



## Roles for Religious Institutions in Facing Guatemala's Healthcare Crisis

### HIGHLIGHTS

The Peace Accords signed in 1996 aimed to end Guatemala's devastating decades-long civil war and set the nation on a new and positive path. The government and its partners (which deliberately included religious institutions) promised to expand health coverage, notably to address deep inequalities and to serve the rural and indigenous communities that bore the brunt of violence during the war years. In large part through these partnerships with faith-inspired and non-governmental organizations, Guatemala's national health indicators have improved over the past 20 years. However, deep inequalities and institutionalized discrimination mean that universal accessible and affordable healthcare is far off. Changes in government, unpredictable and insufficient funding of the national healthcare system, and lingering distrust between the government and local communities have thwarted efforts. Political dynamics and corruption scandals have exacerbated ethnic and cultural divides. Religious approaches have special significance for the critical issues facing Guatemala on health, notably high maternal and child deaths, malnutrition, and teenage pregnancy. Religious institutions play vital, if largely unheralded, roles in healthcare, but in a piecemeal fashion. Large but unmeasured and largely unregulated religious health missions, many of them short term, fill important gaps but can undermine local capacity. Twenty years after the Peace Accords, it is time for a full assessment that takes religious partnerships into account.

### GUATEMALA'S HEALTHCARE SYSTEM AND ITS MAJOR CHALLENGES

Guatemala's current health system is a complex combination of long-established service delivery networks that survived conflict and civil war; initiatives reflecting health priorities in the 1996 Peace Accords; and recent government, partner, and private sector initiatives. The basic long-standing official health system assumes a largely government run system managed by the Ministry of Health (MOH). It is basically a four-tiered public health system: specialized hospitals at the national level; department hospitals at the regional level; health centers and health posts at the municipal level; and health posts and individual health promoters at the village/hamlet level. The Guatemalan Institute for Social Security provides insurance for formal sector workers, and the Military Health Service provides public health services. However, the three decades of civil war, beginning in the early 1960s, delayed and devastated plans for public healthcare and operation of existing facilities and, because the poorest regions with large indigenous (Maya) populations bore the brunt of war, longstanding health disparities became worse.

Some argue that the government deliberately curtailed services for Guatemala's rural indigenous population, as the indigenous Maya were seen to be aligned with guerrilla fighters.<sup>1</sup>

Although the Guatemalan constitution guarantees a universal right to healthcare, state healthcare is largely absent in rural and indigenous areas. Obstacles include physical security, frequent budget cuts, communication barriers with Spanish-speaking Ladino doctors, and challenges in reaching patients in isolated, largely indigenous communities. Guatemala has a severe shortage of health workers, with only 12.5 health workers (not including traditional birth attendants) per 10,000 Guatemalans, the lowest ratio in Central America.<sup>2</sup> In rural areas, the ratio is three health workers per 10,000 people; reasons for this disparity include low salaries and lack of recognition.<sup>3</sup> Thus, while the state in theory provides free or very low cost healthcare to the population, in practice, 52 percent of total health expenditures in Guatemala come from out-of-pocket expenses, the highest level of private expenditure as a proportion of total health expenditure among Latin American countries.<sup>4</sup>

## TWO GUATEMALAS

Guatemala (Central America's largest economy) is often described as two distinct countries: one for wealthy urban people—the richest 20 percent of the people receive 60 percent of the income—and one for the poor, who are predominantly indigenous and rural. Nearly half the population (15.5 million total in 2013) lives in rural areas and some 40 percent identify as indigenous.<sup>5</sup> Over half of the population lives below the national poverty line.<sup>6</sup>

Discrimination towards indigenous peoples is also deeply entrenched. Institutionalized during Spanish colonial rule and successive independent regimes, the divides between indigenous and non-indigenous Guatemalans were accentuated during the Civil War. Guatemala's Historical Clarification Commission that examined the conflict experience found that, of the estimated 200,000 who were killed or “disappeared” in the Civil War, 83 percent were indigenous. The Commission estimated that state forces were responsible for 93 percent of the atrocities committed in Guatemala. The conflict profoundly undermined the indigenous population's trust in the state.

