REFRACTIONS OF "DOING GOOD": THE STATE, SUBJECTIVITY, AND NGO HEALTH WORKERS IN MAYA GUATEMALA

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ABSTRACT

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On a global scale, NGOs have played an important role in development and addressing healthcare inequities over the last several decades. Yet in recent years, the work of NGOs is continuously impacted by processes of socio-cultural, political, and economic change in increasingly post-neoliberal contexts. NGOs working within a social justice framework for health are a unique area to examine this shift as they continue to operate in the ebb and flow of changing fields of social power. The Guatemalan context has provided a salient example of this process, as changes in NGO-state relationships, health policy, and an increasingly pro-impunity state that protects perpetuators of corruption, have steadily impacted the subjectivities, resources, and practices of those working for NGOs.

This dissertation explores the changing socio-political healthcare climate in Guatemala and its effects on the abilities of NGO workers to continue serving the needs of marginalized Indigenous Maya communities in the intersecting fields of health and social justice. Subjectivity is a useful theoretical framework for understanding how this larger shift in socio-political context impacts the actions, perceptions, and experiences of NGO workers involved in health intervention. This dissertation is guided by the notion that subjectivity is the site in which larger socio-cultural, economic, and political forces shaping social policy can likewise be seen to shape actors immersed in the ramifications of policy change. I propose that subjectivity is an amalgamation of individually, institutionally, and politically formed subjectivities. NGO worker's subjective realities are individually formed through their unique personal experiences

and identities; institutionally formed through the structure, history, and agenda of their organizations and funding institutions; and politically formed through their intrinsic and fluctuating relationship with the state and government institutions.

This dissertation presents findings from a research project conducted over several summers between 2014 and 2019 exploring NGO workers' experiences in health intervention from multiple NGOs in Guatemala. Utilizing semi-structured interviews, participant observation, textual and discourse analysis, this dissertation examines how NGO workers continue to serve Indigenous Maya communities despite dramatic shifts in state supports for NGOs. This work discusses how factors such as identity, indigeneity, and institutional legacy can impact the health interventions and community activism implemented in Indigenous communities. NGO workers navigate both their personal subjectivity as Indigenous individuals with unique connections to the Maya community, and an institutional subjectivity as actors immersed in NGO rhetorics of development. These competing subjectivities yielded profoundly gendered understandings of empowerment and feminist solidarity within approaches for health intervention. NGO workers also possess institutional and political subjectivities that are defined by a complex relationship with the state. Health activism in the context of NGOs can be transmuted over time through contractual relationships with the state whereby bureaucratic policies that place value on managerialism over social justice, thoroughly shift the nature and content of health intervention. Ultimately, I argue there is a fundamental link between non-governmental and government institutions, as NGO workers' political subjectivities are continuously shaped by politically driven policy change, authoritative discourse, and popular belief. It is through this fundamental link with the state where regimes of truth manifest that can ultimately manipulate the actions of NGOs, refracting their perceptions of "doing good" for the most marginalized.

For my mother, Laureen Catherine Martínez and my father, Tiburcio Antonio Martínez Benavides, who have taught me so much about patience and hard work. I love you.

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PREFACE

“Go to the people.
Live with them.
Learn from them.
Love them.
Start with what they know.
Build with what they have.
But with the best leaders,
when the work is done,
the task accomplished,
the people will say,
'We have done this ourselves.’”

-Lao Tzu

Poem on the wall at Asociación para Nutrición y Desarrollo Integral,
as recited to me by José Manuel.

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KEY TO ABBREVIATIONS

NGO: Nongovernmental organization

PEC: Programa de Extensión de Cobertura

FMS: Fundación Maya Salud

ANDI: Asociación para Nutrición y Desarrollo Integral

IDB: Inter-American Development Bank

IMF: International Monetary Fund

WHO: World Health Organization

PAHO: Pan-American Health Organization

USAID: The United States Agency for International Development

MDGs: Millennium Development Goals

UN: United Nations

SDGs: Sustainable Development Goals

WID: Women in Development

UNICEF: United Nations Children's Fund

MSPS: Ministerio de Salud Pública y Asistencia Social

IGSS: El Instituto Guatemalteco de Seguridad Social

ASINDES: Association of Guatemalan Service and Development NGOs

CEH: Commission of Historical Clarification

URNG: The Guatemalan National Revolutionary Unity

PRONADE: Programa Nacional de Autogestión para el Desarrollo Educativo

SIAS: Sistema Integral de Atención en Salud

CICIG: La Comisión Internacional Contra la Impunidad en Guatemala

Chapter 1: Introduction

The work of individuals involved in health, in both the public and private sector, is continuously shaped and impacted by the ebb and flow of how contextual socio-cultural, political, and economic factors affect policy, discourse and action. Actors addressing health disparities, such as those working within health non-governmental organizations (NGOs) are especially subject to these factors, as they operate in fields of ever-changing social and political power that stand to shape the nature and content of health intervention. On a global scale, NGOs have played an increasingly important role in addressing healthcare inequalities and inequities over the last several decades.

NGOs are non-profit institutions operating independently from government to address social, cultural, political, and economic issues within a society. Throughout their history, NGOs have served as sites of aid, refuge, social and political representation, knowledge production, collectivity, and resistance; in short, as sites of social solidarity. NGOs have a long history of addressing social problems and assisting disadvantaged peoples and groups around the world. When neoliberalism came to the forefront of global politics, promoting social policy that endorsed privatization and reduced state intervention, the nonprofit NGO sector was called upon to deliver many services previously delivered by the state. NGOs were thought to possess the capacity to increase the efficiency of healthcare delivery, help achieve numerous public health goals, reduce chronic health disparities, and improve universal healthcare access and equity. Thus, in some countries NGOs have been integrated into healthcare systems through inventive policy recognizing the non-profit sector as a means to strengthen and assist the state in areas of development it is unequipped to address.

While the integration of NGOs into healthcare systems fit into political agendas over the last several decades, shifts in state policies, law, and socio-political contexts have called into

question the utility of NGOs in assisting the state in areas of health and human welfare. NGOs have been problematized for the variability in their capacities to achieve state development goals, including goals for health, as factors such as development agenda, funding, state institutions, social policy, and business interests impact their abilities to "do good" (Fisher 1997, Lashaw, Vannier, and Sampson 2017, Lewis 2017). What happens when policy supporting NGO-state relationships for health intervention no longer serves the principles and priorities of the state?

In 1998, Guatemala integrated NGOs into the healthcare system through social policy crafted by the state and international funding institutions as an innovative approach to addressing immense health needs and inaccessibility for the most marginalized in the country's post-conflict context, particularly Indigenous Maya communities (Maupin 2009, Maupin 2015, La Forgia, Mintz, and Cerezo 2005). Yet, as the social and political supports for such health policy shifted in recent years, NGOs have been cast in a new light, no longer envisioned by the state as a so-called "magic bullet" (Edwards and Hulme 1996) for development. For NGOs and those who work for them, this context has in effect redefined the task of implementing health interventions for the most underserved.

Guatemala's long history of systemic social inequality, social movements, international funding, limited state intervention, and increasing privatization has produced an abundant NGO sector over time such that NGOs are said to represent the "face" of development (Rohloff, Díaz, and Dasgupta 2011). Within Guatemala's abundant NGO sector exist many small grassroots organizations with which many Guatemalan's are increasingly accustomed to interacting with (Beck 2017a, Frank 2013, Chary and Rohloff 2015, Cardelle 2003). These small NGOs are most often run by local community members and individuals with experience, knowledge, and unique social links with marginalized Indigenous communities. NGO workers in this context rely on

their personal experiences, often as individuals from the very communities in which they serve. They also draw on institutional knowledge and skills imbued in them by their organizations and funders. NGO workers rely on this intimate connection and social capital when designing and implementing health interventions. This dissertation explores how NGO workers like these continue serving the needs of Maya communities in intersecting fields of health and social justice amidst the shifting healthcare climate. As many NGOs remain steadfast in their commitments to continue serving others, this dissertation asks: How are the various subjectivities of NGO workers integrated into their strategies and adaptations for continuing to serve the needs of marginalized Indigenous communities?

Subjectivity Theory's Significance for NGO Studies

This work is guided by the theoretical framework of subjectivity as a way to illuminate how the larger shift in context impacts the actions, perceptions, and experiences of NGO workers involved in health intervention. Anthropologists understand subjectivity as "as actors' thoughts, sentiments and embodied sensibilities, and, especially, their sense of self and self-world relations" (Holland and Leander 2004:129). Subjectivity is "the ensemble of modes of perception, affect, thought, desire, fear, and so forth that animate acting subjects" and where these intricacies of the self and larger political and social processes coalesce (Ortner 2005:31). Subjectivity is not only an outcome of political and social control, but a site where individuals navigate the competing and contradictory circumstances of their lives. This dissertation is led by the notion that subjectivity is the site in which larger socio-cultural, economic, and political forces shaping social policy can likewise be seen to shape actors immersed in the ramifications of policy change. Throughout this work, I will show that subjectivity is an amalgamation of personally, institutionally, and politically formed identities. NGO worker's subjective realities

are personally formed through their unique experiences and identities; institutionally formed through the structure, history, and agenda of their organizations and funding institutions; and politically formed through their intrinsic and fluctuating relationship with the state and government institutions.

The value of subjectivity theory lies in its framework for uncovering the dynamics and "tension" between the self and political and social processes (Biehl, Good, and Kleinman 2007: 15). As some have argued, the significance of this framework is its attention to the true agency of individuals as they navigate such tensions, mitigating the constraints of social determinism, and resisting and overcoming subjective states (Luhrmann 2006, Ortner 2005). As Lurhmann writes, "people are both formed and free, chosen and choosing" (Luhrmann 2006: 347). Attention to the subjectivities of individuals, as used in this dissertation, highlights the boundaries of freedom and choice by locating the friction between the subjection of the subject and their agency. Thus, subjectivity theory is the foundation of human agency, and pertinent for understanding how individuals are shaped, organized, and provoked to act and are acted upon.

Subjectivity is therefore a useful theoretical framework for understanding the nature of NGOs, how they change, and how they adapt to changing political contexts in order to continue addressing community needs. It is also a useful framework that demonstrates the value and significance of anthropological modes of investigation. Anthropologists often find themselves in positions where we have the privilege and honor of being narrators of other people's worlds. We do so in ways that link peoples lived realities to the larger fields of social, cultural, economic and political power operating in our increasingly globalized world. The strength of subjectivity, in its focus on the subjective realities of peoples' lives, is that is forces us to uncover the details of their connections to this larger field in such ways that we can see specifically how various

streams of power may have influence over an individuals' beliefs, ethics, values, actions and agency in the world.

