommended additional training for caretakers and first-level medical personnel not only in traditional perceptions and treatments for diarrhoeas, but also in the preparation of treatments (including ORTs), in order to improve their effectiveness. The following comment of a mother illustrates some of the misperceptions with regard to the use of ORTs: 'The man at the pharmacy gave me a bottle of Pedialyte (ORT) with cherry flavor for Lidia, but she didn't like it. The health promoter said it was important to give her liquids so I mixed it with a Tiky (carbonated drink). I think children don't like [ORTs] because [they] are not sweet enough'. A study carried out in Chiapas, Mexico

among an indigenous population revealed some reasons for the low use of ORTs. These included perceived lack of effectiveness, deficient public-health campaigns, reduced availability, and low prescription rates by physicians, pharmacy personal and traditional healers (Granich et al. 1999).

These problems have led to several studies conducted since the 1980s. The concern has been not only about socio-economic and environmental aspects, but also cultural perceptions of diarrhoea and the use of ORT. Using ethnographic methods such as interviews, KAPs, and focus groups, among other models, the aim has been to understand local practices, behaviours, beliefs and knowledge related to diarrhoeas in order to adapt the promotion techniques for governmental policies and education programmes. Two other recurrent problems were the difficulty in accurately measuring one liter of water, and the labeling, which required a level of literacy among caretakers. In addition, when the solution was not completely consumed it was stored and frequently became contaminated. The practice of combining partially used packets resulted in incorrect concentrations (cf. PATH 1988). This led to changes in the packaging design in some countries, including drawings to make the instructions clear.



Figure 8.5: Carbonated soft drinks are widely consumed in the rural areas of San Marcos. These can be found at every little shop, whereas purified water is more expensive and harder to find. Carbonated soft drinks are also used for ORT purposes.

In Guatemala several primary health projects, such as Community-based Integrated Health, were launched during the mid-1980s. These programmes focused on the development of environmental and sanitation systems and included a component of immunisation and oral rehydration'. By the middle of 1986 the project

was amended to strengthen the ORT component, and additional objectives were established to increase the rate of use of ORT to 80% for the treatment of acute diarrhoeal disease. However, due to political conditions, many projects could not be conducted or supervised (cf. IDRC 1989). By the late 1980s ORT was added to immunisation programs (which included coverage of vaccines for BCG, polio, DPT and measles) for children under 5 years of age and for pregnant women who lived in the rural areas of Guatemala. One major achievement previous to that decade was the training of a large number of Rural Health Technicians (Técnicos en Salud Rural, TSRs), who received two years of training, focusing on preventive and community development activities during the 1970s. The TSRs were trained to work in local communities and to help select and train community volunteers or health promoters to provide primary health care in their communities. They also played an important role in promoting ORT among caretakers and increasing their use for the treatment of acute diarrhoeal disease. However, studies led by AID found that the normative training manuals for case management of children during and after episodes of diarrhoea were ambiguous and inconsistent. As a result, the recommended frequency and quantity of fluids were not administered, and breast-feeding and other appropriate fluids and food were often reduced or stopped. In addition, ORT packages were frequently prepared incorrectly, and caretakers often mixed them into ‘sport’ or carbonated drinks, which are readily available. The levels of salt in these drinks are inadequate and they contain too much sugar. These many deficiencies had a serious impact on mortality rates (cf. IDRC 1989). Furthermore, the availability of promoter training manuals varies by districts or areas. Some promoters have no access to written reference materials, or receive obsolete training modules which are inconsistent with new guidelines.

In the 1980s a specific agenda called the “Diarrhoeal Disease Control Programme” was introduced by the WHO to reduce global morbidity and mortality rates. Under this plan, ARIs and diarrhoeal diseases become part of an integrated program of child, maternal and reproductive health. The same goals have also been included in several other agendas and initiatives:

- (1) Every Woman Every Child (part of the Global Strategy for Women’s Health and Children’s Health), launched in 2010, which seeks a ‘continuum of care’ approach launched in 2010.
- (2) Global Action Plan for Pneumonia (initially only focused on pneumonia but expanded to diarrhoeal diseases in 2009), a prevention and control strategy established within ‘Diarrhoea: Why Children Are Still Dying and What Can Be Done’.

- (3) Committing to Child Survival: A Promise Renewed, a global movement led by UNICEF and USAID to mobilise political leadership among national governments, the private sector, civil actors and global partnerships, which seeks to advance the Every Woman Every Child strategy.
- (4) UN Commission on Life-Saving Commodities for Women and Children, a program to increase the supply of, and access to, medicines and other health-related measures among the most vulnerable populations, including the integration of the private sector and consumer, and mandatory utilisation of ORT, zinc and oral amoxicillin.
- (5) Global Vaccine Action Plan, initiated by the WHO in 2012.
- (6) Declaration on Scaling Up Treatment of Diarrhoea and Pneumonia, initiated in 2012 by private donors, industry and NGOs.
- (7) Diarrhoea and Pneumonia Working Group, formed in 2011 to support the UN Commission on Life-Saving Commodities for Women and Children in some countries of Africa and Asia.
- (8) USAID Global Health Initiative, which focuses on women and children and coordinates with Guatemalan national government and other bilateral and multilateral programs (Chan & Lake 2013:1436; UNICEF & WHO 2013:113; USAID 2010:3).

In 2004, recommendations by the WHO for ‘routine prevention and health behaviours’ were formulated as basic benefits to reduce high case fatality rates by focusing on (1) ORTs to prevent dehydration, (2) breastfeeding, (3) zinc supplementation for 10-14 days for children with acute diarrhoea, and (4) the selective use of antibiotics when appropriate. In 2009 UNICEF and WHO expanded these efforts through the ‘seven-point plan for comprehensive diarrhoea control’. This plan includes, parallel to the promotion of ORS with continued feeding, the factors outlined in the 2004 Joint Statement (WHO 2004b, 2009), the latest recommendations for treating diarrhoea in low-income countries), rotavirus and measles vaccinations, enhancement of exclusive breastfeeding during the first six months, and vitamin A supplementation, increased use of soap to wash hands, increased safety and quantity of water supply, including proper storage within households, and promotion of community-wide sanitation (UNICEF & WHO 2009a:2). Yet by 2010 only 39% of children suffering from diarrhoea received the recommended treatment (Wardlaw et al. 2010:871). Continued healthcare inequities and constant reallocation of national resources constitute a burden on rural populations,

resulting in out-of-pocket spending to finance treatments and access to healthcare services.

Under the coordination of WHO, UNICEF and USAID, the programme Global Action Plan for Pneumonia and Diarrhoea (GAPPD) has been launched in 2013. Its goal is to ‘end childhood deaths due to pneumonia and diarrhoea by 2025’.³⁰ The strategy is to find more ‘generalisable’ solutions to reach the most vulnerable children through a three-level approach of ‘protection’, through good health practices; ‘prevention’, by providing universal immunisation and healthy environments, and ‘provision of treatments’ for children who are sick with pneumonia and diarrhoea, as part of an integrated package. These targets require the active support of governments, national as well international global organisations, and the community in order to deliver the necessary resources (UNICEF & WHO 2013:9-11). The agenda also calls for the implementation of strategies such as (a) the use of community groups and vendors; (b) the appliance of ‘evidence-based behavioral-change techniques’ and ‘social marketing’ approaches; (c) the use of mobile technologies to collect data; and (d) the prioritising of treatment and the promotion of ‘health behaviour change’ (Idem 13). One of the constraints has been that many programmes have focused only on partial, disease-specific interventions rather than integrated actions within national health agendas. Thus, these strategies often do not develop into mandatory policies.

Diarrhoeal Diseases

“We were curing Leonel from Evil Eye because he was constantly vomiting and had diarrhoea. After the cures he got better for a while but then he started with the same symptoms again. The stools were white, like foam. We gave him the “pill of life” and medicines to stop the vomiting and diarrhoea—Trimethoprim, it was, I think. The next day he unexpectedly died. He even asked for porridge and bread before he died... Look, the man wrote this in his death certificate: “hypovolemic shock and acute diarrhoea””. Valentina, Santa Teresa

Diarrhoea is the second leading cause of death after pneumonia among children under 5, accounting for 9% of all deaths worldwide (UNICEF 2012a). Diarrhoeal episodes are frequently accompanied by respiratory infections and further complicated by undernutrition, zinc deficiency, and non-exclusive breastfeeding during the first months of life (Kosek et al. 2003; UNICEF 2014; Walker et al. 2013).

³⁰More specifically, the goals are to reduce the incidence of severe pneumonia and diarrhoea by 75% compared to 2010 levels, to reduce mortality from pneumonia to fewer than 3 per 1000 live births, and to reduce mortality from diarrhoea to fewer than 1 per 1000 live births (UNICEF & WHO 2013:7).

However, the lack of active and precise monitoring in some countries makes it difficult to accurately estimate the total number of (acute) diarrhoeal episodes and deaths that occur worldwide. Moreover, in some cases diarrhoea is not counted as a cause of death if it is not listed as the primary cause (Kosek et al. 2003:198). Persistent high rates of acute diarrhoea have long-term outcomes in children, such as (1) slowed growth, (2) malnutrition due to reduced dietary intake, poor absorption of micro- and macronutrients, and increased protein catabolism caused by an acceleration in basal metabolic rate, and (3) impaired cognitive and physical development in low- and middle-income countries (UNICEF & WHO 2009a:9). Diarrhoea has a significant impact on juvenile nutritional status, particularly in cases where energy intake is less than adequate (Brown et al. 1990; Lutter et al.1992).

Diarrhoea is recognised as a common symptom of gastrointestinal infections caused by a wide range of pathogens, which provoke frequent loose or watery stools at least three times or more per day. Severity can range from mild to acute. Children under 5 years old have an average of three episodes of acute diarrhoea per year (Idem). Associated symptoms are repeated vomiting and dehydration, which are extremely important for caretakers and CHWs to recognise, since most diarrhoea-related deaths are due to dehydration (UNICEF 2012a). Infants and children under 5 years old are more vulnerable to dehydration as a consequence of diarrhoea because the exchange in total body fluids is higher, compared to adults, as are their metabolic rates. As a result they require a proportionally higher volume of water than adults to maintain their fluid equilibrium.³¹ Children who become ill with diarrhoea are at an increased risk of malnutrition and prone to chronic illness. In Guatemala, 54% of children under five years old suffer from moderate to severe growth stunting (UNICEF 2012b). The IMCI book includes guidelines for the diagnosis and treatment of diarrhoea, yet the case definition for diarrhoea varies among studies. Categorisation of diarrhoea varies in terms of clinical onset, based on the type and volume of the feces, presence of blood, frequency, symptoms and duration, as well as according to the aetiological agent based on laboratory tests of feces samples (Rice et al. 2000:1208) and the extent of dehydration (UNICEF & WHO 2009a:15). Severe dehydration and fever are not only the most common clinical characteristics of acute diarrhoea, but also dangerous when not treated properly (Walker et al. 2013; Wardlaw et al. 2010).

