Introduction

“The right to health is a fundamental right of the human being without any discrimination.”
Section VII, Article 93, Guatemala Constitution (1986)¹

In 2002, a group of American and Guatemalan doctors founded Primeros Pasos Clinic to address the prevalence of gastrointestinal parasites in the Palajunoj Valley. Prior to the clinic’s conception, the Guatemala Civil War (1954-1996) devastated rural indigenous areas such as the K’iche’ Maya communities of the Palajunoj Valley, leaving these regions with limited access to healthcare services. In the aftermath of the civil war, a variety of non-governmental organizations (NGOs) such as Primeros Pasos emerged, combining local, grassroots, community-based efforts with foreign aid to repair the crumbling healthcare infrastructure. These organizations provide healthcare primarily in the form of biomedical treatments and are mainly serviced by doctors and nurses. The rise of such healthcare aid efforts has led to an infusion of alternative forms of healthcare to existing, local healthcare systems in postwar Guatemala.

In 1954, a US-backed military coup overthrew a democratically elected president in Guatemala, setting the stage for a civil war that lasted until signing of the Peace Accords in 1996. A framework of human rights permeates the rhetoric of the reformed Guatemala Constitution as well as in the mission statements of NGOs in this post-conflict setting. In the case of healthcare, “Everyone has the right to a standard of living adequate for the health and

¹ Section VII, Article 93, Guatemala Constitution
well-being of himself and of his family.” In the case of healthcare for indigenous populations such as those in the Palajunoj Valley, “Indigenous peoples have the right to their traditional medicines and to maintain their health practices.” With these multiple framings of health from the Guatemala Constitution to the United Nations’ *Universal Declaration of Human Rights* and the *Declaration on the Rights of Indigenous Peoples*, how do NGOs such as Primeros Pasos define “health” in a “right to health?” How do the members of communities that receive NGO health aid interpret these concepts of health? In this paper, I will examine how definitions of healthcare, illness, and medicine are contested through the interplay of plural healthcare forms in the case of grassroots community health development in the rural, indigenous K’iche’ Maya communities of the Palajunoj Valley of Guatemala. The plurality of healthcare forms in this context reveals how, oftentimes, the way in which a right to health is effectively carried out assumes universality in forms of health determinants, healthcare, and illness. Such assumptions, if not realized, discriminate against alternative definitions of healthcare in a way that a formal right to health no longer operates “without any discrimination” by claiming the universalizability of certain forms of healthcare access, practice, and treatment.

*Mal de ojo* is an illness that commonly affects children in the Palajunoj Valley. Roughly translating to “evil eye,” symptoms usually involve vomiting and diarrhea. It can be transmitted by a simple stare and prevented by the color red. Only *curanderas*, community healers that practice natural medicine, can treat local illnesses categories such as *mal de ojo*, its more advanced stage, *el chipe*, and similar afflictions, *lombrices* and *susto*. Healthcare practitioners at clinics such as Primeros Pasos often do not recognize or are not well-informed about local illness categories that afflict individuals in Palajunoj. With the lack of knowledge about these local

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2 Article 25, *Universal Declaration of Human Rights*
3 Article 24, *Declaration on the Rights of Indigenous Peoples*
illness categories amongst doctors and nurses at Primeros Pasos and those at similar biomedically-oriented clinics, community members often seek alternative treatments from local curanderas. As a result, community members draw upon various sources of healthcare for consultations, treatment, and advice.

In this paper, I examine the interplay between existing, local healthcare practices and the infusion of biomedical healthcare aid in the Palajunoj Valley. I then interrogate how this interplay reifies abstract distinctions such as those between natural and clinical medicines, curanderas and doctors, and traditional and biomedical healthcare. How do these categories map onto distinctions between how staff at Primeros Pasos provide universal healthcare as a human right vs. what the community members of the Palajunoj Valley perceive to be healthcare? The vagueness in defining health and healthcare lend to their uptake as a certain, biomedical definition of health by staff at Primeros Pasos that operates as a claim to universal healthcare that is generalizable to all contexts. However, in the face of plural meanings of health, illness, and treatment in the Palajunoj Valley, I argue that a right to health that operates through biomedicine alone is limited in its ability address the full scope of health-related problems, effectively excluding alternative meanings, practices, and treatments.