Summary of Dissertation Chapters

In Chapter 2, I will discuss the historical, socio-political, and economic factors that have influenced the proliferation of non-governmental organizations within healthcare system around the world. I focus the discussion on the history of nationalized healthcare in Latin America, with attention to healthcare models preceding healthcare reforms of the 1980s and 1990s. I then discuss the factors that shifted these nationalized healthcare models toward privatization, especially how neoliberal ideology and notions of modernization were significant in the proliferation of health NGOs. I explore this shift in more detail in the context of Guatemala's healthcare system where multiple factors, including neoliberal ideology, international financial institutions, and dominant development discourses have encouraged the integration of health-focused NGOs in healthcare policy. I argue that Guatemala's shift away from nationalized healthcare toward a hybrid model that includes NGOs and the private sector, has produced a fragmented healthcare landscape characterized by uneven geographies of curative and preventative biomedical care.

Chapter 3 introduces the methodology and research settings for this dissertation research. I discuss in detail a demographic overview of Guatemala, noting the social and economic inequities experienced by Indigenous Maya communities. I provide an overview of Indigenous health, with attention to the health disparities and issues in healthcare access prevalent in Maya communities. Next, I discuss the context of NGOs involved in health intervention, providing detailed description of the health policy known as the Programa de Extensión de Cobertura (PEC), which integrated NGOs into the healthcare system as providers for rural Indigenous

Maya communities. I introduce my two primary research sites in the Department of Chimaltenango, Guatemala—Fundación Maya Salud (FMS) and Asociación para Nutrición y Desarrollo Integral (ANDI)—providing a detailed overview of each NGO and the unique connection between them. Finally, I discuss my methodology, describing my semi-structured interviews, participant observations, documental data, and my analysis.

Chapter 4 examines how the personal subjectivities of NGO workers have important implications for understanding how NGO workers are able to continue performing their roles in health intervention amidst Guatemala's changing socio-political healthcare landscape. I discuss the unique subjectivities of NGO workers at ANDI, including how factors such as identity, indigeneity, and institutional legacy can impact the health interventions designed and implemented in Indigenous Maya communities. I argue that NGO workers at ANDI navigate both their personal subjectivity as Indigenous individuals with unique connections to the Maya community, and an institutional subjectivity as actors immersed in NGO rhetorics of what it means to "do good." I argue that these competing subjectivities impact how workers perform their roles in health intervention, ultimately shaping collective understandings of empowerment and feminist solidarity.

Chapter 5 discusses how institutional and political subjectivities are manifest in the nature and content of health intervention in shifting healthcare contexts. I discuss the history of the liberationist health activism and community solidarity focus shared by both FMS and ANDI. I then discuss how this focus was transmuted over time at FMS through their contractual relationships with the state via the PEC. I argue that NGO workers at FMS possess institutional and political subjectivities that are defined by a complex relationship with state institutions. As a result, I argue the NGO workers at FMS have increasingly become preoccupied with

bureaucratic policies and requirements that place value on managerialism over a social justice focus on community empowerment, thoroughly shifting the nature and content of health intervention at FMS.

Chapter 6 discusses how the political subjectivities and actions of NGO workers are shaped by state discourse in Guatemala's shifting socio-political context. I describe the history through which NGOs have become targeted by critical discourse from the state. I then explore how public and state discourses of corruption impact how NGOs workers at ANDI, FMS, and other organizations understand and implement their work in health. I argue that NGO workers have internalized the larger discourses of corruption in a variety of ways manifesting in fear, stigmatization, and social distrust, and that these internalizations shape the how NGOs perform their roles. I argue that discourses of corruption are a powerful regime of truth that can shape actions of NGO workers through socio-political and legal tactics that attempt to manipulate views of truth and reality. I contend that such internalizations demonstrate that corruption discourse is a political tool of the state with the power to re-articulate the political subjectivities of NGOs and those who work for them.

Chapter 7 discusses how NGO workers at FMS and ANDI strategized and adapted to the changing socio-political healthcare context in Guatemala while continuing to serve the needs of marginalized Indigenous communities. I argue that differences in the approaches of these two organizations were mediated by the personal experiences of NGO workers, institutional demands, and a varying relationship with the state. Moreover, the individual, institutional, and political subjectivities of NGO workers often interacted with each other, informing their strategies and adaptations in their labor of "doing good." I discuss how contextual factors can be tremendously determinative in the work conducted by NGOs, and that the framework of

subjectivity yields much needed documentation of how the substantial shifts in politics of the last two decades affects NGOs and communities they serve. I contend that NGO worker's various subjectivities are important sites for investigation in anthropology and NGO studies, as they work together to influence the agency of individuals. Lastly, I consider the potential value of integrating solidarity theory with subjectivity frameworks for future anthropological research to better understand how multiple and amalgamating subjectivities shape and provoke the actions of those who strive to be "doing good" on behalf of others.

Chapter 2: Neoliberalism, Social Policy and Healthcare: The NGOization of Healthcare Delivery

Introduction

The privatization of national healthcare systems has long been an object of inquiry for medical anthropologists. Since the 1980s, the devolving of development responsibilities of the state to the private sector has resulted in dramatic shifts from historically nationalized healthcare systems toward privatized models of care. One outcome of this process throughout much of Latin America has been the emergence and proliferation of the Third Sector, largely comprised of non-profits and non-governmental organizations. For decades, these organizations have been called upon by states and international development institutions as facilitators in global development to fill in delivery of social services like healthcare (Kamat 2004, Almeida 2006, Sending and Neumann 2006, Schuller 2009).

This chapter will discuss the historical and socio-political economic factors that have influenced this shift and the resulting NGOization of healthcare, or the proliferation of non-governmental organizations within healthcare systems. I will first discuss the ideological underpinnings and history of nationalized healthcare in Latin America, examining the region's "golden age" of nationalized healthcare that preceded neoliberal healthcare reforms of the 1980s and 1990s. I argue that multiple factors, including social medicine ideology, views of healthcare as a "right" to be provided by the state, and the emphasis on "modernizing" Latin American medicine, were all influential in shaping nationalized models of healthcare throughout the region. Next, I will discuss the factors that shifted nationalized Latin American healthcare models toward privatization under the ideologies of neoliberalism and modernization, and consider the significant implications this had for the proliferation of NGOs. Guatemala is a particularly salient example to explore this process, where multiple factors, including neoliberal

ideology, international financial institutions, and dominant development discourses have played important roles in the growth of health-focused NGOs. I examine how Guatemala's shift away from nationalized healthcare models and subsequent NGOization of healthcare has ultimately produced a fragmented healthcare landscape throughout the country characterized by heterogeneity and uneven geographies of curative and preventative biomedical care.

Latin America's "Golden Age" of Nationalized Healthcare

Prior to the major political economic reforms of the 1980s and 1990s, many post-colonial Latin American countries made strides toward providing nationalized primary healthcare. Starting in the 1910s, many Latin American governments, in efforts to grow their post-colonial power, began forming secretariats of health, social security institutions, and began merging medical education and research in medical schools (Cueto and Palmer 2014). Following this, beginning in the 1930s many Latin American countries experienced what some have called the region's "golden age" of medicine (Mesa-Lago 1985, Waitzkin et al. 2001). This period of healthcare saw the rise of Latin American social medicine, an ideology of medicine and public health grounded in the notion that illness is inherently linked to social status. Within social medicine, health and illness were seen as a "dialectic process rather than a dichotomous category" where factors such as social class, economic exploitation, and individual material conditions worked in synergy to produce health disparities and inequitable access to healthcare (Waitzkin, et al. 2001:1594). Latin American social medicine fundamentally linked health and social position and produced discourses of health as a universal "right" to all citizens, placing the burden for managing structural barriers to health in the hands of national governments and state institutions.

Social Medicine and the "Right" to Health

Numerous Latin American countries that sought to nationalize their healthcare systems were influenced by social medicine and came to define healthcare delivery as an obligation to be fulfilled by the state. The boom in social medicine throughout Latin America is often described as having roots in Chile, where the ideology was touted by political leaders and the Chilean Ministry of Health for decades (Hartmann 2016, Waitzkin et al. 2001). During the 1950s, based on principles of social medicine the country passed legislation for a national program aimed at guaranteeing universal access to healthcare services, which was the first national healthcare program in Latin America. This legislation linked improving health access to improved living conditions, job security, income redistribution, and alleviating malnutrition, conditions that notably affected the working class (Waitzkin et al. 2001). In Costa Rica, a healthcare boom in the 1960s based in the ideologies of social medicine resulted in an increase in the construction of state-run public hospitals, pay increases for providers, and establishment of universal social insurance coverage (Mesa-Lago 1985).

In Cuba, nationalized healthcare based on social medicine occurred in a context where a unified post-revolutionary Cuban identity was the central motivating component for the framing of health not only as a "right" to all citizens, but the responsibility of the state (Brotherton 2012). During the 1960s, Cuba realized profound changes in its healthcare system, improving primary and public health systems, reforming medical education, establishing healthcare planning and administration institutions, and implementing a system for measuring public health indicators (Brotherton 2012, Waitzkin et al. 2001). Universal healthcare in Cuba emerged as, "a social revolution in which accomplishments in health occurred as an integral part of broad structural changes in the society as a whole" (Waitzkin, et al. 2001:1595). As these examples showcase,

social medicine and the notion of health as a universal right, were emergent Latin American ideologies that influenced the development of nationalized healthcare systems in the region.

Aspirations of Modernity in National Healthcare Models

While Latin American nations made strides to develop inclusive healthcare system models, alternative medicine continued to coincide amidst increasing biomedicalization of healthcare. Nationalized healthcare in the region was also influenced by state aspirations for national modernity, including a "modernized" medical system. In medical anthropology, "modernizing" healthcare is typically understood as a process of medicalization, integrating dominant biomedical norms and standards about health and healing. Modernizing healthcare is also a convincing discourse of post-colonial nationalism and identity (Lock 2004). Moreover, as Cueto and Palmer (2014) argue, Latin American medicine and public health during the second half of the nineteenth century and beyond was not only integral to the strengthening of nation-states, but reforms were important state tools for nation-building as well. Increasing power of public health agendas led to more regulation and discrimination against Indigenous healers and popular health practices, and increased medicalization of everyday life. Aspirations for a unified society often put an emphasis on the pursuit of scientific and technologized medicine to "modernize" the healthcare sector. Aspirations of national modernity were influential in the outcomes of nationalized healthcare systems, as the sector experienced extensive changes in structure, education, technology and biomedicalization.

The Shift Toward Privatization of Healthcare in Latin America

In the 1970s, amidst the emergence of new diseases including a regional malaria epidemic, rhetorics around new approaches for primary health care emerged in the region that emphasized the work of medical auxiliaries and the reorganization of health services (Cueto and

Palmer 2014). Moreover, in 1978, the International Conference on Primary Health Care at Alma Ata in Kazakstahn underscored the necessity for new primary health care models for providing efficient health services globally, especially in Latin America. However, these rhetorics also promoted a growing interest in proposals supporting increased privatization of healthcare services. By the 1980s, multiple social, political and economic factors began to influence the shift away from nationalized care toward privatized healthcare models. A new biopolitics of healthcare emerged, characterized by shifting the burden of responsibility for health away from the state and onto individuals. As I will discuss, the foundational underpinnings of Latin America's "golden age" of medicine were recast in new ways that served to promote privatization of healthcare in the neoliberal era.