In low-income countries, a variety of enteric pathogens are associated with childhood diarrhoea. The most common bacterial agents are *Escherichia coli*, *Campylobacter*, *Shigella* species, *Vibrio cholerae*, and salmonella. Viral agents associated

³¹<http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3460795/>

with childhood diarrhoea are rotavirus (the most common cause of acute diarrhoea worldwide), human calici viruses and *Adenovirus*. Protozoan parasitic organisms causing diarrhoea include *Giardia intestinalis*, *Entamoeba histolytica*, *Cyclospora cayetanensis*, and *Cryptosporidium parvum* (WGO 2012). Because there are multiple causal agents, definitive aetiological clinical diagnosis for diarrhoea is normally not possible (UNICEF 2009:10; 2012a:7).

Identification of a pathogenic agent in a stool sample is not an indication that this is the cause of the illness. In fact, it may result in a different diagnosis, especially for acute diarrhoea in children, such as pneumonia, otitis media, urinary tract infections, bacterial sepsis and meningitis (WGO 2012:11). The use of broad-spectrum antimicrobials and antibiotics to treat acute diarrhoeal infections has raised the problem of high rates of resistance among many enteric pathogens, especially in developing countries (cf. Gheghesh et al. 2008:15-16). The typical biophysical sign of increased water in the stools is considered to be chronic when an episode persists for a period of longer than 14 days, and acute when it starts abruptly with 3 or more loose stools per day and lasting no longer than 14 days. The stool features (i.e., frequency, volume, color, consistency) need to be directly associated with enteric symptoms and possible exposure to contaminated food (cf. Guerrant et al. 2003). This applies to both the biomedical profile and the traditional model of symptom recognition. Although studies of iatrogenesis of diarrhoeal illness among children have not been performed, acute diarrhoea can be caused by large doses of acetylsalicylic acid or ASA (aspirin), baking soda (also known as sodium bicarbonate or sodium hydrogen carbonate), citric acid, dexmedetomidine, tetracycline, erythromycin, metronidazole, sulfamethoxazole, and trimethoprim, all of which can be acquired at the pharmacy without prescription.

The overuse of antibiotics and underuse of ORT, along with the prevalence of pathogens (such as *E. coli*, *Yersenia*, *Shigella*, *Salmonella* and *Campylobacter*) and undernourishment, are crucial factors in the treatment of diarrhoeal disorders. Since the 1980s, a few organised rural groups of healers and midwives in Guatemala have produced educational materials for caretakers and pregnant women. The availability of drugs without a prescription has contributed to the overuse of medication and to frequent delays in seeking qualified help, including from traditional healers. Many of these drugs are used for diarrhoeal symptoms. The use of antibiotics in Guatemala is estimated at around 9% of child illness episodes, most of them obtained from pharmacies and biomedical practitioners (cf. Goldman & Heuveline 2000; Kroeger et al. 2001).

Although mortality due to acute diarrhoea diseases, including cholera, among children under 5 has decreased over the past 20 years from an estimated 5 million

EJEMPLOS DE ABUSOS DE MEDICAMENTOS

1. Uso exagerado e indebido de "Sueros Vitaminados" intravenosos, muchas personas creen que lleva mucho "alimento", que dan fuerza, apetito y que curan muchas enfermedades. La realidad es que son apenas agua estéril con color con unas pocas vitaminas, azúcar y sal, lo mismo que si preparamos suero casero, pero mucho más caro y peligroso.

2. Uso exagerado de anti-diarréicos. Esta clase de medicamentos casi nunca paran la diarrea, no curan la enfermedad, hacen que gastemos dinero y a veces son peligrosos, la realidad es que en la mayoría de los casos sólo se necesita suero casero tomado (suero oral).
3. También se abusa de las inyecciones, jarabes y pastillas de "vitaminas", la realidad es que el dinero que se malgasta comprando inyecciones de vitaminas o "tónicos", se usaría mejor en buenos alimentos como huevo, frijol, leche, hierbas, frutas, incaparina y carne.

4. La penicilina es otro medicamento que se usa muy mal, se inyecta muchas veces sin que haya necesidad, o sea sin que haya infección por bacterias, que es para lo que sirve. Este y otros antibióticos sirven cada vez menos, debido a que cuando se usan mucho, los microbios se vuelven resistentes.

RECUERDE: LAS MEDICINAS PUEDEN MATAR

SE PUEDE APROVECHAR LO MEJOR DE LA MEDICINA MODERNA, SI SE USA LA CABEZA Y SE ACTUA CON PRECAUCION. NUNCA USE UNA MEDICINA CUANDO NO SE NECESITA O CUANDO NO SABE PARA QUE SIRVE.

PROGRAMA TERAPEUTICO

Figure 8.6: Medication overuse campaign

to 1.9 million deaths annually (18% of all deaths), there are around two billion yearly cases worldwide, and 90% of these cases occur in low- and middle-income countries (UNICEF & WHO 2009a:5; UNICEF 2012a). According to a study in Guatemala, the prevalence of diarrhoea infections among children under five years of age increased from 12% in a 1998-99 survey to 30% in 2000. By 2009 more than 13% of deaths in this age group were attributed to diarrhoeal diseases (ENCOVI 2011). An article published the same year in *Prensa Libre*, the largest newspaper in Guatemala, reported over 300,000 official cases of diarrhoeal disease registered by the MSPAS, primarily due to high levels of water contamination by fecal waste

and chemical residues.³²

Prevention

“The *Zero Hunger Plan* aims to coordinate interventions, programmes and projects carried out on food and nutrition security to ensure food and nutritional security to all Guatemalans. This implies ensuring that all families, without any distinction, enjoy the conditions and livelihoods necessary to access health, welfare, and especially adequate food, enabling them to enjoy dignified, productive and fulfilling lives”. Plan Hambre Cero 2012-2016, Gobierno de Guatemala 2012

“Guatemalan diet has an intake of excessive energy, particularly the consumption of sugar and other simple carbohydrates, and is increasing in fats and oils. There is evidence that these diets of low nutrient density in relation to energy and high energy are associated with anemia and obesity”. Martorell, 2012:viii

“Yes, I know the programme Zero Hunger Plan. Some of my neighbors are part of it. The day they came to take data from the families the men said we didn’t fill the requirements, that we weren’t too poor and that my children were old enough. . . I was pregnant again but I didn’t know it then. The baby died of diarrhoea a few weeks after birth. The doctors said he was too fragile”. Martina, Ixtaguacán

An important intervention strategy has been immunisation programmes, which help decrease deaths from diarrhoea by reducing certain kinds of infections that cause diarrhoea directly, such as rotavirus, and by preventing infections that can lead to diarrhoea as a complication of another illness, such as measles. According to UNICEF and WHO, rotavirus leads to some 100 million episodes of acute diarrhoea each year that result in 350,000 to 600,000 child deaths and account for an estimated 40% of all hospital admissions for diarrhoea among children under five (UNICEF & WHO 2009a:14).

Approximately 10% of children in developing countries are severely underweight with high rates of macronutrient and micronutrient deficiencies, often the result of severe and prolonged diarrhoea, as well increased hypokalemia and rectal prolapse³³ in association with iatrogenic illnesses and dysentery (WGO 2012:11). The iatrogenic problem is coupled with accessibility to treatment. Normally, antibiotic demand exceeds the availability at public health services, although the drugs are still available out-of-pocket at local stores and pharmacies. The importance

³²<https://visionsalud.wordpress.com/2009/11/10/autoridades-de-salud-informan-que-el-98-de-las-aguas-naturales-en-guatemala-estan-contaminadas/>

³³It occurs when a part or all of the wall or lining of the rectum protrudes through the anus.

of exclusive breastfeeding is demonstrated by the clear association between reduced exposure to infectious agents and the incidence and prevalence of diarrhoeal cases, as well as reduced hospitalisations and mortality due to diarrhoeal infections (Ghenghesch et al. 2008:16; Lamberti et al. 2011). Exclusive breastfeeding for the first 3 months reduces the incidence of diarrhoea and prevents 66% of deaths, while partial breastfeeding until the end of the first year of life can prevent 32% of infant mortality due to ARIs and ADDs (León-Cava 2002:53).

Vitamin supplementation in children is also a vital preventive measure, reducing mortality rates by 19 to 54%. The provision of vitamin A reduces the duration, severity and complications associated with diarrhoea. Zinc supplementation has also been identified as an effective treatment for diarrhoea, particularly in children who are already zinc deficient (UNICEF & WHO 2009a:14; 2013). In Guatemala around 50% of children under 5 years of age have low height-for-age (INE 2013; MSPAS & OPS 2012) and most of the height deficit of Guatemalan adults can be attributed to growth failure during early childhood (Martorell 2012). However, there are many misconceptions concerning vitamin intake. Vitamin supplements can either be seen as a form of medicine, enough to cover the levels of essential nutrients, or given as a more beneficial nutritional option when children are underweight. There is a widespread notion among pregnant women that prenatal vitamins can make the baby grow too large, which would result a more difficult labor.

Diarrhoeal illnesses seldom require antimicrobial treatments; yet because they can be purchased without prescription, they are widely overused in developing countries, making them less effective in cases where they are genuinely needed (cf. Kariuki 2010:177; Kroeger et al. 2001). A direct cause of diarrhoea is untreated drinking water or incorrect water storage, together with lack of basic sanitation services. One of the Millennium Goals (MDG 7 target 10) seeks to provide sustainable access to safe drinking water and basic sanitation; improve feeding practices, and overcome deficient hygienic practices, especially by hand-washing, which can reduce the incidence of diarrhoeal disease by over 40% (cf. Fewtrell et al. 2005; Luby et al. 2005). Hand-washing is infrequent in rural communities, primarily due to the cost and lack of access to potable water (cf. Curtis et al. 2009). It is estimated that approximately 88% of diarrhoeal deaths are associated with these factors (UNICEF & WHO 2009:2). UNICEF and WHO have launched the Joint Monitoring Programme (JMP) for Water Supply and Sanitation, in order to monitor the success of these interventions. In the 1990s only 71% of developing countries made some effort to improve drinking water sources; by 2006 this had increased to 84%. Nevertheless, the provision of safe drinking water in rural areas

remains inadequate. Approximately 1 billion people worldwide still have no access to safe drinking water, or to safe ways of handling and storing household water supplies (UNICEF & WHO 2009a:19).