First Steps: Primeros Pasos, and the Palajunoj Valley

I first set foot onto Primeros Pasos Clinic on June 24, 2015. Located at the bottom of the Palajunoj Valley, it is about ten minutes by motorcycle, or thirty minutes by chicken bus, from Quetzaltenango, the second largest city in Guatemala. The shift from urban to rural is immediately noticeable, as the cracks in the road grow wider and deeper and paved asphalt crumbles to gravel and dirt. In this landscape of postwar Guatemala, predominantly indigenous areas continue to remain isolated and marginalized, with limited access to government-run
services such as water, education, and healthcare. In the Palajunoy Valley, poor health is not solely the product of a lack of healthcare access, but rather a culmination of a multitude of similar deficits. Malnutrition and gastrointestinal infections are also the product of a lack of educational services, access to clean, running water, and infrastructure for transportation to, from, and through the valley. With this multifaceted array of health determinants, a right to universal healthcare alone does not wholly encompass a right to health.

I worked with Primeros Pasos Clinic from June to August 2015. As an intern with the Nutrition Recuperation Program (NRP) in three communities of the valley – Las Majadas, Chuicavioc, and Xepache – I designed and led weekly charlas in each of the three aforementioned communities. Primeros Pasos began the NRP for pregnant women and young mothers in 2012 as an effort to provide health in the form of education through classes about cooking, nutrition, hygiene, reproductive health, and family planning. During this time, I surveyed community members in and outside of the program about their perceptions of healthcare access. These conversations developed into unstructured interviews about experiences with clinics, alternative forms of healthcare, and factors that affected healthcare treatment decisions amongst community members.4 I found that there was a lack of health literacy not just amongst the local community, but also amongst the biomedical healthcare practitioners at health posts, hospitals, and clinics such as Primeros Pasos. In the case of the former, this was a lack of literacy in biomedical definitions of parasites, disease, and medicine. In the case of a latter, there

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4 In total, I interviewed thirty individuals, which consisted of three group and sixteen individual interviews. Eight of my informants were unaffiliated with the NRP. One of these unaffiliated community members was a curandera. Interviews were conducted in Spanish and recorded either by hand or with an audio recorder.
was a similar lack of understanding for natural medicines\(^5\), the practices of community healthcare entities such as *curanderas*\(^6\) and midwives, and local illness categories such as *mal de ojo*, *el chipe*, *lombrices*, and *susto*. In the case of both, health takes on different forms that are not necessarily in conflict, but each require shared recognition, awareness, and understanding amongst all of the actors in the Palajunoj Valley in order to fully address health-related problems.

*Giving the evil eye and disturbing las lombrices: defining illness in the Palajunoj Valley*

Healthcare access often connotes availability of services and supplies, affordability, and physical accessibility.\(^7\) Yet access to healthcare does not necessarily mean access to the appropriate form of healthcare. I learned this from a conversation with a NRP participant in Las Majadas. After one of the weekly *charlas*, she helped me take down posters that depicted healthy meal plans and suggestions for reducing sugar intake.

**A:** Last week, we had a little case of *mal de ojo*. My mother, she cured it with rue and a little bit of liquor. Rue and some peppers and herbs like *pimientas gordas*.

**Me:** Is *mal de ojo* only curable with natural medicine or is it also curable at the clinic?

**A:** No, only natural medicine.

**Me:** Why can’t you cure *mal de ojo* at the clinic?

**A:** They don’t know about this, they don’t believe in it. So we have to do it here [in Las Majadas].

**Me:** Have you tried to cure it in the clinic?

**A:** No.\(^8\)

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5. Natural medicine, or *medicina natural*, often involves herbal remedies and is sometimes accompanied by rituals. It can be further broken down into *medicina casera* and *curanderismo*. The former refers to home remedies that are often practiced by mothers as an initial attempt to address an illness before seeking further assistance, whereas the later refers to spiritual healing that is only practiced by *curanderas*.