Income inequality and discrimination affect health directly and indirectly. Poor Guatemalans have lower access to public services, including healthcare; barriers are exacerbated if the individual is indigenous and rural. Discrimination limits employment opportunities and increases stress, leading to negative health outcomes and driving conflict. The effect of being rural and/or indigenous in Guatemala nearly doubles the likelihood of being stunted, an indication of chronic malnutrition, which results in lower cognitive and physical abilities over the course of a lifetime, limiting an individual's earning potential and perpetuating an intergenerational poverty trap.<sup>7</sup>

Guatemala's private sector represents a large and growing segment of the healthcare market, including high-end tertiary hospitals, small specialty and general clinics and hospitals, individual practices, pharmacies, and traditional providers. Private sector services include both for-profit and nonprofit providers, including civil society organizations, faith-inspired organizations (FIOs), and local traditional providers. As of January 2015, 9,553 registered private health providers operated in Guatemala.<sup>8</sup>

Community groups, NGOs, and traditional healers fill gaps, but in a partial and patchwork fashion. Many charge for their services, limiting access for poorer families. MOH established a cadre of trained voluntary health promoters in the mid-1980s, using both Western and traditional healing practices. Their focus was on preventative rather than curative methods, encouraging these health promoters to refer patients to the public health system for treatment. While many community-based health promoters continue to practice independently of the public health system, they are an integral part of the effective health services available in isolated rural communities.

A significant but poorly documented feature of Guatemala's health system is short- and longer-term health-related missions from overseas, especially the United States. Guatemala is a target country for such missions, due to the country's poor

health situation and its proximity to North America. Missions, often hosted by NGOs founded by expatriates, cross the spectrum of healthcare delivery in terms of sophistication: Near the capital they host world-class surgeons that attract rich Guatemalans, while in rural areas they tend to focus on vaccination or basic service delivery.

## REFORMS TO ADDRESS HEALTHCARE CHALLENGES

The 1996 Peace Accords were an important landmark in the history of healthcare in Guatemala, emphasizing the state's responsibility to address poverty and foster civil society participation in policymaking, with particular attention to the needs of women, indigenous people, children, youth, the elderly, and people with disabilities. They included plans for a reformed healthcare system, which was to benefit poor, marginalized populations, primarily through the Expansion of Coverage Program (PEC), which aimed to provide primary health services to the country's rural population. The PEC program centered around mobile health teams consisting of a ministry doctor or nurse, an instructional facilitator who visited the community once a month, and community facilitators based at newly opened Convergence Centers close to the communities. MOH capitalized on the presence of civil society and faith organizations that had provided

primary care throughout the war years by entering into formal contracts with them for community-based service delivery. The first group of organizations contracted under PEC were all affiliated with the Catholic Church: the parish of Santiago Jocotán; the dioceses of Jalapa and Santa Rosa; the Elizabeth Setón Dispensary in Baja Verapaz; and the Foundation for the Development and Education of Indigenous Women in Alta Verapaz. PEC grew rapidly from three departments in 1997 to 20 out of 22 departments in 2012, increasing coverage from 0.46 million in 1997 to 4.3 million people in 2012.<sup>9</sup>

Guatemala's partners, including the Inter-American Development Bank, USAID, and the World Bank, lauded the PEC program for reaching vulnerable populations through an innovative public-private partnership model. However, constant disagreements between the contracted NGOs and the government undermined the program: MOH claimed that NGOs were not meeting the service delivery targets, while the NGOs claimed that they were unable to deliver services because they were not paid in a timely manner by the government, which was prone to frequent budget cuts and reallocations.<sup>10</sup> Funding levels and the overall approach to the program fluctuated with each new administration. In 2008, in an effort to institutionalize healthcare within MOH, President Alvaro Colom reduced funding to the PEC program and canceled contracts with NGOs that had previously overseen the Ministry's mobile health teams. This measure was reversed during the administration of Otto Perez Molina in 2012 and funding was renewed as part of his Zero Hunger campaign. The program, however, faced many accusations of inefficiency and complaints of a lack of transparency in the award of PEC contracts to NGOs. Delivery of sub-quality care to indigenous populations was another concern. Ministry officials reported that the per capita cost of providing services through PEC was three times higher than providing them through Ministry facilities.<sup>11</sup> In 2013, new legislation prohibited the outsourcing of healthcare services to NGOs. By the fall of 2014, the MOH had cancelled contracts with more than 80 NGOs and a vast network of 26,000 community health workers and closed the Convergence Centers. These moves disrupted primary healthcare services for some four million Guatemalans.

