AN ANALYSIS OF THE NATURE AND EXTENT OF REHABILITATION IN GUATEMALA

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ABSTRACT

AN ANALYSIS OF THE NATURE AND EXTENT OF REHABILITATION IN GUATEMALA

by John Charles Toth

In many underdeveloped countries of the world today, the prevalence of disabilities resulting from diseases and accidents has created a major health problem. This is especially true when disabilities result in lifelong handicaps and forced dependencies. In an effort to understand the problems faced by underdeveloped countries, the present study was designed to investigate the nature and extent of rehabilitation practices in the Central American Republic of Guatemala.

The study began with a preliminary investigation to obtain some rudimentary knowledge regarding current rehabilitation facilities and practices. The resultant information helped in planning the methodology and selection of the population to be studied.

The data in the present study were obtained through structured interviews, observations, examination of records and a Personal Information Inventory. Eight institutions in Guatemala were found to have rehabilitation programs; all were included in the survey. The information obtained from each institution was organized under the following headings:

1. History and Development
2. Administration and Organization
3. Finance
4. Facilities
5. Personnel
6. Programs and Services
7. Clientele.

The data were analyzed for each institution after which a general overview of rehabilitation in Guatemala was prepared.

The results of the survey indicate that organized rehabilitation in Guatemala began about fifteen years ago and is still in the developmental stage. It began through the efforts of a few local physicians who received post-doctoral training in foreign countries. This gave early rehabilitation programs a medical orientation which still exists today. The training of the rehabilitation personnel determines the quantity and quality of the services. The training and competence level of the professional rehabilitation personnel may be listed in the following order of decreasing competence: physiatrists and other medical specialists, prosthetists, physical therapists, social workers, occupational therapists, vocational instructors, psychologists, and vocational rehabilitation counselors.

Rehabilitation institutions have three major sources of income: the Social Security Administration, government

allocations, and public lotteries. The Social Security Rehabilitation Hospital is the most complete rehabilitation institution in Guatemala and has the best financial support, although realistically it is inadequate for the services rendered. It provides excellent medical, physical therapy, prosthetic, occupational therapy, and vocational training programs.

Most of the physical facilities of the institutions in Guatemala are old and inadequate, and all of the institutions, except one, are located in buildings that were built for other purposes.

Many of the handicapped presently receiving rehabilitation services are farm laborers who are unable to pay for protracted treatment. The nature of the medical profession, clientele, and the socio-economic structure of Guatemala influences the development of rehabilitation programs.

Generally speaking, all of the rehabilitation programs and services are inadequate and only a fraction of the handicapped individuals in Guatemala receive services. However, rehabilitation is rapidly developing and considerable improvements in the quantity and quality of the services may be expected within the next few years.

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To my wife, Gladys,

and sons, Norman and Nolan.

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CHAPTER I

INTRODUCTION

There are millions of men, women, and children throughout the world today who are facing life with some serious mental or physical disability. Many of them have been disabled since birth while others are victims of diseases or accidents. The nature of their disabilities and handicaps are described by various medical and paramedical terms such as blind, deaf, paraplegic, retarded, and psychologically maladjusted. Their handicaps began with a disability and then became greater as the individual realized that he could not obtain gainful employment, assume customary responsibilities or otherwise function as a normal member of society.

In many countries the prevalence of diseases and accidents of man and nature have become a matter of national concern and a major health problem. This is especially true when disabilities result in lifelong handicaps and forced dependencies. The burden of dependency in a relatively large segment of society may significantly contribute to a country's poverty and relative backwardness. From the social and economic point of view, a waste of manpower is a matter of grave concern, not only because of the loss of productive capacity, but also because of the added burden imposed upon the rest

of the population. These facts are now being recognized by a number of underdeveloped countries which are presently attempting to lift themselves and bring about an industrial revolution (55).

Since physical disabilities know no geographical, racial, linguistical or political boundaries, the field of health and rehabilitation may be a uniquely effective area of service in improving international understanding. Health and the rehabilitation of the chronically handicapped are fundamental to the prime democratic concept of equal opportunity and social justice for all. A country in which good health is enjoyed only by a minority cannot be politically or economically stable. Good health is a prerequisite for economic self-sufficiency and good government. People who are sick, crippled, or otherwise disabled have difficulty in seeking human rights and the principles of democracy and freedom. Citizens can enjoy the fruits of their labor only if they work and become customers for the goods they, and the rest of the world, produce. Ill health, poverty and bad government are circular; they generally foster the existence of each other.

Assisting these countries to develop effective rehabilitation programs may be one way of helping to break this circle of unfortunate events. This is true especially since rehabilitation involves much more than medical treatment. It may include a variety of necessary services to integrate each

handicapped person into society. Services in addition to medical restoration may include vocational training and education--factors which are also essential to good government.

The disability areas that need the most attention differ from one country to another. It depends largely upon national occurrences such as wars, occupational hazards, and various disease incidences and epidemics. Rehabilitation programs and services are generally planned to meet the immediate pressing needs of the particular country.

Until comparatively recent times, efforts in the development of rehabilitation programs in most underdeveloped countries have been of a circumscribed nature.

It is important to remember that the very nature and conditions of underdeveloped countries indicate that they are lacking in rehabilitation resources. They lack wealth to invest in medicine, education, technology, and community services. They concentrate their efforts and limited financial resources on economic development such as manufacturing, industrial processing, transportation, and other wealth-generating activities. As a result, health and rehabilitation programs receive relatively small amounts in the national budgets. Privately operated institutions are also unable to adequately finance themselves because of the generally depressed economy. However, the fact that the need for rehabilitation exists cannot be obscured.

Today, the picture is changing as many of these

underdeveloped countries are struggling to develop complete and adequate rehabilitation programs for their handicapped. This need is pressing for expression and the time is right in many of these countries to develop their rehabilitation programs.

An Overview of Guatemala

The present study was directed toward obtaining information regarding current rehabilitation provisions in Guatemala. However, to more fully understand the conditions and problems in Guatemala, it is first necessary to become familiar with the country in general.

Geography

Guatemala is bounded by Mexico to the north; British Honduras, Honduras, and the Caribbean Sea on the east; and El Salvador and the Pacific Ocean on the south and west. Guatemala has an area of 108,889 square kilometers and is approximately the size of the State of Ohio. This area does not include Belice (British Honduras) which is claimed by the Guatemalans. It is the third largest Central American Republic and has the largest population. Geographically it may be divided into three regions: (1) the Pacific Coast flat lands; (2) Central highlands; and (3) the Jungles of Peten. The Pacific Coast area is mostly farmland and is generally owned by large "finca" operators. It has roads and a railroad for the transportation of produce to the port

of San Jose and to Guatemala City which is located in the highlands 4,850 feet above sea level. The Jungles of Peten are virtually uninhabited and undeveloped (19:657, 30:213).

Population

The estimated population of Guatemala in December, 1960 was 3,822,233. This figure is a projection from the last national census which was taken in 1950. If the population were evenly distributed over all of the land, there would be thirty-five persons for each square kilometer. However, this is not the case since the entire country is very unevenly populated. The country is divided into twenty-two Departments: the three most heavily populated are Guatemala, with 283 persons per square kilometer, Sacatepequez with 167, and Quezaltenango with 126. The three least populated Departments are Peten with one person per square kilometer, Izabal with nine and Quiche with twenty-nine (10:31).

The city of Guatemala is the capital of the Department of Guatemala and is the seat of the national government. It has a population of about 400,000 (6:3).

The people of Guatemala live in a highly stratified society with a relatively large lower class and small middle and upper classes. People may be clearly contrasted in many ways--for example, by the type or absence of shoes, clothing, language, color of skin, education, employment, mode of transportation, diet, house and property, ancestry, et cetera. It is estimated that 71.9 per cent of the population is

illiterate and 73 per cent live in rural areas (10:35, 17:121).

Sixty per cent of the population are pure Indian; 35 per cent are ladinos, i.e., a mixture of races and cultures; and 5 per cent are of pure Spanish ancestry (19:658). The only Negroes in Guatemala are those who have migrated in from Belice in order to find employment; however, they constitute an insignificant percentage of the total population. British Honduras is claimed to belong to Guatemala by the Guatemalans; therefore, Negroes are considered citizens of Guatemala.

The religion of most Guatemalans is Roman Catholic, but all creeds are granted freedom of worship. Many Indians supplement their Christian faith with pagan rites and beliefs. The official language is Spanish; however, thousands of Indians speak only their native dialects.

Civil Heritage

The history of Guatemala is rooted primarily in the Mayan civilization which had its beginning over 1,000 years before the discovery of America. The Mayan civilization occupied an area comprised of Chiapas, Tabasco, Campech, Yucatan, and Quintana Roo in today's Mexico and almost all of the territory of Guatemala including Belice and the extreme western part of Honduras. Some archaeologists estimate that the Mayan civilization existed from about 400 B.C. to 1500 A.D. These dates span a period of years during which time the Mayans developed their highest level of civilization. However, it is questionable if such an advanced culture could

have developed entirely in such a short period. The actual beginning date of the Mayan civilization is not known at the present. The Mayans could record time and they knew the length of a single lunation (29.52 days) and the tropical year (365.24 days). These facts and their demonstrated ability to build huge temples, palaces, and use the concept of zero, indicate that the Mayan civilization had a relatively long developmental period. The Gregorian equivalent of the beginning of their calendar is October 14, 3373 B.C.; however, on the basis of other evidence, most archaeologists do not accept such an early date (33:17-48).

The apogee of the Mayan civilization was between 700 and 1000 A.D. (after which time the civilization began to decline). Reasons for its decline and ultimate collapse are not known with certainty; however, civil wars, social decadence, food shortage or epidemics may have been etiological factors. Gradually the Mayan civilization was infiltrated by the Mexicans who brought new leaders, causing a dilution of both cultures. The Mexican-Mayan mixture led to a compromise and the formation of the League of Mayapan. The new Mexican-Mayan dynasty flourished until a great civil war broke out between the two cities of Chichen-Itza and Mayapan in the year of 1194 A.D., marking the end of the "golden age" of the remarkable Mayan civilization.

Incessant warfare against each other and continued disorganization caused them to be easy prey for the Spanish

conquistadores of 1524-1546. The conquest, under the leadership of Don Pedro de Alvarado, swept through Guatemala and moved down Central America to Panama. The Spanish consolidated and set up the kingdom of Guatemala which covered all of present-day Central America and the southeastern parts of Mexico.

On September 15, 1821, Guatemala declared its independence from Spain and annexed to the newly formed Mexican Empire under the rule of Agustin de Iturbide. This lasted only until 1823 at which time Guatemala became a part of the United Provinces of Central America. The Federation collapsed in 1839 after which Guatemala formed its own independent government (33:49-83).

Political History

Since the Guatemalan declaration of independence, its history has been one of gradual and intermittent progress--politically, socially, and economically. There has been a long series of dictatorships interspersed with bitter factional turmoil and resistances. In 1944, a popular revolution suddenly broke down the political, economic, and social structures of the regime of General Ubico. A subsequent regime headed by an exiled school teacher, Juan Jose Arevalo, opened the door to communism and the communists gained control of the most important governmental positions. The communists lost control June 18, 1954 to the exiled anti-communist leader, Castillo Armas. On July 3rd of the same year

Castillo Armas became president of the governing Junta. During the following period the United States furnished substantial economic aid to Guatemala in order to help establish a democratic form of government. Castillo Armas was assassinated on July 26, 1957, and a period of political uncertainty and instability followed, during which time two interim presidents ruled (19:667, 7:231, 55).

General Ydigoras was elected president and took office on March 2, 1958. He renewed relations with the United States and upheld the constitution of 1956 which states the separate powers of the executive, legislative, and judicial branches of the government. As this constitution was written, but not necessarily practiced, it outlined a representative form of government. This may be seen from the translations from Title 1 quoted below (36:1).

Title 1, Article 1.

> Guatemala is a sovereign, free and independent nation, established for the purpose of guaranteeing to its inhabitants respect for human dignity, enjoyment of the fundamental rights and liberties of man, security and justice, to promote the complete development of culture, and to create economic conditions which are conducive to social well-being.

Title 1, Article 2.

> The system of government is republican, democratic, and representative.
>
> Sovereignty rests with the people, and power is exercised by legislative, executive, and judiciary bodies, which are not subordinate one to the other.
>
> The functions and powers of state bodies are governed by this Constitution, and officials are

> not owners, but mere depositories of authority, responsible for their official conduct, subject to and never above the law.

Numerous unsuccessful attempts were made to remove Miguel Ydigoras Fuentes from the presidency. Early in 1963, a few months before the end of his term of office, the Guatemalan Army defected and the office of the presidency was replaced by an Army Coup. The motivating force behind the removal of Ydigoras as president was the threatened rightist factions who thought former president Arevalo would be permitted to return to Guatemala. Juan Jose Arevalo had announced earlier that he would be a candidate for the presidency in the forthcoming elections.

Economic Development

Economic activity in Guatemala is currently leveling off or declining to some extent. For three years after the fall of the communist Arbenz regime, high coffee prices, strong United States economic aid, and considerable new business investment created active rising economic conditions. Subsequent price reductions in the world coffee market (Guatemala's chief export), less United States economic aid, the completion of road building and other projects which put many workers into the labor market, and graft may have caused a general economic slowdown. The government was slow to readjust to the new economic conditions and an acute cash shortage developed that caused delays in the meeting of payrolls and other obligations by the government. This cash

shortage caused internal stress, discontent, and political unrest which resulted in periodic demonstrations, strikes, and revolutions. These uprisings were believed to have been incited by leftist groups who knew how to capitalize upon prevailing conditions. However, none of these uprisings were successful to the point of bringing about any major governmental reforms (55, 19:667, 7:231).

The overall long term economic trend in Guatemala is upward and is relatively strong. Guatemalan money has been on a par with that of the United States for over thirty years except for recent 2 to 4 per cent discounts caused by legislation restricting the outflow of money (53:246). The Guatemalan government is currently seeking ways and means to stimulate the economy. Various public works projects, such as building roads to open up new areas to commerce and agriculture, fostering economic interaction with neighboring republics, increasing revenues by broadening and enforcing income tax, and high import taxes, are some of the current measures being taken to improve economic conditions.

The Guatemalan national economy is largely based upon agriculture. Industry is limited chiefly to the processing of agricultural products, principally textiles and leather. Industrial processing is also provided for the production of cigarettes, cement, beverages, furniture, soap, plastic products, tires, soluble coffee, plywood, and recently added petroleum products (55, 17:121, 19:656).

Principal exports include coffee, bananas, chicle, abaca, sugar, cotton, and timber. The three exports of coffee bananas, and cotton comprise 90 per cent of the country's total value of exports (17:121, 19:667).

Leading imports in Guatemala are petroleum products, clothing, processed foods, and steel manufactures such as cars, trucks, and various types of machinery (8:45-332).

Occupational Structure

Guatemala is one of the many countries of the world that may be classified as economically underdeveloped. The average worker has a very low income derived principally from agriculture. Their agricultural techniques are relatively old and not based upon modern scientific technology. This does not imply that all Guatemalans are poor; it only indicates that the majority of the people live under substandard conditions. Like many other Latin American countries, Guatemala has striking social and economic contrasts between a few rich and middle class and the many poor. Industrial revolutions in the other parts of the world have had little effect in Guatemala, especially outside of the capital city. Production for domestic consumption as well as for export has predominantly been of an agricultural nature. Corn is the principal crop grown throughout the country, although it is not exported. Coffee is the chief commercial crop and it accounts for about three-fourths of the total value of exports (56:85).

The wealthy people are mostly large land (finca) owners and may also have business enterprises in Guatemala City or hold high positions in government or industry. These "finca" operators provide employment for the majority of the working population.

The small middle class in Guatemala is composed of such occupational groups as white collar workers, highly skilled industrial workers, shop keepers, large farm (finca) managers, average sized "finca" operators, school teachers and other professional groups. Members of the middle class are too few to have much influence on economic or government policies although they do provide an element of threat to some of the upper class, especially since their number is steadily increasing.

Approximately 70 to 80 per cent of the population belong to the lower class. Most of them are illiterate farm laborers who have very low incomes or they are subsistence farmers who supplement their income with household handicrafts. The proportion of these people is so large that it holds down the average per capita income of the nation. Guatemala ranked fifth from the bottom among sixteen Latin American countries in 1957, with an annual per capita income of only sixteen dollars (56:87, 43:22). Farm and road construction laborers receive from forty to sixty cents a day. According to the last census (1950), 68 per cent of all economically active persons over the age of seven were

engaged in agriculture (Table 1).

Table 1. Occupational Classification of Workers Seven Years of Age and Over, 1950

Type of Occupation	Number of Employees	Per Cent
Agriculture	659,550	68.2
Manufacturing	111,538	11.5
Domestic services	43,755	4.5
Non-domestic services	51,950	5.4
Commerce	52,561	5.4
Construction	26,427	2.7
Transportation and communication	15,352	1.6
All others	6,681	.7
Totals	967,814	100.0

Health Conditions

The level of living conditions in a country may be quite accurately estimated from the health standards and mortality rates. The Guatemalan infant mortality rate in 1955 was 101.4 per 1,000 live births. The seriousness of this figure can be vividly appreciated when it is realized that between one-fourth to one-fifth of all Guatemalans who die are infants under one year of age. Children under five

constitute 51.2 per cent of all deaths (56:215). Even these figures may be too low since many births and deaths are not registered or reported. Only about 5 per cent of all births in the country occur in hospitals and only 13 per cent of all deaths are certified by physicians (32:112).

The limited statistics available indicate that the principal causes of infant mortality in Guatemala are diarrhea, enteritis, intestinal parasites, malaria, bronchitis, and pneumonia. Inadequate sanitation, lack of medical facilities, malnutrition, and poor housing are all contributing factors to the prevalence of these diseases.

Perhaps the best illustration of the nature of Guatemala's health problems may be found in the percentage of deaths due to infectious and parasitic diseases. Most of these diseases could be eliminated with proper sanitation and medical care. Infectious and parasitic diseases are responsible for about one-third of all deaths in Guatemala. In the United States, only about 2 per cent of the total deaths are due to these diseases (56:218).

Many of the health and disease problems in Guatemala probably result indirectly from malnutrition due to deficiencies in animal protein, vitamin A, riboflavin, and iodine (32:110). Malnutrition lowers the individual's resistance to diseases which might not otherwise prove serious or fatal. The incidence of malnutrition is greatest among children from one to five years of age and is related to feeding practices

that are poorly adapted to the children's needs after weaning (56:208, 14:157).

An inadequate supply of physicians and medical facilities also contributes directly to the problem of raising health standards in Guatemala. In 1950, there were 420 physicians in the entire Republic, or an average of one physician for every 6,600 inhabitants. In 1955, the number of physicians had increased to 469, but the total population had also increased so the new ratio became one physician to 6,800 persons (56:229). If one takes into consideration the distribution of the physicians, the shortage is even greater than indicated above. In 1950, nearly three-fourths (310) of the physicians were practicing in Guatemala City where only about 10 per cent of the population lived. There were 917 persons for each practicing physician. The ratio for the rest of the country was 22,787 persons for each physician (56:229).

Most of the hospitals in Guatemala are operated by the Minister of Public Health or the Social Security Institute. There are a few private hospitals, most of which are located in the capital city. The total number of beds in all of these hospitals is very low. According to statistics obtained by the United Nations, there were only 8,738 hospital beds in Guatemala in 1956. Just as the capital has a disproportionate number of physicians, it also has most of the medical facilities. In 1956, over 52 per cent of all

hospital beds in the Republic were located in the Department of Guatemala (56:232).

The matter of health and mortality should not be viewed apart from Guatemala's other problems. Inadequate communication and a pattern of isolated settlements pose serious obstacles to any effort to raise the standards of health. If more Guatemalans could read, speak Spanish and afford radios, knowledge of the fundamental rules of modern medicine and sanitation could be more widely disseminated. A final and critically important consideration is the low overall economic condition of the country. Because of the high cost of living and the low wages received by the average worker, even the simplest medicines are often prohibitive in cost to many rural Guatemalans.

Statement of the Problem

This study was designed to investigate the nature and scope of rehabilitation practices in the Central American Republic of Guatemala. The investigation included all agencies and institutions in Guatemala, both public and private, which actually provided or professed to provide rehabilitation type services for the chronically handicapped.

All relevant data was obtained, in as complete and concise a form as practicable, pertaining to the following aspects of rehabilitation in Guatemala:

1. History and development

2. Administration and organization
3. Finance
4. Facilities
5. Professional personnel
6. Programs and services
7. Clientele
8. Research endeavors.

One of the primary difficulties of beginning research in an undeveloped country such as Guatemala is to obtain complete and valid data. Therefore, a preliminary investigation was made of a few agencies and institutions in order to obtain a rudimentary knowledge of the existence or status of rehabilitation in Guatemala. This information made it possible to ascertain if there was a problem, and to provide the basis upon which to formulate the present study.

Justification of the Study

The results of the preliminary investigations indicated that the concept and need for rehabilitation services have been recognized in Guatemala. This statement is documented by two facts:

1. There are some forms of rehabilitation services presently being offered in Guatemala.
2. Legal provisions have been made for the support of rehabilitation as part of government social services and for the "condoning" of privately

operated rehabilitation oriented agencies and institutions. However, due to the nature of the Guatemalan economy, government and social systems, cultural traditions, educational systems, material resources, and the large number of other pressing needs, they have been unable to functionally implement adequate rehabilitation services.

Preliminary investigations also indicated that there was no adequate, systematic, or reliable information available regarding the nature or scope of rehabilitation in Guatemala. However, it was found that there were both public and private rehabilitation type activities being conducted by various agencies and institutions. These rehabilitation services in Guatemala, as in most countries which are in the early stages of program development in this area, have emerged independently in an unplanned and unorganized fashion. No information was available regarding the number or location of the various organizations providing rehabilitation services nor the type, quantity, or quality of their services.

The justification for this study is then twofold:

1. Guatemala, as a nation, has developed to the point where rehabilitation services are recognized, desirable, and feasible. The need is pressing for satisfaction and the time is right for providing this nation with technical and material aid in formulating and developing their

rehabilitation programs and services.

2. There is virtually no information regarding the nature and scope of the existent programs. Consequently, there is a need at this time for basic demographic information in order that a better understanding of the problems involved in adapting and implementing rehabilitation type services may be obtained.

Therefore, in light of the above facts, this research was directed toward examining, describing, and analyzing the nature and structure of rehabilitation programs and services currently being offered in Guatemala. This survey shall complete the first essential and necessary step for the future research and development of rehabilitation philosophies, theories, and practices in Guatemala and other Central American countries. To this date there have been no systematized studies of rehabilitation made in any of the Central American countries.

The purpose of this survey shall be as follows:

1. To provide a basis for further research and development in both theory and practice.
2. To obtain as complete data as practicable regarding rehabilitation programs in Guatemala.

It is anticipated that this research and the resultant conclusions shall be of valuable assistance to any individual, agency, or organization, national or international,

that may be interested in the future development of rehabilitation programs and services in Guatemala.

Limitations

1. This study is limited, to the extent that there has not been to this date any previous research, statistics, or other literature published regarding rehabilitation in Guatemala. The absence of background literature changed the nature of this research and created the prime necessity of providing this lack of information.

2. The population was found to be very heterogeneous and each institution is unique in character, which imposes certain limitations in analyzing the data and in making generalizations.

3. Because of the underdeveloped nature of this country, especially in the area of rehabilitation, it was found that many institutions had relatively poor internal organization and/or were otherwise indisposed to provide or have available certain information. Some institutions kept poor records, while others hesitated to reveal certain types of information for fear they might lose their competitive advantage or because they did not care to be "investigated."

4. The data obtained through this research are culture bound. Extreme caution should be exercised when comparing these data with those of other countries. There is wide variation in the usage of terminology and statistics,

and rehabilitation programs must be considered within the context of the particular nation's social, cultural, and economic development.

5. Because of the difficulty of personally contacting each professional rehabilitation employee in the country of Guatemala, it became necessary to use a personal information questionnaire to collect these data. Certain limitations inherent in the use of this type of instrument may be found in this study, especially with regard to validity and obtaining complete information and questionnaire returns.

The Thesis in Perspective

This dissertation is divided into five chapters as follows:

Chapter I presents an introductory section briefly describing the country of Guatemala. It also has sections on: the statement of the problem; the justification of the study, which explains the importance of the study; and a section that outlines the most important limitations of the study.

Chapter II is devoted to a review of relevant literature.

Chapter III explains the methodology used in the present study. It discusses the preliminary investigation, population studied, development of the survey instruments, procedures used for data collection, validation, and analysis.

Chapter IV contains the analysis of the data. All pertinent data regarding each agency or institution are first organized in separate sections, after which rehabilitation is discussed on a national basis.

Chapter V presents a summary on the entire study, conclusions, recommendations for further research, and implications.

CHAPTER II

REVIEW OF LITERATURE

It has been recognized that it is important to have international cooperation in planning rehabilitation programs and services for the physically and mentally disabled and handicapped. This is evident from the fact that national governments, universities, and various public and private agencies and institutions frequently organize international seminars and arrange for the provision or exchange of technical assistance and consultation services with other nations of the world where rehabilitation programs are in operation or are currently being planned. However, to this date there remains much to be desired with regard to international research and exchange. Many countries understand and desire to develop rehabilitation programs but are unable to gain the full benefit from international cooperative endeavors because they lack a fundamental appraisal of their existent services, conditions, and problems. In many countries there is a complete lack of rudimentary statistics primarily because there is also a lack of human and material resources for obtaining this needed information. Rehabilitation statistics, if available at all, for many countries fail to meet the most elementary requirements of completeness,

accuracy, recency, and comparability. Guatemala, the object of this study, is a classical example of such a country. The following is a discussion of the results of an intensive search for literature pertinent to the present study of Guatemala.

According to its charter, the United Nations (U.N.) has been commissioned to help achieve international cooperation in solving problems of an economic, social, cultural, or humanitarian nature. It was also designated to act as a center for coordinating the actions of the various nations in the attainment of these ends. As a result, a number of special organizations such as the United Nations Educational, Scientific and Cultural Organization (UNESCO), World Health Organization (WHO), and the International Labour Organization (ILO) were created to effect international assistance and cooperation. The U.N. and its special organizations have published a wealth of articles, pamphlets, and books which necessitated systematizing them in a logical fashion to increase their usefulness. Consequently, the U.N. Document Index was prepared which has listed and indexed reports and papers from all of the U.N. and its special organizations. In addition many articles and papers prepared by various public and private agencies and institutions from all over the world are also listed in the U.N. Document Index. As a result, this Index is the most complete source of information available regarding international rehabilitation and many

other publications (48:1948-62).

A review of the past fourteen years of the U.N. Document Index revealed that there was a resolution passed by the General Assembly in 1949 to draft a general report on the world social and cultural situation. This resolution initiated the preparation of a 180 page manual bringing together all available information regarding food, health, housing, education, social conditions, et cetera in many of the countries of the world. Examination of this publication showed no mention of rehabilitation in Central America (50).