6. I refer to community healers as *curanderas* rather than *curanderos*, based on accounts from my interviewees, which informed me that or that *curanderos* did not exist, or were extremely rare.


8. Interview A, Las Majadas, 7 July 2015
Despite my several attempts to clarify, our conversation left me unclear as to whether the mother claimed that the clinic could not cure *mal de ojo* because clinical medicine is ineffective, because biomedical healthcare providers did not recognize *mal de ojo*, or because of a combination of the two. If it had been the inefficacy of clinical medicine, perhaps this would have suggested a lack of health literacy about clinical treatments on her part, whereas the misrecognition of or lack of awareness about *mal de ojo* as illness would have suggested a lack of health literacy on the part of the doctors at the clinic. She did inform me that all of her knowledge about treating *mal de ojo* was based not from her own experiences of seeking treatment from *mal de ojo* at the clinic, but rather on accounts from her mother and other family members of their experiences with the illness. When I spoke with the doctors, medical students, and other staff at Primeros Pasos, they referred to illnesses such as *mal de ojo* as cultural illnesses that they did not know much about, aside from symptoms that sounded similar to those of gastrointestinal infections.\(^9\) Regardless of whether the mother I spoke with in Las Majadas thought that clinical medicine was an ineffective remedy for *mal de ojo* or whether she thought that doctors and nurses would not be receptive to her diagnosis, Primeros Pasos provides healthcare that addresses some of the health problems in the Palajunoj Valley, but not all.

In an attempt to clarify whether the mother from Las Majadas, and perhaps other community members, thought that doctors at the clinic “could not” or “would not” treat *mal de ojo*, I tried to engage with the subject of these mysterious, clinically-incurable illnesses with other community members and in other communities where I taught for the NRP. During a cooking class in Chuicavioc, the commencing *charla* about food groups was brief and I stationed myself at the fruit station, chopping up strawberries, bananas, and mangoes with NRP.

\(^9\) Interview with Primeros Pasos staff, Quetzaltenango, July 3, 2015
participants and other Primeros Pasos staff. One of the mothers told me that something else gives *mal de ojo* for the illness to take effect. Although this etiology is oftentimes a strange stare from a passerby on the street, it can also include proximity to a woman with poor hygiene, a pregnant woman, and black dogs like the shaggy, bearish *chucho* that, despite shoos from the mothers in the NRP, would linger outside of the dimly lit, one-room home. In the face of these many avenues for illness susceptibility, mothers could take a few simple measures to prevent *mal de ojo*. The mother I was speaking with nodded to the red bandana wrapped around the head of the baby that she had tied to her back using a thick, textile blanket. She then tugged out her child’s hand to show me the delicate, clear thread that was wrapped around his wrist, adorned with tiny red beads. After that day, I began to notice the ubiquitous splashes of red that decorated the children not just in Chuicavioc, but throughout other communities in the Palajunoj Valley. In addition to conceptualizing different forms of illness, mothers had developed alternative healthcare solutions for preventing illness transmission.

Along with these methods for inoculating children against *mal de ojo*, the mother in Chuicavioc explained to me how medications provided by the clinic could not effectively cure illnesses such as *mal de ojo*. However, this did not mean that the clinic was a completely ineffective source of healthcare. For some illnesses, it worked, and for others illnesses, such as *mal de ojo*, it did not.