Waterborne contaminants from groundwater and surface water, as well as unimproved water supply systems and sanitation, contribute to the transmission of diarrhoeal diseases. Currently only 70% of Guatemalan households have access to basic sanitary services, piped water and drainage. Many households, especially in rural areas, turn to rainwater, rivers, public streams and wells for their water supplies. People must frequently walk long distances to collect water, thus reducing the quantity of water collected (ENCOVI 2011). In many rural areas and peri-urban communities in Latin America, Africa and Asia, residents depend on (municipal) groundwater (Bartram et al. 1999), making them vulnerable to waterborne diseases and to other hazardous elements such as nitrates, uranium, selenium, and arsenic (cf. Prüss et al. 2002; WHO 2004c). Continued urban population growth presents a growing challenge to the provision of improved drinking water (UNICEF & WHO 2009a:20).

Most of the rural areas in San Marcos lack organised sanitation and solid waste management. Solid waste is either burned or dumped indiscriminately. Public waste collection and municipal water and drainage infrastructure are only found in municipal centers, such as San Lorenzo or Comitancillo. Where drainage systems can be found, they often lack manhole covers. Piped water must often be boiled before it is consumed, although a water analysis made in San Lorenzo and Comitancillo between 2009 and 2010 showed that major water sources were bacteriologically safe if consumed directly from the source (cf. Slocombe 2010). Chlorination is an effective decontamination process, and is recommended in areas lacking safe drinking water, especially in localities with larger numbers of diarrhoea cases. However, residents frequently reject this option because of the altered taste and odor of the water, and also because it is difficult to measure the required amount of chloride for household water containers. Some people have common wells, while others collect water at public tanks or adjacent rivers. At the time of the study, a substantial amount of time was invested in this activity, commonly performed by women. Water for household use is generally stored in uncovered plastic containers, and people normally do not take showers or baths, but instead heat pots of water for use in their sweat lodges. Latrines are located a few meters away from the main house, not only because of the odor, but also because defecating is associated with a feeling of shame. Children who are not old enough to use a latrine on their own tend to defecate in the area around the home.

Reusable diapers (normally old clothes that can be washed) are used not only for

babies but also for young children. Clothes are normally washed in nearby rivers, where some children also bathe. The practice of washing hands after defecation or cleaning diapers is infrequent. Even when people do wash, they normally do not use soap, first because frequently they cannot afford to buy it, and second, because they believe that clear water is safe. Consequently, recurring episodes of infectious diseases are common due to underlying environmental factors, inadequate or absent public services, and poor hygienic practices. The combination of these factors with malnutrition contributes to an increased risk of death from diarrhoeal and respiratory infections. Although health intervention plans may recognise the importance of improving environmental conditions and personal hygienic practices, these efforts are frequently inadequate.

Governmental public health interventions, such as the use of public standpipes, protected dug wells or boreholes, have been shown to reduce the incidence of diarrhoea by 47% (UNICEF & WHO 2009a:12). In Guatemala, according to the Ministry of Environment and Natural Resources, 90% of surface water is contaminated and only 69% of households have access to household water, with only 36% having a drainage network connection. Additionally, while 60% of households in urban areas make use of municipal trash collection, only 5% in rural areas are able to do so; the remaining 95% burn or indiscriminately dispose of their trash. Only 35% of household solid waste is disposed of in landfills, while the rest is left exposed. These practices present an increased risk for gastrointestinal diseases and infant mortality (MSPAS 2012:7).

8.5 The Effects of Drug Acquisition

A significant revelation that emerged from caretaker interviews in San Marcos is how well acquainted they are with the names of medicines for treatment of diarrhoea and respiratory infections. This knowledge, however, is associated with factors that contribute to iatrogenic illnesses, polypharmacy, loss of resources, erosion of patient confidence, adverse drug reactions and antimicrobial resistance (Sosa et al. 2010; WHO 1999, 2010). Antibiotics are the most commonly sold category of drugs in developing countries (Buke et al. 2003). Only a few caretakers were well informed about the dosage and the importance of not interrupting the treatments. Most of them were poorly informed regarding the time of day, the intervals, the number of days, and the dose they should give to their children, especially to newborns. Although caregivers normally correctly recognised which drug could be used for certain symptoms, they usually did not know when to expect relief of symptoms, and what side effects were possible. Some even increased the

dose in order to obtain faster results. A major problem in treating symptoms of ARI and ADD is that they are often treated without knowing whether they are caused by parasites, virus, bacteria or fungi, leading to the use of drugs that are not necessarily appropriate.

A related problem is the high probability of developing a systemic infection with symptoms similar to those of ARI, ADD, and Evil Eye, such as fever, nausea, aches, chills, vomiting and weakness. In addition, a few widely-used antibiotics may cause side effects such as vomiting and diarrhoea. Caretakers may identify side effects as a different illness. A relapse of infections is also fairly common, and is often the result of resistance, decreased drug effectiveness and non-efficacy of medications, especially when the treatment consists of a combination of two antibiotics. Many caretakers stopped giving the antibiotics after the perceived main symptom was considered cured. Even when caretakers knew about the importance of the correct administration of a drug, they were unaware that certain foods should not be combined with certain drugs, since they could interfere with drug effectiveness. Further, although most of the medications should not be used in children under 4 months of age, many children have been exposed to antibiotics, even shortly after birth (cf. Levy 2002). Thus, inappropriate application of pharmaceutical treatments is a serious problem. The following case highlights some of these concerns.

Nuria: “After breakfast we all got ready to go to San Marcos. We seldom go there but my husband needed to do some business so we all went to the city. He was a soldier before but left the army after he injured his back; then he got an opportunity to work for a bank as a private security guard. I’ve been there some times but this time my children and I just wandered around while we were waiting for Julio. In San Marcos you can find everything. There are so many shops, also many pharmacies. There are a few *clínicas naturistas* too but they are attended by *ladinos*. I said to Julio, “We should get some medicines now that we are here”. Some [medicines] are even cheaper here, or they have much more than we have in Santa Rosa, where you can only find a few things, nothing *special*. Sometimes we get a prescription from the health center because they don’t have medicines left, and when you go to the pharmacy they offer us some that are more expensive. So we went to the pharmacy and asked for some medicine that could be useful. The woman asked what [the illness] was but we were not sick so I just ask for medicines for when you have diarrhoea, cough, fever or headaches because that’s what children always get, and a few for Julio because he’s always in pain. From those medicines we bought I gave some to Sara when she started with diarrhoea. We got several medicines but I remember that the woman said this one

was very strong and could be taken for emergencies. First I gave her Imodium® (loparamide), a spoonful I think, but it didn't work so I gave her again another spoonful. I thought that should be enough because she is still a baby. It worked only for a few hours because the next day she started with diarrhoea again and then got high fever. I gave her Tabcin®, which helped her for a bit. I knew it wasn't Evil Eye because her stools were brown, almost liquid. I went to see if Seño Blanca was around. She cured a bad case of *puj* last time. She is very good at curing, but she only told me to keep breastfeeding Sara, but she was also vomiting. Seño Blanca always does me the favor to cure my children when they catch the Eye so she also knew it wasn't the Eye. I got scared and went to San Lorenzo. That day there had been a motorcycle accident and the doctors were busy at the health center. There were many people waiting in the room [to be seen]. When they called us I explained to a nurse that Sara was having brownish diarrhoea and she just told me to give Sara many liquids and gave me a bottle of sulfa (sulfaprim). I bought a bottle of Gatorade at the shop too"

Mayarí: "Did you tell the nurse that Sara also had fever?"

Nuria: "No, because Sara's fever was almost gone with the *calmantes* and *Bebetinas*® I bought at the shop the next day after the Tabcin® didn't work. Sara was much better after two days, so I stopped giving her the sulfa and prepared *agüitas* (herbal teas) with peppermint and *panela* (whole cane sugar). The sulfa is a *hot medicine*; that's why it's not good to give children too much of it. There are other medicines that are not too hot so you can give them for much longer"

Mayarí: "Hot? What do you mean by that?"

Nuria: "It means that it warms your body and kills the disease, but if you keep taking it your body will get too hot and *fragile* (*débil*), [prone] to other diseases; that's why it works fast"

Mayarí: "But what did the nurse say to you when she gave you the medicine for Sara?"

Nuria: "She just told me to give her the sulfa with a little spoon. Too much medicine is bad. They [the doctors] also say so- "Too much medicine is bad"- so I just give [my children] the necessary".

According to Nichter, 'drug resistance is the primary factor underlying multiple drug therapy strategies in tuberculosis control. Resistance to a medication needs to be viewed both epidemiologically and anthropologically. Resistance may reflect patterns of pharmaceutical misuse related to over-the-counter drug use for self-medication or self-regulation of prescription drugs; poverty (the inability to afford recommended treatment beyond symptomatic relief); local interpretations of tuberculosis and expectations from drugs; the compliance of private practition-

ers with public health guidelines given practical contingencies; and the availability and accessibility of drugs for effective chemotherapy' (1994:651). The impact of modernisation on health practices in rural communities has sometimes adversely affected the healthcare within those communities. By creating the notion that access to drugs is paramount to healthcare, along with almost non-existent control of the sale of medicines, including mobile medical providers (cf. Harvey 2003; 2011), people are able to use a wide range of pharmaceutical therapies that should remain limited or completely inaccessible without a medical prescription. In addition, pharmacy employees are often viewed as experts. This appears to be more general in Latin America, where 'although drug salesmen cannot be classified strictly as health providers their impact on health is enormous' (Rivera et al. 1986:1267). In many areas, antibiotics from global pharmaceutical companies were normally a preferred option for treatment. Not only lay diagnosis, but the facility to acquire drugs without prescriptions, has increased the dependence upon pharmaceutical treatments without proper drug information being provided. There is also a presupposition in favor of the idea that biomedical healthcare measures work faster.