Another resolution was passed to prepare a survey of national and international measures taken to improve social conditions throughout the world. It was understood that this survey would be concerned primarily with measures carried out since 1945 and would be a supplement to the preliminary report mentioned above. A 219 page report was published in 1955 which brought the previous report up to date. Rehabilitation was discussed in broad terms and may be summarized as "the promotion of in-hospital rehabilitation services and specialized rehabilitation centres has been slow, even in well-developed countries, primarily because of lack of personnel" (47:142).

The United Nations' organizations in cooperation with the government of Denmark, World Veterans Federation, and the International Society for the Rehabilitation of the Disabled (formerly the International Society for the Welfare

of Cripples) organized a seminar on rehabilitation of the physically handicapped for participants from Latin American countries. The seminar was held from June 21 to July 24, 1959 for the purpose of demonstrating modern methods and techniques for the rehabilitation of the physically handicapped which are applicable to conditions in Central and South America. A total of twenty-seven countries including Guatemala and fifteen other Latin American countries participated in this seminar. This was primarily a training program; however, opportunities were provided for an exchange of information regarding existing conditions in the various Latin American countries. The exchange was minimal and general in nature primarily because adequate information was not available. References to Guatemala were made in regard to a lack of trained personnel and the existence of professional training facilities for physical therapy (51: 108, 49:Vol. 6, No. 3).

A seminar on the organization and administration of social services in Central America was held from February 15 to 26, 1960, in San Jose, Costa Rica. The Bureau of Social Affiars and the Division for Public Administration of the United Nations Secretariat provided the technical and financial support. Six countries, including Guatemala, were represented while social services, organization, and practices were discussed. Conclusions drawn from the discussions indicated there was a need for coordination between the

various agencies and institutions, and that no clear differentiation existed between public and private service organizations. Social services were discussed in general and it was evident that accurate data regarding the nature and structure of social services in Central America were lacking (52).

The United Nations also publishes a Yearbook as an authoritative record of all phases of its work. These books were examined for possible information pertinent to this study. Rehabilitation was included under social services; however, mention of Guatemala was limited to a brief sentence or two, stating that some rehabilitation services do exist but no information is available (54:1950-62).

The Vocational Rehabilitation Administration (VRA) under the United States Department of Health, Education, and Welfare has been in existence for over forty years. Six years ago the VRA (formerly the Office of Vocational Rehabilitation) started a research program aimed at discovering better ways to rehabilitate handicapped individuals. The program was so successful in helping to meet the demands for research in this area that two years ago (1960) it was extended to foreign countries. During the last two years twenty-five foreign research projects were supported by the VRA. The number of overseas research projects is expected to be doubled within the next year. A review of these projects disclosed that none were conducted in Guatemala or any

of the other Central American countries (35:Vol. 3, No. 3).

The National Society for Crippled Children and Adults publishes a monthly review called Rehabilitation Literature (34:Vol. 13-23). Rehabilitation Literature serves to promote communication between all professional personnel and students in rehabilitation and also related areas of specialization. It is a reviewing and abstracting journal that identifies and describes current books, pamphlets, and periodicals pertaining to the care, welfare, education, and employment of handicapped children and adults. This journal lists many of the domestic and foreign books and articles that are published or privately circulated. A search of this review did not reveal any materials regarding rehabilitation in Guatemala.

Another excellent source of information for rehabilitation publications around the world is the Psychological Abstracts which is a bi-monthly publication of the American Psychological Association. It classifies and lists non-critical abstracts of the world's literature in psychology and related subjects. The listings are obtained through a regular search of 545 journals and various other books, monographs, and pamphlets. A search of these abstracts did not reveal any articles or books regarding the nature and extent of rehabilitation practices in Guatemala (3:1950-62).

The Economic and Social Council of the United Nations passed a resolution in 1950 for the organization of The United Nations Coordinated International Programme for the Rehabilitation of the Physically Handicapped. Its objectives were to ensure the closest possible co-ordination between the United Nations and rehabilitation organizations all over the world, provide direct assistance in the organization and staffing of rehabilitation programs, and to conduct research activities and provide technical advice (46:1). One type of assistance provided by the Programme is to make surveys of the existent rehabilitation services and conditions in the various countries.

> At the request of governments, fact-finding missions can be sent out by the United Nations and its specialized agencies to make a survey of local conditions and resources . . . . If the assistance provided under the Programme is to be fully effective, it must be based on adequate information about the particular problem it is designed to meet.

Much information has been gathered by the co-ordinated International Programme but no studies have been made in Guatemala (46:3-4).

The oldest international organization in the world today is the Organization of American States (OAS). It unites the twenty-one republics of the Western Hemisphere into a "community of nations" dedicated to peace, security, and prosperity (39:4). The objectives of the Organization of American States are accomplished through various means including research and publications. The Pan American Union

is the central organ and General Secretariat of the Organization of American States and one of its functions is to publish information and research articles, pamphlets, and books of national and international interest. The Pan American Union periodically publishes catalogs of their own and various other Latin American publications (44, 37, 45, 38). A review of these catalogs did not reveal any materials pertinent to the present study.

Suslow, a graduate student at the University of Connecticut, made a study of the social security system in Guatemala during the summer of 1950 (43). He traced the development of the program and included some information about two rehabilitation centers that were organized as part of the social security system. Rehabilitation was defined within the social security program as "the re-education of the injured organs as one stage of medical treatment, the replacement or improvement of the damaged organs by prosthetic or orthopedic appliances wherever possible and necessary, and vocational readaptation" (43:201).

The first government rehabilitation center in Guatemala was located in a large two-story house called "Simeon Canas," and it contained eighty-two beds at the time it was founded in 1948. In addition to ninety-two inpatients, twenty-eight outpatients were also receiving daily rehabilitation services at the center. Rehabilitation programs at this center included medical treatment, the fitting of

prostheses, limited physical therapy, social services, training in carpentry, mechanics, sewing, radio repairing, adult education, and weaving. The only personnel working at the center who had formal training were the physicians and one occupational therapist who had studied occupational therapy for six months.

The second center was located in a two-story cement building in the suburbs. The building was a former hotel called "Casa Linda" which had forty-two beds. This smaller center worked in conjunction with the larger one by transporting the patients back and forth by bus. Casa Linda was also an agricultural experiment station and rehabilitation services were limited to medical treatment, bookbinding, and agricultural training.

The Guatemala social security administration spent $217,164.00 on rehabilitation up to the end of February, 1951, and had "rehabilitated" a total of 479 patients during the years of 1948-50 (43:206).

In 1952, the two rehabilitation centers were merged into one large center located in a former private home in a residential district of Guatemala City. Government rehabilitation in Guatemala in 1952 was limited to the above center operated by the social security program. The need and value of rehabilitation services was recognized and plans were made for the building of a $1,000,000.00 rehabilitation hospital which has not materialized to this date, although some

progress has been made in this direction.

The United States Senate, 85th Congress, 1957-58, recognized and stressed the importance of rehabilitation and directed the subcommittee on Reorganization and International Organizations to prepare a report on the status of rehabilitation services in certain countries. The purpose of the publication was "to provide background information on the status of medical and related services for the disabled in certain countries on which such information is relatively available" (41:III). Thirty-seven countries were reviewed in the report, including Guatemala. The report on Guatemala is one page in length and simply states that Guatemala has a polio center for children, a modern school for blind and deaf, a workshop for blind adults, a school of physical therapy, and a rehabilitation center for disabled workers. The latter is operated by the Guatemalan Institute of Social Security (IGSS) and provide services to disabled workers covered by the social security system. The report stated that services provided workers at the IGSS Center "include medical and rehabilitation care and also vocational training in tailoring, radio repair, handicraft, shoe repair, clerical work, and other trades" (41:43). The only other institution about which comments were made was the polio center. It mentioned that the polio center served an average of 100 inpatients and 100 outpatients daily and that they used a modern team approach. The team consisted of

specialists in pediatrics, orthopedic surgery, rehabilitation, social services, physical therapy, bracemaking, and nursing.

The above report prepared by the Senate subcommittee was the most detailed information found regarding the nature and extent of rehabilitation in Guatemala.

A number of articles in professional journals dealing with special education and rehabilitation in Guatemala and Latin America are currently in process; however, none of these articles were available at the time of the present investigation. It is likely that a number of publications on special education and rehabilitation in Guatemala and other underdeveloped countries shall result from the research program currently being conducted in these areas at Michigan State University (20, 21, 22, 23, 24, 25, 26, 27, 28, 29).

In addition to the above references a search was made for materials that may be available only within the country of Guatemala. The office of the Minister of Public Health was visited but no information regarding rehabilitation in Guatemala was found. The officer in charge stated that they lacked such information and that they would appreciate very much to have a copy of any data we may obtain in regards to the nature and scope of rehabilitation in Guatemala. Visits were also made to the National Statistics office, the University of San Carlos, National Library, United States Embassy, Pan American Union, United Nations

Educational, Scientific and Cultural Organization, and the Minister of Public Education. No information pertinent to rehabilitation was found through any of the inquiries made in Guatemala.

Summary

The literature cited above represents the extent to which research and information are currently available regarding rehabilitation programs and facilities in the Republic of Guatemala. The studies reviewed were found to be general in nature and incomplete in coverage and detail. None of the studies were planned research projects directed toward ascertaining the status of rehabilitation in Guatemala. The various offices and agencies in Guatemala are not informed about local rehabilitation programs. Agencies and institutions in Guatemala appear to put little emphasis upon the desirability of keeping accurate records and civil regulations do not require the submission of such accounts.

The results of the research of literature may be summarized in two sentences: (1) There are rehabilitation type services currently being offered in Guatemala. (2) The nature and extent of these services are unknown.

There are no national statistics available and there have been no studies conducted of the institutions offering rehabilitation type services. There is not even fundamental information such as the number and types of

institutions in Guatemala that have rehabilitation programs. This complete lack of information clearly demonstrates the need at this time for a comprehensive study of the nature and scope of rehabilitation in Guatemala. This information is necessary in order that Guatemala, as a participating nation, may benefit more from international seminars and conferences, and enable the representatives to act on behalf of rehabilitation in general and not limit their considerations to their own particular affiliations. This information is essential to all individuals who are interested in understanding, evaluating, planning, or improving rehabilitation programs in theory or in practice. The objective of the present study shall be to provide this essential fundamental information regarding existent rehabilitation programs and conditions in the Central American Republic of Guatemala.

CHAPTER III

METHODOLOGY

The review of literature indicated a lack of information regarding the nature and extent of rehabilitation services in Guatemala. The present study was designed and directed toward obtaining this basic information. However, before beginning such a study, it was necessary to have at least a rudimentary knowledge of the nature and size of the population to be studied. Such information about the population was necessary in order to determine the type of instrumentation, the particular methodology and procedures that should be used, and for the selection of the population sample. To obtain this necessary information, a preliminary investigation was made of the rehabilitation programs and services in Guatemala.

Preliminary Investigation

The preliminary investigation was conducted in two stages. The first stage consisted of procuring the names and locations of the agencies and institutions in Guatemala which had rehabilitation type programs. Efforts were also made to obtain a general description of the types of services provided by each agency or institution. This information was not available from any single source and it was

necessary to make inquiries at various offices and organizations such as the Ministry of Public Health, the University of San Carlos, Social Security offices, UNESCO of Guatemala, National Statistics offices, Social Services office (Consejo de Bienestra Social), Committee for the Blind and Deaf, Social Security Rehabilitation Hospital, U.N. Social Service Agent, and other informed individuals in Guatemala. As a result of these inquiries, a tentative list was made of all agencies and institutions in the Republic of Guatemala which might be providing rehabilitation services (Appendix A).

The second stage of the preliminary investigation consisted of making personal visits to six institutions for the purpose of interviewing key personnel and observing institutional conditions and operations. Efforts were made to select those institutions which would provide information regarding the range or limits of size, services, facilities, personnel, et cetera, which might be encountered during the survey. Visits were made to the Social Security Rehabilitation Hospital, Rodolfo Robles Institute, Neurological Institute, Roosevelt Hospital, Vocational Rehabilitation Center for the Blind (no longer in operation), and the Alcoholics Sanitorium.

The purpose of the preliminary field investigation was to acquaint the researcher with the general nature of rehabilitation services in Guatemala. In addition to the obvious advantages of actually observing the facilities

and practices and conversing with the rehabilitation personnel in the field, the information and experiences gained from the preliminary field visits materially helped in the selection of the best methods and procedures for collecting the final data.

Population

All agencies and institutions found through the preliminary investigation were considered for inclusion in this survey. The concept of rehabilitation varied greatly from one institution to another and it was necessary to use a tentative criteria for the final selection of institutions. After discussing the problem with key professional rehabilitation workers in Guatemala, it was decided that any organized institution which provided services for chronically handicapped individuals, whether physical or mental, should be investigated. The services provided should be oriented toward adapting the clients to their handicaps, and assisting them to become self-sufficient members of society. Institutions which provided only medical treatment, welfare services, employment, or subsistence were not to be considered as rehabilitation. Agencies and institutions which could not be obviously excluded from the study were visited and then evaluated in terms of the above tentative criteria. As a result, eight institutions were selected for inclusion in the present study. These were:

1. Centro de Recuperacion No. 1 (Recuperation Center No. 1)
2. Centro de Recuperacion No. 2 (Recuperation Center No. 2)
3. Instituto de Rehabilitacion Infantil (Children's Polio Hospital)
4. Sanatorio Antialcoholico (Alcoholics Sanatorium)
5. Centro de Salud Mental (Mental Health Center)
6. Instituto Rodolfo Robles (Robles Institute)
7. Hospital Neuropsiquiatrico (Neuropsychiatric Hospital)
8. Centro de Rehabilitacion del IGSS (Social Security Rehabilitation Hospital).

Due to the limited number of rehabilitation institutions in Guatemala, it was possible to include the total population in the study and thereby eliminate sampling errors. This was of particular importance since the population was found to be extremely heterogeneous and diverse in all respects. The individual institutions varied in size from two room service units to the complex sixty room rehabilitation hospital of the government social security system. Large variations were also found in regard to their services, facilities, clientele served, and professional personnel.

Instrumentation

The results of the preliminary investigation indicated that structured interviews, observations, and the examination of institutional records and papers were the best methods for data collection. Therefore, a set of data sheets was devised for use by the researcher. They were used to provide structure during the interviews and as a tool for systematizing all of the information obtained from each institution. They categorized all aspects of institutional conditions and operations under the following general headings:

1. History and Development
2. Administration and Organization
3. Finance
4. Facilities
5. Personnel
6. Programs and Services
7. Clientele
8. Research Endeavors.

These data sheets consisted of a number of questions under each category to guide the researcher and spaces in which to record responses (Appendix B).

All information was obtained in the above manner except the personal data from professional personnel. Since it was impractical to interview each staff member, a Personal Information Inventory was devised which they could personally

complete at their convenience (Appendix C). This questionnaire was divided into the following sections:

1. Personal data
2. Professional training and experience
3. Professional activities
4. Professional opinions.

McAlees conducted a study of special education in Guatemala simultaneously with the present investigation (28). Therefore, the above instruments were constructed to permit their use in either the special education or rehabilitation study.

Procedure

The procedures used for collecting data from the various rehabilitation agencies and institutions were simple and direct. To initiate the study, an appointment was made for an interview with the director of each institution for the purpose of introducing the nature of the study, and to obtain his cooperation. This initial interview was not directed at obtaining data but rather to make definite arrangements for future data collection from the various institutional personnel.

Numerous subsequent visits were made to each institution and it was necessary to work with all of the institutions simultaneously rather than to survey them one at a time. Appointments were made with the various service and administrative personnel for the purpose of obtaining

specific types of information. Institutional data were obtained through structured interviews, observing the institutional facilities and operations, and by examining records, reports, and papers provided by the institution or other organizations in Guatemala, such as their "Patronato," central offices, or the Department of National Statistics.

The interviews were conducted in Spanish by the researcher and a "National" who was intimately familiar with colloquial Guatemalan Spanish and the nature and purpose of the study. The presence of a "National" was of particular importance at some interviews because the institutional personnel were either ambivalent or had negative feelings toward cooperating with United States researchers.

The Personal Information Inventories were distributed and collected by the director and administrator of each institution. It was not possible for the researcher to supervise the completion of the questionnaires because of the disrupting effect such a meeting would have had upon institutional operations and because of the irregular hours worked by most of the professional service staff.

Data Validation

A major difficulty in conducting survey type research in the United States is that of obtaining reliable and valid data. This problem is of particular importance when conducting surveys in Latin America because of the social and cultural customs and values found in these countries. This

difficulty became vividly apparent to the researcher during the preliminary investigation and efforts were made to structure the present research design to preclude as many errors as possible. The following measures were taken to increase the reliability and validity of the data gathered:

1. Because of the limited number of rehabilitation institutions, the entire population was surveyed to eliminate errors due to sampling statistics.
2. Most of the data were obtained through personal interviews, observations, and the examination of various reports and papers.
3. Researchers obtained the endorsement of key community and institutional personnel in rehabilitation and certain other influential community members such as the University of San Carlos Rector and the Dean of Humanities, Minister of Public Health, et cetera.
4. Provisions were made for the active participation of Guatemalan Nationals in the study.
5. Efforts were made to preclude data biasing due to various factors such as leading questions, halo effects, and divulging the nature and purpose of the study when such information may have had a biasing effect for the informers.
6. The overall data was scrutinized for internal consistency and any irregularities were explored.

Data Analysis

It shall not be possible to present comparable types and amounts of data from all agencies and institutions in this study because of their limited stage of development, lack of systematized record keeping, and great heterogeneity. Consequently, the analysis of data shall consist of descriptive statistics such as Tables, Figures, percentages, et cetera. These statistics shall be interspersed throughout a systematic description of the conditions and operations of each institution. After the institution-by-institution analysis of the data, a national overview of rehabilitation in the Republic of Guatemala shall be presented.

The analysis of the data shall lead to the generation of descriptive statements, generalizations, conclusions, and recommendations for further research. Whenever possible, conclusions shall be drawn in the light of existing conditions and circumstances in Guatemala and not particularly by externally imposed criteria.

CHAPTER IV

ANALYSIS OF THE DATA

This chapter presents the analysis of the data obtained from the eight institutions surveyed in the study. The data will be analyzed institution-by-institution in order that a complete and realistic understanding may be obtained of the current rehabilitation practices in Guatemala. This type of analysis is considered desirable because of the great diversity found between the various institutions.

The following is a list of the institutions studied and the order in which they are presented in this chapter:

1. Recuperation Center No. 1
2. Recuperation Center No. 2
3. Children's Polio Hospital
4. Alcoholic Sanatorium
5. Mental Health Clinic
6. Robles Institute
7. Neuropsychiatric Hospital
8. Social Security Rehabilitation Hospital.

The data from each institution were analyzed and summarized under the following headings, which are the same ones used in the data sheets:

1. History and Development

2. Administration and Organization
3. Finance
4. Facilities
5. Personnel
6. Programs and Services
7. Clientele

Although an eighth category, Research Endeavors, was a part of the data sheets, it shall not be included in the present analysis of the data because none of the institutions reported any organized studies of rehabilitation.

After a detailed presentation of the data, a brief overview of rehabilitation on a national basis will be presented. Efforts will be made in the overview to show the overall nature and extent of current rehabilitation practices in Guatemala.

Recuperation Center No. 1

History and Development

This center is located in an old residential section of Guatemala City close to the business district. It was founded about one hundred years ago as an asylum for the crippled and sick who were unable to care for themselves. Patients with all types of ailments and disabilities were accepted for treatment, and custodial care was given for various lengths of time. As time passed, the number of chronic cases given custodial care began to accumulate until

today most of the hospital beds are occupied by chronically disabled patients.

From the time that the hospital was founded until about 1952, the objectives and services were not changed except for increases in the quantity and quality of the services. Due to the large number of custodial cases, the philosophy of the hospital administrators began to change in 1952 and more emphasis was placed on the discharge of patients. It was at this time that Drs. Von Ahn and Miguel Aguilera outlined plans for developing a rehabilitation program. It was realized that the hospital could perform a greater community service by rehabilitating patients and integrating them into society rather than fostering increasing invalidism. As a result of this new philosophy, the objectives of the institution were changed accordingly and efforts are currently being made to develop adequate rehabilitation programs and services. Programs for physical rehabilitation have already been developed and plans have been drafted for the addition of social and vocational services.

Administration and Organization

This hospital is under the jurisdiction of the Guatemalan Minister of Public Health. It is administered by a Director who is appointed by the Minister. The Director has the authority and responsibility for all institutional operations except for decisions involving major policies which must be approved by the Ministry. Institutional

affairs such as administration, personnel, services, and routine matters are generally left to the discretion of the Director and his staff. The Minister is primarily interested in the budget which he must submit to the National Congress for appropriation. It has been very difficult to negotiate budget increases through Congress because of the many other pressing needs in the country and there is always the possibility of receiving a budget reduction. Some progress has been made in recent years in the introduction and acceptance of rehabilitation by the Ministry of Public Health and members of Congress. As a result, it has been possible to implement a physical therapy section in the Hospital under the direction of a physiatrist who received post-graduate training in physical medicine and rehabilitation at New York University. He is Chief of the Rehabilitation Department and is the Director of a small school for physical therapists which he organized at the hospital. The purpose of the school is to supply physical therapists for all of the hospitals and rehabilitation institutions in Guatemala. The school is not part of Recuperation Center No. 1 since it is supported by a separate grant from the National Congress through the Ministry of Public Health. However, it is located in and uses some of the facilities in the hospital. Part-time instructors are obtained from the University of San Carlos Medical School. The students receive practicum experience by working as physical therapy aides at various

hospitals in the community.

The Director is Chief of the Medical Staff and the responsibilities of directing the social services and administering the hospital have been delegated to the Chief Social Worker and the Head Sister of Charity, respectively. The Sisters of Charity have been delegated full responsibility for routine hospital operations. They provide nursing services and are in charge of the domestic employees. Figure 1 is an organization chart showing the lines of authority and responsibility at the hospital.

Finance

The budget is prepared by the Director and his staff and sent to the Minister of Public Health. The Minister approves it after making any necessary changes and submits it to the National Congress for appropriation. The members of Congress review the proposal and make any further changes they consider necessary before deciding upon a monetary assignation. Their annual appropriation has been the same for the last three years although budget increases have been considered. The hospital is, and always has been, completely supported by government funds.

Table 2 shows the amount of money appropriated by Congress for the fiscal year of July 1, 1961 to June 30, 1962.

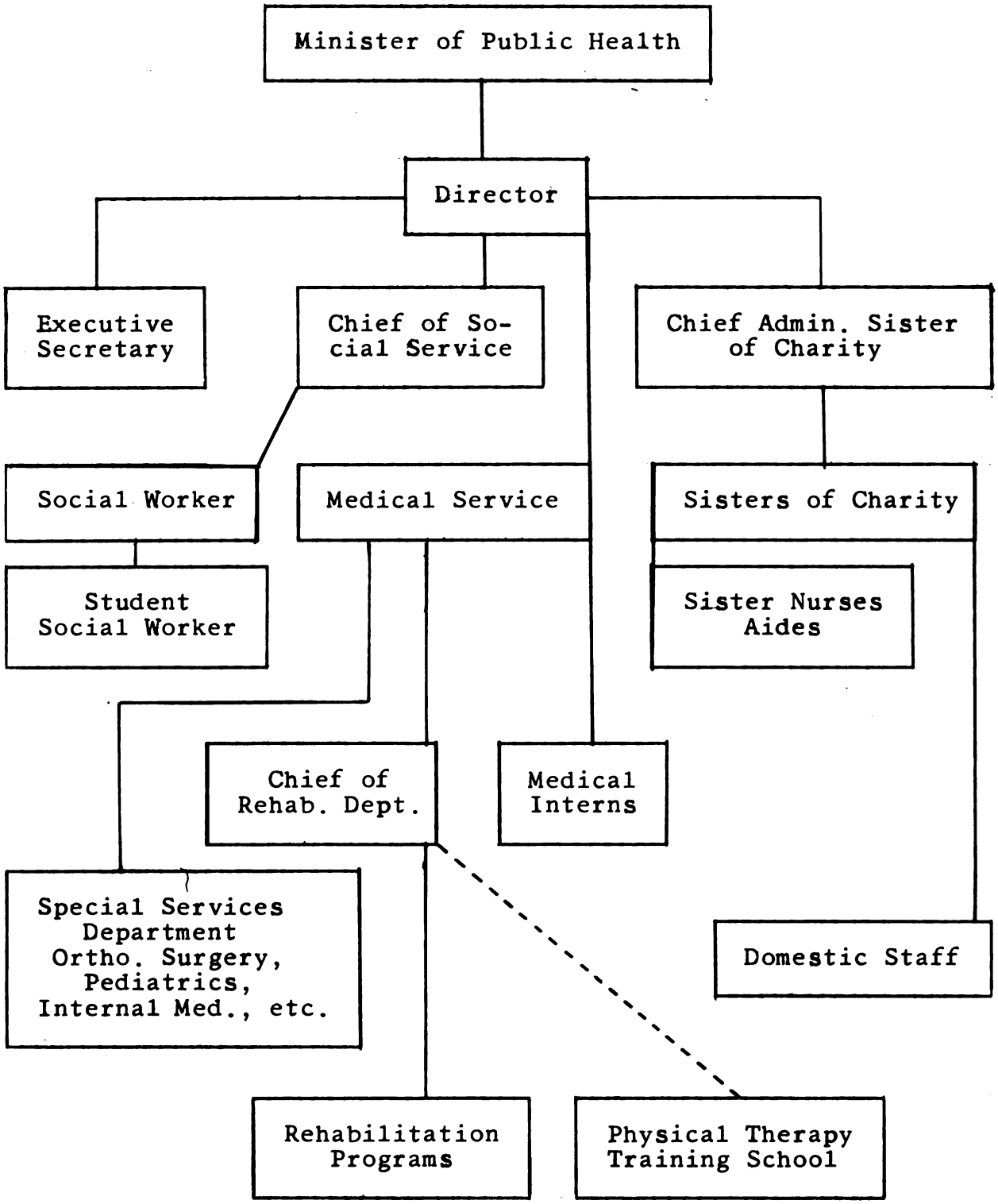

Fig. 1.--Organization Chart of Recuperation Center No. 1.

Table 2. Budget for Recuperation Center No. 1 and the School of Physical Therapy in 1961-62

Institution	Salaries	Operational Costs	Total
Recuperation Center No. 1	$72,720.00	$57,732.00	$130,452.00
School of Physical Therapy	7,800.00	204.00	8,004.00

The expenditures for the 1961-62 fiscal year as they were categorized for the Bureau of Statistics are shown in Table 3.

Table 3. Expenditures for Recuperation Center No. 1 in 1961-62

Expense Category	Amount
Food	$ 38,539.22
Clothing	3,861.50
Medicines	1,931.72
Salaries	71,648.54
Other Costs	16,962.51
Total	$132,943.49

Records show there were 154,088 patient-days during the 1961-62 fiscal year for an average cost per patient-day

of $0.86.