**Me**: And do you go to the clinic for *mal de ojo* or –
**B**: Never.
**Me**: Why? Have you ever tried?
**B**: They don’t know…Yes, I go to the clinic, but that’s when [the children] have a fever, cough, cold, yes I go, but when it’s *mal de ojo*, no.
**Me**: Is one better than the other? The doctors at the clinic or the *curandera*?
**B:** Equal. They’re different. It’s that the curanderas have the herbs. For the mal de ojo. Those they do not have at the clinic.¹⁰

Oftentimes, when I would ask mothers about whether they preferred the clinic or the curandera, mothers would inform me that they drew upon both the services of both biomedical healthcare and the local curanderas. One was not better than the other, but rather served different purposes. Whereas the curandera treated mal de ojo, the clinic treated fevers, coughs, and colds. Thus, mothers based their treatment decisions on perceived illness. However, these initial diagnoses only served as a heuristic for seeking treatment. If a prescribed form of healthcare failed, whether from the clinic or the curandera, mothers would change their initial diagnosis to prescribe alternative remedies.

**Me:** Are there illnesses that are not curable with clinical medicine?

**C:** Yes, like lombrices, when they’re disturbed, they come through the nose and the mouth. This cannot be cured at the clinic. Yes, this can only be cured by natural medicine…And when a child is given mal de ojo. You know when they cry, cry, and cry, and they have a fever, an upset stomach, and no dichlorophen¹¹ or acetaminophen¹² can cure it, that’s when you go to the natural medicine.¹³

I spoke with this NRP participant in Chuicavioc after we had wrapped up our cooking charla. She told me that if one medicine failed, she would opt for the other. In addition to defining illnesses such as mal de ojo and lombrices as afflictions that the clinic did not possess appropriate treatment for, mothers furthermore identified these illnesses as cases for which the clinic had failed to provide successful treatment. Thus, experiences with treatment efficacy

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¹⁰ Interview B, Chuicavioc, 28 July 2015
¹¹ Dichlorophen is an antiparasitic.
¹² Acetaminophen is a common fever reducer and pain reliever.
¹³ Interview C, Chuicavioc, 28 July 2015
reinforce distinctions and decisions between doctors and curanderas, illnesses such as fever and those such as mal de ojo, biomedical healthcare and local healing practices.

In the Palajunoj Valley, an adjective of “biomedical” precedes the healthcare that is carried out by clinics such as Primeros Pasos, such that their definition of a “right to health” is synonymous with a “right to biomedical healthcare.” Yet no matter how sufficient biomedical healthcare may be for addressing biomedically-defined health problems such as fevers and coughs, a right to this form of healthcare excludes alternative conceptualizations of poor health such as mal de ojo and lombrices. In addition to this exclusion, equating a right to biomedical healthcare with a right to health predicates upon an assumption that biomedicine is a ubiquitous solution, despite the potential limitations of its efficacy that shape definitions of local illness categories. Thus, the vagueness in the right to health renders the concept vulnerable to reinterpretation and redefinition as a specific form of healthcare, such as that of biomedical healthcare. This specific articulation of a right to health threatens to homogenize the plurality of health under the guise of universality, claiming a singular, biomedical solution. These generalizations mask the exclusions and limitations of a biomedical lens. Although health aid workers at organizations such as Primeros Pasos might provide healthcare that is “adequate for the health and well-being”\(^{14}\) of community members for some afflictions, this form of healthcare is not universally adequate for the full range of illnesses and health problems that afflict the Palajunoj Valley.

**Chemical and natural: alternatives in healthcare and treatment**

In order to better understand alternative forms of healthcare and treatment for illness in the Palajunoj Valley, I explored how community members distinguished between categories of

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\(^{14}\) Article 25, *Universal Declaration of Human Rights*
natural and clinical medicines. Mothers introduced these categories when describing how different illnesses require different forms of treatment. In Xepache, after a charla that discussed the benefits and proper practice of breastfeeding, I asked a mother how she distinguished between natural and clinical medicines. We had been discussing prenatal vitamins provided by the clinic and she described to me how she supplemented these with her own herbal teas, an alternative treatment in addition to biomedical aid.