The treatment of ARIs and ADDs with antibiotic drugs is supported by the belief that, since drugs are expensive, favorable outcomes will be the result. Some healers and midwives regularly use biomedical methods in a very autodidactic way, for example, giving drugs to newborns and young children. These factors can result in a longer-than-expected recovery. While the use of antibiotic treatments for ARIs and ADDs steadily increases, there is no clear understanding that such infections can cause chain reactions that make children vulnerable. In the last analysis, caretakers do not realise that they live within unsafe and polluted environments, and are constantly at risk of falling ill. In this context, Kleinman's analysis of the management of 'risk' differs from the epidemiological definition wherein 'we claim to know more than we actually know, blacking out the world. *Risk* tends to euphemize *danger*. How to get through? By creating categories that help you to negotiate life in the middle of uncertainty and danger as if you really could understand and control it, when in fact you cannot understand and have control, because the so-called "indifference of nature" cannot be faced by people, so we make it over into something else'.³⁴

The usual treatment paradigm still consists of the recognition of signs and a rapid response to manage the disease appropriately. Specific health-seeking behaviours illustrate how unexpected onsets may cause caretakers to believe that previous treatments have been unsuccessful, changing antibiotics to ones that can be easily

³⁴Personal conversation with Arthur Kleinman at Ethnological Institute, Freie Universität (29.07.2011).

purchased at local pharmacies. Unfinished treatments, especially those bought at pharmacies, are occasionally stored and reused when symptoms reappear, which can lead to increased side effects, making the condition of the patient worse. (Injectable medications are a better choice, as they eliminate the possibility of wrong dosage and make the caretaker less likely to seek an alternative treatment). In 1981 the problem of antimicrobial resistance led to the publication of the 'Antibiotic Misuse Statement' by the Alliance for the Prudent Use of Antibiotics (APUA). In the year 2004, responding to the worldwide misuse of antibiotics, the APUA created the first international network in Latin America. Two years later APUA, in conjunction with PAHO, developed a survey of knowledge and prescription practices among physicians in several countries in Latin America.³⁵

A study carried out by Kroeger et al. (2001) showed that pharmacy personnel frequently recommended unnecessary or even inappropriate treatments for acute respiratory infections and diarrhoeal disease. Many of the recommended drugs required a prescription, but were sold freely by pharmacy personnel. Further, the lack of adequate control of drugs has resulted in the widespread trafficking of falsified drugs, often by street vendors, with dangerous or ineffective outcomes.³⁶ The WHO estimates that in developing countries the percentage of patients treated in accordance with standard medical regulations for common diseases in national primary care facilities is less than 40%, and only 30% in the private sector. Specifically, less than 60% of children with acute diarrhoea obtain recommended oral rehydration therapy and more than 40% receive unnecessary antibiotics. In cases of pneumonia barely 50–70% of the patients are treated with the correct antibiotics, thus between 30% and 50% of individuals with viral upper respiratory tract infections receive incorrect antibiotics (WHO 2009a).

8.6 The Implications of Cultural Coding in Health

By looking closely at life stories, Biehl and Petryna observe that 'the global health community has overemphasized individual risk factors that ignore how health risks are shaped by law, politics, and practices ranging from industrial and agricultural

³⁵Alliance for the Prudent Use of Antibiotics (APUA), <http://www.tufts.edu/med/apua/>

³⁶The factors behind this troublesome practice were documented as lack of awareness of standard treatments and official regulations for selling certain drugs, lack of knowledge on the part of pharmacy staff, commercial pressures, and general failure to implement the existing policies covering the drug market and its merchandise practices. Instead of promoting a rational use of medicines, drug advertising is similar to any other mercantile product. Further, according to Nichter and Vuckovic (1994), pharmaceutical corporations also play a role in popular ideas about certain illnesses and treatments.

policies to discrimination, violence, and lack of access to justice' (2013:3). In particular, extended families with differentiated power dynamics and hierarchies can have a great impact on illness management. The beliefs and practices of many family members affect the prompt recognition of symptoms and may determine the initial treatment (cf. Nielsen et al. 2001). Several studies focused on the 'household production of health' have shown that family routines and relationships have direct implications for the recognition of the illness, and for the provision of monetary resources or other forms of support for adequate treatment (Harkness & Super 1994; Scheper-Hughes 1992).³⁷ Culturally established patterns of care are based on social values such as deference toward authority, recognition of people's experiences, and vertical gender roles, etc., which sometimes conflict. Many health interventions focus exclusively on the mother's role rather than identifying the important family dynamics that are central to healthcare decisions (cf. Cody et al. 1997).

However, one of the problems encountered by global health strategies is that certain practices are regarded as cultural barriers to healthcare. Such approaches do not take into account the fact that alternative understandings of illness and health sometimes endure because of their social value, i.e. certain practices are customary and work as a reference to (or are part of) relationships. These practices connect individuals with their families and communities but also forge habituated orientations towards what is perceived as a 'proper' way to cope with an illness. Thus, intervention programmers and health workers are confronted with practices that in fact are not easy to overcome, when established customs provide material or emotional assistance that constitute relations of care. These kinds of challenges are factual spaces that can prove to be extremely resilient when practices that are rooted in people's experiences shape the prevailing family or social order. Thus, the notion of 'cultural barriers' is normally attached to conflicts and negotiations that can have direct (even negative) responses. It also deals with particular perceptions of causes, classifications and practices that not only contribute

³⁷Some cultural practices—including health behaviours—work as (social) orientations that organise and provide values that are part of a community's habits or normative forms of socialisation and knowledge. Paradoxically, evidence of unhealthy or even deadly practices has in some cases improved the health of a group, such as the case of endocannibalism in Papua New Guinea. A study of the practice provided direct evidence of how *kuru*, a type of spongiform encephalopathy prion disease, affected people who consumed nerve tissues of the deceased as a part of a post-preparation. Direct intervention stopped outbreaks of the disease, and the practice was eradicated in the 1960s (Alpers 2008; Wadsworth et al. 2008). Other examples show how specific sociocultural activities or sociodemographic patterns can place a population at risk. In Guatemala, seasonal migration to participate in the coffee and sugar cane harvests, often involving entire families, frequently brings additional health risks. Public health efforts cannot always reach these vulnerable populations, since they are not easily tracked. Further, some patients undergo long and difficult diagnostic processes and/or inappropriate treatments. Examples of this in Guatemala are onchocerciasis and cyclosporiasis.

to the morbidity and mortality rates of children's illnesses, but are also related to caretaker's agency, social boundaries and control of resources (cf. Chand & Bhattacharyya 1994). Illnesses exist or co-exist precisely because they are influenced or triggered in different degrees by a variety of circumstances.

Causes of illness are therefore classified and categorised by domains that are identified as community dependent, describing types of diarrhoea, for example, using local terms and organised by causes related to beliefs, health status and other conditions. This results in different conceptualisations of diarrhoea that do not necessarily coincide with standard biological explanations and methods of treatment. Thus, not only is the aetiology of the illness important but also the meaning and implications of the behaviours that prevail within a community concerning an illness. With regard to *Dracunculiasis*, for example, Moran-Thomas explains that 'parasitic worms by their very nature breach intimate human boundaries, which is exactly what makes the ways people struggle to understand them such a revealing microcosm of health cultures and local histories—and so it is not surprising that the guinea worms emerging from people's flesh became a battleground for much bigger social and political conflicts, raising questions of how to cure and whose responsibility it is to heal, and even metaphysical issues about where life ends and death's parasitic hold begins' (2013:232-233). Consequently, the perceptions of severity of an illness—i.e., the importance given to it and to its assessment—rather than the incidence of an infection, explains the discrepancy in mortality rates worldwide (Cody et al. 1997:331). Early investigations have shown that 'the study of diarrhoea classification and treatment response requires research strategies which are more dynamic and attend to contingencies' (Nichter 1996:117-120). Nichter's approach to diarrhoeal *diseases taxonomy* and *illness taskonomy*, with its focus on dysentery and its culturally informed assessment and treatment in view of the pluralistic approach proposed by medical anthropology, comprises the ambiguities and contingencies in an illness event, criticising the reductionist approach often displayed by 'cosmopolitan medical practitioners', who are schooled in looking at a disease solely as a physiological dysfunction of the body.

Nichter's account describes the distinction between taxonomy and taskonomy of illness identities. *Disease taxonomy* is 'a systematic presentation of logical relations between illness categories based on a "rational man" model of cognitive thought' (idem 117) supported by data from methods such as 'KAP type surveys'. These are inadequate for a broad understanding of multi-dimensional illness-related components. In contrast, *illness taskonomy*, based on Dougherty and Keller (1982), to which he extends Wittgenstein's (1985) theory of 'language games' and 'words as tools' and Bourdieu's (1990) debate of 'practical logics' draws attention to the

flexibility of illness labelling influenced by social relations, the relative advantages of representing illness in coextensive ways, and emergent knowledge associated with the practical task of caring for the ill (Nichter 1996:120). The *taskonomy* of diarrhoeal and respiratory infections helps to elucidate not only practices concerning treatments but, more importantly, to understand why people do or do not recognise and fear these infectious diseases. This is illustrated by the following short excerpt about Lidia, a 3-year-old child who died at the national hospital.

Sully: “Lidia had only cough. First the people at the post center gave me some medicines that didn’t work. When I was referred to the health center the doctor immediately called the ambulance. Lidia was taken into the emergency room and for the next hours they put some tubes in her mouth and veins. The next morning she died. They said her heart didn’t resist but she only had cough. I’m afraid of hospitals now. Now when my other children fall ill I’m afraid they will be referred [to the hospital]. I would rather keep trying with herbs and other medicines at home. . . coughs are normal, no one dies of it”.

Dr. Ruiz: “We received the patient with stertors, tachypnea, extended distended jugular veins with clinical symptoms of congestive heart failure. A few hours later the patient developed purple jaundice and hepatomegaly. The girl died in the morning of septic shock and cardiopulmonary arrest”.

Though it can be difficult to medically diagnose ARIs and ADDs, recognise their danger signs or provide efficient healthcare, fatal cases have the effect of redefining the trajectories of ‘healthy bodies’ and ‘illness’, an ambiguity that challenges healthcare policies. Paying attention to caretakers’ reasoning about the uncertainty of treatment options—based on their own illness experiences—help us to understand the ways in which multidimensional illness-related factors intertwine. The taskonomic approach with regard to diarrhoeas and respiratory infections contributes not only to the understanding of a conceptual model of illnesses but also to the particular conditions of the illness episodes, including social relationships and management of resources (Chand & Bhattacharyya 1994).

One symptom, several responses

As discussed at length in previous chapters, according to Mam beliefs, diarrhoea and respiratory infections can be the consequence of natural factors that are part of the environment, such as a hot/cold imbalance, seasonal changes (e.g., the beginning of the rainy season), intrinsic properties of food, over-eating, predisposition, teething, exposure to ‘microbes’ (a general term that people use to refer to contamination or to bacterial, parasitic and viral infections), and the actions of spiritual

or magical agents. Because people believe that all ‘microbes’ are generally the same, they fail to make adequate use of available treatments. The idea of ‘pre-disposition’ permeates local understandings of an individual’s biological condition. This idea suggests that children easily fall ill and only recover temporarily. Thus, the ‘normal’ state is to be ‘ill’ or weakened. Similarly, concerning *Dracunculus medinensis*, Moran-Thomas explains that ‘the recurring notion that the guinea worm can be an intrinsic part of a person also reveals deeper working ideologies of the body and self, which allow the physical resemblance between worms and veins to take on such layered meanings’ (2013:213).

Several infants who died of acute diarrhoea or respiratory infections during the research were perceived and described by their mothers as ‘feeble’ from birth, for whom treatments were simply provided to ‘alleviate’ the symptoms rather than cure the illness. A *weak* condition is almost a fixed feature that people come to accept as natural. Since this ‘state’ debilitates the whole body, children become vulnerable to disease. Recurrent experiences of illnesses are an obvious characteristic of such bodily states. Accordingly, people define themselves and others not only through their well-being and good health but also through illness. Typical responses to cure or treat an illness among feeble children only varied when caretakers believed that the child could not be saved. In such cases the avoidance of health facilities, especially hospitals, was very common.