The Guatemalan government has since developed several plans to address healthcare gaps. In 2014, the whole-of-government development strategy, called the K'atun, emphasized the needs of the Maya and rural populations. Ambitious goals include reducing chronic malnutrition by at least 25 percent, reducing the maternal mortality rate by at least 5 percent annually, and eliminating teen pregnancy for girls under 16 years by 2032. The MOH Strategic Plan for 2014-2019 highlights a new "Strategy for

the Institutional Development and Strengthening of the Primary Level of Care" to replace the PEC. It calls for the identification of health "territories" of approximately 5,000 inhabitants each, and the establishment of one or more health posts in each territory (making use, in some cases, of the Convergence Centers established under the PEC). MOH expects to achieve coverage of more than five million people nationwide, especially in rural areas that were previously covered under the PEC.

Implementation of these plans has been problematic and, in late 2015, Guatemala's chronic budgetary crisis spilled over into the public healthcare system. Guatemala spends about 2.1 percent of its GDP on healthcare (one of the lowest in Central America).<sup>12</sup> The largest public hospital, which was \$100 million in debt, shut down all but emergency services in November 2015, claiming it could no longer afford to pay medical personnel.<sup>13</sup> President Jimmy Morales said that Guatemala could run out of vaccines by April 2016.<sup>14</sup> A successful tele-health program that the ministry promised to finance stalled because of budget problems. On July 19, Guatemala's health minister, Alfonso Cabrera, submitted his resignation over the ongoing health crisis.

## WHAT DO HEALTH INDICATORS TELL US?

In the early 1990s, Guatemala was among the countries with the worst health and nutrition indicators in Latin America.<sup>23</sup> It made the least progress in health indicators in the Western Hemisphere between 1974 and 1994, the years of most intense conflict in the Guatemalan Civil War.<sup>16</sup> Indigenous populations were most affected, both through neglect and because lack of trust impeded even well-intentioned programs to expand health coverage.

The 2014-2015 Demographic Health Survey (DHS), published in early 2016, reflects improvement in almost all indicators since the previous DHS (2008-2009).<sup>17</sup> This progress likely can be attributed to foreign assistance earmarked for health, as well as campaigns by the MOH such as the Zero Hunger Pact to target malnutrition.<sup>18</sup> However, progress falls well short of plans and targets. Table 1 shows that Guatemala did not meet any Millennium Development Goal (MDG) health target. In effect, they reflect the absence of a coherent national plan.

## CURRENT HEALTH CHALLENGES

*Guatemala has the second highest rate of maternal mortality* (140 deaths per 100,000 live births) in the Western Hemisphere, behind Haiti (380 deaths per 100,000 live births in 2013), where GDP is five times lower than Guatemala.<sup>19</sup> Guatemala will not meet the MDG target of only 67.5 maternal deaths per 100,000 live births

until at least 2025.<sup>20</sup> Current overcrowding of hospitals means that women are sometimes discharged within 24 hours of giving birth, which can lead to complications. Most maternal deaths are concentrated among poor, indigenous women in the rural Western Highlands. Indigenous women are twice as likely to die in childbirth (163 deaths per 100,000 live births) as non-indigenous women (77.7 deaths per 100,000 live births), and rural women (66 percent of all maternal deaths) are twice as likely to die in childbirth as urban women (33 percent of all maternal deaths).<sup>21</sup> This pattern reflects different rates of institutional delivery for the subgroups: less than half of all births by indigenous mothers are assisted by a trained medical professional (doctor or nurse) in a health facility, compared to 80 percent of births by non-indigenous mothers.<sup>22</sup>

Differences in culture and access contribute to disparities. Many indigenous women prefer to give birth at home in the presence of family and assisted by a *comadrona*, or indigenous midwife. A commonly held perception in indigenous communities is that people go to the hospital only to die. Nearly half of all maternal deaths occur in public hospitals.<sup>23</sup> For this reason, Maya women often trust churches or NGOs to provide health

care rather than the government. MOH, however, does not view *comadronas* as “qualified” practitioners and promotes institutional delivery. In 2006, the government recognized the need to incorporate *comadronas* into the public health system and began offering training. With the emphasis of non-discrimination in the Peace Accords, public health facilities began allowing indigenous women to choose more culturally-appropriate birthing processes, including being accompanied by a traditional birth attendant or family member to the health facility or hospital, use of traditional teas, and choice of birthing position. These practices, however, have yet to be consistently implemented in all public health facilities.