Neoliberalism and the New Biopolitics of Healthcare in Latin America

The rise of neoliberalism in the 1980s and 1990s had significant impacts on Latin American national economies and the provision of social welfare services including healthcare. Neoliberalism became recent history's most dominant global political economy, characterized by the notion that, "human well-being can best be advanced by liberating individual entrepreneurial freedoms and skills within an institutional framework characterized by strong property rights, free markets, and free trade" (Harvey 2005:2). This prioritization of the market spurred decentralization and the devolution of state-run services to the private sector, a process that was largely linked to neoliberal structural adjustment programs.

Structural adjustment programs were a fundamental mechanism for neoliberal reform that targeted all social programs, and had a profound impact on models of healthcare delivery. During the 1980s and 1990s, most Latin American countries took on structural adjustment loans to stabilize post-Cold War economies, often to prevent defaulting on existing loans with other

nations or institutions, or to build credit. The conditions and stipulations of the loans from financial institutions often required nations to decentralize their existing social programs, including healthcare. Governments were encouraged to cut healthcare expenditures, increase or implement fee for service care, and emphasize "multisectoral development" and "community participation" in healthcare reforms (Armada, Carles Muntaner, and Navarro 2001, Pfeiffer and Chapman 2010:151-152, Uzwiak and Curran 2016). Reform proposals under this approach conceived of health interventions in terms of cost-effectiveness and focused health interventions toward controlling diseases, improving nutrition, and promoting immunization programs (Cueto and Palmer 2014). Such discourses employed assertions that a managerial approach to health policy that relied on the private sector was more efficient and less corrupt than one that relied on the public sector.

Structural adjustment significantly transformed existing nationalized healthcare systems. Responsibility for care was effectively devolved to the private sectors (such as private hospitals, specialists, private clinics), and to NGOs (Pfeiffer and Chapman 2010, Mitlin, Hickey, and Bebbington 2007). Thus, privatization of healthcare constituted a new form of "biopolitics," or a neoliberal "governmentality" of managing population, whereby the responsibility for health and wellbeing was shifted from the state, to privatized institutions and organizations (Adorno 2014, Lock and Nguyen 2010, Armada and Mutaner 2004, Sending and Neumann 2006). Critics argue that this form of biopolitics prioritizes ideology over public health knowledge, shifting attention away from the socio-cultural, economic, and structural determinants of health and wellbeing (Baker and Hunt 2016, Bell et al. 2017). These approaches began to detract from the legacy of social medicine in many countries taking on such reforms.

While privatization is typically understood within the dominant neoliberal paradigm as a total withdrawal of the state from the delivery and oversight of social services, this was not always the case for every Latin American country. As Ferguson (2010) argues, neoliberalism is best understood as a toolkit with which states craft policies in different ways based on the utility of neoliberal ideas and approaches in particular contexts. In some cases, such as in El Salvador, Mexico and Guatemala, the state was not permanently removed from healthcare provision, but instead took on a transformed, limited role, or devised plans that merged state regulation of the health system and of civil society (Maupin 2015, Molina and Palazuelos 2014, Smith-Nonini 2010). Regardless, however, the ideology Latin American social medicine that once formed the foundation of nationalized healthcare systems throughout the region, was largely dissolved in favor of ideologies of limited state intervention, individualism, and personal responsibility for health.

In some places, as individuals were compelled to buy their own preferred healthcare insurance plans or pay for services, the new privatized "sellers" of healthcare had to compete against other private providers to attract consumers (Abadia and Oviedo 2009). Increasingly, healthcare in some places of Latin America shifted toward resembling a market, where individual health and wellbeing was an object to be bought and sold (Chary and Rohloff 2015, Ross, Timura, and Maupin 2012, Hoyler et al. 2016). Moreover, this market of privatized care operated under the guise of "modernized" healthcare.

New Aspirations of Modernization

Rhetoric of "modernization," once an influential discourse for promoting nation-building and nationalized healthcare, also played an important role in the shift toward healthcare

privatization. However, while this discourse was previously used to infuse a sense of nationhood and unity in post-colonial Latin America, in the neoliberal era of the 1980s and 1990s, this discourse was re-cast in new ways that further encouraged privatization. International organizations promoting development and healthcare reforms relied on an understanding of "modernization" as a remedy for countries now deemed to be "underdeveloped" and as "having 'needs' and 'problems' but few choices and no freedom to act" due to the enduring effects of the social and economic unrest of the Cold War period that devastated numerous social programs (Escobar 1995: 6;8). Revitalizing and modernizing healthcare systems required "technological progress" to be undertaken by "experts" in the field (Rist 2002: 22). Emerging discourses of development increasingly came to envision experts to be the actors who operated on a localized level with intimate knowledge, including networks of community healthcare workers, non-governmental organizations and the private sector, instead of national governments and ministries of health (Maes 2015, Rist 2002, Willis and Khan 2009, Armada and Mutaner 2004, Maupin 2011).

The ideologies of "individual responsibility" for health, healthcare as a commodity, and discourses of modernization, were often entrenched in structural adjustment programs and the reforms resulting from the requirements of these loan programs, which ultimately ensued in privatized models of care. In Latin America, some of the most influential actors in promoting such new approaches to healthcare were large international financial and development institutions.

International Institutions and the Push for Privatized Care

International institutions were important in pushing such neoliberal ideologies to rationalize healthcare privatization in Latin America. International financial institutions, such as the World Bank, the Inter-American Development Bank (IDB), and the International Monetary Fund (IMF); and large healthcare development organizations such as the World Health Organization (WHO), the Pan American Health Organization (PAHO), and the United States Agency for International Development (USAID), played major roles in restructuring healthcare models throughout Latin America (Armada, Carles Muntaner, and Navarro 2001, Donahue 1989, Homedes, Ugalde, and Rovira 2005, Easterly 2006). These organizations often directly impacted healthcare by crafting reform policies and issuing conditional bank loans, while stressing the need for financial sustainability. Privatization of healthcare sectors, and the implementation of cost recovery approaches, such as insurance plans and user fees, were pursued as a way to achieve sustainability and were rationalized as a way to provide "equity, efficiency, and quality of health services" (Armada, et al. 2001:733).

Global health initiatives were often wrapped up in such efforts to privatize the healthcare system, as international development institutions were influential in putting forth global health goals taken up by many states as measures for improving healthcare systems and health outcomes. The World Health Organization and World Bank, for example, have been influential in establishing and funding global health initiatives in grant-recipient countries aimed at tackling infectious disease, hunger, and maternal and child health among numerous other public health issues. Another major influence was the United Nations' Millennium Development Goals (MDGs), adopted from 2005-2015, which included numerous goals focused on health including reducing child malnutrition, improving maternal health, and combating HIV, malaria, and other

communicable diseases with a focus on establishing global partnerships for addressing them (UN 2015). The subsequent UN Sustainable Development Goals (SDGs), established in 2016, expanded on these goals, linking the reduction of poverty, gender inequality, and economic inequality, among others, to improving health and wellbeing for all (UN 2021b). As researchers have noted, laden within such global initiatives for development were transnational institutional feminist frameworks that located gender issues and the status of women as contributing to poor health outcomes, in what has been termed "Women in Development", or WID, initiatives (Barrig 1991, Panda 2000, Schild 1998, 2014, Harcourt 1994, Gunewardena 2002, Merry 2016). Influential international development and financial institutions such as these encouraged states to promote processes that "produce women as gendered subjects" (Bernal and Grewal 2014a: 308). In Latin America, women share a commonality in their historical colonial and post-colonial subordination, oppression, and gender inequality, which endures to varying extents and degrees across the region (Bose and Acosta-Belén 1995). Women in development initiatives in Latin America often focused on these historical roots of women's disempowerment, manifesting in initiatives in areas such as midwifery training, maternal and child health monitoring, reproductive health education and interventions, women's microfinance programs, safe motherhood initiatives, and women's empowerment (Berry 2013, Berry 2006, Chary et al. 2013, Beck 2017b, King, Chary, and Rohloff 2015, Goldman and Glei 2003).

Another way these international institutions directly impacted privatization of healthcare in Latin America, was by shifting funds for healthcare from state government and local health institutions, to private sectors (Willis and Khan 2009). In Nicaragua, for example, international health organizations, including WHO, PAHO and UNICEF "cooperated synergistically" with the state and the large international financial institutions to directly fund the private sector under

rhetoric of "community participation" (Donahue 1989: 259). In many countries, such as Guatemala and El Salvador, this increased the integration of non-governmental organizations into the healthcare system, as funding was diverted to NGOs (Cardelle 2003, La Forgia 2005, Smith-Nonini 1998). In these countries, integrating NGOs into healthcare provision was a way for international organizations to encourage state ministries of health to deregulate the health sector, ensure cost-effectiveness, and maintain economic stability. However, as the example of El Salvador demonstrated (Smith-Nonini 1998), this diversion of funding had "anti-reform" tendencies, as states were encouraged by international organizations to be more preoccupied with maintaining political stability with their funding institutions rather than measuring the outcomes of the healthcare reforms being funded (1998:109). As such, these socio-political and economic shifts toward privatization have had important implications for the NGOization of healthcare, and Guatemala is a particularly salient example for examining how these historical trends have impacted the evolution and proliferation of NGO involvement in health intervention.

The Guatemalan Healthcare System

In Guatemala, these socio-political and economic shifts toward privatization, have resulted in a healthcare system fractured by the histories of social policy change in healthcare. Vestiges of nationalized healthcare models are merged together with newer models of privatization to form a mixed system, simultaneously public and private. Today, the Guatemalan Ministry of Health (MSPS) officially recognizes a healthcare system comprised of three divisions: the free public system, the for-profit private sector, and the non-profit NGO sector. This mixed system serves a national population of 16.5 million people (World Bank 2019).

The National Healthcare System

Guatemala's healthcare system rests on infrastructure originating from the Spanish colonial period from the mid-1500s until their independence from Spain in 1821. The first and oldest hospital, Hospital de San Pedro, was created in 1663 by Catholic friars, and continues to operate as a major health facility in the department of Sacatepéquez. By the end of the 17th century, six hospitals had been founded in Guatemala. The University of San Carlos, established in 1680, housed the first medical school in the country, which by the 18th century had produced a small but influential number of Guatemalan medical doctors. In the late 1700s, multiple Guatemalan universities began educating some of the first medically trained doctors in the country, and in response to the smallpox epidemic sweeping the region, established a system for inoculation programs throughout major cities and surrounding pueblos. By the 1820s, Guatemala had about 1300 university trained doctors. (Few 2015).