Mothers of feeble infants described the characteristics of ARIs and ADDs in terms similar to those who are not ‘normally weak’; yet health practices in cases where the illnesses became acute and dangerous were rather fatalistic. A study carried out in Quetzaltenango and Santa Rosa in 2010 showed that caretakers are willing to spend more resources on healthy children ‘who seem more likely to grow into productive adults’ (Masterson 2010:5). These illness narratives provide several examples in which healthcare decisions do not necessarily follow the recommendations of the health personnel but are based on a husband’s or an in-law’s permission to take the child to the hospital for intensive care. Additionally, treatments are sometimes discontinued when the child’s health does not seem to improve as quickly as expected, and help is sought from different health providers, including pharmacies and healers. However, among these caretakers there were no normative healthcare patterns. Underuse or broad use of health facilities varied greatly even when the definitions of illnesses were rather consistent in terms of the supposed aetiology of the illness and the perceptions that the balance of the body was being disturbed.

Diarrhoea, for example, is commonly perceived within a humoral framework, in relation to seasons and temperatures, and is defined as having a ‘hot’ or ‘cold’

property. This leads to specific practices of food consumption and caretaker behaviours. For example, in cases of diarrhoea, if the mother has been in contact with cold water or exposed to low temperatures, her breast milk becomes 'cold', and nursing a child in these circumstances decreases the child's temperature. Respiratory infections can also be the result of indirect exposure to cold weather or temperatures. The importance of such beliefs is that they determine the acceptance or use of certain healthcare options. Considering that on average a child suffers from three episodes of diarrhoea and two of respiratory infections each year, a family with three children would have a child ill every month, and frequently two children ill at the same time. Thus, mothers are aware of children being more vulnerable or prone to fall ill, yet these episodes are seen as merely demonstrating a child's fragility and are not necessarily considered the result of risky behaviours or hazardous environments. Furthermore, some diarrhoeal diseases and respiratory infections are viewed as part of the bodily mechanism for fighting an illness, and thus are interpreted as normally recurrent symptoms. Similarly, Moran-Thomas explained that in Ghana 'people believed that the [guinea] worms were in their blood already, that people were just born with them there' (2013:207), indicating that biomedical and lay classifications of danger signs, care priorities and management differ greatly. Further, caretakers see these illnesses as a crucial measure of a child's strength, if she/he has the capability to recover from common, frequent illnesses. Each symptom and outcome depends on an infant's personal reactions, whereas for a physician any pneumonia in young infants is considered severe according to a standardised case management. In this sense, it is not an illness episode but particular outcomes that engage people to seek help. Furthermore, while in biomedical terms diarrhoea, cough, fever, and the like are classificatory symptoms, caretakers interpret these as independent illnesses.

This notion is important because responses to danger signs and perceptions of the efficacy of treatments largely depend on how caretakers understand and classify illnesses, accordingly to the child's attributes (its strength and other characteristics). Thus, non-specific signs (e.g., fever, body temperature, cough, diarrhoea) and the observation of (normal) body functions or characteristics (e.g., mild chest in drawing in babies due to the softness of their rib cages, recurrent episodes of certain symptoms) determine the caretakers' responses. The confusing or insufficient information provided in health campaigns, inaccurate identification or recognition of symptoms, prolonged use of different medicines for different types of diarrhoea and respiratory infections, and the prevailing ideas of pathogens and infection can also directly affect illness outcomes. Similarly, according to Moran-Thomas, the perception of guinea worm in Ghana came to merge ideas of sacred ancestral mes-

sages, witchcraft and parasites, which are at times contradictory or ambiguous. Eradication campaigns revealed deeper ideas of the self and the community, making the illness not only necessarily concerned with a medical paradigm but also ‘a story full of conflicting priorities and values’ (Moran-Thomas 2013:207-239).

Therefore, illness categories are influenced by ‘connotative’ aspects, which frame, reframe or negotiate the importance of an illness within a context (Nichter 2010), and ‘denotative’ aspects, i.e., physical signs (presence of blood or mucus in stool, consistency, colour, smell, etc.) and concurrent symptoms (fever, rash, pain), as well as the severity, duration and progression of symptoms (Nichter 1996:115) that eventually allow the illness to be specifically categorised. Categorisations are vital to understand why and how people give different significance to an illness and its possible symptoms. Therefore, it is not only the notion of a biological disorder but the ‘social body’ that shapes the responses, since the presence of specific characteristics means that caretakers can (or cannot) assess and treat serious infections. On one hand, medical terminology may decontextualise experiences of illnesses; on the other, it may associate ‘risky’ behaviours with family case management by blaming the illness on people’s life circumstances, the ‘blaming the victim’ approach that has been so strongly criticised by the holistic health movement since the late 1970s (Brown 1985). Such an approach denies the relational and conditioned social, political, economic and environmental aspects that affect people’s illness experiences.

8.7 Conclusions

In recent years, diarrhoeal diseases and respiratory infections have regained the attention of global health programs, as rates of morbidity and mortality have not decreased as expected (cf. UNICEF 2014). Health care intervention programmes are still focusing on socio-behavioural models to assess healthcare perceptions and practices (e.g. vaccination, exclusive breastfeeding during a child’s first six months of life) and treatment choices (consulting a healthcare provider, use of antibiotics, ORT, and zinc supplements). Thus, the usual approaches are still largely focused on ‘behavioural determinants’ concerned with the use (or lack of use) of healthcare facilities, organised around health centers and hospitals, in response to episodes of diarrhoea and respiratory infections, rather than a focus on how ARIs and ADDs are translated into personal and community-level illness experiences and their links to the larger environmental and social conditions that influence the incidence of morbidity and mortality. Ethnographic studies in several countries have demonstrated that local perceptions regarding diarrhoea vary according to personal ex-

periences, local practices, references and knowledge (cf. Martinez & Saucedo 1991; Moran-Thomas 2013; Nichter 1988; Samuelsen 1994; Scrimshaw & Hurtado 1988). When an illness becomes endemic, people transform their suffering, such as Evil Eye, into a *language of distress* (or *idiom of distress*, as Nichter calls it) to make sense of that affliction, not only by communicating suffering, but also to obtain healthcare or other help (cf. Migliore 1997:61-73). Furthermore, health priorities and healthcare-seeking behaviours of caretakers are linked to conditions that add levels of complexity and therapy effectiveness in terms of biomedical assessment. Thus, the integration of ethnomedical classifications into rural healthcare programs for control and treatment of diarrhoeal and respiratory diseases would improve caretaker compliance with recommended treatments. An effective health intervention requires a broad conceptual model of health determinants and a focus on the scaling-up of selected sustainable and affordable initiatives.

Considering that treatment choices are based on perceived aetiologies, social and environmental hazards, and the drugs and other treatment methods available, potential health actions are closely entwined, yet assessed differently with respect to the definitive illness category, i.e., the meaning and implications of the ailment or pathogens. Not only are children exposed to different types of bacterial, viral, fungi and parasitic pathogens, but the degree of exposure, environmental conditions, vaccine coverage and presence of antibodies also influence the transmission and outcomes of infections. These underlying aspects that shape an illness provide points of conflict and possible danger resulting from community health status or conditions. Communicable diseases, for example, demonstrate that treatment interventions, even when efficiently assessed, are affected by important choices that influence the prevalence of infectious diseases, which in turn influence perceptions of aetiologies and practices.

By examining biomedical diagnosis and treatment choices for ARIs and ADDs, we can observe that global and national initiatives are far too complex to allow for standardised diagnosis and compulsory case management at the community and primary healthcare facilities. Manuals or guides for conducting diagnosis and assessment are too general, or differ on what constitutes appropriate or effective case management (in part also due to changing norms and standards). Some procedures require considerable training; yet primary health care in rural Guatemala is based to a considerable extent on voluntary personnel, who are not highly trained. Thus, health promoters' knowledge of illnesses is rather empirical, limited to 'suspected cases' rather than 'confirmed cases' of specific aetiologies according to the reference guides. The causes of the illnesses are diverse, and so are the associated pathologies. The result is an oversimplification of diagnosis and treatments

employed at the primary and secondary levels of healthcare, so that caretakers' approaches to childhood diarrhoeas and respiratory infections are based on symptoms rather than on aetiologies. In contrast, the formal intervention plans, such as the use of ORT or antibiotics, are based on aetiologies. Symptoms provide clues to treatment choices, yet *illness taskonomy* concerning perceptions and beliefs demonstrates that the association of folk categories with particular aetiologies triggers practices that run counter to standard healthcare practices. For instance, the concept of Evil Eye differs from the ARIs and ADDs in its aetiology, but not in its symptoms. The non-integration of ethnomedical classifications into healthcare campaigns for diarrhoeal and respiratory diseases, despite their central role in childhood health, therefore hinders or limits logical relationships among symptoms, causes and treatments.

9 Conclusions: Fighting Death in Rural San Marcos

9.1 Behaviour as a prominent factor in health

Acute respiratory infections (ARIs) and acute diarrhoeal diseases (ADDs) are a threat to children worldwide, accounting for more than 29% of all deaths in children under five. The recognition of this fact has caused a shift in global healthcare policies since the early 1980s; infection diseases have become a major focus of global public health interventions (UNICEF & WHO 2013a:5). The number of children affected by these illnesses, and in turn the death rate, is higher in low- and middle-income countries, where poverty exacerbates the illness outcomes (Barreto et al. 2007; Curtis et al. 2000; Fewtrell et al. 2005). Accordingly, several programmes have been launched to influence healthcare behaviours, with the aim of reducing morbidity and mortality from ARIs and ADDs (cf. Bartlett et al. 1992; Boonstra et al. 2005; Chan & Lake 2013). The failure of these initiatives has frequently been ascribed to lack of awareness of the gravity of these illnesses, and to attitudes that weaken access to and use of biomedical services (Colvin et al. 2013). One crucial aspect of ARI and ADD campaigns is the focus upon the relationship between perceptions of the illness and responses to it (cf. Goldman & Heuveline 2000; Goldman et al. 2002). Although the larger issues of inequality and poverty have been well established as causes of differences in outcomes, as expressed in the 1978 Alma Ata Declaration of the World Health Organization, these factors have not only been marginally addressed but also have not been taken into account when positioning caretakers' practices within their specific economic, social and political contexts. Additionally, because cultural reasoning has been associated with negative healthcare interactions, traditional medicine is perceived as a causal factor in explaining the failure of public health interventions (cf. Greenwood 2008; Källander et al. 2004).