*Although childhood deaths have declined by almost half in the past ten years (from 51 to 28 deaths per 1,000 live births for children under one year and from 68 to 35 deaths per 1,000 live births for children under five), rates are still high for two subgroups: those born to mothers with no education and those born to poor families. Being born to these subgroups increases the risk of death within the first month of life by 40 percent (from 17 to 24 deaths per 1,000 live births), within the first year by 50 percent (from 28 to 42 deaths per live births), and within the first five years by 60 percent (from 35 to 56*

**Table 1. Health Statistics in Guatemala and Central America compared to MDG Targets**

Health Area	Indicator	Guatemala DHS <sup>24</sup>				MDG Target <sup>25</sup>	Central America Region*
		1995	2002	2008-2009	2014-2015	2015	Recent Average <sup>26</sup>
Maternal Mortality	Deaths per 100,000 live births	155	N/A	N/A	140	67.5	112
Infant Mortality (under-one mortality)	Deaths per 1000 live births	51	39	30	28	20	19
Child Mortality (under-five mortality)	Deaths per 1000 live births	68	53	42	35	27	23
Malnutrition Prevalence	% of children under 5 underweight (weight-for-age)	22	17	13	13	11	6 <sup>27</sup>
Contraceptive Prevalence	% of women ages 15-49 that use at least one FP method	32	43	54	61	95	62

\*Central America region is comprised of Belize, Costa Rica, El Salvador, Guatemala, Honduras, Nicaragua, and Panama.



deaths per 100 live births), compared to the national average.<sup>28</sup> Infectious and parasitic diseases and respiratory infections, all attributable to unsanitary and poor living conditions, are the leading cause of early childhood deaths.<sup>29</sup>

*Malnutrition is a critical problem.* Some 47 percent of all Guatemalan children are chronically malnourished and 17 percent are severely chronically malnourished (falling three standard deviations below the mean of the reference population).<sup>30</sup> Chart 2 illustrates the challenge. Guatemala has the highest prevalence of stunting in the Americas (compared to the regional average of 14 percent in 2010) and the sixth highest in the world (global average of 26.7 percent in 2010).<sup>31</sup> In some areas, 90 percent of children are chronically malnourished. Nearly twice as many indigenous children (61 percent) are chronically malnourished compared to Ladino children (35 percent), but chronic malnutrition pervades all of Guatemalan society.<sup>32</sup> Researchers have tracked severe chronic malnutrition to areas where the Civil War was most fierce, linking pervasive stunting in these areas to issues of political will, rather than simply a lack of food.

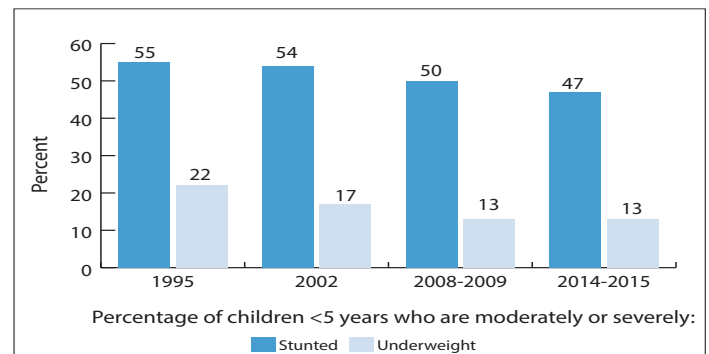
*Pregnancy among adolescent girls in Guatemala is, by international comparison and in public opinion, a grave social problem.* It is linked to high rates of illegal abortion and single motherhood. The DHS found that one out of five teen girls ages 15 to 19 are currently pregnant or had already given birth at least once. By age 19, nearly half of all Guatemalan girls have been pregnant at least once. The likelihood of pregnancy increases for those teen girls in the poorest quintile, who are three times more likely to become pregnant than their peers in richest quintile. There are large differences in teen pregnancy rates for different levels of education: Teens with no education were seven times more likely to become pregnant than their counterparts enrolled in university.<sup>33</sup> These statistics are related to the low rate of contraceptive use nationwide.

Guatemala's MOH also confronts two issues of growing international concern: *increased scrutiny of corruption and the Zika virus epidemic.* Following the unveiling of the La Linea corruption scandal, which led to the resignation and arrest of both the president and vice-president of Guatemala in 2015, the UN and the Public Ministry uncovered a fraudulent scheme within Guatemala's Social Security Administration. The Director of the Administration had awarded contracts to select pharmaceutical companies for personal kick-backs, selecting which companies' products made it in the essential medicines package for public hospitals, including expired drugs, which contributed to unnecessary deaths and illness.<sup>34</sup>

The Zika virus presents new challenges. As of April 2016, the Pan American Health Organization confirmed nearly 200 cases of Zika in Guatemala, including 40 pregnant women, and over

900 cases suspected. Zika is linked to microcephaly (abnormally small skulls and brains) in babies born to infected mothers.<sup>35</sup> On August 17, 2016, the first Guatemalan baby with Zika-linked microcephaly was born in the country.<sup>36</sup> MOH plans involve eliminating mosquitos and disseminating bed nets to pregnant women, but the outbreak highlights Guatemala's inadequate public health system and its inability to prevent and contend with emergencies.