Facilities

The hospital was constructed around a Catholic church which functioned as a chapel for the patients and personnel. The rooms and wards were gradually added as the number of inpatients increased. As a result, there seemed to be no systematic or logical organization of the plant. The total facilities appeared to be generally in need of maintenance and repair.

The hospital is divided into twenty-four patient wards. There are single wards for boys, girls, spastic children, eight wards for women, and thirteen wards for men. There are facilities for 450 inpatients and 100 outpatients. However, most of the facilities for the inpatients are used for custodial care of chronic medical or congenital cases. The hospital has service rooms for performing operations, laboratory analysis, x-ray, sterilization, drug dispensation, isolation, physical therapy, social services, and various special service clinics. In addition to the wards and service rooms, the hospital has offices for the physicians and administrative personnel, a classroom, a conference room, rooms for the School of Physical Therapy, dining rooms, various domestic spaces, and several small recreational areas.

There are two admittance clinics which are also used for outpatient treatment. One clinic is used for

general hospital diagnosis and treatment while the other is only used by the Department of Rehabilitation. The Department of Rehabilitation has sections for individual exercises, mechanical therapy, and group exercises.

The section for individual exercise has provisions and equipment for four physical therapists to work simultaneously. The room is divided into four bays with the open side of each bay curtained off from a central aisle. This section also has a small examination room and a general therapy room.

The mechanical therapy room contains various mechanical exercise equipment such as pulleys, wheels, weights, et cetera. This equipment appeared to be generally inadequate and in poor working condition.

The group exercise section is simply a gymnasium which also serves as a recreation area and a classroom. There are chairs stored in the room which can easily be placed in front of a large blackboard in order to convert the gymnasium to a classroom. The School of Physical Therapy uses the classroom for instruction and the hospital staff uses it occasionally for short courses.

Personnel

The hospital has a total of 130 employees to care for approximately 400 to 450 inpatients and 100 outpatients. Since most of the inpatients are custodial cases, the majority of the personnel are employed for their maintenance.

Excluding the Rehabilitation Department, the hospital has the following general medical staff:

a. Six orthopedic surgeons

b. Two plastic surgeons

c. Two general surgeons

d. Two internal medicine physicians.

The hospital has no graduate nurses. The Sisters of Charity, who have been trained as nurses' aides, perform all of the duties that would normally be done by graduate nurses. The Rehabilitation Department has its own professional staff although it is part of the general hospital. The Chief of the Rehabilitation Department is employed on a part-time basis; he works seven hours each week at the hospital. There are also two volunteer physicians who work infrequent hours. In addition to the physicians there are six physical therapy aides and one graduate physical therapist, all of whom work thirty hours each week. The physical therapy aides are enrolled as students in the School of Physical Therapy which is located adjacent to the physical therapy section of the hospital. They are paid for their services and they obtain practicum experience.

Programs and Services

The hospital has been commissioned to accept any indigent patient who is not covered by the national social security program. It is estimated that about 70 per cent of the people in Guatemala are not covered by social security

and must pay for their own medical treatment or obtain free services. The hospital provides free services for some of the indigent and chronically sick or disabled; however, it is inadequate to handle all of the individuals who apply for services.

Efforts are constantly being made to rehabilitate, place, or transfer as many patients as possible; however, the number of chronic custodial cases is still rising. At the present time about 78 per cent of all the inpatients are receiving only custodial care. Efforts are being made to admit only those patients who may be "cured" or rehabilitated through the services provided in the hospital. In practice these criteria are difficult to follow because many chronic cases do not have any other place to go for treatment or maintenance.

Patients are first received in the admissions clinic and are given a general physical examination after which they are interviewed by a social worker who obtains the relevant background information pertaining to each case. No decisions are made at this time regarding the patient's admittance. These decisions are made only after the cases have been discussed at one of the weekly case conferences.

The services offered at this hospital are predominantly medical. All of the patients receive medical treatment; 50 per cent receive some type of social service, 20 per cent physical therapy, and 20 per cent receive limited

outpatient treatment. A few of the patients are given simple duties such as cleaning, helping other patients, selling lottery tickets, et cetera at the hospital. There are some organized leisure time activities such as sewing and ceramics, but none of these are considered as part of the rehabilitation program. The primary purpose of these types of activities is to provide something for the patients to do in order to reduce boredom. There are no programs or services for occupational therapy, vocational training or placement, specialized nursing, psychiatric or psychological services, rehabilitation counseling, or follow-up.

The Rehabilitation Department (physical therapy) treats most of the patients that are ultimately discharged and also a limited number of the chronically disabled custodial cases. This amounts to about 100 patients per year who are treated for periods of time ranging from three months to one year. There are not enough physical therapy personnel or facilities to provide these needed services to all of the patients at the hospital.

Many patients are treated on an outpatient basis but with only limited success because the patients do not return regularly for treatment. One of the reasons they do not return for treatment is the time and transportation costs involved. Many of the patients come from distant Departments since patients are received from all parts of Guatemala.

Clientele

The hospital usually has from 400 to 450 inpatients at one time and about 100 outpatients registered and eligible for treatment. Out of the 450 inpatients, about 350 are chronic custodial cases, some of whom have been at the hospital for over forty years. Since 350 inpatients are considered custodial cases, only about 100 inpatients at one time receive treatment oriented toward preparing them for discharge. Table 4 presents the movement of patients throughout the year of 1962.

Table 4. Patient Movement at Recuperation Center No. 1 in 1962

Inpatients	Male	Female	Total
Number of patients January 1, 1962	215	209	424
Admitted during 1962	169	158	327
Total discharged during the year	172	178	350
Voluntary discharges	163	162	325
Deaths	9	16	25
Number of patients December 31, 1962	212	189	401

The number of patients discharged reflects to some extent the efficiency of the rehabilitation program. Table 5 shows the number of patients discharged during the years of 1960 and 1961 as compared to that of 1962. In analyzing

these figures, it is necessary to consider the discharges in relation to the average number of inpatients.

Table 5. Discharges from Recuperation Center No. 1 in 1960-61-62

Year	Number of Inpatients Discharged			Average Number of Inpatients
	Male	Female	Total	
1960	125	165	290	428
1961	129	161	290	416
1962	172	178	350	422

Patients come to the hospital through self-referrals, referrals from professional people such as lawyers and physicians, and as a result of letters sent to the Ministry of Public Health by various people regarding certain individuals.

Patients with many different types of disabilities are treated at the hospital; however, complete statistics were not available. A partial list of some of the more common disabilities is presented in Table 6.

Comments

This institution actually functions as a government general hospital for individuals who are not covered by the Guatemalan Social Security Program. It is completely government supported without any contributions from the

clientele, employers, or any other organization, which makes it difficult to obtain adequate operating funds. The present services do not qualify this hospital as a rehabilitation unit. However, a Rehabilitation Department has been organized within the hospital and it is headed by a very capable physician. The growth potential of the rehabilitation program is good since the development of most successful enterprises in Guatemala can be traced to one highly motivated and capable individual. The Chief of the Rehabilitation Department is not only the Director of the School of Physical Therapy but is also the Director of the Social Security Rehabilitation Hospital and the Children's Polio Hospital.

Table 6. Common Disabilities Treated at Recuperation Center No. 1 in 1962

Type of Disability	Total Number	Deaths	Age Range	Number Below 15 Years
TB of the bones and joints	8	0	1-64	6
Residual effects of polio	41	0	5-44	30
Brain damaged, paraplegics	10	1	1-24	6
Cerebral palsy	44	5	1-75	7
Club foot	23	0	1-64	16

* * * * *

Recuperation Center No. 2

History and Development

The need for assistance and rehabilitation of the poor and socially maladjusted was recognized in Guatemala in 1947. Efforts were made at that time to form a "Patronato Contra la Mendicidad" (League for the Eradication of Begging) in order to launch a campaign to help the indigent. However, due to the nature of social and economic conditions at that time, no action was taken and the need persisted.

In 1952, efforts were again renewed to try to establish some organized help for the beggars. Dr. Arriola was Minister of Public Health at that time and he succeeded in organizing a "Comite Contra la Mendicidad." After its organization, the committee was converted into the privately operated "Patronato Contra la Mendicidad" which still exists today.

The League (Patronato) authorized and financed a study of the causes of social maladjustment in Guatemala in order that ways and means could be found for rehabilitating such persons. Their plans were to investigate various cases and then refer them to appropriate community agencies or institutions. However, it was found that the clientele could not be referred because the agencies and institutions in Guatemala were already filled to capacity. It was at this time that the need for a home for the beggars became evident.

A "Home for Beggars" was organized and equipped for the rehabilitation of beggars with the help of government funds and private donations. When the home first opened, the government contributed $3,000.00 each month for its support. After a short time, the allotment was reduced to $1,000.00 per month.

Most of the members of the League are professional or business people from the community. Anyone may join providing they are interested in helping the indigent; however, some of the members join the League for social reasons.

The League holds two general meetings each year at which time major decisions are made. The officers of the League elected at these meetings hold office for two-year periods.

The operation of the institution is under the management of a Board of Control which is, in turn, directed by the League. The Board of Control consists of a chairman, vice chairman, secretary, treasurer, and fifteen voting members all of whom are elected by the members of the League. The board meets once every week or two for the purpose of conducting the affairs of the League and assisting in the management of the institution. About nine members usually attend each meeting; however, business is conducted regardless of the number of members present. If a quorum is not present, decisions are made conditionally, and they are voted on again at the next meeting.

Presently the League plans to establish a farm at Escuintla where the clientele may obtain vocational training. The government has donated land to the League for this purpose, but no more has been done to date. The property is now used for growing sugar cane which serves as a source of income for the League.

Administration and Organization

The institution is governed by a council composed of five members, two chosen from the League's Board of Control and three from the institution's professional staff. The council meets every two weeks for the purpose of discussing institutional business and clientele. The Board of Control members are appointed for two year terms and one of the representatives acts as coordinator between the council and the League. The council members selected from the institution are usually department heads.

The Chief Administrator has complete responsibility for all routine institutional operations. Technical decisions involving services are made by the professional staff members and decisions involving interdepartmental cooperation (other than routine matters) are decided by the council. Major policy decisions such as additional staff, program changes, and entrance criteria are approved by the League's Board of Control.

Figure 2 shows the organization of the institution and its relation to the League.

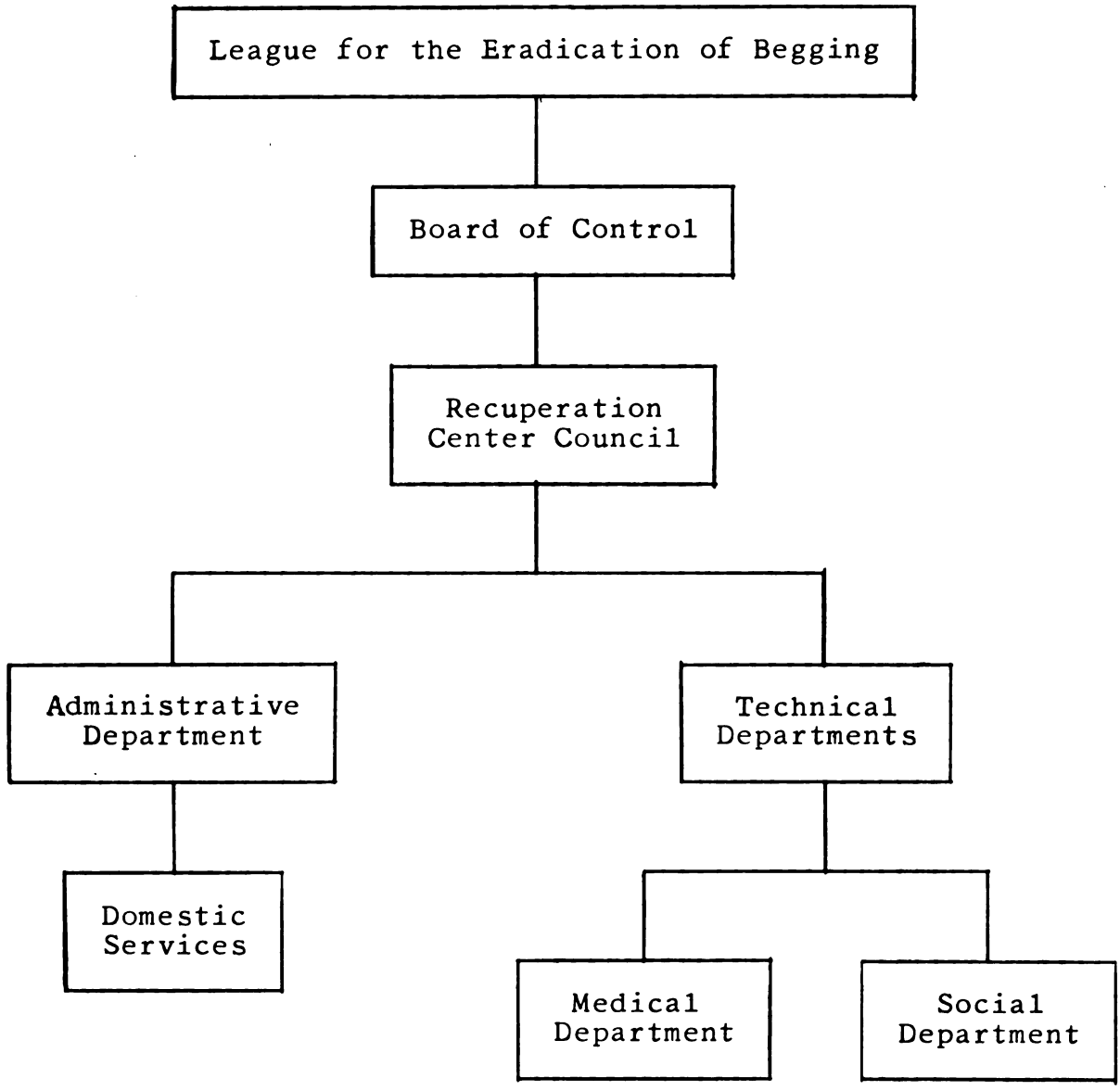

Fig. 2.--Organization Chart of Recuperation Center No. 2.

Finance

The budget is prepared by the League for the institution based upon information submitted to them by the council. The funding of the institution is handled directly by the League. The primary source of financial support is from the

government which has amounted to $12,000.00 each year for several years. The funds obtained from the government are augmented by monies received from the sale of sugar cane, donations, and material gifts such as food, clothing, and medicines. The total income per year, excluding material gifts, is approximately $19,000.00.

Since the income does not vary much from year to year, the expenditures are also approximately the same. The average cost per client-day during 1962 was $0.98. The expenditures for the same year are presented in Table 7. Expenses are usually categorized by the administration department as shown in Table 7, therefore, a more detailed breakdown of the costs was unavailable.

Table 7. Expenditures for Recuperation Center No. 2 in 1962

Expense Category	Amount
Food	$ 3,953.37
Clothing	540.05
Medicines	670.80
Salaries	8,891.03
Other Costs	5,005.82
Total	$19,061.07

Facilities

The institution is housed in a one story sixteen room abode building that was originally built as a large private home. The building is about fifty years old and is in need of general renovation. The sleeping quarters, lavatories, general utilities, special purpose rooms, and recreation areas are grossly inadequate for the number of clients living in the home. There are only four toilets for the total population, and these are all located in one place so that men, women, and children must use the same facilities. Two special education classrooms and a fence to separate the children from the adults were under construction at the time of this survey. The dormitories are overcrowded, poorly ventilated, and difficult to keep clean. There are four rooms with a total of fifty beds for men and three rooms with twenty beds for women and children. Therefore, the total capacity is seventy but there were one hundred and five persons living in the home at the time of the survey. Many of the clientele must sleep on the floor on mattresses because of the shortage of beds.

In addition to the dormitories there is an administrative office, waiting room, reception room, social service office, medical treatment clinic, kitchen, and a storeroom for food, clothing, and other supplies. The medical treatment clinic is generally well equipped and has a large supply of drugs, most of which were donated to the home by various foreign pharmaceutical companies.

Personnel

All personnel employed at the home must be approved by the League's Board of Control. The selection of an employee for a vacancy is usually left to the department chiefs who submit their personal recommendations to the council. If the council approves of the candidate for a particular job, it requests the approval of the League's Board of Control. There are no written criteria for the selection of new personnel; candidates are selected on the basis of personal interviews and their ability to assume responsibility and perform the necessary work. There is no problem of obtaining new personnel because the rate of turnover is very low.

At the time of the survey there were six full-time and one part-time professional staff members. Table 8 shows the titles of the various positions, their sex, and hours worked each week.

In addition to the professional staff, there are two cooks, two laundresses, a seamstress, a janitor, and a watchman employed for domestic services.

All of the institutional personnel are covered by the government social security program. There are practically no opportunities for advancement principally because of the very limited budget and the low rate of personnel turnover. Requests for an increase of personnel have been repeatedly made to the League by the council; however, new

positions could not be created because of budgetary limitations.

Table 8. Professional Personnel of Recuperation Center No. 2

Number of Employees	Position	Sex	Hours Worked Per Week
Administration Department			
1	Chief of Administration	Female	45
Medical Service Department			
1	Gerontologist (M.D.)	Male	12
3	Nurses Aides	Female	45 (each)
Social Service Department			
1	Social worker	Female	45
1	Social worker's aide	Female	45

The Chief Administrator expressed an immediate need for a social worker, nurses' aide, rehabilitation counselor, and two special education teachers.

The two special education teachers are needed because the institution was recently commissioned by the government to take into custody all delinquent, poverty stricken, orphaned, abandoned, and exploited children found in the streets. These children are held in custody for considerable lengths of time and, therefore, need education. Because of the personality, background, and educational deprivation of

these children, it is felt that special education teachers, who are familiar with these types of problems, should be employed to do the teaching.

Programs and Services

The objectives of Recuperation Center No. 2 are to provide shelter, temporary aid, treatment, and guidance for the clientele so they may become self-sufficient members of society. Ultimate plans and objectives of the center are to provide complete rehabilitation programs including psychological and vocational counseling, occupational therapy, and vocational training. The center worked rather informally until 1961, at which time a team approach was adopted, and a professional staff was hired to provide services.

The following activities and services are available to all of the clientele upon the recommendation of the professional staff, or, in some instances, upon the request of the client:

1. General medical treatment.
2. Social services.
3. Maintenance at the center.
4. Supervised family placement, i.e., maintenance in private low income homes. Each family receives $20.00 per month per person. In effect this helps the individual placed and also the family, as it usually costs somewhat less than $20.00 per month to maintain an individual in a low income family.

5. Referral to various organizations and institutions such as:

a. Committee for the Blind and Deaf

b. Casa del Nino (orphanage)

c. Roosevelt Hospital

d. General Hospital

e. Neuropsychiatric Hospital

f. Military Hospital

g. Social Security Hospitals

h. T. B. Sanatorium.

6. Limited psychiatric services by the gerontologist.

7. Limited psychological counseling by the social workers.

8. Limited occupational therapy. Some of the clientele make articles such as bedroom slippers, clothing, rugs, et cetera; however, they are of crude quality due primarily to the lack of equipment and adequate personnel for training.

9. Limited recreational activities. These activities are unorganized and extemporaneous.

10. Limited job placement. This service is also limited because of inadequate vocational counselors and vocational training programs.

11. Location of missing persons. The social workers and other personnel conduct an effective service in finding missing parents and relatives of the various clientele. Many case closures are obtained by placing the client with

friends or relatives.

12. Limited adoption services. A few of the orphaned or unwanted children have been adopted out.

13. Follow-up and family guidance services. The friends, relatives, or foster parents of a client may receive guidance and counseling. This service has proven effective in helping the clientele adjust to their new environment. This service is part of the regular follow-up services provided for all of the clientele.

Service Needs

The League and the institutional staff feel that their services should be extended in the following areas: (They are presently constructing two classrooms.)

1. Special education
2. Vocational (rehabilitation) counseling
3. Occupational therapy
4. Vocational training
5. General increase in all of the services offered at the institution
6. More and better coordination with the community agencies and institutions
7. Better cooperation with the police department and better legislation for the control of the poor and beggars.

Clientele

This institution has a very heterogeneous clientele. Their ages range from two months to over seventy years of age and their reasons for being in the institution are just as varied. Most of the clientele are referred by the police department, but a few are self-referrals or referrals from various other institutions or professional personnel. There are no written admissions criteria except for some informal rules that are often changed. Generally family relations and personal solvency are given considerable weight in deciding admittances. Individuals may be referred because of ulcers, mental disturbances, retardation, amputations, paralysis, poverty, senility, blindness, deafness, orphaned or exploited children, et cetera. The social workers are responsible for admitting clientele and for directing their institutional activities.

The number of clientele has recently increased because of a city ordinance directed to remove homeless and exploited children from the streets. All children found on the city streets after 10:00 P.M. are taken into custody by the police and brought to this institution. As a result, the number of children in the institution is increasing, especially between the ages of six and thirteen. These children generally have behavior problems which are not serious enough to warrant sending them to a detention home. It is hoped that special education and guidance will

rehabilitate these youngsters so that they may be returned to parents, relatives, institutions, boarding homes, or be adopted out. This particular phase of rehabilitation has not as yet been worked out satisfactorily. The placement of clientele is difficult and often impossible, necessitating the maintenance of clients at the institution. In January of 1963 the police brought thirty-one children into the institution and thirteen were still awaiting placement the following April. At present there are eight blind clients who can not be accepted for unknown reasons by the institutions for the blind. There are also some cases of "idiocy" and severe mental retardation who have been referred to the neuropsychiatric hospital, but who could not be received because the hospital was overcrowded. Other cases with chronic disorders such as ulcers, gastritis, et cetera cannot be received by other institutions for a variety of reasons. As a result, this center is overcrowded. Their capacity is seventy, but in April, 1963 there were one hundred and five clients living in the home.

Table 9 shows the clientele movement at the home during the year of 1962 before children and their mothers were admitted.

Comments

The Recuperation Center No. 2 of Guatemala appears to be an important and functional social service unit even though the services performed for the clientele are limited.

Table 9. Clientele Movement at Recuperation Center No. 2 in 1962

Clientele	Male	Female	Total
Clientele January 1, 1962	34	7	41
Clientele admitted during the year	66	36	102
Clientele that left during the year	62	28	90
Left voluntarily	5	--	5
Escaped	16	2	18
Referrals due to illness	13	7	20
Died	5	--	5
Placement and other reasons	23	19	42
Number of clientele at end of the year	38	15	53

It appears from the history of the center that its beginning was brought about by a strongly-felt social need. Originally its primary function was the placement and guidance of the clientele; however, it has become evident that it is impossible to find a suitable place for many of the clients. The Patronato and administrative personnel recognize the problems and they are formulating realistic plans for their solution. This may be seen from their list of needed services.

The institution appears to be relatively well administered and organized and it has the potential of becoming an

effective social rehabilitation agency after the perceived service needs have materialized.

* * * * *

Children's Polio Hospital

History and Development

The need for a children's polio center in Guatemala was first recognized in about 1948, at which time Dr. Monzon Malice organized special services for polio patients at Recuperation Center No. 1. In 1955, Drs. Monzon Malice and Miguel Aguilera planned and founded the present polio hospital. The hospital was organized for the treatment and rehabilitation of all young polio patients in either the acute or chronic stage. The majority of the patients ranged from six months to two years of age, since adult cases of polio are extremely rare in Guatemala. The clientele served today have essentially the same nature and characteristics as those served when the hospital was founded.

The hospital was founded in the old laundry building of the General Hospital. It is still located in the same building, but many changes have been made, such as the building of wheel chair ramps, addition of a wing which includes a special education room, and the construction of a playground for the children. A complete shop for the fabrication and fitting of prosthetic or orthopedic devices has

also been added. The number of professional staff members has increased and new positions created. Additional personnel included physical therapists, pediatricians, prosthetic and orthopedic technicians, nurses, dietician, anesthetist, and X-ray specialists.

Administration and Organization

The Children's Polio Hospital is owned and supported by the government under the Ministry of Public Health. It is an independent government unit and has no relation to the social security system. The hospital is administered by an executive director appointed through the office of the Minister of Public Health.

The Director is responsible for all institutional operations, however, the appointment of various staff members and major policy decisions must be approved by the Minister's office. The Minister is particularly interested in the hospital's operating budget, since this money must be appropriated by the National Congress.

Major policies such as the types of service programs that should be offered, eligibility requirements for service, personnel needs and standards, and hospital developments are decided by the Director, based upon his professional experience, perceived hospital needs, and staff recommendations. The Director then submits these recommendations to the Ministry of Public Health for consideration and approval.

The Director hires all personnel through personal interviews and practical examinations. The practical examinations are competitive and the individuals who are most capable of performing the required work are selected. The individuals selected by the Director to fill vacant positions are usually routinely approved by the Minister's office. New positions cannot be readily created and filled because of budgetary limitations.

Finance

The budget is prepared by the Director and his administrative staff and it is then submitted to the Minister of Public Health for approval. The Minister of Public Health usually makes some changes and presents the budget before the National Congress for appropriation. The Congress may also make some changes before appropriating money for the next year. The budget submitted to the Minister usually contains a number of increases; however, during the past few years these increases have not been granted and the budget has been approximately the same each year. Table 10 presents the monthly budget allocations of Congress for the support of this institution from July, 1957 to June, 1963. The budget is prepared according to the standard government fiscal year from July 1st to June 30th. It may be noticed from Table 10 that a budget increase was granted to become effective mid-year of 1962-63.

Table 10. Monthly Budget for the Children's Polio Hospital in 1957-63

Fiscal Year	Salaries	Operating Expenses	Monthly Total
1957-58	$3,885.00	$3,000.00	$6,885.00
1958-59	4,255.00	2,375.00	6,630.00
1959-60	4,600.00	2,219.00	6,819.00
1960-61	4,150.00	2,219.00	6,369.00
1961-62	4,740.00	1,889.00	6,629.00
1962 July-Nov.	4,740.00	1,889.00	6,629.00
1963 Dec.-June	4,740.00	2,219.00	6,959.00

Efforts were made to obtain monthly expense records from the Administrator, but none were available. Table 11 shows an average monthly itemization of operating expenses as estimated by the hospital Administrator.

Table 11. Estimated Monthly Operating Expenses of the Children's Polio Hospital in 1963

Expense Category	Amount
Food	$ 950.00
Medicines	300.00
Laboratory expenses	100.00
X-ray materials	100.00
Clothing	150.00
Prosthesis shop	400.00
General expenses	219.00
Total	$2,219.00

Facilities

The Children's Polio Hospital is located in the former laundry building of the General Hospital. It is a forty room two-floor concrete structure that was built about ten years ago. The building is in fair condition and has been extensively modified to serve as a polio rehabilitation hospital. Major changes include the addition of a wing, wheelchair ramps, prosthesis shop, playground for children, various room modifications, and the installation of sanitary utilities for hospital patients and staff.

The hospital has four wards with a total of eighty-seven beds for children and youths. The wards are divided according to age groups, and differentiation is not made with regard to sex except for older children and the few adults.

There are three administrative offices in the building. The Director and the Administrator have private offices and the third room is used for hospital office supplies, files, and records.