[Natural medicine] is a great source because it does not have chemicals, and this is the most important, that it does not have other consequences like how the other [clinical] medicines have chemicals and sometimes give you allergies, but it still cures one well.\(^\text{15}\)

I was curious as to what she meant by the consequences of clinical medicines as well as the chemical materiality of these treatments. Earlier in our conversation, she had mentioned that natural medicines were less “strong” than the chemical, clinical medicines prescribed by doctors. However, I realized later in our interview and through conversations with other mothers, that strength did not necessarily mean strength of efficacy.

Natural medicine, in excess, does not do damage on the child like clinical medicine. And natural medicine does not cause other illnesses. My child took many antibiotics, and the antibiotics prevented her from gaining weight, and also now she has problems with her teeth…it is because of taking many antibiotics that her teeth have damage.\(^\text{16}\)

Rather, strength can also indicate damage. In this other interview, I found that perhaps biomedical healthcare was insufficient not only in addressing the scope of different illness beliefs in the Palajunoj Valley, but also that community members might perceive that biomedical

\(^{15}\) Interview D, Xepache, 30 July, 2015

\(^{16}\) Interview E, Xepache, 30 July 2015
treatments have damaging, long-term effects. Biomedical healthcare may not be the sole or most appropriate form of healthcare, nor is it universally the best solution. In addition to these limitations of the biomedical adjective in healthcare, healthcare alone does not address health. For example, if gastrointestinal parasites are a marker of poor health in the Palajunoj Valley, then healthcare in the form of either antibiotics or natural medicines is only one aspect of how this problem might be alleviated. Rather, the health problem is also the product of determinants such as contaminated water and poor diet.\textsuperscript{17} Thus, healthcare as medical treatment, whether clinical or natural, addresses only one facet of health, despite the complexity of health determinants. Just as biomedicine alone does not constitute healthcare, an effective right to healthcare does not constitute a formal right to health. In the case of the latter, health includes, in addition to healthcare, a wide range of co-determinants such as nutrition, access to clean water, and education. Addressing a right to health effectively requires the acknowledgement of each of these processes that shape the health status of individuals in the Palajunoj Valley.

\textit{Here and there: the interplay of structure and culture}

In an attempt to conceptually parse apart biomedical healthcare from other forms of healthcare, health from healthcare, I examined the interplay between concepts of “culture” and “structure.” I use the term culture to describe health-related beliefs and practices and the latter to refer to access-related determinants of health such as geography, availability, and affordability.\textsuperscript{18} However, the line between these two concepts is blurry in both discourse and practice. I found that community members often constituted distinctions in healthcare systems geographically. The mothers that I spoke with would often refer to natural medicines and \textit{curanderas} as an entity

\textsuperscript{17} Cook et al., “A Retrospective Analysis of Prevalence of Gastrointestinal Parasites among School Children in the Palajunoj Valley of Guatemala.”
\textsuperscript{18} Metzl and Hansen, “Structural Competency.”
that only existed “here” in this community rather than “there” at the clinic. When discussing the healthcare practiced “here” or the beliefs about health and illness “here,” some would point an index finger to the ground.\textsuperscript{19} In contrast, when they would mention the clinic, hospital, or health post, they would gesture in a direction beyond the community, sometimes subtly with a brief nod of the head or empathetically with the waving of arms.

I spoke with a mother that used gestures of the latter variety in Las Majadas on one of the slower days with the NRP, when another NGO partner from Quetzaltenango was taking advantage of Primeros Pasos’ established relationship in the community to advertise clear-air cookstoves. With no \textit{charla} to teach that day, I spent the morning playing with the litter of eight-week-old puppies and exploring a small garden with the NRP participant that owned the home, puppies, and the garden. She showed me the different herbs that the resident \textit{curandrea} used, from leaves of rue to spearmint and basil. She would pluck a few sprigs, bundling them up into a small napkin that became increasingly strained by the growing number of leaves that we collected. Sometimes, she would hold a sample up to my nose for me to sniff the strong, spicy scents of these natural medicines.

\begin{quote}
Look, we could bring ourselves all the way down the mountain and through the valley to cure ourselves \textit{there}, but \textit{here} we have the herbs, the plants that cure.\textsuperscript{20}
\end{quote}