Global healthcare models and programmes have therefore been urging the integration of traditional and allopathic medicine, highlighting the function of cultural differences in healthcare and their impact on healthcare interactions and outcomes

(cf. Inhorn & Brown 1995; Kosek et al. 2003). Yet illnesses are a combination of factors that generate diverse relations among people where these ailments emerge. The economic and political situations of a given society also frame behavioural patterns and produce social systems that help individuals to deal with such illnesses within their specific context (Kleinman & Seeman 2000; Knipper 2003). As a result, people's explanations of diseases and behaviours largely depend on perceptions and beliefs, adjusted and organised according to the sociocultural context. Thus, an individual's rational behaviour, together with personal or sociocultural limitations in the prevention and management of illnesses, are all need to be included in health initiatives. This has result on global and national efforts to develop different models of healthcare that circulate between political and (bio)medical interrelations, in order to legitimise allopathic medicine and hold a position of authority. The argument for this approach is that biomedicine is capable of providing scientific—i.e., reliable, effective and safe—healthcare that transcends local ideas and practices. Communicable diseases, such as respiratory infections and acute diarrhoeas, have been the focus of such endeavors since their developmental stages and outcomes are based on people's sociocultural healthcare systems.

The programmes that have been launched since the early 1980s have therefore made reference to behavioural and belief models that influence population's healthcare decisions (Pebley et al. 1999; Pigg & Pike 2001; Rosenstock 1990). 'Appropriate' healthcare-seeking patterns, a hallmark applied to behavioural models, rely on a combination of standardised drug therapies and people's responses to (danger) signs. Failure to effectively incorporate these practices have resulted in the idea on the part of biomedical practitioners that increased infections and deaths due to ARIs and ADDs are the result of indigenous beliefs that endanger the long-term efficacy of intervention programmes (Wongrist 1999). Studies of caretakers' responses and the sociocultural factors that influence the risks and practices associated with ARIs and ADDs have been conducted uniformly across broad regions, revealing that the factors that produce different outcomes are always local (cf. Nations & Monte 1997). As a result, the effect of caretakers' perceptions and attitudes about ARIs and ADDs has been investigated extensively (cf. Escobar et al. 1983; Pebley et al. 1999; Nielsen et al. 2001). Illness aetiologies, and the beliefs that accompany them, are far more complex factors in medical interventions and outcomes; they create fundamental healthcare patterns and hence particular healthcare modalities. The presence of folk illnesses confounds public health intervention programmes, because people's responses are inserted within a traditional healthcare system not necessarily in tune with the allopathic therapeutic regime. This research has shown that responses to respiratory and diarrhoeal infections are

of particular interest because certain problematic behaviours that affect the at-risk population remain unresolved. Different factors can create different health-seeking scenarios for the same set of symptoms. One feature of this phenomenon is the manner in which people interact within pluralistic medical models.

9.2 Healthscapes in rural San Marcos

Although the introduction of biomedical services and improvement of primary healthcare facilities in rural Guatemala have increased in the past twenty years, respiratory and diarrhoeal diseases remain major killers of children under five. In many settings, especially in urban areas, health-seeking compliance is normally unproblematic. However, treatment strategies in rural indigenous areas are complicated by the presence of traditional medicine and folk illnesses, because the treatments and illness experiences that derive from these specific cultural dynamics differ from biomedical concepts. Studies have consistently confirmed that many sick children are not taken to formal health facilities or promptly receive allopathic treatments (Bruce et al. 2014), because these biomedically expected behaviours conflict with traditional expectations (cf. Adams, Hawkings 2007; Bentley 1992). Anthropological studies have shown that folk illnesses generate specific factors that guide the choice to act in a certain way when seeking help or providing curing/healing. Conditional aspects such as environmental and economic aspects are factors, but not exclusive reasons, that guide people's attitudes toward healthcare. From a biomedical perspective, the insertion of allopathic systems into pre-existing, traditional medical systems is often fraught with difficulties. However, it is precisely within this space of encounters that people negotiate the various elements that are produced within a realm of (power) discourses and relations, which ultimately affect national and global interventions.

Traditional medicine in rural San Marcos is an important element of healthcare and sociocultural relations, since it incorporates identity and social values into its practice. Until the late 1980s, the concepts and practices of folk illnesses were understood as unalterable ideas of body functioning, nosologies and treatments. The scope of healthcare choices within indigenous societies, which arose in medical anthropology in reaction against simplistic ideas of healthcare, accounted not only for a better understanding and approach of illnesses but also for efforts aimed to provide equitable and effective national healthcare systems (cf. Farmer 1997, 2001, 2005). This research rejects the assumption that folk illnesses and indigenous healthcare practices are completely separate from the biomedical health system, and more importantly, it recognises that the presumed authority of biomedicine

does not necessarily change an individual's beliefs about health and illness. This disease taskonomy translates the physical realm of illnesses into understandable and manageable healthcare actions amidst the complexities of an illness event.

Thus, although often described as opposite systems of healthcare, allopathic and traditional medicine within contexts of medical pluralism constitute points of encounter where healthcare practices are negotiated (cf. Greenway 2003). In the rural context of San Marcos, conceptual models of illness have become more complex as lay referral networks and traditional health providers have begun to include biomedical ideas and practices, which do not necessarily imply a complete change in ethnomedical ideas or health behaviours. These new landscapes and narratives produce healthscapes where health-seeking processes and social networks are not only 'disease-oriented' but associated with specific social experiences, expectations and relationships. These experiences entail power relations involved in the process of labeling the illness and the practices of curing. When there is the perception that specific symptoms are the result of a specific illness, treatments inevitably depend on such forms of power relations, which biomedical providers are likely to view as problematic. This research has shown that the integration of the two healthcare systems is not only viable but also necessary, since it strengthens access to resources, even if it sometimes leads to conflict. Evil Eye, within this context, is an illness that connects (bio)medical knowledge, treatments and healthcare facilities, producing heterogeneous practices, opening possibilities to negotiate the inclusion of specific ideas and attitudes. It is also a powerful concept that permeates the strong relationships between the invisible (pathogens) and hypervisible (inequalities, marginalisation, economic strains, discrimination, care giving burdens, domestic violence, dominative discourses, etc.).

9.3 The powerful impact of Evil Eye

Evil Eye gained some interest among scholars via the 'exotisation' of the phenomenon as a powerful belief (or culture-bound syndrome), and also as an ancient/traditional narrative, nowadays viewed as more closely related to superstition, ignorance, culturally specific symbolism or even resistance to biomedical interventions. The advocates of cultural relativism have used the presence of Evil Eye and similar phenomena to defend the dichotomy of modern versus traditional healthcare systems; however, the illness processes and treatments of the two healthcare models can in fact coexist, in an intermediate space where specific individual and collective conceptions of the body, the sickness and treatments are articulated (Apostolides & Dreyer 2007; Disderi 2001)

Evil Eye is an illness category that has clashed with early emerging global public health policies, overlapping in the realms of healthcare and cultural aspects, and becoming a peripheral concern in international medical endeavors to overcome diseases (cf. Sachs 1983). Outside of anthropological studies, Evil Eye, among other folk illnesses, is a target for interventions, with the aim of painting local practices as negligent behaviours or barriers, since local healthcare practices differ from the national healthcare standards. Treating an illness as Evil Eye may increase the risk of morbidity and mortality from diseases with similar symptomatology, such as acute respiratory infections and acute diarrhoeal diseases (Burleigh et al. 1989; Escobar et al. 1983; Weiss 1988). However, national and international policies inserted into local theories and realities of health-related practices (specific terms, objectification of care, use of biomedical resources) are not always grounded in particular localities, and do not always take seriously the multiple dynamics involved in folk-defined illnesses. Cultural dimensions need to be incorporated within a biomedical healthcare perspective in order to create a normative framework for decision-making and behavioural strategies.

The presence of a traditional healthcare system is not only “disease purposive”, but a system that provides a *choice* of significant interrelationships. The existing traditional healthcare model enables people to organise particular ways of thinking and acting that ‘make sense’, allowing individuals to engage as families or communities based on acquired and shared experiences and making it possible to give the processes and outcomes of the illness a meaning that rests upon sharing and agreement. Thus, Evil Eye as an illness experience is always subject to changes and various shared assumptions since the relationships and outcomes are arbitrary, allowing the illness to adjust to specific circumstances. This adjustment is therefore a pragmatic contestation as well as a social process through which diverse healthcare practices unfold and can be redirected. Healthcare practices for Evil Eye’s symptomatology are not a replacement for more effective interventions for diarrhoea and respiratory infections; rather, these practices are linked to modern practices that respond to specific (sociocultural) challenges such as interactions between models of healthcare, power struggles, emotional conflict, disagreement and debate. Healthcare strategies among caretakers in rural San Marcos address elements of therapeutic schemas presented as fragments of ‘being in the world’, i.e., a temporality that unfolds into linked events that account for coherent illness experiences. While biomedical concepts and concerns exclude Evil Eye as an illness category (despite its close correspondence to biomedical symptomatology), people carry out health practices that constitute a social resource to overcome health disparities and uncertainties. Evil Eye is an ambiguous but powerful con-

cept with diverse meanings, manifestations and interpretations that occasionally result in misleading practices, from a biomedical perspective.

In general terms, illness experiences differ in significance. Certain symptoms, manifestations or effects of ailments are differently perceived and lived among individuals and groups. On one hand, diseases have a relatively consistent definition in biological terms; on the other, they are contextualised and dependent. The impact that some diseases attain, in specific contexts and environments, expresses and exposes health conditions that call into question people's behaviours and habits. When the global biomedical sector and the community base entwine, it becomes clear that explanations of the nature and causes of diseases diverge, as well as the expected methods of treatment and care. An increased global awareness of ARIs and ADDs has created a focus on programmes to decrease the morbidity and mortality rate among children under five years of age and in the wider at-risk population. This interest has generated specific short- and long-term solutions that do not necessarily respond to people's interests or understanding, with the result that biomedical forms of care may not be well accepted. Because the symptomatology of Evil Eye is culturally defined and the behavioural responses to it are culturally encoded, the illness becomes objectified as directly influential factor related to healthcare behaviours. The higher rates of ARI and ADD morbidity and mortality cases has shattered the power of caretakers to establish better explanations of the illnesses nosologies and more importantly, to provide effective standardised biomedical care. The labeling of an illness, in terms of its biological features, ecological variables, and human behaviours, is therefore quite important, since each illness rise or is tied to a particular sort of discourse and interaction that are crucial to creating solutions. Sociocultural images of the illness and the patient provide dimensions of agency instead of powerlessness or victimisation, the latter of which suggest an incapacity to deal with an illness or elicit rational responses (cf. Migliore 1997:69). This process of 'making and adjusting the illness' helps caretakers to resist the powerful ideas and discourses of medical hierarchies and negligence, thus countering the public health interventions that label traditional practices as misdiagnosis and mistreatment. Accordingly, Evil Eye can be transformed into a recognisable expression of distress, illness, disequilibrium, and other conditions (idem, 68-69).