The colonial healthcare system was gradually expanded on after Guatemala officially declared independence from Spain in 1821. Instilled by regional declarations that healthcare is a "right" to all citizens, Guatemala established a nationalized healthcare system that was universal and free to all citizens, establishing additional medical hospitals and centers in the major urban areas of the country. During the 1970s this system was heavily influenced by international and development agencies promoting primary health care programs for rural communities (Green 1989). The nationalized healthcare system that developed currently consists of 44 federally funded hospitals in the urban centers of each of the 22 departments throughout the country, health centers in municipality seats, and health outposts in rural and highland regions. The system was designed to serve all Guatemalans, and currently the public system covers about 88% of citizens (Becerril-Montekio and López-Dávila 2011) but, as I will discuss in more detail in

Chapter 3, it has been historically inaccessible to rural Indigenous communities without the socio-economic and geographic means to access these facilities (Avila et al. 2015). More than half of the population resides in rural areas, and state healthcare expenditures per person are one of the lowest in all of Latin America. This system is maintained by two main public bodies, the Ministerio de Salud Pública y Asistencia Social (MSPS), and the Instituto Guatemalteco de Seguridad Social (IGSS).

NGOization and Healthcare Reform

NGO involvement in the Guatemalan healthcare system must first be contextualized in the historical trajectory of the burgeoning NGO sector in Guatemala. The first NGOs began to emerge in Guatemala during the 1950s under the Arbenz administration, focusing on supporting land reform, credit expansion and community development in rural regions. This budding NGO sector began to boom beginning in the late 1970s after the earthquake of 1976 when short term relief and aid NGOs surged in response to the disaster (Cardelle 2003). During this time, it was estimated that over 20% of the rural Indigenous population was involved in independent movements, such as the Peasant Unity Committee, which sought to create economic venues for rural Indigenous communities, especially those most impacted by the disaster (Cardelle 2003:20). By the 1980s, Guatemala's NGO sector had developed into a web of organizations providing a vast array of services, from community development to land reform and health intervention. USAID, a major international development presence in Guatemala, even began channeling funding directly to NGOs and to a newly formed umbrella group of non-profits known as the Association of Guatemalan Service and Development NGOs (ASINDES), who they understood as "technocratic" partners for development (Cardelle 2003:22).

The proliferation of Guatemala's NGO sector occurred alongside two major social developments that had important implications for healthcare and NGOs: Guatemala's violent 36-year civil war, which spanned from 1960 to 1996, and the Pan-Maya Movement of the 1970s through the 1990s. During the long civil war, the Guatemalan army, enamored with anti-communism discourses and trained in counterinsurgency, carried out acts of genocide against Mayan communities, academics, social activists, and leftist political actors charged with spreading and encouraging rural insurgency and communism. The increasingly repressive state, which came to frame Mayan culture as innately subversive, culminated in a scorched earth campaign beginning in 1981, characterized by forced disappearances, abductions, assassinations, and the desecration of Indigenous homes and land. The violence resulted in the murders of more than 200,000 people, the disappearance of 40,000, and the rape, torture and displacement of thousands more (Grandin 2011: 3). Multiple accounts including the UN-backed Commission of Historical Clarification (CEH) and numerous damning personal testimonies heard in the international Federal Court of Spain, confirmed that the violence was perpetrated by the Guatemalan military, police, and private death squads at the behest of the state (Wilkinson 2002, Menchu 1984, ODHAG 1999, Doyle 2008). The impact of the civil war on Indigenous communities cannot be overestimated, as it is an enduring trauma today, manifesting in strong community distrust for the state and state institutions (Berry 2013, Hawkins, McDonald, and Adams 2013, Copeland 2019c, Nelson 1999, McAllister and Nelson 2013, Vanthuyne 2009).

Groups advocating for Mayan rights and cultural resurgence during the civil war, including non-profits and NGOs, religious institutions, and those supporting the Pan-Maya Movement, were especially targeted by military repression. In the 1970s through the 1990s, Guatemala's Pan-Mayanism movement for cultural resurgence began to challenge colonial

legacies of class, labor policy, and constructions of racial, ethnic and cultural difference (Warren 1998, Wilson 1999). Maya intellectuals pursued efforts in self-determination, including establishing community participatory projects, grassroots development initiatives, and new institutional social policies throughout the country (Warren 1998). When the civil war ended in 1996, the Guatemalan government signed Peace Accords with a major Indigenous group, the Guatemalan National Revolutionary Unity (URNG), setting the stage for dramatic socio-political changes that attempted to reincorporate the perspectives of the Indigenous majority into policy. For example, the Pan-Maya Movement's focus on education reform for the rural Indigenous poor saw the rollout of the Ministry of Education's Programa Nacional de Autogestión para el Desarrollo Educativo (PRONADE) policy which has extended elementary school coverage with multicultural curriculum by having communities administer and manage primary schooling for children under twelve years of age (Warren 1998). This program was most often organized and managed through grassroots and Indigenous NGOs in these communities (Carter 2012). Other accomplishments include nationalizing an official unified alphabet for Mayan languages, expanding Mayan scholarship, and advocating for territorial autonomy (Fischer and Brown 1996). Mayan intellectuals involved in the Pan-Maya Movement had a history of involvement in rural and urban professional fields ranging from education, law, health, and social work finding roles in research, rural teaching institutions, the press, and with grassroots NGOs. During the post-civil war Guatemala of the 1990s there was a movement toward integrating the community and Indigenous intellectuals in processes of nation-building, although it should be noted that inclusivity in such processes remains a major social issue today (Fischer-Mackey et al. 2020, Warren 1998, Fischer and Benson 2006).

One of the major outcomes of the Peace Accords which ended the civil war, was healthcare reform, specifically the implementation of the Programa de Extensión de Cobertura (Coverage Extension Plan) or PEC, in 1998 by the Ministry of Health. This program, dubbed the "fruit of the accords" (Maupin 2009), involved tapping into the abundant NGO sector, and as with PRONADE, was supported by Indigenous groups interested in managing the extension of healthcare in Maya regions. The health care policy was designed to contract grassroots NGOs, often run by local and Indigenous staff, as healthcare providers and administrators for regions of the country who lacked access to the public and private system. At the time, international health organizations including the World Health Organization, USAID and the Pan-American Health Organization, as well as financial institutions including the World Bank, and Inter-American Development Bank, were influential in shaping NGO involvement in healthcare in much of the region (Armada and Mutaner 2004). NGOs had been framed by these influential development and financial institutions as a "magic bullet" for development and as actors who could best represent public interest (Edwards and Hulme 1996, Vivian 1994, Kamat 2004). These institutions, invigorated with a "pro-NGO international norm," encouraged the Guatemalan government to develop inclusive political relationships with NGOs and non-profits (Reimann (Reimann 2006: 46, Cardelle 2003, La Forgia, Mintz, and Cerezo 2005). From 1998 to 2015, the Guatemalan Ministry of Health utilized contracted NGOs to extend a basic healthcare package to nearly 4.3 million people, with direct influence from the World Bank and the Inter-American Development Bank who provided the financial means to adopt the PEC healthcare reform (Maupin 2009 (Maupin 2009, Cardelle 2003, Inter-American Development Bank 1996, Verdugo 2004). This number included communities that were primarily Indigenous Maya, representing roughly 54 percent of the rural Guatemalan population (Peña 2013, Maupin 2015).

Using contracted NGOs to either provide services directly, or to provide the administration necessary to coordinate services in Maya communities, the Ministry of Health sought to advance numerous public health goals. This included aiming to reduce maternal mortality and chronic childhood malnutrition through strategies such as *Plan Hambre Cero* designed to monitor and provide nutritional support to women and children. PEC contracted NGOs also coordinated and fortified over 2,000 *Centros de Convergencia*, centers that provided preventative health services and health education to communities of 500 individuals (MSPS 2012). Canceled in 2015 amidst political turmoil and accusations of corruption, the PEC has left a legacy of NGO involvement in healthcare, abandoning many Indigenous rural communities to navigate a fractured healthcare landscape populated by a mixture of public, private, and non-profit health service providers—many of who remain out of reach to the Indigenous community due to an extensive healthcare system crisis (Kimmett 2016, Maupin 2015).

Crisis in the National Healthcare System

Since the cancelling of the PEC in 2015, Guatemala's mixed public, non-profit, and private healthcare system has experienced a dramatic crisis due to limited state funding from the Ministry of Health, as well as inadequate medical personnel, equipment, supplies and medicine. Many local health posts and *Centros de Convergencia* operating in rural areas are understaffed, understocked in essential supplies, vaccines and medicines, and are only open for limited hours each week (Avila et al. 2015). This has had a dramatic impact on Indigenous families who cannot attend private clinics due multiple obstacles including high costs, language barriers, and geographic isolation. By and large only those who can afford out-of-pocket costs for healthcare services often utilize the private system. Moreover, this for-profit sector is dominated by private

health practices, specialists, clinics and hospitals, largely operating in urban areas considerably outside of Maya communities. In recent years, the national system struggled financially, especially a number of state-run hospitals which at times was often unable to pay their medical personnel or acquire drugs and medical equipment, limiting their care to only emergency services and leaving thousands without a source for medical care (CDC 2021, Molina 2015, Lavarreda 2019, Avila et al. 2015, TeleSur 2016). Local news stories, acquaintances, and individuals in this study quite often echoed the ramifications of these limited resources and services, describing their everyday realities of this crisis in stories of waiting in long lines at the public hospital, often to not be seen at all, having to purchase medicines and medical supplies before arriving at the hospital, or forgoing much needed care and medicine altogether due to unsurmountable financial strain.

Domestic and international institutions link this healthcare crisis to Guatemala's deep-rooted corruption problem. Over the past decade, numerous investigations have uncovered prevalent bribery networks, composed of public officials embezzling public funds, public contracts, tariffs, and positions in major state institutions. In recent years, the UN-backed anti-corruption group known as The International Commission Against Impunity in Guatemala (CICIG) helped launch numerous investigations revealing the pervasiveness of such state corruption to the general public (Hite and Montenegro 2020, UN 2021a). The Guatemalan justice system, with support from CICIG, has carried out more than 100 corruption investigations implicating high profile officials, including former president Otto Perez Molina and Vice President Roxana Baldetti in the 2015 *La Línea* scandal, resulting in the prosecution and conviction of nearly 400 individuals (Peralta 2015, Hite and Montenegro 2020). However, since 2016, a pro-impunity campaign, rallied for by conservative government administrators,

Guatemalan elites, and factions of the economic sector began stigmatizing local social leaders and officials, non-governmental organizations, and leftist news media outlets involved in the emergent anti-corruption movement. This has had significant impacts for NGOs throughout the country.