Because of the large number of school age children admitted for treatment, a special education classroom was constructed in the new wing added to the building. Approximately twelve children receive special instruction in the classroom each day.

Three rooms in the hospital are used exclusively for medical treatment. This is necessary because many of the patients admitted for rehabilitation are in the acute

stage of poliomyelitis. These patients must be kept in isolation and given intensive medical care until the acute stage has passed. One of the medical clinics is used for admittance examinations in addition to regular medical treatment, and another clinic also serves a dual purpose by serving outpatients as well as inpatients.

There are two physical therapy rooms. The main physical therapy section has eight bays that are used simultaneously for individual treatments, including some mechanical therapy. The second room used for physical therapy has a large and small division, each of which contains mechanical and hydrotherapy apparatus. The large division has a sunken pool which is functional but not used because of the high cost of hot water and poor control of the air and water temperatures.

The prosthesis shop occupies a large room which contains most of the necessary hand and power tools for the fabrication of prosthetic and orthopedic devices. Approximately twenty new prosthetic and orthopedic braces are constructed every month, and about forty others are repaired and/or refitted. The shop needs include a drill press, a nickel plating machine, and a hand sewing machine for shoe repair.

The hospital has one office for social services, a drug dispensary, X-ray room and film laboratory, and an operating room. These rooms are equipped with the minimum

essential apparatus necessary to provide effective social and medical services for the patients.

There are also two dining rooms, a kitchen with two domestic purpose rooms, and several small areas and rooms used for sterilization apparatus and storage of materials and equipment.

Personnel

The Director of the hospital selects all personnel and recommends their appointment to the Ministry of Public Health. The Director's recommendations are based upon applications filled out by the prospective employees, personal interviews, and practical on-the-job examinations. Emphasis is placed upon the individual's training and ability to perform in a work setting. The employees are hired on a two month provisional basis, during which time they are subjectively evaluated by the Director and other staff members. If a particular employee does satisfactorily during this trial period, the Director recommends his permanent appointment to the Minister of Public Health's office. The rate of personnel turnover is very low; there is an average change of two employees per year. Although requests have been made to increase the professional staff, it has not been possible to do so in recent years because of the limited budget.

The personnel have no incentive plan or opportunities for advancement other then inservice training and occasional

professional seminars. Employees are covered by social security and they receive twenty days of vacation each year.

An administrative and service personnel list is presented in Table 12 which also shows the hours worked per week and salary earned per month and per hour for each employee.

Table 12. Personnel and Salary Schedule of the Children's Polio Hospital in 1962

	Position	Hours Per Week	Pay Per Month	Wages Per Week
Administration department				
1	Director and medical specialist in rehabilitation	15	$300.00	$5.00
1	Administrative secretary	44	150.00	.85
1	Secretary	44	50.00	.28
Service Department				
1	Physician--physical medicine	10	100.00	2.50
1	Physician--orthopedic surgeon	10	70.00	1.75
2	Medical interns	15	60.00	1.00
1	Chief physical therapist	30	120.00	1.00
2	Graduate physical therapists	30	90.00	.75
10	Physical therapy aides	30	60.00	.50
1	Physician--pediatrician	10	150.00	3.75
1	Physician--pediatrician	10	140.00	3.50
2	Graduate nurses	35	100.00	.71
1	Physician--laboratory consultant	10	100.00	2.50
1	Physician--X-ray	10	50.00	1.25
1	X-ray technician	30	60.00	.50
1	Anesthetist	5	60.00	3.00
1	Dietician	40	40.00	.25
17	Nurses aides	30	60.00	.50
4	Nurse maids	30	30.00	.25
1	Social worker	30	200.00	1.66

Programs and Services

The objectives of the institution are to isolate and give intensive medical treatment to patients with acute poliomyelitis. After they have reached the chronic stage, the hospital objectives are to rehabilitate the patients and then return them to their families. When patients no longer require daily treatment, they are discharged from the hospital and scheduled for outpatient treatment. If the patients return to receive outpatient treatments regularly, they make satisfactory progress in their rehabilitation. However, many patients do not return for adequate outpatient care, hence some regress and become invalids. Patients are considered rehabilitated when they have completed their outpatient treatment and are able to function satisfactorily in society.

All patients with polio are accepted for treatment at this hospital. If there are no beds available, each patient waits his turn for admittance. Patients on the waiting list are given minimal medical treatment and guidance until they can be admitted for inpatient treatment.

All children brought to the hospital must have a sponsor to present them for admittance. The sponsor may be a parent, relative, or friend who is willing to assume responsibility for the child after discharge. It is necessary to do this because many parents or relatives bring children to the hospital and abandon them. In such cases

the hospital must take care of them indefinitely or find a foster home for them. This practice stems from the popular belief that the state is responsible for the care of all sick and disabled persons in the country.

Table 13 presents the various services provided at the hospital and the approximate percentage of patients receiving each service.

Table 13. Services Offered at the Children's Polio Hospital in 1962

Service Category	Patients Receiving Service
Medical treatment	100%
Social services	100%
Physical therapy	100%
Prostheses	100%
Training in ADL	100%
Hospital maintenance	100%
Outpatient treatment	100%
Special education	20%
Follow-up	50%
Avocational activities	5%

Table 14 shows the kinds and numbers of services administered to inpatients during the month of November, 1962. Table 15 shows the same statistics for the outpatients.

Table 14. Services Offered Inpatients at the Children's Polio Hospital in November, 1962

Service Category	Number of Treatments
Individual muscular exercises	801
Heat treatments	295
Hydrotherapy	403
Ambulation training	633
Verticalizations	329
Mechanical exercises	70
Tractions	24
Spinal taps	28
Gymnasium classes	21
Spinal column examinations	5
Muscular examinations	15
Orthopedic consultations	26
Total	2,670

The Director feels that all of the services in the hospital should be improved and expanded, and treatment should be made available for cerebral palsy and meningitis patients. There is a need for psychological, placement, and follow-up services. A section should also be added to the hospital for preventive medicine. The latter could employ mobile units for conducting virological research and

vaccination campaigns throughout the Republic.

Table 15. Services Offered Outpatients at the Children's Polio Hospital in November, 1962

Service Category	Number of Treatments
Individual muscular exercises	303
Heat treatments	100
Ambulation training	348
Verticalizations	105
Mechanical exercises	110
Tractions	60
Paraffin treatments	15
Muscular examinations	10
Spinal column examinations	6
Orthopedic consultations	17
Total	1,074

Clientele

Patients are admitted for treatment from all of the Departments since this is the only polio hospital in Guatemala. This may be seen from Table 16, which shows the number of patients from various departments at the hospital on August 7, 1961.

Table 16. Geographical Origin of Patients at the Children's Polio Hospital on August 7, 1961

Department in Guatemala	Number of Patients
City of Guatemala	14
Department of Guatemala	9
Escuintla	12
Suchitepequez	4
Santa Rosa	5
Sacatepequez	2
Jutiapa	4
Rehalhuleu	2
Chimaltenango	2
Solola	1
Quezaltenango	2
Totonicapan	1
Peten	1
Quiche	2
San Marcos	1
El Progreso	5
Baja Verapaz	1
Chiquimula	2
Izabal	5
Zacapa	1
Unknown	1
Total	77

The hospital has an inpatient capacity of eighty-seven. In 1960, there was an average of sixty-seven inpatients throughout the year. This figure increased to seventy-seven in 1961, and dropped back to sixty-six in 1962. These figures reflect the prevailing polio incidence in Guatemala.

The average patient spends six months in the hospital and about eighteen months as an outpatient. Outpatient control is poor, and many patients do not return for treatment. The average sex ratio for inpatients for the years of 1960-1962 was 53.9 per cent males to 46.1 per cent females.

The age ranges and numbers of inpatients treated at the Children's Polio Hospital during the years from 1952 through 1962 are presented in Table 17.

Table 17. Age Range and Number of Inpatients Treated at the Children's Polio Hospital from 1952-62

	Age Ranges								
Year	0-2	3-5	6-8	9-11	12-14	15-17	18-20	21 or More	Total
1952	74	18	7	3	3	-	1	5	111
1953	112	22	5	2	-	-	-	1	142
1954	113	17	3	2	-	-	1	3	139
1955	70	15	4	-	3	-	1	3	96
1956	95	30	9	5	2	1	2	2	146
1957	78	34	19	8	2	-	2	1	144
1958	95	25	21	8	6	-	-	2	157
1959	143	37	11	7	7	4	-	1	210
1960	70	18	9	3	3	1	-	3	107
1961	171	25	8	8	1	-	1	2	216
1962	75	18	8	4	1	1	-	-	107

Comments

The services at the hospital appear to meet the minimum needs of the inpatients; however, rehabilitation cannot be fully effective unless the outpatients receive protracted

treatment. This service may be improved by providing effective follow-up and transportation for the outpatients. Outpatient clinics could be established at strategic points throughout the country and coordinated by the hospital. Also mobile outpatient clinics may be used for areas which do not warrant a permanent outpatient post.

Social services need to be increased since many people do not assume responsibility for members of their family who have been stricken by some incurable or chronic disease. Also many of the children brought to the hospital are illegitimate and their mothers do not want or cannot assume responsibility for the children.

* * * * *

Alcoholics Sanatorium

History and Development

A group of citizens recognized that alcoholism was becoming a major problem in Guatemala and especially in Guatemala City. They observed increasing numbers of inebriated individuals who could not control their liquor consumption. Consequently, this group of citizens formed an Anti-Alcoholic League (Patronato Anti-Alcoholico) in 1946 for the prevention and rehabilitation of alcoholics. They petitioned the government for an allocation of money on the

basis of Article 33 of the Alcoholic Law of Guatemala. The Anti-Alcoholic League received a grant in 1951 with which they founded the "Sanatorio Antialcoholico." The objectives of the sanatorium are the same today as they were when it was founded--to serve as a unit for the prevention and rehabilitation of alcoholics.

Administration and Organization

The sanatorium is a legal corporation under the laws of Guatemala and is governed by a set of by-laws written by members of the Anti-Alcoholic League. There are two classes of memberships in the association:

1. Active--Those who "should" attend all meetings and conduct the affairs of the League. Many of these members assume a rather passive role in League affairs.
2. Honorary members--These are supporting members for the League. They may donate their interest, influence, money, skill, or labor for furthering the objectives of the League.

Once each year, the general assembly of the League elects officers and members to a Board of Control. The Board of Control is composed of a chairman, two vice-chairment, six voting members, and a general recording secretary. It holds meetings twice each month for the purpose of conducting the League's affairs. However, these meetings usually have low

attendance, and most of the League's business is conducted by a few members.

The sanatorium operations are controlled by an executive director. The Director, a psychiatrist, has full responsibility for all activities carried out in the hospital, including administration, clinical examinations, and alcotherapy. He is appointed by the League; however, the League is loosely organized and exercises little control over sanatorium operations. The League finds it difficult to obtain members who are interested in, and understand, the problems of alcoholism.

Finance

Shortly after the sanatorium opened, the government funding was reduced considerably and has never been increased again. The sanatorium became economically dependent upon the League, patient fees, and donations.

The budget is prepared by the Director and is then approved by the League's Board of Control. Table 18 shows the amounts and sources of income for the fiscal years of 1959-61. The fiscal year is from July 1st to June 30th.

Table 19 shows the expenditures of the sanatorium as they are usually categorized by the administrative personnel.

Table 18. Sources of Income for the Alcoholics Sanatorium from July 1, 1959 to June 30, 1962

Year	Govt.	Patient Fees	Dona-tions	Truck Garden	League*	Total
1959-60	6,000.00	21,155.88	1,013.00	327.54	3,182.54	31,679.40
1960-61	6,000.00	23,636.38	960.00	233.35	1,269.09	32,098.82
1961-62	6,000.00	22,710.98	960.00	256.85	348.65	30,276.48

*This is an estimate of the monies received from the League (Patronato). The figures are not exact because the expenses generally do not equal income since there may be a surplus or a deficit in any one particular fiscal year.

Table 19. Alcoholics Sanatorium Expenditures From July 1, 1959 to June 30, 1962

Expense Category	1959-60	1960-61	1961-62
Salaries	16,026.80	16,830.33	16,726.57
Food	7,380.93	7,569.84	6,926.14
Overhead	1,815.38	1,379.07	1,004.19
Medicines and materials	2,999,90	2,900.97	2,412.46
Building maintenance	1,384.29	1,580.02	1,438.40
Vehicle maintenance	512.79	495.43	409.24
Office supplies	71.75	37.95	112.97
Contingencies	272.44	384.48	390.65
I.G.S.S.	1,215.12	920.73	855.86
Total	31,679.40	32,098.82	30,276.48

Facilities

The Alcoholics Sanatorium owns two buildings located in a suburban district of Guatemala City--the sanatorium and a residence for the Director.

The sanitorium is a one-floor abode building that was built eleven years ago to serve as an alcoholic sanitorium. It has modern utilities as well as large parking and recreational grounds.

There are eighty rooms in the sanatorium of which four are service rooms. There are two medical clinics, one psychotherapy room, and a small hydrotherapy room used for immersion baths. Other rooms include two administrative offices, two dining rooms, a chapel, and a small library. The sanatorium has three wards and each ward is divided into bedrooms large enough for one bed and night stand. One ward has thirty bedrooms, while the other two have fifteen in each, which makes a total of sixty bedrooms in the sanatorium.

Personnel

The Director makes all personnel appointments in accordance with his perception and judgement of institutional needs. These appointments are restricted to filling vacancies since all newly created or abolished positions must be authorized by the Board of Control. Table 20 is a list of personnel presently employed at the sanatorium.

Table 20. Personnel and Work Schedule at the Alcoholics Sanatorium in 1962

Position	Hours Worked per Week
Director-psychiatrist	20
Administrative secretary	45
Psychiatrist	28
Final year medical student	20
5 nurses (including one female) . . .	45
Officer of the secretariat (clerk) .	45
Domestic personnel	--

The professional service staff has been reduced since the sanatorium was founded in 1951. During its first year of operation, the service staff consisted of three physicians, one psychometrist, eight nurses, and three shop teachers. Because of economic conditions, the present service staff has been reduced to two physicians, one medical student, and five nurses. The Director expressed immediate need for a psychologist, psychometrist, occupational therapist, social worker, female nurse, and two male nurses.

There is practically no personnel turnover except for an occasional change in the domestic staff. Opportunities for advancement are very limited, and there are no immediate plans for increasing the number of staff. All these conditions are attributed to a limited budget. Fringe

benefits for the employees include social security, free medical attention, one month's extra salary each year, and occasional tips from the clientele.

Programs and Services

There was no charge for services at the sanatorium during its first few years of operation. When the government allocation was reduced, it became necessary to charge patients a fee in order to obtain additional operating funds. The Director feels that charging the patients a fee makes the rehabilitation services more effective. Each patient admitted for treatment (with some exceptions) must pay a $40.00 deposit. The patient is charged $4.00 for each day that he remains an inpatient. These charges are deducted from the patient's initial deposit, and any excess money is refunded or additional fees are collected when the patient is discharged.

The services rendered at the sanatorium are primarily psychiatric and medical, with limited physical therapy and outpatient care. These services (except physical therapy) are prescribed and administered to all of the patients by the physicians. Physical therapy treatments are limited to immersion baths given by the nurse attendants.

Table 21 presents the nature and extent of the services rendered in 1962.

All discharged patients are asked to return for about thirty outpatient treatments. The average outpatient receives

one treatment per week at first; the number is then gradually reduced to one visit per month. The majority of the patients do not complete their treatment series, and some of the more difficult cases are readmitted for further inpatient treatment.

Table 21. Services Rendered at the Alcoholics Sanatorium in 1962

Service Category	Number of Treatments
Entrance examinations	525
General medical examinations	1,196
Diathermy treatments	28
Convulsive therapy	152
Saline and plasma transfusions	880
Injections	8,194
Psychotherapy sessions	798

Clientele

The sanatorium treats persons with acute alcoholism, alcoholic psychosis, or other complications caused by excessive alcohol consumption. Because of the limited professional staff, only those individuals are admitted who may still benefit from the treatment or "rehabilitation" services provided in the sanitorium.

The patients admitted for treatment are not

classified in any manner other than simply "alcoholics" and their treatment is also rather undifferentiated. Patients that are in need of some special service such as surgery, or who have some contagious disease, are immediately referred to another institution.

The ages of the patients range from seventeen to seventy, with the greatest number found between thirty-one and fifty years of age. Table 22 shows the ages and number of patients treated during the years of 1960 and 1961.

Table 22. Ages and Number of Patients Treated at the Alcoholics Sanatorium in 1960 and 1961

Age Range	Number of Patients 1960	1961
17-20	5	3
21-30	107	75
31-40	178	196
41-50	167	151
51-60	56	66
61 or more	29	33

Table 23 shows the number of patients by sex who received treatment during the years of 1960-62. Since the average patient remains in the sanatorium from five to eight days, the figures approximate the total number treated each year.

Table 23. Sex and Number of Patients Treated at the Alcoholics Sanatorium in 1960-62

Year	Males	Females	Totals	Daily Average
1960	522	20	542	10
1961	512	12	524	10
1962	508	17	525	9

Comments

The building and facilities of the Alcoholics Sanatorium are spacious, relatively well equipped, and in good condition; however, there is a conspicuous absence of activity. At present the average number of inpatients per day is ten, whereas the capacity of the institution is sixty.

The average patient remains at the sanatorium for one week. Actual rehabilitation can not take place in such a short period since alcoholics are extremely difficult to rehabilitate. It may be possible for the outpatient clinic to effect some degree of rehabilitation; however, most of the patients do not return for treatment.

* * * * *

Mental Health Clinic

History and Development

The development of the Mental Health Clinic was primarily the work of Dr. Carlos F. Mora who was in charge of practicum training for medical psychology and psychopathology students of medicine at the University of San Carlos. In his efforts to find a satisfactory place to train his students, he volunteered to direct the outpatient clinic at the Neuropsychiatric Hospital. During the time he was director, he perceived that many patients receiving treatment and consultation manifested considerable resistance and did not care to utilize outpatient services. On the basis of his experiences, he assumed that much of their resistance was due to the stigma of receiving treatment at the Neuropsychiatric Hospital. Therefore, he considered it wise to separate this clinic from the hospital. In 1955 he obtained funds from the Ministry of Public Health for the foundation of the present Mental Health Clinic. He organized the clinic to provide outpatient treatment for the Neuropsychiatric Hospital patients and to conduct special examinations for other agencies and institutions in the community. The clinic is also used as a treatment center for cases which do not require hospitalization.

Administration

This small clinic is administered by an executive

director who is in charge of clinic operations. All administrative actions and decisions concerning personnel, budget, clientele, services, and purchases are the responsibility of the Director. He reports directly to the Minister of Public Health.

Finance

The clinic is operated from two sources of income. Patients who are able to pay are charged a service fee of twenty-five cents for each visit. In addition to the service fees an annual grant of $11,928.00 is received from the office of the Minister of Public Health. The budget is prepared annually by the Director and submitted to the Minister of Public Health for approval. The annual allocation has been the same for the last few years and efforts to secure additional operating funds from the government have not been successful.

Facilities

The clinic is located on the second floor of an abode building that was originally constructed as a private home. Five rooms on the second floor are used by the Mental Health Clinic, while the first floor is occupied by the Mental Hygiene League. The Mental Health Clinic uses one room for each of the following services: (1) adult outpatient consultations, (2) children's services, (3) psychological services, (4) social services, and (5) medical

psychiatric treatment.

The clinic shares a secretarial office on the first floor with the Mental Hygiene League. The hallway in front of the adult consultation office serves as a waiting room for the patients. The facilities for the clinic are generally inadequate, but they cannot be improved at this time because of budgetary limitations.

Personnel

All of the clinic personnel work on a part-time basis. They average from five to fifteen hours per week depending upon their case load. As a result, it is necessary for them to augment their salaries by accepting other part-time or full-time employment. At present there are five members on the professional staff.

The staff consists of two psychiatrists, a psychology student from the University of San Carlos, a social worker, and a nurse. The Director, a psychiatrist, is in charge of all adult patients and the other psychiatrist is responsible for children's services.

In addition to the regular part-time staff, medical students from the University of San Carlos periodically receive some of their psychiatric practicum at the clinic. However, their work is primarily training and does not materially increase the service capacity of the clinic.

Programs and Services

Since the clinic is small all of the programs and services are of a limited nature. However, some patients do receive long term treatment at the clinic. A considerable amount of diagnostic work is done for various government institutions and for some private organizations. All of the patients who are admitted for treatment to the Neuropsychiatric Hospital must first be examined at this Mental Health Clinic. Individuals may also refer themselves for diagnosis and treatment. All patients who are referred to the clinic are given a general diagnostic examination. A team approach is used for each examination under the direction of one of the psychiatrists. The psychiatrist in charge reviews each patient's record at a case conference and then prescribes treatment or referral to another institution.

The following services are available at the clinic for adults and children:

1. Diagnostic examinations
2. Drug therapy
3. Psychotherapy
4. Electroshock treatment
5. Psychological services
6. Personal-social counseling
7. Marriage counseling
8. Vocational counseling

9. Social services for clientele and/or parents.

The patients who are accepted for treatment at the clinic receive treatments for various lengths of time depending upon the nature of their problem. Some epileptics have been treated for several years, while psychoneurotic cases average six months. The shortest term cases are patients seeking various forms of psychological and social counseling. These cases may receive no more than one interview or they may obtain weekly counseling for as long as three months.

The frequency with which patients are treated varies according to their particular problems. Epileptics may be treated each week or as seldom as once per month. Patients receiving psychosocial counseling are usually scheduled for one interview per week, while more serious cases involving psychoneurosis or psychosis may be treated more often.

Clientele

The clinic is open to anyone in Guatemala who is in need of neurological, psychiatric, or psychological services and who cannot afford to receive treatment from a private practitioner. Due to economic conditions in Guatemala, practically all of the people are eligible for services at this clinic. Patients may refer themselves or they may be referred from other individuals or organizations.

There are generally two classes of patients who receive treatment at this clinic:

1. Outpatients who have not or will not receive similar treatment from another institution.
2. Outpatients or individuals who will be inpatients at some other institution.

All patients with neurological, psychiatric, or psychological problems who do not require hospitalization may be treated. Patients may have functional or organic psychosis, neurosis, brain damage of various types, marital or social problems, or simple transitory frustration states.

Table 24 shows the number and types of adult patients treated during the years of 1960-62.

Table 24. Adult Patients Treated at the Mental Health Clinic in 1960-62

Type of Disability	Numbers of Cases 1960	1961	1962
Brain damage and diseases:			
Acute, rapidly developing	180	169	133
Chronic	383	395	420
Mental retardation	34	22	32
Psychogenic disorders:			
Psychotic	72	74	103
Psychophysiological	33	42	28
Psychoneurotic	75	82	113
Personality disorders	27	16	22
Totals	804	800	851

Approximately 900 patients are treated at the clinic in one year, and as can be seen from Table 24 most of them are adults. About 50 to 100 children (age fourteen or below) also receive treatment, but no statistics were available. Children are treated for various neurological, emotional, intellectual, school, family, behavior, and psychosomatic problems. Efforts are also made to treat the parents or relatives at the same time the children are treated, since it has been found that many of the etiological factors in the children's problems involve their immediate environment.

Comments

This clinic was organized to provide limited services for the outpatients of the Neuropsychiatric Hospital. Although additional services are being provided to other clientele, moving this clinic from the hospital did not materially change its purpose and function. It is still an outpatient clinic for mentally or emotionally disturbed individuals.

While it is true that the services offered in this clinic are important and necessary for the rehabilitation of mental patients, its effectiveness as a rehabilitation unit by itself is limited. It may be advisable for this clinic to work in conjunction with other rehabilitation type agencies and institutions in the community.

* * * * *

Robles Institute

The Robles Institute is an eye clinic owned and operated by the Committee for the Blind and Deaf (Comite Nacional Pro Ciegos y Sordomudos). The Committee is a private enterprise established to provide preventive, medical, and rehabilitation services for the blind and deaf in Guatemala. It consists of a central committee and a group of service organizations which provide special services for the blind and the deaf.

The function of the central committee is to procure money, coordinate, and administrate the various service organizations. The Committee operates a very successful lottery called "Santa Lucia" which provides most of the revenue for the support of the service organizations. Additional income is obtained through the sale of baskets, rugs, and other articles manufactured at a workshop for the blind operated by the Committee. However, this is not the usual rehabilitation workshop because its primary purpose is to manufacture articles for resale and not to provide vocational training for the blind. Efforts are made to retain the productive employees after they have been trained, rather than to find them employment in the community.

With the exception of the Robles Institute, the service organizations of the Committee are of an educational, or social welfare nature. The Committee has recognized the need

to provide vocational training for the blind, and they are presently in the process of planning and constructing a vocational rehabilitation center.

It was not possible to obtain detailed information about the Committee and its organizations because of the apprehension created by the survey. The survey may have been perceived as an "investigation" that might harm the Committee or reduce its competitive advantage with other agencies and institutions in Guatemala.

History and Development

The Committee opened an ophthalmological clinic in 1956, for the purpose of providing medical treatment for the blind and partially sighted. During the first year of its operation, 125 patients were treated, and the following year the number increased to 167. The operation of the clinic was considered so successful that in 1957 similar services were established in Quezaltenango and Antigua.

Thirteen months after the opening of the opthalmological clinic in Guatemala City, it was moved to its present location in order to provide more room for facilities and services. In 1959 the clinic examined 1,245 patients, and by 1960 the number of patients examined or treated reached 4,053.

In 1960, the Committee decided to centralize some of its services located in Guatemala City. The opthalmological

clinic was selected for expansion and other services were moved to the clinic. This amalgamation of services marked the foundation of the present "Instituto Rodolfo Robles." According to the administrator, services in odontology, general medicine, laryngology, otology, ophthalmology, pediatrics, psychiatry, psychology, social services, and speech therapy are currently available at the Robles Institute.

Administration and Organization

The Robles Institute is administered by an executive director in charge of all institutional operations. Major policy decisions involving the kinds of programs and services, eligibility requirements for service, selection of administrative personnel, creation of new staff positions, capital outlay, and preparation of the budget are made by the central committee personnel. The Director is responsible for the administration of all examinations, treatments, and operations conducted at the clinic. He works closely with the central committee and his staff in the preparation of reports and recommendations regarding services and clinic operations. These reports and recommendations are submitted to the central committee for consideration and approval.

The Robles Institute is a member of the Committee's coordination system and it works cooperatively with the other service units. Since this institute has centralized many services, the other committee units are dependent upon this clinic for certain services. There is little or no

coordination or service exchange outside of the Committee's organizations.

Finance

The budget is prepared by the Director and the administrative staff and is then presented to the central committee for review and approval. The Robles Institute receives most of its operating funds from the Committee, with minimum fees being received from the clientele. All of the clientele must be interviewed and approved by the social service department before they may receive clinic services, except in cases of emergencies. The social service department makes judgements as to which clientele should pay a service fee. The charge for the first consultation is fifty cents and twenty-five cents for all subsequent visits. However, approximately 90 per cent of the clientele receive services at no charge.