Just as this mother used “here” and “there” to describe plants that cure and distinguish a form of healthcare practice that takes root in Las Majadas, the contours of “here” and “there” also trace the lines between natural and clinical medicine, biomedical and local community health, and an interplay between structure and culture in defining these healthcare forms.

\begin{flushleft}
\textsuperscript{19} Field notes, Las Majadas, 3 August 2015  
\textsuperscript{20} Interview F, Las Majadas, 3 August 2015
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Me: So what are the differences between the natural and clinical methods? Do you prefer one?
G: I believe the clinic is good but [one night] we had to take my child to a doctor at the hospital. We stayed there for the night. And it was very expensive. But we had to wait...we said to the private doctor that look, this child is very ill, but I think he forgot about us, and he still asked for us to pay the money for a cure. I only wanted to cure my child.
Me: So you think that natural medicine is better or—?
G: Yes, it’s much better, [it] cures much better here.
Me: There are things that the doctors at the clinic can’t cure?
G: There are many things that they cannot cure there.21

This conversation arose one day when I was walking through Las Majadas, distributing flyers for an upcoming open-clinic day. I ran into three community members that were not affiliated with the NRP. They were middle-aged and elderly, older than most of the woman that I worked with at the NRP, with surviving children already at adolescence. Earlier in the week, I had witnessed how the overcrowding and lack of resources and persons at public hospitals such as the one in Quetzaltenango forced those with serious conditions to seek costly private healthcare institutions that might not even provide results.22, 23 As I listened to the woman’s story, I thought back to the NRP participant in Las Majadas that had showed me her garden of herbal remedies. I had interpreted a pride in her garden as a pride in the healthcare practices and medical culture of Las Majadas. Walking away from the three community members, I wondered how this assertion and cultivation of medical heritage might also mask underlying structural insufficiencies that may have shaped the distinction, isolation, and marginalization of these practices.

As I compared this structural distinction between natural and clinical, I thought back to one of my earlier conversations with another NRP participant in Las Majadas and the vagueness

21 Interview G, Las Majadas, 17 August 2015
22 Field notes, 12 August 2015
23 pp. 89-90, West, “Volunteer Tourism: Effective Development Strategy or Feel-Good Travel?”
of whether she thought that healthcare providers at the clinic “could not” or “would not” treat mal de ojo. I found that this ambiguity might reflect how a blend of past experiences had become internalized within Las Majadas as common knowledge that the doctors do not treat mal de ojo. In both these cases of medical as natural and illness category as local, distinctions between illnesses and healthcare systems develop, in part, from both an individually and communally experiential process, in which structural factors, such as affordability and geography, become internalized as cultural beliefs about health and healthcare.

In a conversation with another group of women at a bus stop in Xepache, I saw how this structural landscape of healthcare in postwar Guatemala has been shaped by a history of physical and structural violence that marginalized indigenous populations that has continues in the aftermath of the Guatemala Civil War.

And well, in the years past, approximately fifteen years, twenty years, thirty years ago, it was all the curanderas...but today, we no longer use the curanderas so much...In today’s time, it’s all chemical.

These women were, like the group I came across in Las Majadas earlier that week, older and not affiliated with the NRP. They spoke about the temporal shifts in healthcare and education, from a reliance on curanderas and natural medicines during a time somewhere in the middle of the war, before the NGOs and foreigners came to the Palajunoj Valley, to a time now characterized in part by the introduction of biomedical clinics, health posts, and healthcare education. I was unclear as to whether they were talking about their own experiences during these shifting times, or whether they were relaying the “stories of [their] grandmothers” that had

24 Interview A, Las Majadas, 7 July 2015
25 McAllister and Nelson, War by Other Means.
26 Group Interview H, Xepache, 20 August 2015
also had also taught them about natural medicines.” However, these temporal markers took form in distinctions between clinical and natural, biomedical and traditional, new and old.