Guatemala's anti-corruption movement came to target the NGO sector, especially those involved in healthcare or with ties to the now-defunct PEC. Some political groups have argued that NGOs mismanaged and misused government funds, public contracts, and international funds, because some had been found guilty of money laundering in the past. Others accuse NGOs and other non-profits of seeking to destabilize the government in line with left leaning activism and agenda. In 2020, this intense social debate over NGO roles in civil society culminated in the signing of the highly controversial Decree 4-2020 affecting the *Ley de ONGs* (NGO Law), by President Giammattei (WOLA 2020, Escobar and Rivera 2020). This law stands to increase state control over NGOs, giving the government unrestricted abilities to unregister organizations, control their international funding, and restrict their political criticism and activism. As such, the recent shift toward pro-impunity has coincided with intense political debate and stigmatization of NGOs and those who work for them.

NGO Workers and Subjectivity

As outlined above, the history of Guatemala's embrace of nationalized social medicine and later of neoliberal reforms, have resulted in a dysfunctional system today. Not only are the most vulnerable groups impacted by this fractured and heavily politicized healthcare system, so too are Guatemalan NGO workers who stand committed to serving the health needs of their communities. In their everyday work, NGO workers are aware of the fluctuating and at times volatile relationships they have had with the state, both historically, as realized through the

disappearances of NGO workers and activists during the civil war, and contemporarily, through their experiences with the PEC and its layers of government control and the politicized targeting of NGOs within the recent anti-corruption movement. Thus, even without direct collaboration, contractual relationships, or sharing of resources with the state, NGO political economy is inherently tied to the state. NGO workers can be shaped and constrained by the whims of the state, and depending on the nature of these relationships, some in more ways than others. The state-NGO relationship has important implications for the subjectivity of NGO workers.

Anthropologists understand subjectivity as being dynamically formed. Such understandings of the 'subject' and of 'subjectivity' have roots within Clifford Geertz' (1973) notion that subjects embody culture in ways such that social practices and realities are masked by an "aura" of factuality. Building on this, anthropological discussions of subjectivity have reflected the fluctuating nature of culture. Not only is subjectivity an empirical reality but it is a means for understanding the ways in which culture is "constantly remade through social encounters, ethical deliberations, [and] political processes" in institutional and intersubjective relationships (Biehl, Good, and Kleinman 2007: 7). As such, subjectivity is not simply the end result of processes of power and social control, it is the foundation whereby people navigate the conflicting and competing circumstances, positionings, and experiences of their lived realities. As Biehl et al. (2007) express, "it is fear and optimism, anger and forgiveness, lamentation and pragmatism, chaos and order" (2007:14). Subjectivity is the site in which historical processes and social moralities meet, merge and blend, and wherein the emergence of new kinds of public-private connections and political authority arise.

Guatemala's health NGO sector is a particularly salient example through which the construction and implications of subjectivity can be examined. As parts of a larger whole, NGO

workers possess varying positionalities and identities that are continuously re-made through their competing institutional and intersubjective interactions. Individuals who work in this sector have witnessed and lived the flux in resources and social and political supports for healthcare amidst politicized policy change, both as citizens of Guatemala and as NGO workers. It remains unclear how such subjectivities impact NGO workers abilities to continue implementing health interventions in the communities they serve. The next chapter further explores why Guatemala and the NGOs in this study represent appropriate sites for examining this question.

Chapter 3: Settings and Methodology

Settings

Introduction

Like many countries in Latin America, Guatemala's constitution includes healthcare as a right to all citizens, however, it's nationalized system of federally funded hospitals and health outposts consistently fails to reach the majority of its rural Indigenous citizens (Avila et al. 2015). In the past two decades the Guatemalan Ministry of Health made substantial changes to this public healthcare system, including contracting many healthcare services to private companies and private practitioners, as well as the incorporation of NGOs into healthcare plans. The inclusion of NGOs in Guatemala's healthcare system was encouraged in the late 1990s by the Inter-American Development Bank (IDB), an international financial institution and structural adjustment loan provider, which sought to modernize the nation's healthcare system through decentralization and privatization (Maupin 2009, Cardelle 2003, Inter-American Development Bank 1996, Verdugo 2004). Guatemala's current healthcare system is comprised of three divisions: the public system, the private for-profit sector, and the nonprofit sector. Guatemala is a particularly salient region to examine health interventions in the context of NGOs, as such organizations have been incorporated into healthcare systems and policy.

Demographic Overview of Guatemala

Present day healthcare inaccessibility for Maya communities in Guatemala is not only emblematic of the legacy of colonialism but also of the effects of the Cold War in the region. Guatemala officially declared independence from Spain in 1821. Decades of colonial rule, exploitation, and assimilation policies had resulted in systemic isolation and marginalization of Indigenous Maya groups throughout the country (Lovell 1988). This subjugation created social hierarchies between Indigenous groups primarily in rural and highland regions, and ladinos/as

(individuals of mixed Mayan and Spanish/European descent) in urban centers. These social divisions were further reinforced during the Guatemalan Civil War that occurred between 1960-1996, known colloquially as *La Violencia*. During the war, the Guatemalan army carried out acts of genocide against Mayan communities, academics, social activists, and leftist political actors deemed to have been promoting rural insurgency and communism, as discussed in more detail in chapter 2. By the end of *La Violencia* in 1996, the state had murdered more than 200,000 people and forcefully disappeared thousands more. Such violence further solidified the drastic socio-political and cultural power divides between social classes, cultural discrimination and racism was endemic, and poverty and health inequities permeated Maya Guatemala. The Peace Accords of 1996, which settled this 36-year civil war, stipulated among other social reparations issues and inclusivity, that healthcare reform and the extension of care to Indigenous communities is mandatory (Maupin 2009).

While the Peace Accords brought democratic elections, a boom in tourism, and expanded human rights and a sense of Mayan nationalism, it also ushered in an era of free trade, privatization, resource and land exploitation, narco-trafficking, violence and impunity. As Copeland (2015) writes, "rather than empower Mayan communities, electoral democracy instituted internecine competition for basic resources that weakened grassroots autonomy" and as a result, Indigenous Maya communities face high rates of informal employment, declining subsistence, reduced land ownership, and disproportionately endure ecological destruction and natural disasters. Although Guatemala's unemployment rate is quite low, the majority of these jobs lie outside the formal job market, meaning that most Guatemalans work without social security or benefits, lack protection and stability, and often endure labor rights violations. Since 2010, the rate of informal employment in Guatemala has been over 70%, with rates near 80% for

women (UNDP 2021). Nearly a third of Guatemalans, primarily the Indigenous, work in agriculture, often for large landowners and farms producing major exports including bananas, coffee, palm oil, and sugar for the foreign market (FADPA 2014, UNDP 2021). About 2.5 percent of these major industrial farms control two thirds of the land (Hurtado 2017). Historical legacies of ethnic racism and social and physical marginalization persist today within Guatemala neoliberal democracy, and contribute to widespread poverty, healthcare inaccessibility, poor quality of care, and unrelenting health disparities among Indigenous Maya communities (Copeland 2014, Foxen 2010, Adams and Hawkins 2007). Such disparities represent what medical anthropologist, Paul Farmer refers to as the "pathologies of power." (Farmer 2003).

Indigenous Health in Maya Guatemala

As understood in medical anthropology, health disparity and access to healthcare are sites through which processes of social and political inequality may be illuminated. For reasons outlined above, the public healthcare system in Guatemala has historically been out of reach for the majority of Indigenous communities—the very communities which the Guatemalan Ministry of Health acknowledges as the most vulnerable. Among Indigenous Maya communities, health inequities are widespread, including high rates of maternal mortality, rampant childhood malnutrition, childhood stunting, and chronic diseases such as diabetes, obesity, and hypertension (Chary and Rohloff 2015, Yates-Doerr 2015, Cosminsky 2016, Berry 2008, Berry 2013). Guatemala has the sixth highest chronic malnutrition rate in the world, the highest in all of Latin America (USAID 2019). The most current official national data on maternal and child health, from 2009, estimates that 52 percent of children under 5 year of age are chronically malnourished, with 66 percent of these being Indigenous rural children (UN Women 2021b). In recent years, however, the rate of chronic malnutrition was estimated to have dropped to 47

percent, yet those most impacted continued to be rural Indigenous communities, especially the regions of Totonicapán, Quiche, and Huehuetenango, where rates of childhood stunting are at 70 percent (USAID 2019). In addition to malnutrition, maternal mortality rates are also high at 140 per 100,000 live births, with infant mortality rates at 30 per 1000 live births (USAID 2018). Of the major chronic health problems, type 2 diabetes is the most prevalent and is an increasing public health concern. As of 2020, Guatemala's diabetes prevalence rate was 8.2 percent (International Diabetes Federation 2020).

These challenging health conditions remain persistent for a number of socio-cultural and economic reasons. There are often language barriers between Indigenous patients and their biomedical doctors. Racism and discrimination in the healthcare system toward Indigenous patients is common, and likewise, a lack of trust for state physicians is equally common among Mayan groups. T.S. Harvey's work highlights the importance of language in healthcare for Indigenous patients arguing that culturally appropriate behaviors and approaches to treating Mayan patients lie outside the purview of biomedicine, perpetuating distrust and the problematization of Indigenous beliefs about health and wellbeing (Harvey 2008, Harvey 2013); 2013). Similarly, Nicole Berry (2013) documents maternal mortality in Indigenous communities, highlighting the avoidance of biomedical care and preference for Indigenous Mayan midwives even in cases of extreme risk. Berry argues that health initiatives in Guatemala geared toward Indigenous women are often based on "imaginary clients," and that Indigenous women ultimately did not fit within biomedical notions of the patient role (2008; 2013:193).

Infrastructural barriers between rural and urban regions are also a contributor to health disparity in Maya communities. About 48 percent of the Guatemalan population resides in rural and highland areas (World Bank 2021). Indigenous villages are often physically and

geographically isolated, located in regions with no reliable or quick access to state healthcare facilities or national hospitals. Traveling down from highland communities, sometimes even across bodies of water, to visit the national hospital, in some places may require individuals and their families to travel an hour or more. Moreover, when patients pursue healthcare services, they often have to navigate the fractured and competing healthcare landscape which is occupied not only by state health posts, health centers, and hospitals; but also by private practices, private specialists, and NGOs. Anita Chary (2015), in researching how Guatemalan women seek care for cervical cancer, refers to the complex ways in which individuals make decisions for their health in Guatemala's fragmented healthcare marketplace, as "healer shopping."

Despite such a competitive healthcare "marketplace," stark economic inequality between rural Indigenous regions and wealthier urban centers makes pursuing healthcare services financially difficult for Indigenous communities. The formal labor sector which makes up less than 30% of the job market, is primarily located in urban centers. Meanwhile, the majority of Indigenous communities' work within the informal labor sector. Such jobs are not systematically taxed, see no job security, and provide no financial and healthcare support from the IGSS. By and large, many Indigenous communities work in agriculture, producing crops for local sale and lucrative crops for export, yet the yield from cash crops and produce exported to the U.S. and other neighboring countries has diminished in recent years, making once lucrative crops such as coffee, a calculated risk for small farmers As a result, increased immigration out of Guatemala into Mexico and the United States can be said to reflect the nation's dramatic social and economic inequality between social groups (CDC 2021).