Clients have the opportunity to purchase eye glasses for $3.00. A large supply of lenses are kept in stock. If the particular lens needed is not in stock, it is obtained for the client at one-half cost.

Facilities

The Robles Institute is located in a former private house which has been modified to serve as a clinic. Most of the modifications were made to facilitate the installation of various apparatus. The institute is a one-story abode building about forty-five years old and is in fair condition. It

is of typical Spanish architecture with a large patio in the center of the building. The various service offices are located around the open patio.

There are a total of twenty-two rooms in the building of which nine are service offices or clinics. The institute has a bed capacity for eighteen inpatients; there are fourteen beds for adults and four cribs for children. Because of the very limited inpatient facilities and the nature of the services provided, most of the clientelé are treated on an outpatient basis. The following rooms, offices, and clinics are found in the institute: two administrative offices, a small professional library, two eye examination and treatment clinics, two operating rooms for eye and ear surgery, laryngology clinic, dental clinic, mental health clinic, speech and hearing clinic, laboratory, pediatrics and internal medicine office, social services office, four wards for inpatients, and four domestic and utility rooms.

The eye examination and treatment clinics are used mostly for refraction work with outpatients and for the diagnosis and treatment of various eye diseases. These two clinics are equipped with relatively modern refraction, optical, and medical apparatus. The two rooms used for eye and ear surgery are not adequately equipped, as they consist simply of two rooms with an operating table in the center of each room. No other modifications or apparatus have been installed such as instruments, cabinets, oxygen and other

gases, proper lighting, et cetera. Each surgeon must bring his own instruments for the particular operation he plans to perform, and many times he must bring his own drugs. The institute recently received $5,000.00 worth of surgical tools from the Cooperative for American Remittances to Everywhere, Incorporated (CARE); however, they had not been inventoried and put into use at the time of this survey.

The dental clinic is well equipped except for the absence of X-ray facilities. When an X-ray plate is needed, the client is sent out to another private clinic.

The speech and hearing clinic is composed of two sections. The main portion of the room is equipped as a small classroom and may be used for speech therapy. One corner of this room is walled-off to form a sound-proof chamber for testing the clients' hearing ability and for fitting hearing aids. It is equipped with an audiometer and headphones, but no external controls. The efficiency of the sound-proofing is poor, and extraneous sounds interfere with the proper function of these facilities.

Personnel

The institute has twenty-three employees of whom only four are full-time professional staff. However, some of the personnel work part-time at other service organizations operated by the Committee. Table 25 shows the number of service personnel and their temporal status. All of the

personnel listed are paid employees, except one oculist who is a part-time volunteer.

Table 25. Personnel Schedule of the Robles Institute in 1962

Title	Number	Full-Time	Part-Time
Psychiatrist	1		X
Physicians	2		X
Oculist	2	F	
Oculist	3		X
Laryngologist	1		X
Dentist	1		X
Psychologist	1	F	
Social worker	1	F	
Speech therapist	2		X
Nurses or aides	9	F	

Fringe benefits for the employees include free institutional services, social security benefits, and a Christmas bonus equal to two weeks' salary.

Programs and Services

The objectives of this institute are to combat blindness and deafness in Guatemala through prevention programs, clinical examinations, and medical-surgical treatment. The

institute serves as a central service unit for all of the other committee organizations. In addition to the regular examinations and treatments given to patients at the institute, special services such as psychiatric and psychological examinations, and social services are provided to clientele referred only for these specific services.

The physicians working at the institute determine the eligibility of the clients to receive services, and the social worker decides which clients should pay a service fee. Case closures are made at the institute when the patient's examinations or treatments have been terminated or when they have been transferred to another service organization.

The following services are offered at the Robles Institute:

1. Eye examinations and the issuance of glasses
2. Ophthalmological examinations and treatment
3. Ear, eye, nose, and throat surgery
4. General medical treatment
5. Hearing and speech therapy
6. Issuance of hearing aids
7. Dental services
8. Limited psychiatric services
9. Limited psychological services
10. Operation of mobile units for field examinations
11. Social work services
12. Limited follow-up.

Clientele

The services offered at the Robles Institute are available to individuals of all ages and socio-economic levels, but most of the clientele are adults and children from the lower income groups who are experiencing difficulty with their vision. Clientele are received from all parts of Guatemala and efforts are constantly being made to extend services to remote areas. A prevention program initiated in 1960 utilizes mobile service units which examine children in the city and rural schools. All of the third grade children in the various elementary schools are given visual acuity examinations each year. Children who are found to need eye services are referred to the institute.

Table 26 shows the total number of inpatients and outpatients served during the years of 1960-62.

Table 26. Clientele Served by the Robles Institute in 1960-62

Service Category	1960	1961	1962
Eye examinations or treatment	4,503	8,229	8,431
General medical	153	940	1,091
Ear, nose, and throat	257	883	870
Speech and hearing	214	1,046	506
Dental work	206	445	394
Psychiatry	68	112	60
Psychology	3	16	74
Operations	33	198	625+

Table 27 shows the number of children and adults of each sex who received services during the year of 1962. Clientele up to the age of fourteen were classified as children.

Table 27. Children and Adult Clientele Served by the Robles Institute in 1962

Service Category	Children		Adults	
	Male	Female	Male	Female
Ophthalmological and optical	1,515	1,719	2,273	2,924
General medical	215	197	300	379
Ear, nose, and throat	213	132	247	278
Speech and hearing	117	82	131	176
Dental work	163	48	112	71
Psychiatry	26	22	9	3
Psychology	37	24	7	6

Comparison of the service figures presented in Tables 26 and 27, with the number of beds at the institute, indicate that most of the clientele were treated on an outpatient basis. In 1962, the institute admitted 141 male and 169 female inpatients. During the same year, 140 male and 165 female inpatients were discharged. These discharges refer only to the Robles Institute, as some of the clientele continued to receive various services or benefits from other

organizations operated by the Committee.

Comments

The Robles Institute is primarily a medical examination and treatment clinic. Apparently the Committee plans to consolidate their service units into a few convenient centers. The Robles Institute may serve as an admittance and general treatment center for prospective rehabilitation program clientele. After the clients have been treated for the acute stages of their disability and inititated into the primary phases of rehabilitation, they may be referred to the newly-planned vocational rehabilitation center. The Robles Institute, plus the newly-planned vocational rehabilitation center and the other service organizations of the Committee, may create an effective rehabilitation program for the blind. It might also be advantageous to the Committee and the community if the Robles Institute and other service units of the Committee would seek cooperation and coordination with agencies and institutions outside of the Committee for the Blind and Deaf.

* * * * *

The Neuropsychiatric Hospital

History and Development

The Neuropsychiatric Hospital, was referred to as the "Mental Asylum" when founded in 1890. Previous to 1890, mentally disturbed patients in Guatemala were confined in prisons. The institution was founded by two physicians, Drs. Manrique and Azurdia, and Mr. Isidro Gandara. These men formed the first staff of the newly-founded institution, whose objectives were to provide free treatment and housing for all mentally ill individuals.

Legally, the institution came under the charter of the General Hospital, and was administered and financed through it with government funds. The asylum remained a part of the General Hospital until 1945, when it became an agency of the Ministry of Public Health. The objectives of the institution today are the same as they were when founded, and its legal basis has not changed since 1945.

When founded the Neuropsychiatric Hospital consisted of a large two-story masonry building with ten rooms on the first floor and four large rooms on the second floor. It had nine wards, five for men and four for women, with a capacity for 700 patients.

The institution has suffered from two natural catastrophes. The building was destroyed by the earthquake of 1917 after which it was rebuilt to its original size. The

building was later enlarged by the addition of new wards and boarding facilities. In 1960 the entire plant was destroyed by a fire, in which several hundred patients lost their lives, and all of the records were burned. Institutional operations were temporarily moved to the Instituo Nacional de Avrones and Escuela de Comercio. During this period, a yet unfinished section of the San Vicente T.B. Sanatorium was modified for the new location of the Neuropsychiatric Hospital.

Services

When the institution was founded, services consisted mainly of confinement and some general medical treatment. It was not until Dr. Mora, a psychiatrist, became Director in 1926 that some psychiatric treatment was provided. Later in 1931, Dr. Molina, a staff psychiatrist, was appointed Director of the institution. He reorganized and improved services and for the first time, patients were classified according to their disability. Dr. Campo, the present Director, is attempting to make further improvements in the quality of services, but he is hampered by a low budget/patient ratio. In spite of these difficulties, the institution presently offers relatively modern but inadequate services to its patients.

Staff

At the beginning the institution's staff consisted of two self-trained psychiatrists, eight male and eight

female nurses. Although the staff was enlarged in subsequent years as the influx of patients demanded, it has never reached a satisfactory or desirable staff/patient ratio which could provide effective treatment and rehabilitation to the patients.

Clientele

At the time of its founding, the clientele consisted of 80 patients who had been removed from the various city jails. The number of patients rapidly increased and exceeded the 700 patient capacity of the institution and by 1960, before the fire, there were 1,500 patients in residence. On January 31, 1963 facilities at the Neuropsychiatric Hospital provided for 500 inpatients; however, there were actually 1,103 adult patients and 48 children in residence. Since this is the only neuropsychiatric institution in Guatemala, patients are received from all parts of the country.

Administration and Organization

The Neuropsychiatric Hospital is a governmental institution which is authorized by the Ministry of Public Health. All institutional operations are under the control of an appointed Director who personally directs the services provided by the institution, assisted by an administrative officer. The administrative officer has charge of finances, office management, records, personnel services other than professional, purchases, and general institutional

operations.

Under the administrative officer is a chief of personnel who is in charge of the graduate nurses and the Sisters of Charity. The Sisters of Charity in turn direct the domestic staff and the nurses aides (see Figure 3). The administrative staff is chosen by the administrative officer through interviews, and practical on-the-job examinations.

Policy Determination

Major policies are always approved by the Director and in certain instances, the Director must obtain the approval of the Ministry of Public Health--e.g., the budget, major changes in the physical plant, services, et cetera. Programs and services are generally determined by the Director, with the advice of his professional service staff. As far as possible, services offered are based upon the needs of the patients. Eligibility for services is determined by the Director, who also determines professional personnel needs and standards. Other policies may originate from the various members of the administrative staff.

Training

The training and experience of the administrative staff are generally limited to on-the-job experience at the Neuropsychiatric Hospital. Budgetary limitations make it very difficult to hire trained and experienced personnel.

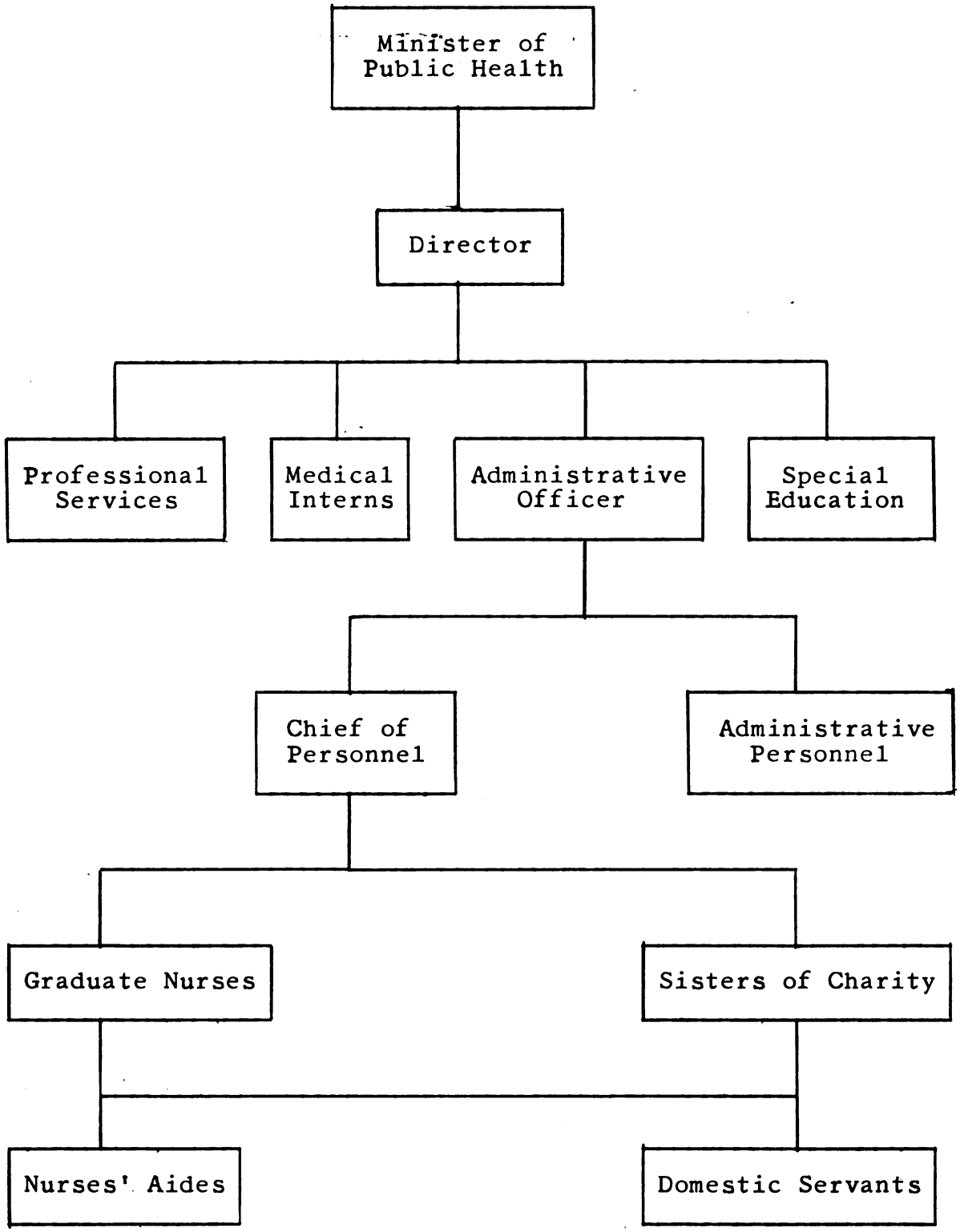

Fig. 3.--Organization chart of the Neuropsychiatric Hospital.

Finance

The administrative officer is responsible for the financial affairs of the institution, assisted by the chief of personnel and the accounting department. Personnel are paid directly by the administrator and his chief of personnel. All other accounting of expenditures are handled through the accounting department; however, the auditing is done directly by the office of the Minister of Public Health. The fiscal year runs from July 1st to June 30th, and most institutional business is conducted on a monthly basis. The budget is formulated in May, at which time the Director discusses it with the administrative officers and the department heads. After the budget is generally approved, it is submitted to the Ministry of Public Health. This office reviews the proposed budget and obtains an appropriation from Congress which is invariably lower than the amount requested. The money allocations to the hospital are usually delayed, running about six months behind the stated schedule. All funds for this institution, except occasional donations which are administered by the Sisters of Charity, are received through the Minister of Public Health. The institution received $420,156.00 from the Ministry during the fiscal year of 1961-62, an amount very close to that received for previous years.

Expenditures

Table 28 shows the expenditures at the hospital for the month of July, 1962. Since the budget does not change appreciably from year to year, it represents the institution's usual monthly operating costs.

Table 28. Expenditures of the Neuropsychiatric Hospital for July, 1962

Expense Category	Cost Per Month	Cost Per Patient-Day
Food	$12,000.00	$0.356
Drugs	2,110.00	0.062
Clothing	1,700.00	0.050
General expense	1,800.00	0.053
Fuel	550.00	0.016
Prof. equipment reserve	300.00	0.009
Furniture and other equipment	150.00	0.004
Maintenance	550.00	0.016
Salaries	14,730.00	0.436
Day labor (planillas)	2,303.00	0.068
Total	$36,193.00	$1.070

Table 29 presents the salary schedule by departments, hours worked, and hourly wage of all hospital employees. All of the personnel, except day laborers (planillas), are on a monthly salary.

Table 29. Personnel and Salary Schedule of the Neuropsychiatric Hospital in 1962-63

Number of Personnel	Type of Position	Monthly Salary Per Person	Hours Worked Per Month	Wages Per Hour
Direction				
1	Director	$300.00	96	$3.12
Administration				
1	Administrator	210.00	176	1.19
1	Typist	90.00	176	.51
1	Chief of personnel	110.00	176	.62
1	Inventory clerk	90.00	176	.51
1	Office clerk	90.00	176	.51
1	Statistics clerk	80.00	176	.45
1	Office clerk	80.00	176	.45
1	Office clerk	70.00	176	.40
1	Store-keeper	80.00	176	.45
9	Sisters of Charity	30.00	336	.09
Technical Staff				
15	Physicians	100.00	96	1.04
2	Inpatient physicians	100.00	96	1.04
1	Neurosurgeon	100.00	48	2.08
1	Dentist	100.00	48	2.08
1	Radiologist	100.00	48	2.08
1	Pediatrician	100.00	48	2.08
1	Children's psychiatrist	100.00	48	2.08
1	Anesthetist	85.00	48	1.77
8	Graduate nurses	110.00	176	.62
1	Pharmacist	60.00	96	.62
4	Interns	115.00	176	.65
1	Blood bank chief	150.00	96	1.56
X-Ray Service				
1	X-ray technician	70.00	176	.40
Laboratory				
1	Laboratory assistant	60.00	32	1.88

Table 29--Continued

Number of Personnel	Type of Position	Monthly Salary Per Person	Hours Worked Per Month	Wages Per Hour
Physical Therapy				
1	Physical therapist aide	$ 60.00	32	$1.88
Infirmary				
6	Male and female nurses	60.00	288	.21
26	First class nurses	50.00	288	.17
22	Second class nurses	40.00	288	.14
Teaching Staff				
2	Teachers for mentally retarded	80.00	40	2.00
Anti-Alcoholic Services				
1	Chauffeur	70.00	176	.40
1	Nurse	60.00	176	.34
1	Nurses' aide	50.00	176	.28
Social Service				
1	Chief social worker	175.00	176	.99
2	Social workers	150.00	176	.85
Pharmacy				
1	Pharmacy aides	30.00	176	.17
Service Staff				
21	Cooks	30.00	176	.17
20	Washers	30.00	176	.17
13	Seamstresses	30.00	176	.17
14	Maids	25.00	176	.14
Other				
2	Chauffeurs	70.00	336	.21
2	Barbers	40.00	176	.23

Table 29--Continued

Number of Personnel	Type of Position	Monthly Salary Per Person	Hours Worked Per Month	Wages Per Hour
10	Porters	$40.00	176	.23
2	Telephone operators	50.00	176	.28
1	Chaplain	30.00	176	.17
1	Messenger	50.00	176	.28
3	Night watchmen	75.00	336	.22

Facilities

The physical plant of the Neuropsychiatric Hospital was designed and built four years ago as a TB sanatorium. The utilities are modern but the building is in poor condition. It contains thirty rooms divided into three large wards. The physical plant is inadequate because it was not designed for its present use or for the number of patients now occupying it. It contains eight administrative offices, a social service office, a special education classroom, four medical treatment rooms, one physical therapy-type room, as well as rooms for the pharmacy, laboratory and X-ray services. There are no special rooms for dining, vocational training, conferences and recreation. Patients eat in the courtyard and hallways.

There is no accurate count of the number of beds in the hospital, as 510 are listed while there are over 1,000 patients in residence. Some patients sleep on straw mattresses on the floor, and in some cases two patients share

a single bed.

Special Service Facilities

The admissions clinic, observation clinic, and the ward clinics have adequate heating and lighting and, except for the ward clinics, have adequate ventilation. They consist of single rooms which are functionally inadequate for lack of partitioning and equipment.

The admissions and observation clinics are open six hours per day, while the ward clinics are open twelve. The admissions clinic processes twenty-five patients per day, averaging fourteen minutes each; the observation clinics treat fifteen patients per day at an average of twenty-four minutes each, while the clinics in the wards, handling three patients simultaneously, can care for thirty a day. The admissions clinic is used for admission examinations of all patients in the hospital, as well as for outpatient treatment. The observation clinics for women and men are located adjacent to the appropriate wards and are used for diagnosis and inpatient classification before patients are assigned to permanent wards.

Three clinics in the women's wards and four in the men's are used to provide medical and psychiatric treatment to the patients in the respective wards. These clinics are also used for some occupational therapy type activities.

The "operations division" consists of the following

spaces: operating room, an adjacent electroencephalograph (EEG) room, a post-operative recovery room, and a surgical supply area. The operating room is used primarily for general surgery related to the treatment of the hospital patients or for emergency treatment. The room and its facilities are adequate for this function, but the equipment is somewhat less than minimal. There is no adequate facility for neurological surgery, and an additional operating setup for this purpose is therefore needed. The EEG section seems adequately equipped and appropriately placed to perform needed diagnostic services. Both the post-operative recovery room and the surgical supply room seem quite adequate for the purposes for which they are used.

Personnel

There are no formal written criteria for the employment of personnel. However, ability and a desire to work in the institution are given high priority in personnel selection. Prospective employees apply in writing to the Director and are then given a practical examination in their field of interest. Selection is based upon the examination and the Director's opinion. Appointments for executive positions come directly from the Ministry of Public Health. There is very little turnover in personnel. Fringe benefits for the employees include social security and free treatment of common illnesses.

Personnel needs as perceived by the Director are as follows:

a. Four resident psychiatrists
b. Two psychologists
c. Two occupational therapists
d. Two rehabilitation counselors
e. Eight graduate nurses
f. Four post-graduate nurses in psychiatry
g. Twenty nurses aides
h. Twenty orderlies.

Monies for additional staff are regularly requested in the budget, but the Minister's office has not been able to grant it.

A complete personnel list may be found in the finance section in Table 29.

Programs and Services

Objective

There are no written objectives or other descriptive literature since all documents were destroyed in the fire of 1960, and have not been replaced. The objectives are to give medical-psychiatric treatment to inpatients with mental disturbances in order that they may again become functional members of society.

Eligibility Requirements

Any person in Guatemala is eligible for services, provided he is ill and that his mental disorder predominates over any other disability. Actual admissions depend upon the seriousness of the disorder as determined by the admissions personnel. Referrals are received from other institutions, especially from the Mental Health Clinic. Patients who are not seriously ill may be treated as outpatients. There are no fees for services, nor are there any private patients treated at the hospital.

Outpatients

Patients not admitted to the hospital are treated as outpatients and in addition, many patients released from it are retained as outpatients for a period ranging from one to six months. About five to fifteen minutes are spent with each outpatient per visit. The number of treatments vary, some receiving treatment three times a month while others come whenever they wish. Many of the outpatients are epileptics and alcoholics. The outpatients are usually seen by the social worker who counsels them and administers the prescribed drugs which she requisitions through the admissions clinic. Some of the outpatients are treated at the Mental Health Clinic instead of at the hospital.

Inpatients

The admission procedures for inpatients is illustrated

by Figure 4, which is a schematic diagram of the hospital service structure.

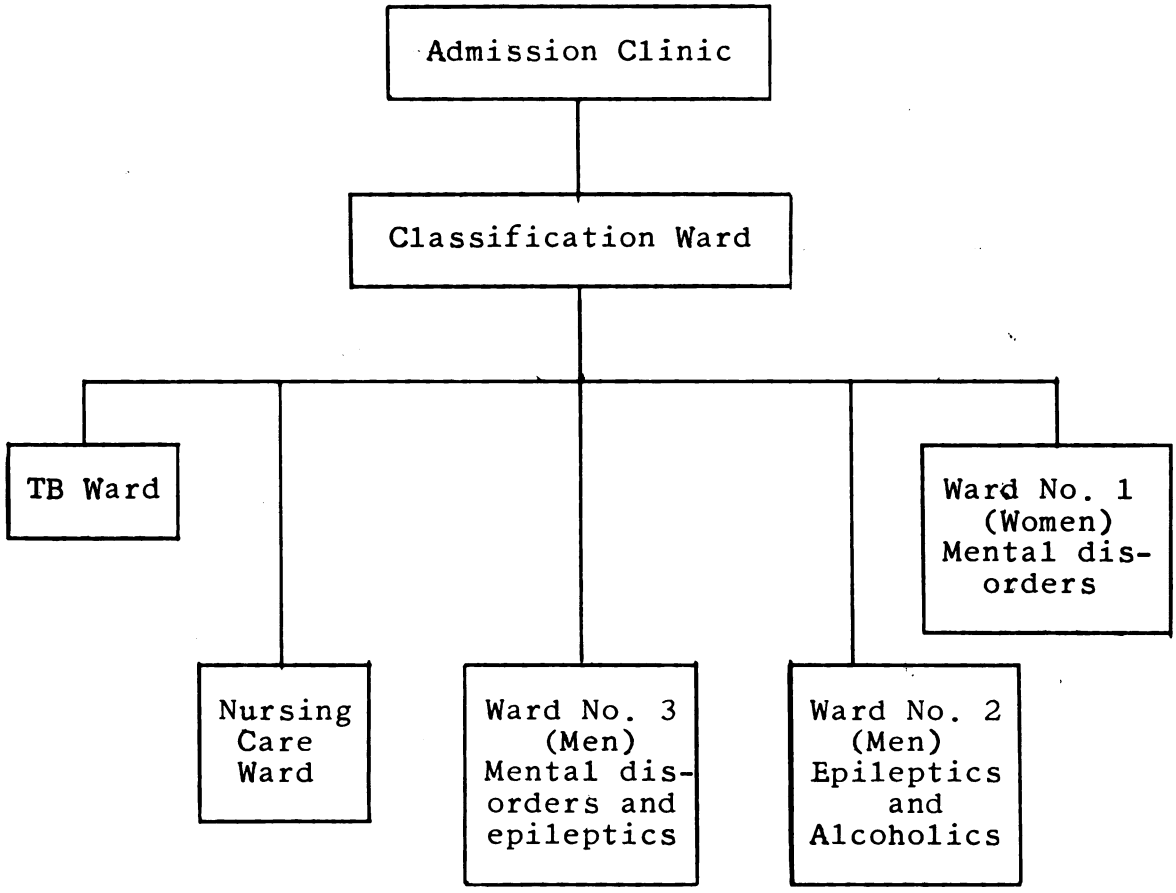

Fig. 4.--Service organization chart of the Neuropsychiatric Hospital.

Patients are received at the admissions clinic which is the same clinic used for outpatient treatments. From the admissions clinic the patients are sent to the observation ward for classification. After eight to fifteen days of observation and classification they are sent to the proper inpatient wards.

Services Offered

Table 30 shows the types of services provided patients at the hospital.

Table 30. Services Provided at the Neuropsychiatric Hospital in 1962

Service Category	Percent Receiving the Service
Psychological testing	5%
Psychological counseling	5%
Psychiatric services	100%
Social services	14%
Medical services	100%
Occupational therapy	10%
Follow-up (by social workers)	3%
Avocational activities	20%

Clientele

The institutional facilities are not adequate enough to permit the inpatients to stay a sufficient length of time to receive effective treatment. Alcoholics stay as inpatients for an average of three to eight days.

Patients who stay for a period of years or for life usually have severe or chronic mental disorders or they have no friends or relatives who can or will care for them if released.