I also shared with these women my role in Primeros Pasos and described some of the *charlas* that I provided about family planning, menstrual hygiene, and birth control. We discussed the emergence of “women’s health” as a concept temporally, and how women’s health before, during the days of their grandmothers did not exist, nor did the women in Xepache ever learn about the reproductive body. They contrasted this knowledge of their “grandmothers” with education such as that of Primeros Pasos that could allow future generations to better understand and learn about women’s health, reproductive health, and the forms of female body-specific healthcare that NGOs had introduced into the region. Part of making healthcare accessible also involves making healthcare understandable, such as through this sort of education that elucidates biomedical healthcare for community members. These mothers explained the importance of this education when I asked them about their decisions between different healthcare systems for childbirth during the earlier years in a time when biomedical aid was still novel and foreign.

Me: But did you go to the hospital, or health post, or clinic [back then] for labor?
All: No, the midwives.
Me: Never? Even when they were there?
I1: Because it’s like with the plants. We once only knew and had the plants, the herbs.
I2: It’s because of many parts. One part, is that our grandmothers taught us a lot about natural medicine. And the other part is that we never had the knowledge to go to the clinic. Today, we do. We could go to the clinic to check on our child.
Me: Then now, do you have more trust in the midwives or the clinic?
I2: The two.
I3: Well it’s also that now we know about the clinic.
Things have changed now. There are more that go to the health posts. Now, the youth uses the health posts more. Thanks to the education. Things have changed from before.27

In this part of our conversation, the women in Xepache constituted the distinctions between a time in history when “it was all curanderas” and they “once only knew and had plants” with a time in “today,” when “now [they] know about the clinic” and seek these clinical health services. Thus distinctions between healthcare forms embody structural differences in time, space, and accessibility, as well as cultural differences in definitions of illness and perceptions of medical treatment.

However, just as distinctions between categories of illness and medicine are shifting, distinctions between structural and cultural determinants of health are also permeable. The examples of women’s health and childbirth healthcare suggest how health organizations might use this interplay of structure and culture as a starting point to both acknowledge local, cultural conceptions and systems of healthcare as well as additional structural determinants of health beyond healthcare access into their definition and implementation of health as a universal human right. Structurally, midwives are geographically closer, oftentimes located within communities. Culturally, midwives are more familiar with existing health-related beliefs, practices, and knowledge. A biomedical toolkit can also supplement the existing practices of midwives. “Midwives have a hospital education, so they know when to send you there when there’s a real complication,” one of the women at the Xepache bus stop told me. The Guatemala Ministry of Health has created training programs for midwives. Although the success of these programs

27 Group Interview I, Xepache, 20 August 2015
remains unpredictable, midwives “may serve as a productive ground for synergistic collaborations between” the community and the biomedical healthcare entities.\textsuperscript{28}

As the healthcare of the midwives bridges their existing practices with insights from the biomedical community, health is redefined and reconceptualized in a ways incorporate the community’s conceptions of health. As the mothers at the bus stop and many others throughout the Palajunoj Valley explained to me, “many parts” frame their healthcare decisions. These many parts, which include stories of their grandmothers and other relatives, education programs, and their own experiences with healthcare systems, influence distinctions between healthcare systems. In this interplay between structure and culture, individual and communally-shared experiences with the efficacy of these healthcare entities inform culturally-ingrained beliefs and practices. In the case of midwives and hospitals, a combination of efforts to integrate the two systems, successes of these collaborations, and how community members shared stories of these successes, informed mothers of the efficacy of biomedical healthcare for childbirth. In the case of local illness categories in the Palajunoj Valley, perhaps similar collaborations between curanderas and clinics such as Primeros Pasos might supplement biomedical healthcare by recognizing and incorporating of alternative definitions of health, illness, and medicine.