NGOs in Health in Guatemala

During the 1980s and 1990s, many Latin American countries took on structural adjustment loans from international financial institutions to stabilize their post-Cold War economies, build credit, or to prevent default on existing loans from financial institutions and other lending nations. The underwriting of structural adjustment loans often required that nations decentralize their existing national healthcare systems, cut federal healthcare expenditures, implement fee-for-service provision of healthcare, and encourage community and non-governmental organization participation in healthcare delivery (Armada, Carles Muntaner, and Navarro 2001, Pfeiffer and Chapman 2010, La Forgia, Mintz, and Cerezo 2005, La Forgia and Harding 2009). In Guatemala, structural adjustment policies of this sort had an especially significant effect on the nationalized healthcare system and the role that healthcare NGOs would have within it.

One policy through which the Guatemalan Ministry of Health attempted to bridge the gaps in healthcare access for Indigenous community was the *Programa de Extensión de Cobertura* (Coverage Extension Plan) or PEC, created by the Sistema Integral de Atención en Salud (SIAS), an arm of the Guatemalan Ministry of Health (MSPS). From 1997 to 2015, this program was designed to contract NGOs as healthcare providers for Indigenous regions of the country who lacked access to the public system. Guatemala's decision to incorporate the NGO sector into the healthcare system was also based on additional reasons, namely that NGOs were already targeting areas of concern; they had the necessary supplies, personnel, and equipment for health interventions; Indigenous communities trusted NGOs more than state health institutions; and utilizing NGOs would bypass a cumbersome and slow hiring process at the Ministry of Health (La Forgia, Mintz, and Cerezo 2005).

The PEC supplied NGOs with a trained health team, medical supplies, and equipment. Each contracted NGO served approximately 10,000 people primarily in Indigenous communities (Llanque 2015). The Ministry of Health also trained administrators to gather public health data relevant for monitoring numerous public health goals, particularly maternal mortality and malnutrition for women and young children. The PEC contracts extended a basic healthcare package to nearly 4.3 million people, primarily Indigenous Maya, representing roughly 54 percent of the rural Guatemalan population (Peña 2013: 21, Maupin 2015: 5). At its height in 2002, the Ministry of Health had signed 160 contracts with 88 NGOs (La Forgia, Mintz, and Cerezo 2005: 9). Toward the end of the program, however, the number of NGOs holding contracts significantly diminished. In 2012, 68 NGOs held 376 contracts (Peña 2013). By 2013, only 41 NGOs held 195 contracts. Although it was canceled in December 2015 due to a lack of State funding and political support, the PEC has left a legacy of NGO involvement in healthcare for a significant proportion of citizens who would otherwise lack access to any significant biomedical care without them.

After the cancellation of the PEC, the Guatemalan Ministry of Health's relationship with the NGO sector continued to fluctuate. Some NGOs received brief contracts to provide healthcare services from the IGSS, the national social security institute, (Maupin 2015), yet these contracts were competitive and ultimately abandoned. Furthermore, the Ministry of Health designed and implemented a revised version of the PEC that utilized MSPS facilities and personnel instead of NGOs to provide basic healthcare services to communities. However, this trial version—or "PEC II," as it was referred to by participants in this study—was ultimately canceled due to lack of political support. In September 2017, the Ministry of Health also applied for a new healthcare loan from the Inter-American Development Bank, estimated at 100 million dollars (USD), the

largest healthcare loan request they have made since financing the PEC. The plan proposes the funding will be used "to implement the new primary health care model in Guatemala" (Inter-American Development Bank 2017). This proposal no longer includes NGOs as healthcare providers, has no provisions for financial support of NGOs, and instead focuses on improving and rebuilding the infrastructure of the existing public system. This re-centralization of healthcare funding and provision of services to state-run facilities reflects emerging anti-NGO political sentiments that have permeated the political establishment over the course of this research. Given the historical legacy of NGO involvement in healthcare, how does the shifting nature of resources, policy, and political supports for NGOs shape the ways NGO workers continue to perform their roles in health intervention in Maya communities?

Site Locations

While there is an abundance of NGOs throughout Guatemala, many of which operate in the urban centers of Guatemala City and Antigua in southern Guatemala, shifting socio-political context and changes in resources for NGOs have had the most important implications for NGOs that work in rural regions with Indigenous Maya communities. This project focuses on the experiences of workers from multiple NGOs to understand the ways in which they continue to perform their roles in health intervention despite the flux in economic, social, and political supports for the NGO sector. While I carried out my research with staff members from multiple health focused NGOs, most of the observations and interviews were conducted at two of these organizations: Fundación Maya Salud (FMS) and Asociación para Nutrición y Desarrollo Integral (ANDI).[1]

[1] Organizational names are pseudonyms. While directors at both NGOs indicated they would like their organizations to be identified in this work, changes in Guatemalan NGO Law in 2020 puts NGOs at risk for persecution for

Overview of Fundación Maya Salud

Fundación Maya Salud (FMS) was founded by a United States physician in 1962 in the department of Chimaltenango, Guatemala. Originally the fundación provided health care services, preventative health interventions, and developed community empowerment programs in Indigenous Kaqchikel Maya villages throughout Chimaltenango. The NGO established a health clinic and hospital, deployed local *promotores de salud* (health promoters) in Indigenous Kaqchikel villages, and established a number of auxiliary programs and community participation centered around land distribution, sanitation, nutrition and disease prevention education, and community health programs. For their liberationist approach, the NGO was hailed as a watershed organization in community participatory development and health care practice by the World Health Organization. FMS endured the 36-year long civil war, and its heightened period of violence and genocide in the early 1980's when NGO workers were among many military targets viewed as social activists, suffering the death and disappearance of nearly two third of its trained *promotores*. In 1984, after fleeing Guatemala under the threat of violence, the founder relinquished management of the fundación to local NGO staff, and returned to Guatemala in 1986. Despite the founder's passing in 1990, the NGO, now often referred to locally as the "*hospitalito,"* continues to operate as a private healthcare clinic and hospital for Indigenous communities in Chimaltenango.

FMS had long been supported by a sister funding institution based in the United States run by their board of directors which provided the major source of financial stability for the

arbitrarily defined "political" agenda. To protect the identities of the NGO workers in this study, all NGOs and participants names have been assigned pseudonyms.

fundación for many years.[2] However, in 2005 this funding partnership ended after allowing local leaders within FMS to take full ownership of the organization to pursue PEC contracts from SIAS. Since then, the fundación has had a long history with the Guatemalan government and Ministry of Health, including many years of PEC contracts for providing healthcare services throughout the department of Chimaltenango. Under the PEC contracts FMS deployed health teams to rural communities, trained health promotors, and gathered and reported health data monthly to SIAS. Presently, FMS is a complex of buildings in the city of Chimaltenango comprised of a small hospital with an emergency room, imaging center, a day clinic, specialty women's clinic, and a pharmacy. The fundación is currently lead and run by local Guatemalan staff and providers and continues to serve primarily Kaqchikel Maya patients and occasionally hosts visiting physicians. However, FMS no longer deploys health teams or promotors to rural communities throughout the municipality as it did in the past. Since the cancelation of the PEC program in 2015, FMS is financially supported solely by revenue from their pharmacy and fee-for-service care. As an institution of care that has relied heavily on state government in the past, FMS was directly impacted by recent socio-political policy change and thus an ideal organization for examining the impact of Guatemala's shifting socio-political climate on NGOs continued involvement in health.

Overview of Asociación para Nutrición y Desarrollo Integral

After relinquishing control of FMS to its local Guatemalan staff in 2005, the U.S.-based board of directors established a new organization in the city of Chimaltenango, Asociación para Nutrición y Desarrollo Integral (ANDI) in 2006, in hopes of continuing the legacy and

[2] This U.S. funding institution will remain unnamed throughout this dissertation to ensure anonymity and protect the identities of the participants.

community empowerment vision of the original founder of FMS. ANDI currently receives all its funding from this partnership and has never received PEC contracts from the Guatemalan Ministry of Health. ANDI focuses on health interventions that achieve the NGOs' overarching objective of reducing childhood malnutrition in Chimaltenango through grassroots development, a goal that continues the community participation approach and vision of its founder. ANDI touts an "integrated approach" based in community participation in three areas including, community mobilization, infrastructure, and nutrition. ANDI is staffed by 12 local workers who specialize in designing interventions in multiple areas including: nutrition education, empowerment, family planning, food security, and water and sanitation infrastructure. Most days, workers conduct field visits in "partner" communities, meeting with local leadership, conducting trainings and workshops with local groups, and monitoring progress on infrastructure, agriculture, and nutrition. ANDI performs their integrated health intervention program in multiple communities throughout Chimaltenango, increasing their reach each year. As an organization whose mission, work, and history are intimately tied to that of FMS, ANDI also provides a unique site for examining how NGOs continue providing health interventions despite shifting social and political supports for NGOs.

Methodology

Introduction

The research protocols for this project received Institutional Review Board (IRB) approval from the Human Research Protection Program at Michigan State University in 2014. I conducted preliminary research with NGOs in Guatemala in 2014 and 2016. During this pilot research I interviewed a total of nine representatives from six different health focused NGOs, in the major cities of Antigua and Chimaltenango. Interview topics included: NGO missions and

healthcare programing; the influence of global health agenda on NGOs; NGO experiences with funders and donors; and NGO relationships with the state and local government. The preliminary project was designed to explore the opinions and experiences of NGO personnel regarding the importance of these factors, in terms of their roles and work within the healthcare system. My participants in this preliminary phase included NGO directors, program managers, and board of director members. All participants were recruited from prior contact and through snowball sampling. I also kept field notes from interviews and visits to NGO sites, public NGO presentations and events that I attended, and tracked local news and media stories for an understanding of the localized context.

After this preliminary pilot research, I focused on FMS and ANDI for this dissertation research, and developed interview protocols for research I conducted with them in 2019. What follows is a description of the interviews, participant observations, document and discourse data collected during the dissertation phase of the research.