No figures are available describing the national geographic origin of the clientele; however, it is estimated that most of the patients come from within the city or adjacent areas, while a minority come from other parts of Guatemala.

The Neuropsychiatric Hospital had an average of 1,123 inpatients in 1960; 1,010 in 1961; and 1,084 in 1962. The average numbers, ages, and classification of all inpatients treated at the hospital in 1961 are presented in Table 31. The classifications in Table 31 are the same categories used in reports submitted to the Ministry of Public Health.

Table 31. Classification of Inpatients at the Neuropsychiatric Hospital in 1961

Disability Category	1 year or less	5-14	15-24	25-44	45-64	65 or more	Total
Schizophrenia Psychotic and other related disorders		1	90	129	49	1	270
Psychoneurotics Mixed disorders and unclassified related diseases	1	3	39	82	10		135
Epileptics and other related diseases--unclassified	2	3	27	46	9		87
Other disease of the brain		1	5	10	6	10	32
Arteriosclerosis without gangerine				1	23	17	31
Nervous System and convulsive disorders		4	38	34	3	1	80
Miscellaneous disorders							375

* * * * *

Social Security Rehabilitation Hospital

The Guatemalan Social Security System

The social security system in Guatemala (Instituto Guatemalteco de Seguridad Social, IGSS) was established in 1946 for the purpose of providing medical and other services to employed individuals. The Social Security Administration initiated services in the department of Guatemala in January 1948, and then gradually established clinics and hospitals in other parts of the country.

Social security is rapidly being extended to provide "benefits and protection" for work accidents, maternity cases, general illnesses, invalidism, old-age, and death. However, due to economic limitations services are currently limited to work related accidents and illnesses, except for maternity benefits available in the department of Guatemala. The ultimate objectives of the Social Security Administration are to extend coverage to all illnesses and to protect the total population of Guatemala. At the present time the program covers all government and private employees in the departments of Guatemala, Izabal, Escuintla, Quezaltenango, Suchitepequez, Retalhuleu, Chimaltenango, Santa Rosa, and the southern parts of San Marcos and Zacapa.

In December of 1961, the Social Security Administration owned and operated eighteen hospitals, eight clinics, and eighteen first-aid centers with a total of 1,122 beds.

At the same time IGSS had fifteen hospital wards and two private clinics under contract which increased the total number of beds to 1,292.

Of the estimated 1,375,625 employed workers in 1961, approximately 275,125 or 20 per cent were covered by social security.

Congressional legislation has established that the program be supported by contributions from the government, employers, and employees. However, in practice the government contributes only its percentage as an employer. The income of IGSS for the year 1961-62 was $8,218,376.03 compared with expenditures of $8,737,127.62. This resulted in an operating loss of $518,751.59 for the 1961-62 fiscal year.

One of the hospitals owned and operated by the Social Security Administration is a rehabilitation hospital. This hospital was commissioned to provide rehabilitation services to affiliated members who had passed the acute state of their injury or illness. The rehabilitation hospital discussed below serves all patients discharged from one or more of the other IGSS hospitals or clinics.

History and Development

The Social Security Rehabilitation Hospital was founded in 1948 through the action of the Board of Directors to provide rehabilitation services for affiliated members. By their agreement, rehabilitation was defined as a physical

and/or psychological process that reconstructs and re-educates a handicapped person for an active life of work. The process is comprised of medical treatments including physical training, provision of prosthetic or orthopedic devices, as well as vocational training and placement. The hospital was founded to give complete rehabilitation services to disabled workers after discharge from other medical centers.

When founded the hospital was merely a gathering place for the disabled and handicapped since there was no rehabilitation program. In 1953 the staff, facilities, and services were reorganized and some rehabilitation programs were developed. Programs and services continued to improve until today it has nearly a complete rehabilitation program. During its first year of operation, about 100 patients received meager treatment. The number of patients increased to 800 in 1953 and at the present time the institution provides services for about 1,000 patients per year.

The staff in 1948 consisted of five general physicians and a social worker. New positions were continually created until today the staff consists of specialists from most of the fields in modern rehabilitation.

The physical plant was moved from a small private home to a rented apartment building, and plans are currently being made for the construction of a new rehabilitation hospital.

Administration and Organization

The hospital has an executive director appointed by the IGSS administration, who is responsible for all institutional activities. Under the Director is a Chief Administrator, who is responsible for the execution of administrative decisions made by IGSS, the Director, and the technical council. The Chief Administrator is recommended for appointment by the hospital Director, but the actual appointment is made by IGSS. The Administrator is in charge of all financial activities, statistics, budget, reports, and selection of the administrative personnel.

Technical Council

The technical council consists of approximately ten members, including the Director, Administrator, and all the service chiefs in the hospital. The meetings are used to discuss administrative problems related to organization, personnel, and services. They are also used for case conferences, utilizing the rehabilitation team approach. These latter conferences may include, in addition to the members of the council, any professional staff members involved in the treatment of the cases being reviewed.

Major Policy Determination

Major policies are subject to the approval of the IGSS administration, based upon budgetary limitations and the policies' relationship to the total array of services

performed by other IGSS service organizations. Personnel needs and standards proposed by the technical council, subject to the approval of the Director, are recommended to the IGSS administration. The budget and capital outlay are handled in the same manner, final approval being dependent upon service demands and funds available.

Coordination

The IGSS Rehabilitation Hospital is one service unit of a coordinated medical service program under the government's social security system. The patients served are referrals from the other affiliated medical units, except for approximately one dozen private cases per year.

Types of Hospital Reports

These reports include periodic summaries of expenditures which are to be reimbursed, monthly progress and service reports, and an annual report which summarizes the year's activities as well as presenting needs and plans for the forthcoming year. The objective of these reports is to provide necessary information for accounting and statistics at the central IGSS offices.

Administrative Officers

The Director.--The Director is retained by the hospital on a half-time basis. He is also the Director of the Children's Polio Hospital, Director of the School of Physiotherapy, part-time physiatrist at the Recuperation Center No. 1,

and chief of services at the General Hospital. His training consists of eleven years work and study beyond secondary school; his specialty is physical medicine and rehabilitation which he studied at New York University. He has been the Director of the Social Security Rehabilitation Hospital for nine and one-half years.

Administrator.--The Administrator is responsible to the Director and conducts all hospital business. He is a full-time staff member, and has been in his present position for five years. The Administrator's training consists of approximately two years' work at the college level, focused specifically on hospital administration and rehabilitation administration--including a three months administrative internship in the United States.

Finance

Authorization of expenditures.--Expenditures are authorized at the hospital by the Director within budgetary limitations. These expenses include medicines, staff payroll (excepting administrative personnel), disability payments, and other service-related materials and labor. Payment of the administrative staff and other costs not directly related to services are handled either directly from a revolving fund, through authorized invoices sent to the central IGSS offices, or in the case of some materials and equipment which are requisitioned from the central offices the payments are handled entirely by the central offices. The last method

would apply to materials generally purchased in large quantities and used by various other service units. Except for items purchased through the revolving fund, all checks for payment of purchases, payroll, and benefits are made and accounted at the central offices with the use of IBM equipment.

Figure 5 below is an organization diagram of the personnel involved in financial administration. The vertical dimension of the diagram denotes the level of authority in regard to financial control, and the connecting lines denote interaction regarding financial matters.

Budget

A tenative budget is prepared by the Director, technical council, and Administrator. This is usually revised by the budget department of IGSS in collaboration with the hospital Director before it is approved.

Income

The hospital is one service unit of the national system of social security services and it receives its operating funds from the Social Security Administration. The sources of the IGSS funds are legally from government contributions equal to 2 per cent of the gross national payroll, employers' contributions of 5 per cent of their gross payroll, and an employees' contributions of 2 per cent of their gross pay. The legal machinery for enforcing the

employers' and employees' contributions seems to be quite effective; however, the government's contributions are usually not made because of some technicality. The IGSS central offices handle the collection and redistribution of funds collected to the various service units, as well as the auditing of each service unit.

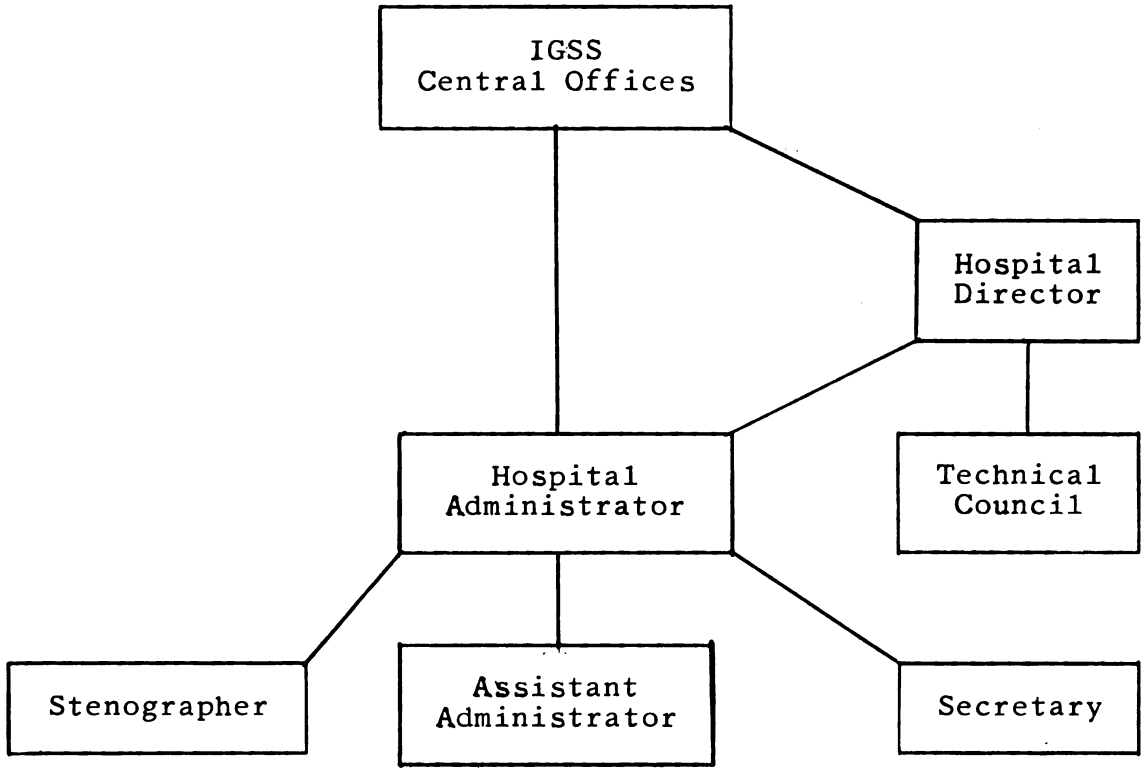

Fig. 5.--Financial administration chart of the Social Security Rehabilitation Hospital.

The only money received by the Rehabilitation Hospital directly is a revolving fund of $2,500.00. This fund is operated as a petty cash fund, and direct cash payments are made for various purchases on sales slips and invoices. When a substantial portion of the $2,500.00 has been spent, the Administrator sums up the sales slips and invoices and presents them to the central offices for reimbursement. These cash payments are made for items such as food, maintenance, and various contingent expenses. The total amount of money allocated for the support of the Rehabilitation Hospital (not including disability benefits and pensions) was $393,212.13 for the 1960-61 fiscal year, and $392,105.10 for the following year.

Table 32 shows the expenses charged against the Rehabilitation Hospital by the central offices for the fiscal years of July 1, 1960 to June 30, 1961 and July 1, 1961 to June 30, 1962.

In addition to the cost of operating the Rehabilitation Hospital, IGSS pays various disability benefits and special pensions to disabled clients, based upon the type and extent of their disability or handicap.

Table 33 shows the usual maintenance and service costs per inpatient-day at the Rehabilitation Hospital.

Table 32. Expenditures of the Social Security Rehabilitation Hospital in 1960-61 and 1961-62

Expense Category	1960-61	1961-62
Salaries	$159,713.04	$164,192.59
Medical supplies and equipment	19,176.58	23,358.48
Food	63,546.35	61,232.18
Private professional services	5.00	40.00
Operational costs	53,466.34	44,947.29
Administration expenses central offices	86,533.34	87,559.13
Depreciation costs	10,775.43	10,775.43
Total	$393,216.08	$392,105.10

Table 33. Costs per Inpatient-Day at the Social Security Rehabilitation Hospital from 1958-62

Year	Number of Patient-Days	Cost	Cost Per Inpatient--Day
July 58 to June 59	65,918	$65,484.00	0.993
July 59 to June 60	67,301	62,341.00	0.926
July 60 to June 61	69,464	61,595.00	0.955
July 61 to June 62	69,569	59,778.00	0.859
Averages	66,813	$62,299.50	0.933

Facilities

The Rehabilitation Hospital is located in a former apartment building with sixty rooms, of which thirty-seven are used to provide services. The building is of abode construction, twenty-five years old and in poor condition. The utilities, lavatories, exits, stairways, and hallways are adequate for the needs of the hospital. Heating is inadequate, and there is not enough space on the grounds for recreational activities or parking. The hospital contains nine men's wards, one women's ward, three administrative offices, six service offices, nine medical treatment rooms, fifteen physical therapy-type rooms, four vocational training-type rooms, two dining rooms, one conference room, one adult education classroom, two libraries, and one lounge. The ten wards contain a total of 148 beds for rehabilitation inpatients.

The present plant is inadequate for the services rendered and plans are being made to build a new hospital at some future date.

Occupational Therapy

For patients with injuries of the lower extremities, therapy is provided through the operation of looms and spinning wheels. The products manufactured are actually used throughout the hospital. The room is used by an average of ten patients at a time. It is adequately lighted but poorly ventilated.

Occupational Therapy and
Recreational Center

This room is used for occupational therapy, speech therapy, recreational, and educational activities. It is equipped with modified pool and ping-pong tables. For recreational purposes, games and puzzles are provided, which also serve to encourage social interaction, particularly for some of the psychiatric cases. Educational activities are encouraged on a voluntary basis and include drawing, painting, reading, and writing. The room is open for use six hours each day and is attended by an occupational therapist. The room can be used by approximately fifteen persons at one time and is used by an average of thirty patients per day. The room is adequately lighted and ventilated, but the noise level is high because of the adjacent looms.

Occupational Therapy--
Bookbinding

All aspects of bookbinding are taught in this room. Patients learn to use the various devices involved in binding books, and actually bind materials for the hospital and other IGSS centers. It is used seven hours each day by an average of fifty patients, many with hand injuries. The lighting and ventilation are both inadequate, and the noise level is too high because of the adjacent looms.

Physical Therapy Room for Individual Treatments

This room contains six bays of equal size, each used by a physiotherapist for patient massages, muscle exercises, et cetera, to prevent muscular atrophy. These bays are used six hours per day, by an average of seventy patients. Lighting and ventilation are adequate, but the noise level is too high. While they are fairly adequately equipped, some additional service apparatus is needed.

Mechano-Therapy

Facilities of this room are available to all patients of the hospital for the purpose of muscle building, improvement of motor coordination, et cetera. They are available for use six hours each week day, and approximately twenty patients use the facilities at one time. An average of 150 patients with injuries of the extremities, shoulder, or back receive mechano-therapy each day. The room seemed well-equipped and the equipment was in good working order.

Manual Therapy

Facilities in this room are used for manual therapy of the fingers, hands, and forearms. The purposes of the exercises are to improve muscle tone and strength, motor coordonation, et cetera. These facilities are attended and used six days a week by patients with a variety of finger, hand, and arm injuries. Twenty patients can be accommodated

at one time and an average of 200 patients receive treatment each day. The room and facilities are in good condition and there is adequate lighting and ventilation, but the noise level is too high.

Heavy Vocational Therapy
(Occupational Therapy)

These facilities are used to provide heavy exercise for patients who are in fairly good condition but who need further muscle development. They perform heavy, work-type exercises using gymnastic and other improvised equipment. The purpose is to prepare certain individuals for employment in jobs which may require considerable physical exertion. This room is used six hours each day by patients who have suffered injuries of the extremities, shoulders, or spinal column. The room has a capacity for twenty patients; however, it is used by an average of only twenty patients per day.

Amputee Clinic

This clinic is used for the examination, treatment, and training of amputees, as well as for fitting and adjusting prosthetic or orthopedic devices. Staff physicians bring their patients to the clinic for examination, and case conferences are held weekly which may include all of the staff members working with the patient. Students in various fields of rehabilitation may attend these conferences as part of

their training. The clinic is open six hours each day and an average of fourteen patients receive services. The patients usually have amputations or injuries to the lower extremities, or a broken hip or femur head. The lighting and ventilation are adequate, but the noise level is too high, especially for case conferences. The room seems adequately equipped for its purpose.

Hydrotherapy

Hydrotherapy is given to patients for its heat and massage benefits just before they receive individual exercises. The facilities are used six hours each day by patients with injuries to the upper or lower extremities. Twelve patients may be treated at one time, and the daily average is ninety. Lighting, ventilation, and temperature are adequate for the services provided, and the room seemed well-equipped.

Thermotherapy--Infra-Red and Parafin

These facilities are used six hours a day for individual heat treatments for patients with injuries of the spinal column, shoulder, and upper and lower extremities. Some of the equipment in this room is in need of repair and additional equipment is needed.

Electrotherapy and Diathermy

This clinic is used for individual treatments and

and exercises with the use of diathermy machines and electrical stimulators. These treatments are given by appointment, as prescribed by the attending physician. From sixty to sixty-five patients are treated per day, usually those with shoulder, arm, leg or spinal injuries, or various forms of paralysis. The room is well equipped and the lighting and ventilation are adequate. Some additional equipment is needed as well as Spanish instruction books for the equipment already present.

Gymnasium for Paraplegics

This gymnasium is used mostly for individual treatments and exercises under the direct supervision of a therapist. Patients with spinal injuries receive pre-ambulation training on an individual basis. The room seemed well equipped and lighted but the ventilation is poor and the noise level is too high.

The Gymnasium

The gymnasium is primarily used for group physical therapy exercises. These exercises re-educate muscles, increase motor coordination and control. They also increase the physical strength of all exercised muscles so the patients may more easily learn to compensate for their disabilities. The exercises performed in the gymnasium are conducted in classes by various physical therapists. Patients are grouped according to their disabilities and appropriate exercises are

selected for each group. The gymnasium is well equipped, but lighting and ventilation are poor, and the noise level is too high.

Prosthesis Shop

This shop consists of a shoe shop, office, prosthesis section, plastic section, and storeroom. Generally speaking all orthopedic and prosthetic devices needed are built in these shops. The shops are adequately lighted, but the ventilation is poor. They are well equipped; however, a hip aligner and adjuster is needed.

Adult Education

Since a large proportion of the Guatemalan population is illiterate, the objective of the functions in this room is to raise the educational and cultural level of some of the patients. They are taught elementary reading, writing, speaking (if their first language is not Spanish), arithmetic, geography, history, civics, and leisure activities which may have cultural value. It is also used to cultivate their vocational interests and to give them vocational information as an initial step to vocational training. The room is used for formal classes one hour each day, five days a week, and it is open five hours each day, during which time patients may use the room and facilities for study under the guidance of a teacher. Approximately thirty-five patients use the room each day, although it can only accommodate twelve at one

time. It is equipped with books, games, pencils, et cetera, and one corner of the room is set off for a barber shop. A professional barber is employed, to cut the patients' hair, and to train certain patients to become barbers.

There is a need for much more equipment and supplies, such as notebooks, pencils, teaching aids, et cetera.

Carpentry Shop

This shop serves for vocational training, occupational therapy, and a place to repair and make various items for the hospital. Patients who have an interest in, and ability for, this type of vocation are given training in this shop. The shop is open eight hours each day and it is used by an average of thirty-three patients. The lighting, ventilation, and equipment are adequate for the services provided.

Shoemaking Shop

This shop is used mostly for vocational training and only incidentally to repair shoes for the patients and personnel. Patients with interest and ability in this area are assigned to the shop for vocational training. It is in operation four hours each day and an average of eight patients receive training per day, most of whom are paraplegics. The shop is fairly well equipped, although there is a need for more materials. The lighting and ventilation are adequate for shoe making.

The Tailor Shop

This shop is used primarily for vocational training and to a limited extent, for occupational therapy for paraplegics, amputees, and patients with hand injuries. All phases of tailoring are taught. The shop is used four hours by an average of thirteen patients each week day. While the shop is well equipped, the lighting and ventilation are inadequate for this type of work, and the noise level is too high. There is a need for more material with which to work.

Radio Repair Shop

This shop serves to train patients to be radio repairmen and to repair other electric and electronic equipment. All phases of electric and electronic circuitry are studied; however, only a few of the patients are qualified for this level of vocational training. The shop is open eight hours each day and about five individuals receive training. These patients usually have lower extremity dysfunction; however, all qualified patients are eligible for training. The equipment, lighting, ventilation, and noise level are satisfactory for radio repair training.

Psychiatric and Psychological Clinics

These are two rooms sharing a common "hallway-waiting room," as the psychologist and psychiatrist work together. The clinics are used for psychiatric and psychological examinations, counseling, and psychotherapy. All patients

admitted for rehabilitation services receive a psychological examination which becomes part of their case record. Psychiatric and psychotherapeutic services are provided for patients who appear to be having psychological problems or various forms of mental illness. Some vocational counseling and testing is also done by the psychologist. The psychological clinic is used twenty-one hours per week and the psychiatric service room fifteen hours per week. Patients are seen one at a time, and approximately forty-five to ninety are examined or treated each month. The equipment and materials used in these clinics are neither adequate for the assessments made nor appropriate for the population treated.

Urology Clinic

This clinic is used for general medical treatment of outpatients and ambulatory inpatients. It is in use thirteen hours each day and about fifty patients are treated. The clinic is well equipped, lighted, and ventilated for the services rendered. There is a need for a laboratory to use in conjunction with the clinic.

Admission Clinic

The clinic is used for general examination of all patients being considered for rehabilitation services at the hospital. Its purpose is to establish patient eligibility for services and to obtain personal data for the records. The clinic is used four hours per day, and an average of ten

patients are examined. The clinic is adequately equipped, lighted, ventilated, and the noise level is satisfactory for the work performed.

Medical Clinics for Physiatrists

These four identical clinics are used by the hospital physiatrists for giving periodic medical examinations to patients assigned to them. The purpose of these examinations is to evaluate progress in rehabilitation. Each clinic is used four hours a day; about fifteen to twenty patients are examined each day. While the equipment seemed adequate, the lighting, ventilation, and noise level were unsatisfactory.

Personnel

Hiring procedure.--Administrative personnel are selected by the Administrator. The names and personal data on prospective employees are submitted to the central offices of IGSS for official appointment. Other personnel are appointed in the same manner, except that the interviews and competency examinations are given by the Director. The primary criterion in hiring is the individual's ability to perform the required work. This is determined by a competitive examination which may be a written or a practical on-the-job demonstration and a personal interview. Preference is given to applicants in the following order:

1. Formal training and professional experience in the chosen profession.

2. Formal training but no experience
3. Learning their profession or trade by on-the-job experience
4. Untrained, inexperienced applicants who appear to be good candidates for informal, on-the-job training.

The fourth category, of course, are hired only as a last resort to fill existing positions. Application of these criteria has been difficult to follow because most applicants have not had adequate training. The difficulty has been minimized because the personnel turnover is very low, less than one employee per year.

Personnel Needs

The Director feels that the following personnel are presently needed at the hospital, but cannot be hired because of budgetary limitations:

a. Six occupational therapists
b. Three rehabilitation counselors
c. Three social workers
d. Two clinical psychologists
e. Six vocational training instructors
f. Two speech therapists
g. One prosthetist
h. One psychiatrist.

Professional Advancement

Employees receive salary increments based upon increased professional competency and seniority. While many employees may be eligible for promotions, they cannot be advanced because of the low rate of personnel turnover and the lack of finances for increasing the number of staff.

Fringe Benefits

All hospital employees, as social security affiliates, are given free hospitalization and medical care, and one month's extra salary per year. The professional staff may accept a paid vacation or receive equivalent pay if they decide not to take a vacation.

Table 34 shows the personnel schedule, annual salaries, hours worked per week, and the hourly wages for the fiscal year of 1961-62.

Table 34. Personnel and Salary Schedule for the Social Security Rehabilitation Hospital in 1961-62

	Personnel	Annual Salary	Hours Per Week	Hourly Wage
1	Director	$4,478,50	18	$5.18
1	Chief of medical services	4,225.00	24	3.67
1	Chief of medical services	4,062.50	24	3.53
1	Physician	3,510.00		
1	Physician	3,250.00		
1	Consulting physician	3,900.00	Not available	
1	Consulting physician	3,510.00		
1	Consulting physician	2,340.00		
1	Consulting physician	3,900.00		
1	Head nurse	2,470.00	36	1.43
1	Head nurse	1,950.00	36	1.13
1	Graduate nurse	1,381.25	26	0.80
1	Graduate nurse	1,625.00	36	0.94
1	Class A nurse	1,586.00	36	0.92
1	Class B nurse	942.50	36	0.55
1	Class B nurse	940.00	36	0.55
1	Class B nurse	1,040.00	36	0.60
1	Class B nurse	845.00	36	0.49
1	Class B nurse	780.00	36	0.45
3	Class B nurses	2,145.00	26	0.45
6	Class B nurses	3,900.00	26	0.38
1	Chief physical therapist	3,380.00	34	2.07
1	Chief physical therapist	2,700.00	34	1.59
1	Physical therapy aide	2,535.00	36	1.47
1	Physical therapy aide	2,470.00	34	1.51
1	Physical therapy aide	2,275.00	34	1.39
7	Physical therapy aides	11,147.00	34	0.98
4	Physical therapy aides	5,590.00	34	0.86
6	Physical therapy aides	7,800.00	34	0.80
1	Physical therapy aide	1,170.00	34	0.72
1	Physical therapy aide	2,535.00	18	2.93
1	Vocational training instructor	1,755.00	20	1.82
2	Vocational training instructors	2,730.00	20	1.42
2	Vocational training instructors	2,470.00	20	1.28
2	Vocational training instructors	1,560.00	20	0.81

Table 34--Continued

	Personnel	Annual Salary	Hours Per Week	Hourly Wage
1	Vocational training instructor	682.50	44	0.32
2	Assistant instructors	2,080.00	44	0.49
1	Assistant instructor	1,170.00	44	0.55
3	Assistant instructors	2,535.00	44	0.40
1	Assistant instructor	1,170.00	44	0.55
1	Assistant instructor	845.00	44	0.40
1	Administrator	3,900.00	44	1.85
1	Administrative assistant	2,177.50	44	1.03
1	Administrative assistant	1,885.00	44	0.89
1	Office clerk	1,495.00	44	0.71
1	Typist	1,235.00	44	0.58
1	Typist	1,950.00	44	0.46
1	Messenger	1,170.00	44	0.55
1	Janitor	871.00	44	0.41
1	Chauffeur	1,170.00	44	0.55
1	Economist	1,040.00	60	0.36
1	Chief cook	1,040.00	51	0.42
1	Case A cook	1,105.00	51	0.45
1	Assistant cook	858.00	51	0.35
1	Assistant cook	845.02	51	0.34
3	Assistant cooks	2,340.00	51	0.32
1	Assistant cook	702.00	51	0.29
1	Wash woman	780.00	39	0.42
4	Waiters	3,120.00	51	0.32
8	Waiters	5,616.00	51	0.29
3	Waiters	1,755.00	51	0.24
1	Dish washer	845.52	51	0.35
1	Dish washer	780.00	51	0.32
4	Dish washers	2,808.00	51	0.29
1	Seamstress	585.00	39	0.31
1	Seamstress	546.00	39	0.29
1	Washing machine operator	728.00	39	0.39
112	Total	$152,637.29		

Programs and Services

Objectives

The Rehabilitation Hospital has been commissioned by IGSS to provide protracted medical treatment, prosthetic or orthopedic devices, re-education and training of various types, and vocational placement to all handicapped employees covered by social security. The goal of this institution is to rehabilitate all eligible clientele so they may become self-sufficient and useful citizens. The client is assisted in every way possible to reduce the handicapping effects of his disability or to eliminate the handicap entirely. Everything in the program that is done to, or by the patient, with this goal in mind, comes within the realm of rehabilitation.