**Chart 2. Underweight and stunting prevalence for children under five years**



Source: Guatemala DHS 2014-2015.

## HEALTH AND RELIGIOUS ENGAGEMENT

Guatemala's high religiosity and mix of traditional and Christian beliefs (see box) affects how healthcare services are structured, delivered, and perceived, which in turn affects health outcomes. For health, three leading influences are the Catholic Church, with both historic and contemporary roles in service delivery and influence on public policy; Protestant churches, notably the evangelical churches whose influence has increased rapidly in recent decades; and the indigenous, principally Mayan, culture and belief systems that have great importance for indigenous populations. The interactions between health and religion in both policy formulation and service delivery have positive results in some instances (filling gaps left by the public health system), and negative in others, notably creating barriers to reproductive healthcare.

The PEC program launched in 1996 built on the presence of churches in hard-to-reach communities by establishing contracts with four faith-inspired organizations to deliver primary healthcare. Ten years later, the program had expanded to include non-Church affiliated organizations, but religious providers were significant, including Catholic Relief Services (CRS), Christian Children's Fund, and the Missionaries of the Sacred Hearts of Jesus and Mary. After the PEC programs closed, many faith-inspired organizations (FIOs) continued to provide primary healthcare services, without funding from the Guatemalan

government. International partners have engaged several international donor FIOs to implement development programs to supplement the weakened public health system. Examples (among many) include: USAID support for CRS and the United States Catholic Conference of Bishops for a food security program that distributes food commodities to approximately 10,500 families and promotes the adoption of improved health and nutrition practices in the Western Highlands;<sup>37</sup> in response to the Zika outbreak, World Vision supports MOH on a behavior change communication campaign designed to prevent further outbreaks and has donated mosquito repellent and bednets; and in response to the 2016 MOH budgetary crisis, the Church of Jesus Christ of Latter Day Saints donated 254 wheelchairs for use in 44 of Guatemala's public hospitals.<sup>38</sup>

Appreciating how traditional beliefs around health influence contemporary Maya practice has particular importance in addressing Guatemala's healthcare challenges. To illustrate, Maya beliefs center on the need to maintain a balance of heat and cold in the body, which can be disturbed by the presence of metaphysical entities within the body. Illnesses tend to be seen as either natural—that is, an illness caused by interaction with nature—or supernatural, that is, an illness caused by someone else, often through witchcraft. For instance, infants that cry frequently or have diarrhea are believed to have been afflicted with the evil eye, which is attributed to contact with someone or something with excessive heat, including animals mating or a jealous woman. People often look to traditional healers, who use a combination of medicinal plants, prayer, and ceremonies to rid the body of illness. Healers, who may be male or female and include traditional midwives, are believed to be chosen by God yet often maintain additional roles such as mothers and housewives.<sup>40</sup>

The growth of evangelical churches in Guatemala has affected the Maya community's understanding of health. Maya Catholics have tended to hold to the traditional belief of human witchcraft as the primary cause of illness, whereas Maya Protestants may see illness as caused by sin, the Devil, or not being Christian. They may believe that a person can be healed if he repents or accepts God into his life. Faith healing, including free and accessible prayer and guidance from Pentecostal, Protestant, and Charismatic Catholic leaders, can take the place of traditional healing, especially when modern clinics and hospitals are inaccessible.<sup>41</sup>

The Catholic Church runs hospitals and clinics and sits on the boards of sector-coordinating bodies. It also has an

## GUATEMALA'S RELIGIOUS LANDSCAPE

The Catholic Church, introduced to Guatemala by Spanish colonizers, was a powerful and leading social, political, and economic institution with pivotal roles in shaping social policy, including health care, through the late twentieth century. Once the overwhelming religious powerhouse in the country, the Church's influence and number of followers have declined in the past several decades (now less than 50 percent of the population); two factors in this decline were persecution of priests and Catholic-affiliated groups during the Civil War and the rise of Evangelical Christianity. Today over 40 percent of the population identifies as Protestant, including Evangelicals.<sup>39</sup> Many Maya identify as Catholics but traditional spirituality still influences beliefs and practice.

especially visible presence in Guatemala's public health policy on family planning approaches. In the 1960s, in reaction to the high maternal mortality ratio caused by unsafe abortions, the Guatemalan government began to consider increasing access to family planning commodities. However, following the publication of the encyclical *Humanae Vitae* in 1968, where the Vatican opposed the use of contraceptive methods other than "natural" methods, the government of Guatemala restricted access to family planning methods. In the late 1970s, the MOH, under pressure from the Catholic Church, interrupted the family planning program completely and ordered the removal of all intrauterine devices from women that had been provided through MOH facilities.