Semi-Structured Interviews

Interviews with NGO Workers

After establishing and building relationships with the directors at both FMS and ANDI, I conducted semi-structured interviews with staff from both NGOs. Each director convened with their staff members about my research project and later provided me with a list of individuals who were interested in participating in interviews and observations. With help from the directors, I recruited staff members by asking if they would be interested in participating in an hour-long interview. Before conducting each interview, I provided each participant with an IRB approved consent form which outlined the overarching goals of the research project and their roles as

participants in the study. I emphasized that their participation in the study was completely voluntary and that they were permitted to end the interview at any time without penalty or choose not to answer any interview questions they felt uncomfortable with or wished not to respond to. I also emphasized that the study was not expected to cause any physical or emotional harm and interview questions were not anticipated to cover sensitive topics that could cause any undue emotional or psychological risks. Although participants received no direct benefits from participating in the study, I expressed that they may find it valuable to explore and share their thoughts and impressions about their roles in health intervention. I guaranteed that their participation in the study would be confidential and that I would not identify individuals or include any information that could identify them personally in any reports resulting from this research. As such, all participant and organizational names have been assigned pseudonyms. After participants signed these consent forms, I also read a brief paragraph reiterating that they could decline to participate at any time, that the interview would be audio-recorded, and gave them an opportunity to ask any questions before the interview began. I conducted 26 semi-structured interviews in total with 24 NGO staff members. Two of these interviews were follow-up interviews with the directors at both FMS and ANDI. The majority of these interviews were conducted in Spanish. Some interviews were conducted in English if the participant preferred. In two interviews participants switched between English and Spanish several times throughout the interview.

I sought to conduct interviews with as many types of workers at each NGO as I could in order to span their varying roles, training, and backgrounds. At FMS, I conducted a total of 10 interviews, which included, 2 health project coordinators, 2 nurses, 3 administrative staff members, and two interviews with the medical director. At ANDI, I conducted a total of 12

interviews, which included 2 community health program supervisors, 2 water and sanitation technicians, 3 health educators, 1 media producer, 2 members of their board of directors, and two interviews with their executive director. At both organizations, I conducted interviews in a secluded or vacant office or conference room space. None of the staff members I invited to be interviewed declined or stopped their participation in the study, however, a few asked that certain things they said or that we later discussed outside of the interview be "off record." I conducted follow-up interviews with the directors of each NGO, asking them additional questions that had developed over the course of the interviews. I did not compose follow-up interviews with other participants since no additional trends or themes had emerged. Table 1 includes selected demographic characteristics about the NGO staff members interviewed during both phases of the research project.

Table 1. Selected Characteristics of NGO Staff Members Interviewed

	Total	
	n	**%**
Participants	24[3]	
NGO		
NGO 1 (FMS)	9	38%
NGO 2 (ANDI)	11	46%
Other NGOs	4	16%
Gender		
Female	10	42%
Male	14	58%
Age		
30-39	16	67%
40-49	6	25%
50-59	0	0%
60-69	1	4%
70-79	1	4%
Race/Ethnicity		
Kaqchikel Maya	14	58%
Ladina/o	5	21%
Caucasian	5	21%

[3] Twenty-six semi-structured interviews were conducted in total with 24 NGO staff members. Two participants received follow-up interviews.

Interviews with NGO staff from FMS and ANDI covered a range of topics including: Their principal job duties at their respective organizations; their experiences working in the Maya community; their impressions of the healthcare system and the role of NGOs; their relationships with other NGO works and organizations; their views of and experiences with the State or Ministry of Health; the ways funding may impact their work; and their views of activism in relation to healthcare. I also gathered background information from each participant including their ethnicity, age, education completed, and additional experience working in the NGO sector.

Other Interviews

In addition to the 26 formal interviews with NGO staff members, I also conducted interviews with one former Ministry of Health official and with 5 local community members. These interviews developed opportunistically through snowball sampling and provided a unique opportunity to understand the context of health inequalities and health policy in Guatemala more extensively. Using the same consent protocols that I developed for NGO staff members as outlined above, these interviews were audio recorded and I also took extensive fieldnotes during and after the interviews.

The former Ministry of Health official interviewed had extensive experience designing and evaluating the PEC program which provided SIAS contracts to participating NGOs. This individual was solicited to participant in an interview after I was introduced to them by the director of ANDI. I followed the same consent protocols as outlined above. The interview was conducted in English, audio recorded with permission, and I also took extensive notes during and after the interview. In this unstructured interview we discussed their work with the PEC, impressions of the successes and failures of the program, and their views of the relationship between the state and NGOs and how this has changed over time in recent years. This participant

also shared multiple official state documents related to the PEC program and its evaluations, official presentations, and other reports.

Additionally, I conducted 5 exploratory interviews with local community members in the city of Antigua. During my interviews with NGO staff members, I discovered the state of the healthcare system was a dominant topic of interest. I wanted to explore how community members experiences might validate these discussions. I solicited community members participation through convenience sampling after a local church member took interest in my study. The church allowed me to share a recruitment flyer with their members. Interviews with community members covered their experiences and opinions with the healthcare system, their experiences with health NGOs, and expectations for healthcare policy reform. I provided participants with my contact information if they had questions about their participation following the interview and asked them to share my flyer with others who may be interested in participating. Interviews were conducted in Spanish and held in participant's homes or in public spaces. While these community members do not reflect the demographic of the communities in which the NGOs do their main work, I felt these 5 exploratory interviews provided sufficient contextual data to corroborate themes that emerged from my interviews with NGO staff members about the general state of the healthcare system more broadly.

Participant Observations

Participant observations conducted for this study included observations at FMS and ANDI, observing everyday work in the physical organization and accompanying NGO staff members to local communities. My observations were of NGO activities, meetings, and trainings, conducted in Spanish, Kaqchikel Maya, or a mix of both languages. My observations at FMS were substantially restricted compared to that of ANDI. Due to its functions as a clinic,

hospital and pharmacy, FMS limited my observations to the waiting room space for patients during the morning for about an hour, on days in which I was also conducting interviews with staff members. In these observations I recorded descriptions of the clientele visiting the day clinic or the pharmacy and detailed descriptions of the physical organization of the clinic.

At ANDI, I was allowed to observe NGO staff members everyday work and community field visits. At ANDI I observed 3 health education trainings with local women's groups, 1 masculinity training with a men's group, 1 *primera piedra* (first stone) celebration ceremony in a local community at the end of their intervention program with ANDI, and I also observed the implementation of sanitation and water systems in a community who had recently become a partner community with ANDI. Prior to the observational stage, the director of ANDI asked their staff members if they would be interested in allowing me to observe their field work and attend their community visits and provided me with names and contact information for staff members who were willing to participate. The majority of staff members I shadowed at ANDI were individuals who I had already interviewed and who were familiar with my project. However, before shadowing an NGO staff member, I introduced myself, gave a brief summary of my project, and obtained oral consent. None of the NGO staff members asked declined to participate. I clarified that I was merely observing and taking notes about their work, and that I was not evaluating or reporting back to their superiors about their performance. Upon convening with community groups, the staff member I was observing would introduce me in either Spanish or Kaqchikel and allowed me to briefly describe my project. I ensured that with each introduction I clarified that I was an anthropologist there to observe the work of the NGO staff member and that I would be taking notes about the activity and discussions during the interactions. Among individuals who did not speak Spanish, the staff member translated my

introduction into Kaqchikel. I received oral consent from these groups to take observational notes and permission to take photos of these trainings and any materials used in them. During my observations at ANDI, I took detailed notes about the topics of the trainings, and how staff members interacted with community members. I examined: What are the NGO staff member's goals for the training or interaction with partner community members? How do they present information to the community members? How do community members respond to this information? How does the NGO worker relate the topics presented to health or specific health issues? I handwrote my observations each day and typed them into a cumulative field notes document at the end of each day. In my electronic field notes, each observation was assigned a time and date, location, and an ID number was assigned to the staff member observed. I recorded basic characteristics about the NGO staff member I observed including, age, gender, ethnicity, and job title.

Document & Public Content Data

Document data gathered for this research included official Ministry of Health documents related to the PEC health policy and its evaluation, Official Inter-American Development Bank documents related to the funding of the PEC policy, and the official SIAS contract for participating NGOs. From FMS, I gathered documents including published works and annual financial and activity reports. I also retrieved discourse content from their public website and Facebook page describing their organizational goals and values, events, strategic plan, and history of the organization. At ANDI, I gathered information from their public website, Youtube films, and content and photos posted on their public social media accounts and Facebook page. I also took photographs and detailed descriptions of materials used during trainings in their affiliated communities. Physical documents were scanned and digitalized. Public content data

was either screenshot, described in detail in my field notes, or digitally retrieved via Nvivo's NCapture function.

Data Analysis

Data analysis was an ongoing process throughout the course of this research. Pilot interviews helped shape the trajectory of the research questions and interview protocols. The interviews conducted in Spanish were transcribed using Verbal Ink transcription service. I transcribed the remaining interview audio files, which were conducted in either English or in both English and Spanish, using Express Scribe transcription software. All interviews were transcribed and analyzed in the language used during the interview.

I read the transcripts and created a summary of each interview following a template based on the interview questions I posed to the participants. From these summaries, I developed a series of preliminary thematic codes based on frequently mentioned topics. Next, I selected one of the transcripts that I felt best exemplified these various themes and topics and hand-coded the document, carefully developing a code for everything that was said during the interview. I grouped these codes into a thematic codebook and developed definitions for each code to use as a guide when coding the remaining interview transcripts. Using the qualitative data analysis software NVivo, I coded each interview transcript line-by-line following my codebook. The codebook's codes and definitions were frequently updated as new themes or topics emerged during this process. This ensured that I consistently developed and applied codes that captured the content of what participants expressed and discussed. This in-depth process was guided by a grounded theory analysis approach, where the emergent themes and topics in the data were inductively and systematically organized into dominant concepts and categories. Emergent themes reflect the empirical content and experiences in the data, and conceptual links to the

wider analytic context. Some codes were also created based on specific questions posed to the participants.

In addition to coding my interviews, all interview notes, observational field notes, photos, documents and public content data were uploaded into NVivo and coded according to the codebook. The codebook was further refined throughout this process to ensure all aspects of the data, unique or common, were coded. In my interviews and observations at ANDI and FMS, I found that NGO workers frequently invoked aspects of their unique subjectivities and personal identities in relation to their everyday work. When asked questions about their roles, motivations, and experiences working at a health focused NGO, their responses fell into several dominant thematic categories which I delineated as emergent codes, such as: indigeneity, gender, empowerment, and responsibility. I defined "indigeneity" as references to Indigenous status, identity and culture, such as identifying as Kaqchikel Maya, being "from" an Indigenous Maya community, or speaking a Mayan language. I defined "gender" as references to the link between gender and cultural roles, inequality, and power differences between men and women, such as references to Mayan women's disempowerment in their respective communities or discussions of machismo. I defined "responsibility" as references to accountability and obligation in relation to NGO work. Such expressions include descriptions of heightened feelings of responsibility for the wellbeing of communities. In addition to this coding, I conducted text search queries in NVivo for terms I used to define these themes. For example, in relation to the code for "indigeneity", I queried for additional qualifying terms including "Indigenous" "Maya" and "Kaqchikel" so that references were incorporated into my coding scheme. I then processed the results, further sub-coding these responses and cross-coding them with additional intersecting codes such as "gender" and "identity". I also conducted additional coding queries in NVivo,

finding intersecting themes among my emergent codes. Themes of "corruption" and "empowerment" were particularly dominant in these queries, overlapping with multiple codes. For example, the code for empowerment was predominantly cross coded with themes concerning gender inequality, women, indigeneity. At the end of my analysis, I developed 20 major emergent thematic codes, many of which were further developed through sub-coding. In the chapters that follow, I will present findings from this analysis.[4]

[4] In this research, the data collected was either in English or Spanish. All quoted material in this dissertation has been translated by me and will be presented in English.