Eligibility

The basic eligibility requirements for service are two-fold:

1. The prospective client must be an affiliate member of IGSS.
2. The prospective client must be a likely candidate for the type of services offered in the IGGS rehabilitation program.

Most of the patients are referred to the Rehabilitation Hospital from other IGSS service units. Some cases are received from various government institutions such as the welfare services, and a few (ten to fifteen per year)

private cases are also accepted for rehabilitation. These collaboration cases are presented to the technical council for a decision regarding their admittance.

An important factor in the selection of patients for treatment is the service requirements of the patient as compared to the services provided in the Rehabilitation Hospital. As a rule, all of the clientele referred from IGSS hospitals are admitted for rehabilitation treatment, since protracted treatment for these patients was the basic reason for the inception of the Rehabilitation Hospital. The fact that some of the professional personnel of the IGSS Rehabilitation Hospital also work in other IGSS hospitals and centers increases the degree of coordination among these units. Consequently, many patients only change hospitals and not physicians.

Case Closures

As mentioned above, the hospital has a technical council which conducts case conferences intended to serve the following functions:

1. Decide admittances
2. Coordinate information about each patient
3. Evaluate the patient's overall progress
4. Prescribe future treatment
5. Decide when a patient should be discharged.

If the patient has adapted to his chronic disability and handicap, and is able to accept employment, the possibility of discharge is considered. Employers are contacted and the patient is discussed with them and if accepted as an employee, the patient is discharged and the case closed.

These decisions are made at a meeting of the technical council attended by the client and the employer. If the client cannot find employment, due to some aspect of his handicap, the Rehabilitation Hospital is required to readmit him for further rehabilitation. Case conferences on admittances and discharges are an important function of the technical council, since, in effect, they are deciding benefits for the IGSS system. Some clientele like the pay, treatment, and living conditions at the hospital; thus they are difficult to discharge, even though they may be employable. Each client receives three-quarters pay while disabled and receiving treatment. For example, if a cane cutter earned $1.00 per day in the field and he cut himself accidentally, he would then receive $0.75 per day while receiving medical treatment and rehabilitation.

Patients also receive lump sum disability benefits according to a predetermined plan based upon a point system. Various disabilities have been awarded certain numbers of points. Each point is worth $50.00 in the municipality of Puerto Barrios and the Department of Peten, while in the rest of the country, it is only worth $30.00. Table 35 is

a list of selected disabilities, the points awarded each disability, and the benefits paid to each person.

Table 35. Schedule of Benefits Paid Disabled Workers by the Instituto Guatemalteco de Seguridad Social in 1961-62

Disability Category	Points	Benefits at $30.00	at $50.00
Two fingers amputated	6	$180	$ 300
Two fingers, 1 thumb, or 3 fingers	12	360	600
Four fingers and thumb	18	540	900
One to four small toes	6	180	300
Big toes; all toes, or extremity of foot	12	360	600
One eye blinded	12	360	600
Two eyes	30	900	1,500
One hand	18	540	900
Forearm	18	540	900
Arm	24	720	1,200
Complete foot or below knee	12	360	600
Knee and above knee	18	540	900
Complete leg	24	720	1,200
Spinal injury	30	900	1,500
Facial disfiguration	18	540	900
Nose	12	360	600
One ear (external)	6	180	300
Complete deafness	18	540	900
Mental disorders	30	900	1,500

Prosthetic or orthopedic devices are provided for many of the individuals with permanent disabilities or handicaps. The number of these devices provided, repaired, or refitted during the year 1961-62 is presented in Table 36.

Table 36. Prosthetic and Orthopedic Devices Fitted at the Social Security Rehabilitation Hospital in 1961-62

Device	Number Refitted or Repaired	Number Constructed
Artificial legs	42	20
Artificial arms	19	16
Orthopedic devices	32	705
Total	93	741

Services Needs

The Director feels that the following services need to be added, improved, or expanded:

1. Rehabilitation counseling
2. Occupational therapy
3. Clinical psychology
4. Speech therapy
5. Special education (adult)
6. Technical training programs
7. Social services
8. Psychiatric services.

Evaluation

There is no formal evaluation system for the services performed. Informal evaluations are made of the various personnel by observing their performances on the job and by the

results of their treatments. These observations are made by the Director and department chiefs.

Clientele progress and conditions are formally evaluated at case conferences. The total records and service complement are available at the conferences to facilitate evaluation. The following aspects of each patient are discussed at case conferences before discharge:

1. Legal aspects of the case
2. Physical condition of the client
3. Psychosocial implications
4. Chronic handicapping effects of his disability
5. Degree of rehabilitation effected
6. Economic factors
7. Employment propensity and feasibility.

The hospital as a whole and the personnel are evaluated by IGSS on the basis of performance statistics compiled at the end of each year. Considerations include the number and types of clientele successfully rehabilitated and the cost per client.

Table 37 shows the various kinds of services provided at the hospital and the approximate percentage of the clientele receiving each service.

The Rehabilitation Hospital is responsible for the transportation of all outpatients to and from the hospital. All of the facilities and staff at the hospital are available for outpatient use.

Table 37. Type and Extent of Services Offered at the Social Security Rehabilitation Hospital in 1961-62

Service Category	Per Cent of Clientele Receiving Service
Psychological testing	100
Psychological counseling	20
Psychiatric services	20
Social services	100
Vocational counseling	10
Medical services	100
Prostheses	10
Physical therapy	100
Occupational therapy	10
Speech therapy (limited)	2
Ophthalmological and/or optical (limited)	5
Vocational training	15
Educational training	80
Training in activities of daily living	10
Vocational placement	5
Follow-up	100
Transportation	50
Avocational activities	100
Daily allowance	100
Disability benefits	100
Financial guidance (re-disability benefit)	29
Pensions (for severe cases)	6

The majority of the patients admitted for rehabilitation leave in an employable condition. Many patients receive work with their former employer after discharge, while about 5 per cent are placed in new jobs. Five to seven per cent of the clientele are rated unemployable after discharge and put on pensions.

Clientele

The IGSS Rehabilitation Hospital provides rehabilitation services to all workers covered by social security who have suffered a disability and have a consequential handicap.

Each prospective client must be examined by an IGSS physician to determine his eligibility on the basis of his disability and handicap.

Injuries are classified into two large categories by the IGSS central offices:

1. Accidents that occurred while working

2. Common accidents that did not occur on the job.

Accidents must be understood in this usage to include physical trauma of various sorts, such as industrial injuries, and infectious diseases. The IGSS Rehabilitation Hospital serves both inpatients and outpatients; all of the facilities and staff are available for outpatient use as well as for inpatient use. The average patient remained in the hospital for 76.5 days in 1960-61, and 64.1 days in 1961-62.

Table 38 shows the average number of patients in the hospital per day during the fiscal years from 1958 to 1962.

Table 39 shows the inpatient and outpatient movement at the hospital during the fiscal years of 1960-61 and 1961-62.

Table 38. Average Number of Inpatients at the Social Security Rehabilitation Hospital from 1958-62

Year	Patient-Days	Daily Average
July 1958 to June 1959	65,918	180.60
July 1959 to June 1960	67,301	184.39
July 1960 to June 1961	64,464	176.61
July 1961 to June 1962	69,569	190.60
Four year average	267,252	183.05

Table 39. Inpatient and Outpatient Movement at the Social Security Rehabilitation Hospital in 1960-61 and 1961-62

Patient Classification	Number of Patients	
	1960-61	1961-62
Newly admitted inpatients	596	574
Newly admitted outpatients	363	409
Total	959	183
Discharged inpatients	574	536
Discharged outpatients	336	417
Total	910	953

* * * * *

An Overview of Rehabilitation in Guatemala

History and Development

Modern rehabilitation in Guatemala began to emerge some fifteen years ago when the government social security program was in its developmental stage and a few private agencies began to think in terms of "rehabilitating" various classes of handicapped individuals. Activities which could be classified as components of rehabilitation programs existed long before 1948; however, they were not thought of as organized programs directed toward re-integrating clientele into society. For the most part, early rehabilitation was thought of as medical treatment and maintenance. This idea still exists among many professional and non-professional individuals in Guatemala.

There appears to be a relationship between the development of the nation as a whole and rehabilitation services and practices. This may be due to the increased cultural, social, educational, technological, and economic interchange between Guatemala and the more developed northern countries. This is especially true with regard to education. Many physicians in Guatemala have received post-graduate training in various specialties in foreign countries. Since modern rehabilitation generated from the medical arts and allied social sciences, the physicians trained in North America and Europe were subjected to these new ideas and practices.

Although the new approaches to the disabled and handicapped were not readily adoptable in Guatemala, there was a considerable amount of transfer of training. Consequently, rehabilitation in Guatemala began with a medical emphasis, especially through physical medicine.

Administration and Organization

Most of the rehabilitation agencies and institutions in Guatemala are administered by an executive director who is generally responsible for all institutional activities. This is one of the most efficient and successful methods of administering agencies and institutions in Guatemala. It is common to find one dynamic and highly competent individual responsible for the development and continuance of practically any rehabilitation institution in the country.

The various directors are responsible to a board or league. However, these governing bodies generally limit their control to the financial aspects of institutional operations. Within the confines of a prescribed budget and by-laws of the organization, most directors are free to operate the institution in the manner they feel will best serve the clientele.

Finance

The rehabilitation institutions in Guatemala receive their financial support from three main sources. The sources of their revenue depend to a large extent upon the ownership

of the institutions. Government institutions receive their operating funds from Congressional appropriations. These institutions usually do not receive funds from any other source except perhaps occasional gifts or grants. They are usually inadequately financed, which is reflected in their physical plant, facilities, personnel, and services. Due to the generally depressed economy in Guatemala, private medical care is not possible, and most individuals must be served by these institutions.

The best financed institutions belong to the government social security program. These institutions receive contributions from the employees, employers, and the government. Even though the government may not always make its contributions to the program, it still has better financing than most other agencies or institutions in Guatemala. Consequently, the most complete and developed rehabilitation institution is owned and operated by the Social Security Administration. The Rehabilitation Hospital and other social security operated institutions receive their operating funds from the Administration; very little, if any, monies are received from other sources. The government has stringent laws to insure the payment of social security contributions by the employers and employees.

All registered employers withhold 1.5 to 2 per cent from the employees' pay and supplement it with their own 5 per cent payroll contribution. These contributions must

be made by the employers, regardless of whether the employees were paid or not. As soon as the employers incur a legal debt to their workers, the contributions must be made to the Administration under the penalty of law. Out of 8,530 legally registered employers, 393 were ordered to suspend operations in 1962 because they did not make their social security contributions.

The third main source of revenue for the support of agencies and institutions offering rehabilitation or para-rehabilitation programs in Guatemala is the lottery. Since it is legal to conduct private lotteries, it has become a major source of revenue for many privately operated organizations. The best example of such an organization is the Committee for the Blind and Deaf. The Committee owns and operates a successful lottery called "Santa Lucia" which provides most of the operating funds for their service organizations.

Some private rehabilitation institutions receive a substantial portion of their revenue from service fees and gifts from their sponsor(s) or various national and international philanthropic foundations. The disadvantages of these types of financing are obvious. The amount of money obtainable through service fees is necessarily limited because of the small percentage of clientele able to pay for services. Complete reliance upon gifts and grants from sponsors or philanthropic foundations is not desirable because of the uncertainty and sporadic nature of their

contributions. Consequently, the greatest advances toward developing complete rehabilitation programs are being made by private agencies backed by relatively sound sources of income, such as a successful lottery. However, all lotteries are not successful and profitable; to be profitable, a lottery must be popular. The popularity of the various lotteries is relative to the promotion campaigns, benefits paid, and public appeal; e.g., helping the "poor blind" arouses much public sympathy and appeal. One of the most popular lotteries in Guatemala is the "Santa Lucia."

Facilities

The physical plants of most agencies and institutions in Guatemala are grossly inadequate. The majority were converted from private homes which were not readily adaptable for use as rehabilitation institutions. The lack of adequate financing has prohibited the complete renovation of such buildings and in most cases only minimal modifications were made for the installation of equipment. Generally the plants are too small for their intended use and are poorly maintained and repaired. The utilities, exits, size and arrangement of rooms, lavatories, et cetera, are usually inadequate or improper for institutional use.

The service equipment and apparatus in most institutions are generally inadequate, imcomplete, and a mixture of old and relatively new. The average age of the various

equipment used for services was estimated by the researcher to be about ten years. The Director of the Neuropsychiatric Hospital estimated that 90 per cent of the service facilities should be replaced with new; at the same time, however, there is a completely new, unused electroencephalograph installation at the hospital. It is not unusual to find new equipment that is not being effectively used. This may be due to the orientation and training of the personnel, the lack of adequate Spanish instructional materials, and appropriate normative data.

There is one outstanding exception to the above generalizations regarding physical plants. The Alcoholic Sanatorium was originally designed and built as an institution. However, due to the nature of its financing and administration, the institution operates far below capacity.

Personnel

The level of training of the professional personnel in Guatemala strongly reflects the quality of the services offered at the various rehabilitation institutions. The most highly trained personnel were found to be in physical medicine. Most of the practicing physiatrists received their rehabilitation training in North America and Europe. The other professional personnel may be listed in the following order of decreasing training and competence: the various medical specialists, prosthetists, physical therapists, social workers,

occupational therapists, vocational training instructors, psychologists, and vocational (rehabilitation) counselors.

There is a need for all types of rehabilitation personnel in Guatemala, especially in the areas of psychology, occupational therapy, rehabilitation counseling, and vocational training. Reasons for the lack of professional personnel include:

1. Inadequate training programs in Guatemala
2. Failure to use existent training programs and facilities
3. Limited number of job opportunities
4. Little or no salary increases after personnel have received specialized training.

The University of San Carlos in Guatemala offers a degree in psychology, but the average psychologist working in rehabilitation settings is relatively untrained and does not have a degree in psychology. Rehabilitation counselors are non-existent, and only a few of the physiatrists seem to be familiar with the specialty. Attempts are currently being made to establish a rehabilitation counseling program at the Social Security Rehabilitation Hospital.

An important reason for the few competent, well-trained professional rehabilitation personnel in Guatemala is a lack of remuneration for increased training and competence. Many individuals receive training abroad and then

return to work for the same rate of pay. There is a large pay differential between the various rehabilitation personnel. The highest paid are the directors and physicians who receive as much as $5.00 per hour, while the less trained educators, occupational therapists, et cetera, receive $0.50 per hour. Relatively untrained personnel, such as aides and domestic help, receive as low as $0.16 per hour.

Most institutions cannot afford to pay high wages to trained professional personnel. As a result, institutions employ professional individuals on a part-time basis at an acceptable rate of pay. It is common to see professional persons who have three or four jobs. It is necessary for these individuals to hold multiple jobs in order to earn enough money to live on a "middle class" standard.

Programs and Services

Rehabilitation programs and services in Guatemala are primarily medical. This may be due to a number of reasons. The highest trained rehabilitation personnel are the physiatrists who naturally have a medical bias. While medical restoration must necessarily precede or run concurrently with other rehabilitation services, it is also recognized that medical restoration per se is not the goal of rehabilitation.

Other considerations in favor of medical rehabilitation are the nature of the Guatemalan culture and economy. The physical disability of the handicapped is often considered

their outstanding characteristic. The obvious human limitations, especially of the blind and seriously crippled or diseased, elicit considerable public sympathy. This public concern and sympathy generates a motivating force within people to do something for the disabled. The results of such movements are usually of a welfare or medical nature.

Modern rehabilitation has a strong vocational orientation. Since Guatemala is still relatively under-developed industrially, this phase of the rehabilitation program receives less emphasis.

Some of the rehabilitation programs are currently in the process of expanding and adding more services. The additional services are following the conventional pattern of similar programs in the more developed countries. Physical therapy may be found in three of the rehabilitation hospitals and some of the general hospitals in Guatemala City. Practically all of the institutions have at least limited social services, and some occupational therapy type activities. Definite vocational training is limited to the Social Security Rehabilitation Hospital although other institutions are presently planning to develop vocational rehabilitation programs.

Generally speaking, all of the rehabilitation programs and services, including physical rehabilitation, are inadequate and cannot serve all of the handicapped individuals in Guatemala. However, rehabilitation is rapidly

developing and considerable improvements in the quantity and quality of the services may be expected within the next few years.

Clientele

Actually not much is known about disabled or handicapped persons in Guatemala. There has been no national census or other studies of incidences of the various disability categories. Information is limited to the statistics and records kept by the various institutions that provide services for the disabled and handicapped.

Many of the clientele currently receiving services were crippled by polio or vocational accidents. These individuals receive rehabilitation treatment at the Polio Center, Social Security Rehabilitation Hospital, and Recuperation Center No. 1. Another large group which is receiving rehabilitation services of a limited nature is the blind and partially sighted. These individuals are treated at the Robles Institute and are maintained by the other organizations operated by the Committee for the Blind and Deaf.

A smaller class of disabled individuals is the "mentally" handicapped. These persons may be retarded, psychotic, neurotic, or psychosocially maladjusted. They are given limited rehabilitation treatment at the Neuropsychiatric Hospital, Mental Health Clinic, Alcoholic Sanatorium, and Recuperation Center No. 2.

Invariably the clientele served by the rehabilitation programs in Guatemala are unable to pay for protracted rehabilitation treatment. Many farm laborers become handicapped through machete or other accidents and their rehabilitation consists of medical restoration and retraining for farm work. Vocational rehabilitation is difficult since most of these men are illiterate and a large percentage cannot speak fluent Spanish. Many of the clientele referred to the Social Security Rehabilitation Hospital come from distant parts of Guatemala where little Spanish is spoken. These Indians speak only in their native dialects. Undoubtedly the nature of the clientele and the vocational structure in Guatemala have considerable influence on the development of rehabilitation programs and services.

It was not possible to summate the number of disabled into various disability categories. Many of the institutions do not keep accurate records, nor do they use standardized diagnostic categories. Some institutions do not diagnostically classify their clientele and when classifications are made, they are usually very broad, overlapping, and inclusive. The data obtained from one institution was not found to be comparable with that of the others.

CHAPTER V

SUMMARY, CONCLUSIONS, RECOMMENDATIONS FOR FURTHER RESEARCH, AND IMPLICATIONS

Summary

In many underdeveloped countries of the world today, the prevalence of diseases and accidents has created a major health problem. This is especially true when disabilities result in lifelong handicaps and forced dependencies. In an effort to understand the problems faced by underdeveloped countries, the present study was designed to investigate the nature and extent of rehabilitation practices in the Central American Republic of Guatemala.

The study began with a preliminary investigation to obtain some rudimentary knowledge regarding current rehabilitation facilities and practices. The resultant information helped in planning the methodology and selection of the population to be studied.

The data in the present study was obtained through structured interviews, observations, examination of records, and a Personal Information Inventory. Eight institutions in Guatemala were found to have rehabilitation programs; all were included in the survey. The information obtained from

each institution was organized under the following headings:

1. History and Development
2. Administration and Organization
3. Finance
4. Facilities
5. Personnel
6. Programs and Services
7. Clientele.

The data were analyzed for each institution after which a general overview of rehabilitation in Guatemala was prepared.

The results of the survey indicate that organized rehabilitation in Guatemala began about fifteen years ago and is still in the developmental stage. It began through the efforts of a few local physicians who received post-doctoral training in foreign countries. This gave early rehabilitation programs a medical orientation which still exists today. The training of the rehabilitation personnel determine the quantity and quality of the services. The training and competence level of the professional rehabilitation personnel may be listed in the following order of decreasing competence: physiatrists and other medical specialists, prosthetists, physical therapists, social workers, occupational therapists, vocational instructors, psychologists, and vocational rehabilitation counselors.

Rehabilitation institutions have three major sources

of income: the Social Security Administration, government allocations, and public lotteries. The Social Security Rehabilitation Hospital is the most complete rehabilitation institution in Guatemala and has the best financial support although realistically it is inadequate for the services rendered. It provides excellent medical, physical therapy, prosthetic, occupational therapy, and vocational training programs.

Most of the physical facilities of the institutions in Guatemala are old and inadequate and all of the institutions, except one, are located in buildings that were built for other purposes.

Many of the handicapped presently receiving rehabilitation services are farm laborers who are unable to pay for protracted treatment. The nature of the medical professions, clientele, and the socio-economic structure of Guatemala influence the development of rehabilitation programs.

Generally speaking, all of the rehabilitation programs and services are inadequate and only a fraction of the handicapped individuals in Guatemala receive services. However, rehabilitation is rapidly developing and considerable improvements in the quantity and quality of the services may be expected within the next few years.

Conclusions

The following conclusions were made upon the basis of the present survey:

1. Modern rehabilitation programs began to emerge in Guatemala in 1948, with the development of the social security program. Early rehabilitation had a medical orientation which still exists today.

2. Each of the eight rehabilitation institutions in Guatemala is administered by an executive director under the direction of a league or board of control. A relationship was found between the motivation and competence of the director and institutional progress.

3. Rehabilitation institutions receive financial support from three main sources: national Congressional appropriations, Social Security Administration, and private lotteries. The best financed institution is the Social Security Rehabilitation Hospital.

4. All rehabilitation institutions in Guatemala, except one, are located in physical plants built for other purposes. The service facilities in most institutions are inadequate, incomplete, and a mixture of old and new. The average age of the various equipment was estimated to be ten years old and in poor operating condition.

5. The professional rehabilitation personnel may be listed in the following order of decreasing training and

competence: physiatrists and other medical specialists, prosthetists, physical therapists, social workers, occupational therapists, vocational training instructors, psychologists, and vocational rehabilitation counselors. Rehabilitation counselors are non-existent, and only a few of the physiatrists know about the specialty.

6. Rehabilitation programs and services in Guatemala are primarily medical, although additional services are being developed at most institutions. Rehabilitation programs and services are provided by eight institutions in Guatemala. Three institutions have programs for orthpedically handicapped; one clinic provides eye and ear services for the blind and deaf, and four institutions treat individuals with "mental" disabilities or handicaps.

7. All of the rehabilitation institutions are located within the Department of Guatemala.

8. Many institutions classify their clientele into broad categories. They accept a variety of disabled and handicapped individuals rather than select certain clientele based upon some predetermined criteria.

9. There is no community or national coordination system of rehabilitation programs and services between agencies and institutions in Guatemala.

10. There seems to be a close relationship between medical, educational, economical, and industrial development and the development of modern rehabilitation programs and

services in Guatemala.

11. Many Guatemalans feel that it is the duty and responsibility of the government to care for disabled and handicapped persons.

12. There is a complete lack of accurate information regarding disabled and handicapped Guatemalans. For example, there are no statistics describing the number or types of disabled and handicapped individuals in the Republic.

Recommendations for Research

The selection of pertinent questions for further investigation is an important aspect of all research endeavors. Isolated research may be relatively valueless without continued efforts to build and accumulate knowledge on the basis of past experience. The raising of important questions is of value because it may assist in the summarization of past research and may serve as a basis for generating hypotheses for future research in Guatemala. Questions such as the following need to be investigated:

1. What are the attitudes of the Guatemalan people toward disabled and handicapped individuals?
2. What is the incidence of various disabilities in each Department of Guatemala?
3. What is the relative distribution of disabled and handicapped individuals among the various

social, cultural, economical, and racial sectors of the population?

4. Why has it not been possible to implement effective coordination of rehabilitation programs and services?
5. Are there cultural, societal, and/or educational implications in the causes of low efficiency and poor internal institutional organization?
6. What are the possibilities of training competent rehabilitation personnel in Guatemala?
7. What is the occupational structure of Guatemala? Obtain an estimate of the number of jobs in each classification.
8. Investigate the desirability and effectiveness, in Guatemala, of adapting various rehabilitation techniques and procedures developed in the more advanced countries.

Implications

The following discussion does not evolve entirely from the data obtained through the present investigation. It includes the personal observations and opinions formulated by the author in his attempts to examine the theoretical relationships between social services and developing nations.

The development of rehabilitation in Guatemala may be seen as a slowly changing evolutionary process. This

process can be compared with the evolution of the concept of rehabilitation itself as it grew and took on new and broader meanings. Because of the changing and rather amorphous character of the term, it was found in this study that "a" definition of rehabilitation in Guatemala does not exist. Definitions of rehabilitation depend primarily upon who is making it and for what purpose. There is some confusion in associating the term with medical and surgical treatment. This is not unusual as the term has been an accepted medical concept long before the advent of modern "vocationally oriented" rehabilitation.

The evolution of the term began as a sequel to socio-economic and industrial development in the United States and in Europe. Progressive medical and social scientists realized that to functionally rehabilitate individuals it was necessary to equip them with far more than new arms, braces, or wheel chairs. It became obvious to many professional people working with the handicapped that it was necessary and desirable to provide guidance, training, re-education, and job placement as part of rehabilitation programs. Without such services medical restoration per se is of limited value to the individual and society.

Another fact that directed the course of rehabilitation was its close association with the provision of services for individuals with acquired versus congenital disabilities. Disabled and handicapped individuals were

frequently the victims of industrial or vocational accidents. Because of the legal and moral obligation that employers had for injured employees, money was made available for the rehabilitation of these individuals. Rehabilitation then became closely associated with employment and vocational rehabilitation received the greatest impetus. These circumstances and early realizations regarding the desirability of expanding the rehabilitation process prompted social scientists to build theories of occupational choice. As these theories and related occupational information became public knowledge and interest, rehabilitation began to take definite shape. Rehabilitation became synonymous with vocational rehabilitation almost to the exclusion of the former. In the United States this movement was supported by large federal grants given to states on a matching basis for the purpose of vocationally rehabilitating the handicapped.

It may be seen from the above that rehabilitation as conceived in developed countries is closely allied with the industrial movement, employment, and medicine.