Treatment strategies for ARIs and ADDs generally rely on medications and visits to healthcare facilities. This dependence creates uncertainties when treatments do not work or caretakers are not able to follow recommendations. The experience of no longer having control over their children's health affects many caretakers at an emotional level as well as influencing healthcare decisions. This difficulty strains

healthcare strategies and helps to shape healthscapes by impacting people's ability to make decisions and take responsibility. Public health messages are important instruments in dispelling misconceptions about treatments; yet these messages are meta-communicative, framing traditional caretaker behaviour in terms of risk, hygiene, healthcare practices, sociocultural attitudes and relations. The displacement of indigenous concepts of illness is nothing new to the rural population in San Marcos. The political system of Guatemala has systematically constrained or even eradicated traditional healthcare practices. By the late 1990s, however, these dynamics were attenuated by the Peace Accords, which attempted to integrate traditional medical knowledge into biomedical practices and healthcare institutions as a way of increasing the effectiveness of allopathic interventions.

9.4 Negotiating healthcare practices among systems of care

While the national health programmes are absorbed within the institutionalisation of policies for care, there is no real concern to incorporate traditional healthcare interventions into the health system and recognise its particularities, not only as cultural practices, but also as a developed and organised body of knowledge that is intimately central to ideas of health and care. Therefore, the institutional integration of traditional medicine into the primary and secondary levels of the national healthcare system has so far not been fully executed, but rather oversimplified as a framework for interactions among health providers and caretakers from different cultural backgrounds. In general, primary healthcare interventions have been an attempt to incorporate, regulate and control traditional medical practices, especially where allopathic treatments or forms of healthcare are not accessible or affordable. The result has been restrictions of traditional medicine in the form of minimum training requirements, limited inclusion of 'cultural practices' in biomedical treatments, and reduced reliance on midwives and medicinal plants within the national healthcare system. The focus on macro-models tends to neglect local modalities of domestic care. Dynamics of power, between governmental or other forms of control, extend to the dominion of caring, which suggests that for Guatemala, the health system and structures remain a method of exclusion and discrimination against indigenous individuals. One characteristic of this dominative system is that cultural beliefs are not ingrained into applied forms of healthcare practices, but viewed as adverse forces against allopathic medicine.

Guatemalan healthcare is theoretically based on a system of medical pluralism, relatively more common in rural areas of the country where national healthcare pro-

grammes have been inefficient, inadequate or nonexistent. The existing model of healthcare has been created via unequal power relations (from colonial, hegemonic or dictatorial forces), whose dynamics have emerged from politically, economically and socially discriminatory relations, not only imposing practices of care but also subjugating the traditional healthcare system to the point of aggravating the suffering of poor and rural people. Furthermore, acts of violence towards traditional practitioners were commonplace during the civil war, contributing to the decline of these practices. In the post-civil war era there has been considerable improvement in the health status of the most vulnerable segments of the population, helping to reduce the rates of infant morbidity and mortality from communicable diseases. Additionally, the Peace Accords signed after the war were an important acknowledgement of traditional Mayan medicine as part of healthcare practices within a particular established system, with a greater focus on sociocultural indigenous landscapes (e.g., perceptions, values, mixed rationalisations). However, whereas the biomedical system holds a 'privileged' space, traditional practices are still reported as hindrances and cultural barriers by physicians or practitioners trained as part of the allopathic medical system, and are not appropriately recognised and applied. Traditional illness beliefs and behaviours are considered to clash with biomedical treatments, jeopardising their efficacy.

Within this frame, the presence of traditional healthcare practitioners, and the acknowledgement of folk illnesses, are considered to be explanations for the high levels of morbidity and mortality. Accordingly, many studies and initiatives have sought to encourage behavioural changes based on dichotomist arguments and ideas of traditional versus allopathic healthcare systems, beliefs versus medical knowledge, by offering arguments based on hierarchical thinking, calling into question any practices and perceptions that are not based on scientific rationality. Certain specific diseases have been targeted in this way in the primary healthcare system, which has had a profound impact on illnesses perspectives and practices from both biomedical practitioners and caretakers. Strategies favoring the allopathic cure as the one most likely to succeed, regardless of the circumstances, tend to use behavioural models tied to particular therapeutic actions. Behavioural models and analysis are designed, planned, evaluated, monitored, managed and applied in terms of exposure to a variety of health risks and probabilities that result in predictable outcomes. However, factors affecting the ongoing dynamics of the caretaker's actions are difficult to determine if the broader frames, backgrounds, experiences, priorities, and exposure to specific social, environmental, economic and political conditions are not taken into account.

Behavioural models are helpful in recognising and assessing certain factors that

influence people's ideas and practices of healthcare; yet these models are confined to an underlying rationality of medical interpretations oriented towards 'objective' knowledge and practices. This poses the problem of representations of the world based upon people's own experiences and meaning. The idea that beliefs are not structured knowledge, but deviant behaviours, denies social constructs that are actually open to interpretation and change. Evil Eye, as an illness category, carries more than superposed ideas of sickness and health, and does not constitute an authoritarian statement or uncritical assumption that questions the validity of biomedical practices. The reasoning of the illness belief is limited by people's observations and experiences concerning objective and subjective moral dimensions of illness and suffering that account for much more than the physical effects of an illness, such as personal needs, interactions and reciprocity. In deprived areas, support from the family and community becomes more important, since it increases the chances of getting the necessary help. For example, social support is vital in treating the illness, as the illness aetiology is primarily formed and guided by sociocultural forms of socialisation, norms and values.

National and global efforts to improve health outcomes are therefore inevitably associated with local systems of healthcare. Although most of the programmes recognise the pluralistic health systems, processes that seek to scale-up efforts and accelerate a transition towards universal access and quality healthcare cannot avoid implementing programmes that are organised around specific, biomedical values and knowledge. This emphasis challenges the ways in which such efforts are enhanced or increased, since they automatically endorse specific practices based on arguments within the context of modernity versus tradition. The arguments of biomedical discourse are largely based on a knowledge system that appears to be universally applicable because of its reliance on clinical trials and scientific approaches. Consequently, in order to assess cultural aspects that affect healthcare interactions, most of the programmes attempt to empirically understand people's perceptions and the way people relate to concepts of illness and healthcare. By including these models, health professionals seek to operationalise measures included within the biomedical perspective.

Since governmental health programmes do not recognise illnesses such as Evil Eye, broad policies for the institutionalisation of healthcare practices lack the appropriate prevention programs that could benefit children's health. Fundamental to understanding illnesses and health-related problems, we need to realise how policies of isolation and negligence have systematically repressed and deprived people of a healthy environment and livelihood. Planning and implementation of health programs has previously been based on inappropriate models in which 'the enormity

of the task can feel overwhelming... which can encourage the use of mechanistic and overly simple strategies based on the perceived need for a rapid response. As such, these strategies can be very compelling. This is compounded by an uncritical confidence in the overall efficacy of pro-market, biomedical scientific models that have arisen out of the same socio-cultural context as the International Development Community' (Bristow 2005:14). It is important to note that it is not just healthcare behaviours that pose a threat to health. The rural population of San Marcos experiences poor housing conditions and lacks access to adequate sanitation, safe water and efficient healthcare services, which is an example of how structural forces continue to cause a deprived health status among the poorest rural indigenous people. Various programmes and policies have been approved, yet structural factors have kept them from providing adequate institutional healthcare services.

9.5 Intentional behaviour

A major limitation of the existing research is that only a few studies have examined Evil Eye in the context of other comorbid diseases, namely ARIs and ADDs. Studies exploring caretakers' healthcare behaviours with respect to respiratory and diarrhoeal infections have reported how symptoms can be interpreted as a result of folk illnesses, such as Evil Eye, and are therefore closely linked to traditional medical practices. The link between Evil Eye and these two diseases is associated with the presence of biological or environmental factors. The findings of this dissertation may help to address the concept of Evil Eye not just as an 'add-on' to cultural healthcare practices, but as an integral component involved in complex, dynamic relationships with other forms of illness. Evil Eye is not just an illness category, but a mechanism of intelligible content with pragmatic and sensible connotations for the mother and child. The significance of Evil Eye, in terms of therapy efficiency, is that every day practices provide access to interpretations and purposeful actions, as Evil Eye's symptoms are consistent with exposure to particular social and natural environments.

This folk illness is mostly seen in indigenous and rural populations. Evil Eye may be one of the culturally mediated processes by which people link symptoms of respiratory or diarrhoeal symptoms as a result of diverse events that cause a vulnerable body to lose its balance, resulting in somatic symptoms, and in extreme cases death. Caretakers in rural San Marcos experience a seriously disruptive healthcare system. Lack of treatments, limited personnel, and an inefficient referral process, among other factors, have led to damaging behaviours. A diagnosis of Evil

Eye allows alternatives to this inadequate system, and also provides access to social networks and relations via treatments of the illness's symptoms. Evil Eye mobilises social networks into therapy management. This social course of action is not only linked to the importance of seeking interventions, but also shapes the quality of social relations. Rural practices of care show the important of interpersonal aspects in contexts where other factors are involved, such as repeated treatment failures, lack of economic resources, and the stigma attached to ARIs and ADDs, among others.

Structural factors, such as the impossibility of following a referral to the hospital or formal pressure to attend healthcare facilities, strongly influence people's decision-making behaviours. Whatever the 'rationality' of the illness, there is always an intimate domain of intrinsic personal experiences. Therefore we need to deconstruct the general assumption—linked with simplistic notions of cultural factors that regard behaviour and ethnicity as inherent barriers to recognising and treating certain illnesses—that people's knowledge and perceptions regarding Evil Eye are not a misinterpretation of the biomedical terms of ARIs and ADDs. An increasing dependence on biomedicine does not automatically grant the answers to medical problems. Rather, biomedicine is characterised by inconsistencies, strong paradoxes, power struggles and emotions. Following Evans-Pritchard's primary approach among the Azande, we encounter 'apparently irrational beliefs' or behaviours, but instead of relativising them as cultural responses and beliefs, such practices should be assessed with reference to objective reality (the cure or treatment) and also in relation to its subjective effects as a form of knowing and suffering. Evil Eye's intentionality entails important aspects of knowledge, cultural meaning and power. As a result, explanations of its aetiology and healthcare strategies refer to at least one of these characteristics, holding normative dynamics or ways of acting that correspond to people's social moral and order.