\textit{Conclusions}

At many moments in my experiences in the Palajunoj Valley, I found – and continue to find – it difficult to grapple with and parse apart the different forms of health, healthcare, illness, and medicine. For example, I never was able to elucidate a coherent reason for why community members did not see doctors for \textit{mal de ojo}, nor did I ever determine the extent of how these

\textsuperscript{28} Chary et al., “The Changing Role of Indigenous Lay Midwives in Guatemala.”
decisions were informed by structural constraints on healthcare access. Health itself became extremely fragmented, in which healthcare was only a piece of the puzzle.

However, this diversity of voices and incoherence in conceptualizations of alternative healing in the Palajunoj Valley also demonstrate the incoherence of concepts of the “local,” “traditional,” and “indigenous.” I recall my early days with Primeros Pasos, and how I worked with doctors that regarded local illness categories as traditional, K’iche’ Maya, cultural categories that operated as simply different words for the same, universal illnesses.29 This assumption equated terms such as *mal de ojo*, *el chipe*, *susto*, and *lombrices* as synonymous for biomedical illness terms such as gastrointestinal parasites. Yet I also found from the community members of the Palajunoj Valley that these illness categories represented different definitions and conceptions of illness etiology and treatment options that biomedicine alone could not and had not addressed. Equating *mal de ojo* with gastrointestinal parasites disregards *mal de ojo* as a substantive illness that afflicts Palajunoj Valley, just as equating biomedical healthcare with universal healthcare disregards the healthcare infrastructure also in place to address illnesses such as *mal de ojo*. Furthermore, these assumptions and disregard of local, community health as a coherent category homogenizes histories of indigenous marginalization and different experiences with insufficient healthcare systems have shaped and developed these multivariate forms and definitions of health, illness, and medicine. The complexity of the voices that I engaged with reflects the complexity of these processes.

First, before taking clinical medicine, one needs to believe in its biological effects. That is how the medicine also has an effect on a person.30

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29 Interview with Primeros Pasos staff, Quetzaltenango, July 3, 2015
30 Interview E, Xepache, 30 July 2015
I conclude with this quote from a conversation I had with a NRP participant in Xepache, after another charla about breastfeeding. Rather gracelessly, I asked her why she believed the things that I, or any of the many temporary, foreign strangers from Primeros Pasos, talked about at these weekly charla sessions. In the case of breastfeeding, she told me that it was because these things worked. Health-related information such as this was passed between community members and across generations. The women at the bus stop in Xepache described how similar processes that included the stories of their grandmother, education, and both individual and communally-shared experiences had informed the increased use of hospitals for childbirth and women’s healthcare. Furthermore, just as experiences with mal de ojo and other local illness categories were passed down to embody knowledge about distinctions between these illnesses and other clinically-treatable illnesses, stories of improved health and well-being are also passed along and internalized. The apparent coherence of these distinctions, however, masks the complexity of the processes that undergird health.

In addition to its incoherencies, health in the Palajunoj Valley is, not a static entity, but rather a shapeshifting genre. Thus, the formal, theoretical framework of universal human rights runs the risk of operating in a way that might reconstitute authority by effectively staking claim to an specific interpretation of a right. A formal right to health loses its universal applicability as NGOs such as Primeros Pasos generalize an effective right to biomedical healthcare to include, and thus disregard, local conceptions of non-biomedical health, illness, and medicine. To participate in the health genre of the Palajunoj Valley, alternative meanings of health, such as biomedical definitions, must first conform to the structures and patterns of existing forms within this genre in order to improvise their own meanings and practices. Rather than a universally recognized, accepted form of health, biomedical health must be proven in a way that builds upon
and incorporates into existing forms of health. Thus, the mother I spoke with in Xepache did not believe in the clinical medicine I had grown up with. Rather, she had to be convinced of its efficacy.

I suggest that first, rather than claiming a right to distribute health and implement a certain system of healthcare, one needs to examine how and why the recipients of this intervention should believe in this particular method of addressing health. Rather than defining an all-encompassing, universal form of healthcare, this approach looks towards ways to make healthcare fluid and adaptable. The aim is not to make a certain form of health universal, but rather examine how to make this form contextual. That is how a framework of human rights might begin to take effect on the world.
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