After the evangelical-based Guatemalan Republican Front came to power in 2000, the conversation shifted. Senator Zury Rios, daughter of former President Rios Montt, worked alongside the United Nations Population Fund to pass the Social Development Law in 2001, which created the National Reproductive Health Program and expanded access to family planning commodities. While all prior legislation involving reproductive health had been blocked by the Catholic Church, the Catholic bishops supported the Social Development Law, which was framed as a strategy to reduce infant and maternal mortality, rather than expand family planning access. Alejandro Silva, director of Guatemala's National Reproductive Health Program, maintains that there have since been fewer major conflicts with the Church on public reproductive health policies, including family planning and sexual education.<sup>42</sup>

Uptake of modern family planning methods is still relatively low. It is influenced to varying degrees by religious and traditional beliefs. The recent DHS survey covering 2014 to 2015 shows a contraceptive prevalence rate for married and coupled women of 61 percent, with 49 percent using a modern method and 12 percent using a traditional method like the rhythm or withdrawal methods (the latter are considered natural family planning and are thus acceptable in the eyes of the Catholic Church). In the heavily indigenous area of Sololá, use of traditional methods reaches 23 percent (compared to 30 percent using a modern method). The most commonly used modern family planning method in Guatemala is female sterilization (21 percent of all married or coupled women are sterilized), a permanent choice usually made by women who have already had several children.<sup>43</sup> Among the Maya population, beliefs like the idea that birth control pills and injections can make women sick or impotent or can cause cancer limit uptake of modern family planning methods.<sup>44</sup> Maya have a spiritual connection to the process of birth; some view family planning as commensurate to “killing children.”<sup>45</sup> There are, however, unmet needs for family planning; the DHS found that 14 percent of coupled or married women of reproductive age are not using a form of modern family planning but want to limit or space births. This unmet need is highest for the youngest group of women (22 percent of 15 to 19 year olds) and the poorest quintile (23 percent).<sup>46</sup>

Guatemala’s maternal mortality rate is higher than its poorer neighbor, Honduras. Lingering effects of civil war and religious restrictions on family planning play significant roles. The Catholic Church, for example, in 1995, blocked a maternal health survey designed to draw attention to the high risks of giving birth. In Maya communities, where maternal mortality is especially high, maternal deaths are often attributed to witchcraft, attracting the evil eye, other conditions like a heart attack, the mother having a poor relationship with God, or having committed other sins. The main causes of maternal mortality like hemorrhage are not well understood by either the communities or the traditional midwives, and thus transportation of a laboring mother to a hospital is often delayed until it is too late.

The HIV/AIDS epidemic in Guatemala, as in most of Central America, is concentrated among most-at-risk populations, including sex workers, men who have sex with men, and intravenous drug users. The prevalence rate for adults aged 15 to 49 in 2014 was 0.5 percent of the total population or about 49,000 people.<sup>47</sup> The most recent DHS explored comprehension of HIV prevention within the population: Knowledge about how to prevent HIV transmission doubles between the lowest and highest brackets for income and education for both women and men, indicating that the poorest and least educated are most at risk for new infections.

For youth (ages 15 to 24), knowledge about HIV/AIDS is twice as high in urban than rural areas for both men and women. The DHS noted that the three most common misconceptions among beliefs regarding HIV transmission were that infections could occur through mosquito bites, sharing food, or supernatural forces.<sup>48</sup> Misconceptions may persist given that many organizations do not address prevention, other than teaching abstinence and fidelity. For example, a recent study on FIO activities in Central America found that most FIOs focused on care and treatment activities, such as providing counseling and hospice/shelter to people living with HIV/AIDS, rather than on prevention activities.<sup>50</sup> The Proyecto Vida project, led by Maryknoll nuns, emphasizes that abstinence and fidelity are the best ways to avoid infection but will discuss condoms as a last resort.<sup>49</sup>

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