The fluidity of Evil Eye's meaning in the unfolding realm of medical pluralism expresses different voices and practices, an important aspect to debate with regard to the apparent ultimate authority of healthcare systems. The illness adjustment, i.e., the capability to adapt to uncertainties, provides ways for healthcare seekers to move within overlapping explanations of intentional behaviour, closer to one or another system of care at different times. Evil Eye is an enabling factor that directs caretakers' possibilities into guided actions. Although healthcare practices for ARIs and ADDs are also carried out intentionally, the diseases are the 'agent reasons' that require standardised actions, explaining why they may create conflicts and misunderstandings between healthcare providers and caretakers. Yet Evil Eye makes certain responses desirable for the caretakers. This function of Evil Eye

underscores the importance of understanding the processes of illness adjustment, since cultural healthcare behaviours incorporate knowledge of the caretaker's cultural values, family structures, interrelation dynamics, religious beliefs and beliefs about illness. Furthermore, Evil Eye's pathology raises the question of how to deal with illnesses with similar symptoms, bringing into focus the ways in which social inequality shapes practices and outcomes that regulate daily life (and death) in rural San Marcos.

9.6 Implications of this study

One of the limitations of this study is that its findings may not be applicable to other areas where the phenomenon of Evil Eye persists, where the illness and healthcare processes may differ and therefore have a different meaning. However, the phenomenological approach used in this research produced important insights about healthcare strategies and sociocultural dynamics concerning Evil Eye. The findings revealed that somatic and asymptomatic conditions of the Eye were central aspects within a pluralistic medical frame in rural San Marcos. People's responses to instances of the illness suggest that the caretaker's attitudes in the assessment and treatment process can help to enhance understanding of cultural values, the importance of treatment compliance and the relationships that impact diagnosis accuracy and treatment engagement, which in turn can help to improve the outcomes of healthcare strategies. The perceived relationship between the symptomatology of Evil Eye, ARIs and ADDs observed in this research stressed the several ways in which these three illnesses influence each other. These findings underpin the incorporation of Evil Eye as an illness concept when assessing child illnesses in rural San Marcos in order to improve clinical outcomes, as well as the importance of the cultural value that traditional medicine and the concept of the Eye have in the strategies of care management.

One of the main reasons for the failure of intervention programmes to reduce childhood deaths from diarrhoeal and respiratory infections is that the rural population of San Marcos consists of poor communities that lack favorable environmental and socioeconomic conditions. These factors cause a bottleneck in the existing public national healthcare system, making the usual biomedical interventions more difficult to apply. Any endeavor at educating caretakers in 'better case management' should take into consideration the many scourges affecting healthcare practices and people's priorities to engage or assess them. Thus, Evil Eye is not 'the' problem but an aspect within a much wider context, a sign of a more pervasive limit on caretaker's behaviours, such as concerns over availability, accessibility and

social status. Evil Eye should be taken into account in public-health efforts to negotiate between caretakers and healthcare practitioners as to how to implement programmes in the least contentious way.

This dissertation hopes to contribute to the improvement of healthcare in rural San Marcos by applying the illness concept of Evil Eye as a patient strategy in healthcare interactions. By including Evil Eye in the attempt to treat diarrhoeal and respiratory diseases, health providers could overcome challenges of treatment compliance by adopting certain approaches, such as eliciting the considerations that are important to caretakers, and developing individual strategies of care based on these concerns. While statistical information remains important in assessing common illnesses and establishing treatment models, anthropological methods and research can discern potential explanations for particular behaviours likely to impact the provision of healthcare. Evil Eye captures both objective and subjective elements of the complex interplay among the dynamics of systems of healthcare, cultural communication, care interactions, illness perceptions and cultural competence in the provision of health.

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Zusammenfassung

Bei der Behandlung von Krankheiten können Konflikte und Machtdynamiken entstehen. Gerade in der heutigen globalisierten Welt wird die Schulmedizin mit kulturgebundenen Syndromen oder *folk-illnesses* konfrontiert, die zwar nach wie vor von dem biologischen, allopathischen Blick dominiert werden, in welchem aber eine Vielzahl von unterschiedlichen und dynamischen medizinischen Systemen anzutreffen sind. Diese wiederum werden auch von *folk-illnesses* beeinflusst. Dabei gehören die Prävention und Kontrolle von akuten Atemwegs- und akuten Durchfallinfektionen zu den wichtigsten Herausforderungen im Gesundheitsbereich. Die Zahl der Infizierten und Erkrankten ist in Entwicklungsländern um ein Vielfaches höher. Im Jahr 2013 starben 6,3 Millionen Kinder unter fünf Jahren, d.h., etwa 17.000 pro Tag, an den oben benannten Krankheiten. In Guatemala sind die beiden Krankheiten die häufigste Todesursache von Kindern. Seit Beginn der Achtzigerjahre hat die Bekämpfung von beiden Krankheiten eine große Bedeutung erlangt und sich später zum Millenniumsziel etabliert. Ein großer Anteil aller Todesfälle ist auf fehlende Medikamente oder die Unzugänglichkeit der Versorgung und anscheinend abergläubisches Verhalten zurück zu führen. Ein wichtiges Instrument bei der Bekämpfung von beiden Krankheiten ist folglich eine steigende Nutzung der Nationalen Gesundheitssysteme, was einer Änderung der Verhaltensweise der Eltern bedarf, da diese die Notwendigkeit des Zugangs zur biomedizinischen Versorgung für ihre erkrankten Kindern erkennen müssen. Der scheinbare Widerspruch und zugleich die Herausforderung besteht nach Ansicht des allopathischen medizinische Personals darin, dass auf der einen Seite die präventiven und interventiven Maßnahmen erfolgreich sind, auf der anderen Seite aber die Möglichkeit der Anwendung allopathischer Therapieverfahren bei akuten Atemwegs- und Durchfallinfektionen durch die traditionelle Medizin beeinträchtigt wird.

Die steigenden Todeszahlen sind zum Teil auf die Präsenz des Glaubens an den Bösen Blick', zurück zu führen, eine *folk-illness*, die das Immunsystem der Kindern schwächt. Der Böse Blick wird in zahlreichen Ländern und Kulturen als eine Krankheit angesehen, die durch ihre Kräfte verschiedene Symptome verursacht. Es handelt sich um eine Erkrankung, die durch den Einfluss von Menschen oder der Umwelt, bzw. Naturelementen auftreten kann. Die therapeutische Praxis vom

Bösen Blick orientiert sich neben der Behandlung mit pflanzlichen Stoffen und Medikamenten vor allem an sozialen Elementen. Da die Kinder, die an akuten Atemwegs- und gastrointestinalen Infektionen erkrankt sind, die gleichen Symptome wie beim Bösen Blick entwickeln, wird das Konzept von Ärzten als "Kulturbarriere", bzw. als ein kultureller Aspekt, der normatives Wissen und Praktiken verhindert, angesehen. Obwohl es in Guatemala eine staatliche Anerkennung von traditionellen medizinischen Praktiken gibt, weisen alltägliche Handlungskontexte innerhalb von biomedizinischen Therapien auf die negativen Auswirkungen von ärztlichem Handeln im Hinblick auf kulturgebundene Syndrome und dem Umgang mit Kranken hin, da Eltern sich schließlich nach dem Bild der Krankheit und nicht nach den Symptomen zur Behandlung orientieren. Sowohl die Diagnostik als auch die Behandlung des Bösen Blicks beinhalten besondere Bedeutung, denn sie fundieren auf einer speziellen Form von Wissenssystemen und Sozialisierung. Die Annahme dieser Dissertation ist, dass der Böse Blick ein wichtiger Prozess ist, der einerseits die Öffnung der Medizinische Möglichkeiten betrifft, andererseits im Kontext eines diskriminierenden Diskurses zur Bekämpfung gegen die Legitimierung von allopathischen Therapien und normativen Diskursen verwendet wird.

Innerhalb des medizinischen Pluralismus im ländlichen Guatemala, wo die Morbidität und Mortalität von akuten Atemwegs- und Durchfallerkrankungen und der Glauben an den Bösen Blick gemeinsam zu finden sind, ist sehr problematisch, da die drei Krankheiten ähnliche Symptome haben, die aber unterschiedlich verstanden und behandelt werden. Der Böse Blick gehört zu den kulturellen Praktiken mit sozialen Verknüpfungen und Therapieformen, die wichtig für die Therapie, Autonomie und Sozialisierung der Eltern sind. Die Analyse der Verhaltensmuster der Eltern von am Bösen Blick erkrankten Kinder im ländlichen San Marcos, wo in den traditionellen Therapien allopathische Herangehensweisen integriert werden, stand im Fokus dieses Forschungsprojektes. Bei der Analyse wurden die drei Krankheiten untersucht, da die anscheinende Ablehnung der allopathischen Medizin und die Unterschiede zwischen den Krankheiten lediglich diskursiv konstruiert sind. Ihre Abgrenzungen sind in der Praxis aber nicht trennscharf, da sie einander beeinflussen. Anhand von verschiedenen Quellen und empirischer Arbeit, wie beispielsweise ethnographischer Beobachtung und Befragung von betroffenen Eltern, Heilpraktikern sowie von medizinischem Personal, wurde das Phänomen des Bösen Blickes in dem Departamento von San Marcos analysiert. Die Krankheit des Bösen Blickes erweitert sowohl die unterschiedlichen Formen der Pflege, Versorgung, Zugehörigkeit und Identität innerhalb des medizinischen Pluralismus, als auch das Management der sozialen und ökonomischen Ressourcen und Netzwerke, die zu einer Strategie zur Lösung des Zugangs zu Therapien beitragen. Der dynamische Prozess und die Bedeutung des Bösen Blicks bietet Hand-

lungsmöglichkeiten für Eltern, vor allem Müttern, die innerhalb von unterdrückten Handlungsprozessen stehen. Durch das Konzept vom Bösen Blick finden die Eltern auf kollektive Weise individuelle Heilungslösungen, die innerhalb der unterschiedlichen medizinischen Systeme den Umgang mit diversen Symptomen ermöglichen, die konkret behandelt werden können.

Anlage zum Antrag auf Zulassung zur Promotion

Eidesstattliche Erklärung

Ich versichere hiermit an Eides statt, dass

- Ich die Dissertation ohne unzulässige Hilfe Dritter und ohne Benutzung anderer als der angegebenen Hilfsmittel angefertigt habe; die aus fremden Quellen direkt oder indirekt übernommenen Gedanken sind also solche kenntlich gemacht.
- Ich die Arbeit weder im Inland noch im Ausland in gleicher oder ähnlicher Form einer anderen Prüfungsbehörde vorgelegt oder veröffentlicht habe.
- Ich weder dieser noch andere gleichartige Doktorprüfung endgültig nicht bestanden habe.

Berlin, den 27. August 2015

(Mayarí Hengstermann)

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Titel der Arbeit: "Movimiento Gay y Lésbico en Costa Rica ante las normativas del paradigma Estatal Homofóbico"
- 15.01.97 – Anthropologie an der Universidad San Carlos de Guatemala
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