The underdeveloped countries of the world today are receiving assistance from the developed countries. Various technical and scientific advances are transplanted to underdeveloped countries but may not be entirely assimilated because of differences in cultural and socio-economic structures. One result of this aborted assimilation is a degree of confusion and different levels of understanding between professionals

working in the field of rehabilitation. Some of the more progressive minded individuals attempt to adopt the latest techniques and practices that are used in the highly developed and industrialized countries. Their efforts are met by the resistances of uninformed and conservative individuals who assert that socio-economic and other conditions are not satisfactory to permit the successful assimilation and implementation of rehabilitation programs designed for use in developed countries. Consequently, efforts to use foreign ideas and practices have met with limited success.

It has been noted that a close relationship exists between medical education and practices, economic and industrial development, and the development of rehabilitation programs and services.

In light of the above, it can be predicted that "modern" rehabilitation programs are unlikely to develop in economically and industrially underdeveloped countries. Such underdeveloped countries usually have poor medical programs and services and an agricultural economy. However, as a country begins to develop its human and natural resources, definite changes take place with regard to education, medical practices, and the types of employment. Invariably some degree of industrialization begins to take place and with it comes a need for trained workers and technicians. It is these changes and increased complexity

of mechanization and industrialization that give much of the cultural content necessary to develop modern rehabilitation programs and services. It would seem that the ideal time to implement rehabilitation programs is when these changes begin to take place.

In recent years, the Republic of Guatemala has made considerable progress in areas such as medicine, education, and industrialization. As Guatemala continues to develop as an industrial nation, it will become increasingly easier to assimilate "new" ideas from the more developed countries. Progressive individuals interested in developing rehabilitation should have greater acceptance and success.

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APPENDIX A

LIST OF AGENCIES AND INSTITUTIONS OBTAINED FOR THE PRELIMINARY INVESTIGATION

LIST OF AGENCIES AND INSTITUTIONS OBTAINED

FOR THE PRELIMINARY INVESTIGATION

	Institution	Address
1.	Asilo de Ancianos	Antigua, Guatemala
2.	Asociacion Amigas de San Vicente	7a Avenida 2-36, Zona 1, Guatemala, Guatemala
3.	Asociacion Guatemalteca Rehabilitacion Lisiados	9a Calle 0-16, Zona 1, Guatemala, Guatemala
4.	Asociacion Nacional de Muchachas Guias	7a Avenida y 13 Calle, Zona 9, Guatemala, Guatemala
5.	Asociacion Pediatrica de Guatemala	9a Calle 2-64, Zona 1, Guatemala, Guatemala
6.	Asociacion Pro-Salud del Nino	7a Avenida 3-39, Zona 1, Guatemala, Guatemala
7.	Asociacion de Scouts de Guatemala	9a Calle 0-16, Zona 1, Guatemala, Guatemala
8.	Asociacion de Trabejadores Sociales de Guatemala	9a Calle 7-55, Zona 9, Guatemala, Guatemala
9.	Asociacion Cadettes de Cristo	6a Calle 2-20, Zona 1, Guatemala, Guatemala
10.	Centro Educativo Asistencial	4a Avenida 15-36, Zona 1, Guatemala, Guatemala
*11.	Centro de Rehabilitacion del IGSS	Ruta 7, No. 4-5, 4, Zona 4, Guatemala, Guatemala
*12.	Centro de Recuperacion No. 1	3a Calle 0-18, Zona 1, Guatemala, Guatemala

	Institution	Address
*13.	Centro de Recuperacion No. 2	Calle San Juan 30-81, Zona 9, Guatemala, Guatemala
*14.	Centro de Salud Mental	4a Calle 0-27, Zona 1, Guatemala, Guatemala
15.	Ciudad de Los Ninos	13 Avenida 29-29, Zona 5, Guatemala, Guatemala
16.	Club Altrusa de Guatemala	12 Calle "A" 0-59, Zona 1, Guatemala, Guatemala
17.	Club de Leones de Guatemala	11 Calle 4-52, Zona 1, Guatemala, Guatemala
18.	Consejo de Bienstar Social	1a Calle 4 y 5 Avenida, Zona 9, Guatemala, Guatemala
19.	Depto. de Extension Agricola	Finca La Aurora, Zona 13, Guatemala, Guatemala
20.	Depto. de Servicio Social del Ministerio	8a Calle 3-51, Zona 1, Guatemala, Guatemala
21.	Division Genito-Infecciosas de Sanidad Publica	17 Calle 11-56, Zona 1, Guatemala, Guatemala
22.	Division de Tuberculosis	15 Calle 6-28, Zona 1, Guatemala, Guatemala
23.	Escuela Superior de Sericio Social	9a Calle 7-55, Zona 9, Guatemala, Guatemala
24.	Hogar del Adolescente	7a Avenida 3-73, Zona 1, Guatemala, Guatemala
25.	Hospital General	1a Avenida 9-88, Zona 1, Guatemala, Guatemala
*26.	Hospital Neuropsiquiatrico	San Vicente, Zona 7, Guatemala, Guatemala
27.	Hospital Roosevelt	Carretera Roosevelt, Zona 13, Guatemala, Guatemala

	Institution	Address
28.	Instituto Guatemalteco de Seguridad Social	7a Avenida Prolg., Zona 4, Guatemala, Guatemala
29.	Instituto Indigenistra Nacional	6a Avenida 1-30, Zona 2, Guatemala, Guatemala
30.	Instituto Neurologico	4a Calle 9-46, Zona 1, Guatemala, Guatemala
*31.	Instituto Rodolfo Robles	9a Calle 3-07, Zona 1, Guatemala, Guatemala
32.	Liga Guatemalteca contra las Enfermedades del Corazon	9a Calle 10-55, Zona 1, Guatemala, Guatemala
33.	Liga Nacional contra la Tuberculosis	9a Calle "A" 0-65, Zona 1, Guatemala, Guatemala
34.	Liga Nacional contra la Poliomielitis	5a Avenida 1-07, Zona 1, Guatemala, Guatemala
35.	Padres de Maryknoll	14 Calle 9-40, Zona 1, Guatemala, Guatemala
36.	Patronato Antialcoholico	9a Calle 2-64, Zona 1, Guatemala, Guatemala
37.	Patronato contra la Mendicidad	10 Avenida 13-75, Zona 1, Guatemala, Guatemala
38.	Patronato Pro-Hospital de Coban	Coban, Alta Verapaz, Guatemala
*39.	Instituto de Rehabilitacion Infantil	26 Calle 3-43, Zona 3, Guatemala, Guatemala
*40.	Sanatorio Antialcoholico	Avenida Petopa y 23 Calle, Zona 12, Guatemala, Guatemala
41.	Senatorio Antituberculoso "San Vicente"	Finca la Verbena, Zona 7, Guatemala, Guatemala

	Institution	Address
42.	Servicio Auxiliar de Bienestar Social	12 Calle 4-10 Altos, Zona 1, Guatemala, Guatemala
43.	Sociedad Protectora del Nino	1a Avenida "A" 8-65, Zona 1, Guatemala, Guatemala
44.	Socio Educativo Rural (Direccion General de Desarrollo)	11 Avenida 9-70, Zona 1, Guatemala, Guatemala
45.	UNESCO of Guatemala	6 Calle 9-27, Zona 1,, Guatemala, Guatemala
46.	Unidad Asistencial de San Juan Sacatepequez	San Juan Sacatepequez, Guatemala

*Included in the present study.

APPENDIX B

STRUCTURED INTERVIEW DATA SHEETS

(English Translation)

INSTITUTE OF RESEARCH AND
IMPROVEMENT OF EDUCATION

Special Education and Rehabilitation Project

- SERP -
SS- FS

Face Sheet

CODE [ ]

Name of the Agency or Institution_____

_____

Address_____

_____

Telephone_____ Public [ ] Private [ ]

Name of person to contact_____

Other locations_____

_____

Special Education [ ]; Rehabilitation [ ]; Both [ ]; None [ ]

General nature of services offered_____

_____

_____

Best times for interviews_____

Estimated time necessary to collect data_____

Researchers comments_____

_____

_____

Nov. 1962 Researcher_____Date_____Informant_____

HISTORY SS - H1

CODE

1. When founded

2. By whom

3. Purpose when founded (obtain charter)

4. Major changes since founded

   a) Programs and Services

Dec. 1962 Res Date 1963 Informant

CODE

b) Clientele- Type and number when founded and subsequent major changes_____

c) Types and number of service personnel when founded and subsequent major changes_____

CODE

d) Organization when founded and subsequent major changes

e) Facilities when founded and subsequent major changes

ADMINISTRATION SS - A1

CODE

1. *Major Control: Govt._____ Private_____

2. Organization Structure (obtain copy of by-laws).

(a) Board of Control: YES_____ NO_____

1. Number and composition_____

_____

_____

_____

2. How often do they meet?_____

*_____

3. How elected_____

_____

4. Length of service_____

5. Role of Chairman_____

_____

(b) Admin. Organization (obtain organizational chart or draw an organization chart if unavailable)

1. Duties of chief admin. officer_____

_____

2. How are admin. personnel selected?_____

_____

_____

_____

DEC. 1962 RES_____Date_____1963_Informant_____

SS - A2

CODE

3. Major Policy Determination

(a) How are programs and kinds of services determined?

(b) How are eligibility requirements for service determined?

(c) How are personnel needs and standards determined?

(d) How is the budget formulated and approved?

CODE [ ]

(e) How is Capital outlay decided?_____

_____

_____

4.*Board Admin_____ Executive Admin_____

5. Autonomy or Coordination with other agencies.

(a) Are facilities shared with other agencies? Explain

_____

_____

_____

(b) Do you refer and/or exchange clientele? Explain

_____

_____

_____

_____

(c) Do you share fund raising programs? Explain_____

_____

_____

_____

_____

(d) Do you share personnel? Explain_____

_____

_____

_____

_____

_____

_____

_____

FINANCE SS - Q1

CODE

1. Total and SE or R budget by years: (obtain copy of budgets for 1960-61-62)

   1962_____ _____ 1961_____ _____

   1960_____ _____ 1959_____ _____

   1958_____ _____ 1957_____ _____

2. Expected 1963 budget (obtain a copy) _____ _____

3. Sources of income: (also enter expected 1963 figures)

   (a) Govt. (Name specific agencies and amounts)

   1962_____ Q_____; _____ Q_____

   1961_____ Q_____; _____ Q_____

   1960_____ Q_____; _____ Q_____

   1963_____ Q_____; _____ Q_____

   (b)

PVT.	Individual donations		Companies or Organizations		Non-Cash gifts Indicate the kind and estim. value
	solicited	unsolicit.	solicited	unsolicit.	
1962					
1961					
1960					
1963					

   (c) Lotteries: Who conducts it?_____

   _____

   1962 Q_____; 1961 Q_____; 1960 Q_____

   Expected 1963 Q_____ _____

Dec. 1962 Res_____Date_____1963 Informant_____

FINANCE SS - Q2

CODE

(d) Fees:

	1962	1961	1960	1963	Rate and/or kind
Tuition					
Edu. Materials					
Medical					
Subsistance					
Materials and equip.					
Other services fees					
TOTALS					

(e) Sales:

	PRODUCE		RESALE	
	Amt.	Kind	Amt.	Kind
1962				
1961				
1960				
1963				

(f) Other income: (indicate year, amount, and source)

_____

_____

_____

4. What are the dates of your fiscal year?_____

5. What are the dates of your school year?_____

FINANCE SS - Q3

CODE

6. Expenditures: (obtain salary schedule)

EXPENSE CATEGORY	1962	1961	1960	1963
(a) Salaries of admin. personnel				
(b) Salaries of service personnel				
(c) Service material costs				
(d) Service equip. purchases				
(e) Overhead and maintenance				
(f) New Construction				
(g) Debt management				
(h) Other service costs				

Explain (h)_____

_____

_____

7. Who does your auditing? (obtain statement for 1962-61-60)

_____

8. 1962 Insurance value: (if any) Q_____

9. 1962 Book value or estimated assets Q_____

10. Comments:_____

_____

_____

_____

_____

_____

_____

	(obtain floor plan) Building	Total # of rooms	# rooms class/ service	type of constr.	Stor- ies	A G E	Condi- tion	Originally designed for
1								
2								
3								
4								
5								

2. Size of property _____

3. Numbers in boxes below refer to buildings listed in above chart.

(a) Electricity _____	1	2	3	4	5
(b) Water Fountains _____	1	2	3	4	5
(c) Lavatories _____	1	2	3	4	5
(d) Gas- Oil _____	1	2	3	4	5
(e) Heating Plant _____	1	2	3	4	5

DEC. 1962 Res_____ Date_____ 1963 Informant_____

FACILITIES - GENERAL

CODE

SS - F1

(f) Exits _____ | 1 | 2 | 3 | 4 | 5 |

(g) Stairs _____ | 1 | 2 | 3 | 4 | 5 |

(h) Hallways _____ | 1 | 2 | 3 | 4 | 5 |

(i) Parking (by No. of Cars)___ | 1 | 2 | 3 | 4 | 5 |

(j) Recreational grounds_____ | 1 | 2 | 3 | 4 | 5 |

4. Types of rooms and number:

(a) Special Education classrooms _____ | 1 | 2 | 3 | 4 | 5 |

(b) Admin. offices _____ | 1 | 2 | 3 | 4 | 5 |

(c) Service offices _____ | 1 | 2 | 3 | 4 | 5 |

(d) Medical treatment _____ | 1 | 2 | 3 | 4 | 5 |

(e) All types of physical therapy _____ | 1 | 2 | 3 | 4 | 5 |

(f) Voc. Training type rooms _____ | 1 | 2 | 3 | 4 | 5 |

FACILITIES - GENERAL

CODE

SS - F2

(g) Dining rooms _____ | 1 | 2 | 3 | 4 | 5 |

(h) Conference rooms _____ | 1 | 2 | 3 | 4 | 5 |

(i) Lounges _____ | 1 | 2 | 3 | 4 | 5 |

(j) Library _____ | 1 | 2 | 3 | 4 | 5 |

(k) Recreation type rooms _____ | 1 | 2 | 3 | 4 | 5 |

Other service related rooms. Please describe each.

(l) _____ | 1 | 2 | 3 | 4 | 5 |

(m) _____ | 1 | 2 | 3 | 4 | 5 |

(n) _____ | 1 | 2 | 3 | 4 | 5 |

(o) _____ | 1 | 2 | 3 | 4 | 5 |

(p) wards or dormitories. Indicate: # of rooms/ beds

	1	2	3	4	5
M					
F					

FACILITIES - SPECIFIC SS - F4

use one sheet for each service room or class room CODE

1. Identification of room by number and/or name.

2. Relative location in building

3. Draw a sketch and indicate size and openings.

4. What is this room currently used for?

5. What kind of activities take place in this room?

6. How many hours per day is this room in use?

7. What are the characteristics of the clientele/students using this room?

   (a) Age range

   (b) Kinds of disability

   (c) Largest number at any one time

   (d) Average number utilizing this room each day

8. Number and kinds chairs or desks: (fixed?)

DEC 1962 Res Date 1963 Informant

FACILITIES - SPECIFIC SS - F5

use one sheet for each service room or class room CODE

9. Types and amounts of equipment in this room.

10. Lighting		
11. Ventilation		
12. Noise		
13. Temp.		

14. *What is the capacity for services in this room?

15. What materials or equipment do you need or have in excess: (Indicate which?)

16. *Is this room adequate for the services conducted? Explain

FACILITIES - SPECIFIC SS - F6

use one sheet for each service room or class room CODE

17. Types and amounts of rehab. materials in this room?_____

18. List of teaching materials:

(a) Types and amounts of institutionally provided teaching aids._____

(b) Availability of common supplies (paper, pencils, etc).

(c) Books._____

(d) Types and amounts of teacher produced materials.

PERSONNEL SS - P1

CODE

1. Administrative personnel: (get list of total personnel)

TITLE	Sex	Pd.	Vol.	Full-time hrs/wk.	Part-time hrs/wk.

2. Service Personnel: (indicate average hours per week)

TITLE	Total #		# F	Full-time		Part-time	
	Pd.	Vol.		#	hrs.	#	hrs.
(a) Prim. Teacher							
(b) Sec. Teachers							
(c) Speech therapists							
(d) Counselors							
(e) Social workers							
(f) Psychologists							
(g) Psychiatrists							
(h) Physicians							
(i) Physiatrists							
(j) Oculists							
(k) Phys. Therapists							
(l) Occ. Therapists							
(m) Prosthetist							
(n)							
(o)							
(p)							

Dec. 1962 Res_____Date_____1963 Informant_____

PERSONNEL SS - P2

CODE

3. What additional staff do you presently need?_____

(Indicate type and number)_____

4. Have provisions been made for additional personnel in your 1963 budget? (indicate type and number)_____

5. What is the rate of turnover among your service personnel, (paid and voluntary)? Explain_____

6. What criteria are used for employment of service personnel? (if written obtain a copy)_____

CODE

7. Are your hiring criteria difficult to follow?_____

8. What are your hiring procedures? (obtain copy)_____

9. What opportunities exist for advancement?_____

10. Fringe benefits:

(a) Social Security_____

(b) Retirement_____

(c) Insurance_____

(d) Other_____

SERVICE PROGRAMS SS - S1

CODE

1. What are the objectives of this institution? (Obtain copy)

2. What are the elibibility requirements for service? (Obtain copy)

3. What are the referral methods to and from this institution? (List agencies and numbers also)

Dec. 1962 Res_____Date_____1963 Informant_____

CODE

4. How are those admitted for services selected?

5. What is the criteria for case closure?

6. How do you evaluate student performance? (SE)

   (a) Grading system

   (b) Examination procedures

   (c) Testing programs (list types of tests used)

7. What is the criteria for grade placement? (SE)

SERVICE PROGRAMS SS - S3

CODE

8. Indicate below the specific services provided by this institution and the percentage of the clientele receiving each service.

(a) Psychological testing _____
(b) Psychological counseling _____
(c) Psychiatric services _____
(d) Social work _____
(e) Vocational counseling _____
(f) Medical services _____
(g) Prostheses _____
(h) Physical therapy _____
(i) Occupational therapy _____
(j) Speech therapy _____
(k) Ophthalmological and/or optical services _____
(l) Vocational training _____
(m) Educational training _____
(n) Training in activities of daily living _____
(o) Maintenance _____
(p) Subsidies _____
(q) Vocational placement _____
(r) Follow-up _____
(s) Transportation _____
(t) Avocational activities _____
(u) Services for parents, etc. _____
(v) _____ _____
(w) _____ _____
(x) _____ _____
(y) _____ _____
(z) _____ _____

CLASSIFICATION AND TALLY
1962-61-60-59-58-57
also Enter projected 1963 Tally

SS - ClR

CODE

YEAR	Disability	# in m	# in f	# out m	# out f	$\overline{x}$ time/client in	$\overline{x}$ time/client out	Age Range	Type of Service

DEC 1962 Res_____ Date_____ 1963 Informant_____

CLASSIFICATION AND TALLY SS - C2R

1962 ☐ 1963 ☐ CODE ☐

2. Disability Classification	Service Capacity In	Service Capacity Out		Unmet Needs	Service Area City	Service Area Km	Nature of Clientele

CLASSIFICATION AND TALLY SS - ClS

CODE [ ]

1. Approximate number of students applying or recommended for admission in:

1962 [ ] 1961 [ ] 1960 [ ]

1959 [ ] 1958 [ ] 1957 [ ]

2. Number of students in special classes or receiving special services in:

1962 [ ] 1961 [ ] 1960 [ ]

1959 [ ] 1958 [ ] 1957 [ ]

3. Number of students graduating in:

1962 [ ] 1961 [ ] 1960 [ ]

1959 [ ] 1958 [ ] 1957 [ ]

4. Number of special classes taught in:

1962 [ ] 1961 [ ] 1960 [ ]

1959 [ ] 1958 [ ] 1957 [ ]

DEC 1962 Res_____Date_____1963 Informant_____

CLASSIFICATION AND TALLY SS - C2S

CODE

Students Served During 1962

5.

Type of Disability	Number	Type of class or service

6. Enrollment by grade level: (1962 only)

	M	F		M	F		M	F
Pre school			I			II		
III			IV			V		
VI			VII			Other		

7. Number of students in age ranges from: (1962 only)

4 to 6		6 to 8		8 to 10	
10 to 12		12 to 14		14 to 16	
16 to 18		Other-			

CLASSIFICATION AND TALLY SS - C3S

CODE

8. Number of residential students (1962 only)----

   Number of day students: (1962 only)----------

9. Number of students from city: (1962 only)-----

   Number of students out of city: (1962 only)---

10. Anticipated applications and recommendations for enrollment in:

    1963-1964 1964-1965 1970

11. Anticipated enrollment in:

    1963-1964 1964-1965 1970

RESEARCH ENDEAVORS SS - R

CODE

What research, if any, has been conducted by members of the staff of this institution?

INVESTIGATOR_____TITLE_____

Publisher_____Date_____

Where available_____

Brief summary_____

INVESTIGATOR_____TITLE_____

Publisher_____Date_____

Where available_____

Brief summary_____

DEC 1962 Res_____Date_____1963 Informant_____

DOCUMENTS SS - D

CODE ☐

Please obtain the following documents when available. Check the ones obtained and write in the number of pieces of materials.

1. Legal Charter or by-laws . . . . . ☐
2. Printed materials on aims, services, etc . . . . ☐
3. Budgets for years 1962-61-60 . . . . . ☐
4. Auditors statements or financial reports for 1962-61-60 . . . . . ☐
5. Floor plan of building if service areas are extensive . . . . . ☐
6. Salary schedules . . . . . ☐
7. Personnel list . . . . . ☐
8. Criteria for hiring professional personnel . . . ☐
9. Application forms for professional service personnel . . . . . ☐
10. Criteria for admitting clientele . . . . . ☐
11. Applications and admissions forms for clientele. ☐
12. Student/clientele classification . . . . . ☐
13. Class/service schedules . . . . . ☐
14. Fee schedules . . . . . ☐
15. Copies of available statistics . . . . . ☐
16. Copies of various annual reports . . . . . ☐
17. Institutional procedure guides or manuals . . . ☐
18. Research reports or publications . . . . . ☐
19. _____ ☐
20. _____ ☐
21. _____ ☐
22. _____ ☐
23. _____ ☐

APPENDIX C

PERSONAL INFORMATION INVENTORY

(English Translation)

INSTITUTE OF EDUCATIONAL RESEARCH AND IMPROVEMENT

(IIME)

Survey of Special Education and Rehabilitation Programs

Personal Information Inventory

IIME is conducting a survey of Special Education and Rehabilitation programs and facilities in Guatemala. An estimated twenty public and private institutions and agencies are cooperating in the study. Most of the information to be collected will be obtained through interviews and visitations. However, some of the most vital information can only be obtained directly from individual professional workers in the field.

Will you assist the Institute in this important study by completing all the information requested below?

Your responses will be kept in strict confidence and analyzed only by IIME researchers. Thank you for your cooperation.

INSTITUTE OF EDUCATIONAL RESEARCH AND IMPROVEMENT
(IIME) SS - P4

Survey of Special Education and Rehabilitation Programs

Personal Information Inventory

A. PERSONAL DATA

1. Name of Institution in which you are employed:

_____

2. What is the title of the position which you now hold?

_____

3. Describe in about one sentence the nature of the work that you do. _____

_____

_____

4. For how many years have you been employed in this Institution?

(Check one)

a. Less than 1 year ( ) d. 4 to 6 years ( )

b. 1 to 2 years ( ) e. 6 to 10 years ( )

c. 2 to 4 years ( ) f. 10 or more years ( )

5. Normally, how many hours per week do you work?_____

6. Is this position considered to be full-time or part-time? (check one)

a. Full-time ( ) b. Part-time ( )

7. In what way are you paid? (Check one)

a. by salary ( )

b. by hourly rate ( )

c. non-paid volunteer ( )

8. If paid by salary, what is your regular monthly salary?

Q_____

9. If paid by means other than by salary, what are your earnings per hour? Q_____

10. What is your sex? a. male ( ) b. female ( )

11. Are you married? a. yes ( ) b. no ( )

12. Approximately what is your age? (Check one)

a. under 20 ( ) c. 30-39 ( ) e. 50-59 ( )

b. 20-29 ( ) d. 40-49 ( ) f. 60 or more ( )

B. PROFESSIONAL TRAINING AND EXPERIENCE

1. Have you taken a course at the University of San Carlos in the last three years? If so, please identify the courses in the space below. (If more than three, list the three most recently completed).

Name of Course	Faculty	Date Completed

2. In general, of what value were the courses you took at the University of San Carlos in your professional work? (Please check one)

a. of great value ( ) c. of little value ( )

b. of some value ( ) d. of no value ( )

3. Please identify the professional organizations to which you belong.

_____

_____

_____

4. To what professional publications do you regularly subscribe?

_____

_____

_____

B. PROFESSIONAL TRAINING AND EXPERIENCE

5. Please indicate how many years of education you have had.

Name of Institution	Location	Curriculum	Years in which attended	Degree or certificate earned

6. Please list the positions or occupation you have held during the past ten years. (List in order of most recent to least recent.)

Title	Name of institution	Location	Years in which employed

C. PROFESSIONAL ACTIVITIES

If you are a teacher, omit questions 1 through 5 and CONTINUE DIRECTLY TO QUESTION 6.

1. Approximately how many clients do you see during the average day?_____

2. What is the average length of time you spend per visit with each client?

   a. Less than 30 min. ( ) c. 1 to 1½ hour ( )

   b. 30 min. to 1 hour ( ) d. more than 1½ hour ( )

3. Do you limit your practice to specific disabilities?

   Yes ( ) No ( )

4. Briefly state the type(s) of disabilities you treat.

_____

_____

_____

_____

_____

_____

5. What additional training, if any, do you believe would help you to better perform your present duties?

_____

_____

_____

_____

_____

_____

_____

THIS TABLE SHOULD BE FILLED OUT BY TEACHERS ONLY

SS - P8

6. Please provide in the chart below the requested information for each of the special education classes which you taught in this institution during 1962.

Name of class	Length of class in minutes	Grade level	Number of Students M	F	Age range of students	Subjects taught in class	Nature of Students' Disabilities
1							
2							
3							
4							
5							
6							
7							

7. Do you hold any other position in addition to your employment in this institution? a. Yes ( ) b. No ( )

If yes please describe in the chart below.

Title of position	Institution	Hours per week	Salary or wage per month

D. PROFESSIONAL OPINIONS

1. What do you consider to be the four greatest problems or needs in the field of special education ( ) or rehabilitation ( ) in Guatemala? (Please check one)

a)_____

b) _____

c)_____

D. PROFESSIONAL OPINIONS (continued)

d)_____

_____

_____

_____

_____

2. In your opinion, how great are the opportunities for professional advancement in the field of special education ( ) or rehabilitation ( ) in Guatemala? (Please check one)

   a. Many ( ); b. Some ( ); c. Few ( ); d. None ( ).

3. Do you have specific plans for additional training in your field? (Please check)

   Yes ( ) No ( )

   If yes, please describe below:_____

_____

_____

_____

4. Do you plan to remain in your present field of specialization? (Please check)

   Yes ( ) No ( )

   If not, please describe the reasons why you are choosing to leave this field of specialization.

_____

_____

_____

_____

_____

_____

_____

_____