Chapter 4: “If not me, Then Who?”: Empowerment and NGO Worker Subjectivity at Asociación para Nutrición y Desarrollo Integral

The drive to Palima takes about an hour and a half from Chimaltenango. Four health education workers from ANDI and I drive into the countryside, passing pine forests, rolling hills and slopes, following winding asphalt roads up and up. Everything is a deep green, wet, and misty. Heavy cool fog floats over the tops of trees in the valleys below. After a while, our truck drives along the edges of steep yellow and burnt orange rocky embankments. There are large stones in the road that tumbled from the incline next to us. We come upon a construction crew in the middle of the road clearing a large cache of stone that fell into the road, waiting 15 minutes before we can pass. The road from here is treacherous, precariously rocky, with many stomach wrenching twists and turns. "Welcome to Palima," Inez laughs as she catches my nervous eye in the side view mirror. We arrive in the rural Kaqchikel Maya village of Palima, Tecpán. Inez and I enter a small school classroom, followed by 16 women, all wearing vibrant floral huipiles, and many with small babies strapped to their backs in handwoven rebosos[5]*. Inez tells the women that today's training is about derechos humanos (human rights) and divides them into two groups. Speaking in both Spanish and Kaqchikel, Inez passes an envelope with two puzzles in it to each group, explaining they must glue them together on a large sheet of paper. Sitting on the floor, they begin sorting the puzzles. Inez tells me, "I want them to think about what these images mean to them." As the women work the puzzles, Inez blows up a balloon and passes it to a baby strapped to their mother's back. In my head, I question whether it's wise to give such a small child a balloon, but as the mother lets her daughter out of the sling, I realize the infant is much older than she appears: a 3-year-old stunted to the body of a 1-year-old. Taping their puzzles on the wall, the women then describe what they think they mean: Of an image of a man and a woman on either side of a scale, they say: "Machismo is bad." Of the image of children sitting in a classroom: "Children should go to school." Of an image of a boy with a thermometer in his mouth: "Children get sick." And of the image of a woman raising her hand in front of a man: "Women get pregnant." Inez asks, "But what kinds of rights do these represent?" Then above each image, writes in Spanish: "Right to Equality," "Right to Education," "Right to Health," and "Right to Participation." The rest of the training is devoted to explaining what these rights mean. After the training the women sign an attendance sheet. Some sign their name, but most cannot, and instead use their thumbprint. For a few, Inez asks them, "How many children do you have?" I hear, "Eight" and "Ten, but only 3 are boys." One woman responds, "I have 50," and all the women in the room laugh. "No. That was a joke," the woman turns to me in broken Spanish, "I'm lying. I only have 13," then pushes her thumb into the ink pad and presses it to the paper, signing her name.*

-Field Notes, Palima, Tecpán with Inez from Asociación para Nutrición y Desarrollo Integral, May 2019

[5] Huipiles and rebosos are intricately handwoven and embroidered blouses and slings, typically worn by Mayan women.

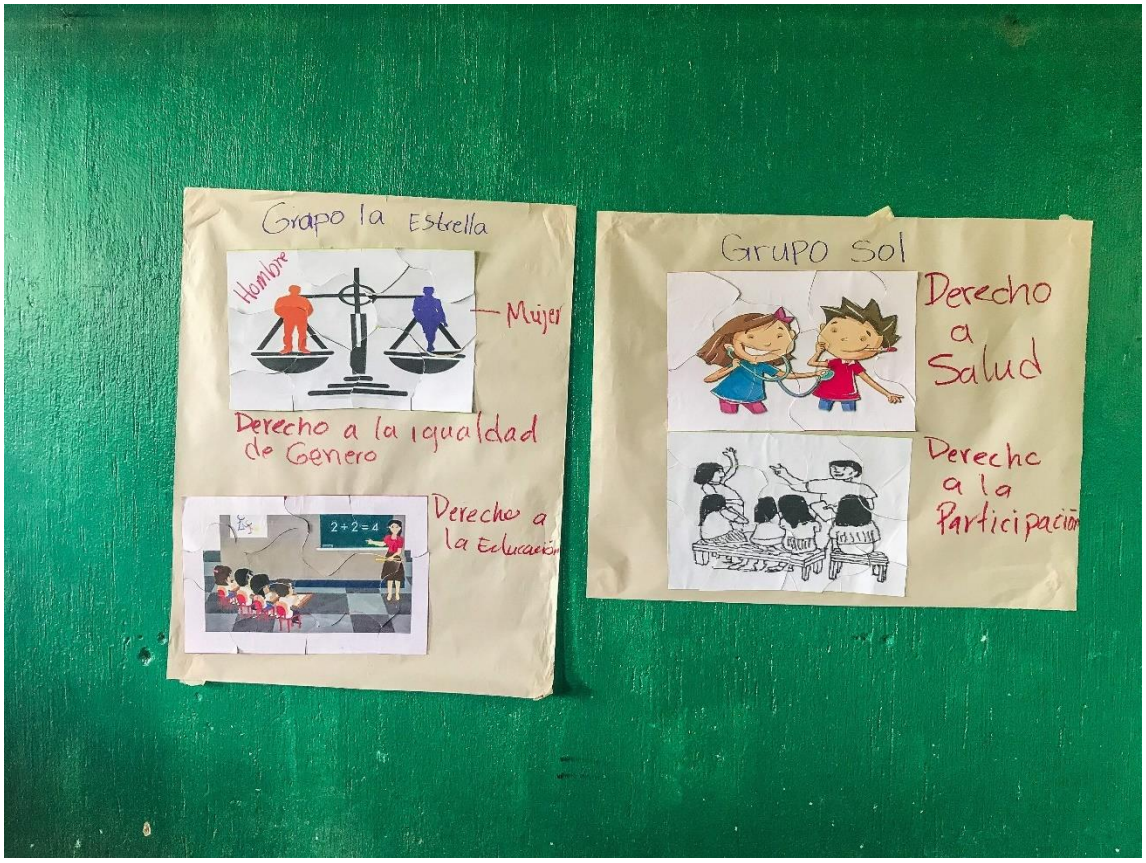

Figure 1. Women's Rights Puzzle Activity
Image from Inez's empowerment training depicting women's rights during a health education training in Palima in 2019. "Right to equality" (top left), "right to education" (bottom left), "right to health" (top right), and "right to participation" (bottom right).

Introduction

While instructing women to think about these images from their own subjective realities, Inez simultaneously encourages them to think about them differently; in terms of "rights." Dressed in similar Kaqchikel *traje*[6] as the women attending her training and donning a vest embroidered with the ANDI insignia over her *huipil* blouse, Inez mixes lighthearted games with discussions about women's rights and the gender inequality that women in the community face. Her training positions women at the heart of health problems in the community, weaving, for

[6] Culturally significant dress worn by many Indigenous Mayan women consisting of densely woven fabric skirts, belts, and embroidered blouses, which vary by region and by language group.

example, their idea of *machismo* to women's social inequality, to unwanted pregnancies which perpetuate family poverty and childhood malnutrition. For Inez and her colleagues at ANDI, women are positioned at the root of health problems in Guatemala, and the solution is their empowerment.

As previously discussed, Maya Guatemala has the largest rate of maternal mortality, chronic malnutrition, and childhood stunting in all of Latin America. Indigenous women often become the targets of health interventions aimed at addressing the social inequities that keep communities from maintaining healthy lives. While Inez, as she expressed to me in an interview, is herself a product of similar contexts of social and cultural inequality of Maya women —which would stand to validate the realities of the women in the room around her—as an NGO worker she is also tasked with altering how the targets of her health interventions see their world. To do her job Inez must balance these competing subjectivities; her role as a health educator steeped in institutionalized discourses of empowerment, and her personal identity as an Indigenous Kaqchikel woman who may know all too well the limitations in realizing the empowerment of Maya women.

As parts of a larger organization, NGO workers, like Inez, possess varying subjectivities that are continuously re-made through their institutional and intersubjective interactions. The concept of subjectivity illuminates the competing nature of one's unique attributes and environments that lead individuals to act in particular ways. Subjectivity has important implications for understanding the larger question that guides this dissertation. In trying to understand how NGO workers are able to continue performing their roles in health intervention amidst Guatemala's changing socio-political healthcare landscape, this chapter explores the unique subjectivities of NGO workers and how factors such as identity, indigeneity, and

institutional legacy may impact the health interventions designed and implemented in Maya communities. NGO workers at ANDI are simultaneously individuals who possess profound connections to the communities in which they work, and who are also actors immersed in NGO rhetorics of what it means to "do good." I argue that these subjectivities impact how workers perform their roles in health intervention, and ultimately shape collective understandings of empowerment.

Defining and Understanding Empowerment

Empowerment is generally understood as a process in which individuals increase and maintain their own self-determination and autonomy in their everyday lives and in their communities, in ways that allow them to better represent their interests and obtain resources. Interventions promoting empowerment are based on the premise that such individuals battle a deep sense of powerlessness, lack rights, and experience limited influence and representation in their everyday lives and among their larger communities and society. Rappaport (1987) in articulating the notion of "empowerment" writes that it "conveys both a psychological sense of personal control or influence and a concern with actual social influence, political power, and legal rights. It is a multilevel construct applicable to individual citizens as well as to organizations and neighborhoods; it suggests the study of people in context" (1987:121). Empowerment is thus a process and a means by which people, organizations and communities "gain mastery over their affairs," and this process manifests in different ways based on socio-political contexts (Rappaport 1987: 122, Rappaport, Swift, and Hess 1984).

In the context of NGOs, empowerment interventions have become highly prioritized development agenda since the 1990s, specifically the empowerment of women (Cheater 2003, Dawson 1998, Panda 2000, Schild 1998, 2014, Sen 1989). Many NGOs, often heavily influenced

by development institutions and their funding agencies, have since framed empowerment and 'women in development' interventions as long-term poverty alleviation strategies to increase the self-reliance of the poor, especially poor women (Bose and Acosta-Belén 1995). Often, such interventions target Indigenous women who have been especially socially marginalized.

The historical disenfranchisement of Indigenous peoples, and subsequently of Indigenous women in Latin America, is an enduring vestige of colonialism and the long history of social and political repression and violence against Maya communities (Bose and Acosta-Belén 1995, Castañeda 2008, Copeland 2019a, Fischer and Benson 2006, Foxen 2010). The process of colonization used gender as a form of social control, imposing new norms of gender that became profoundly entrenched through patriarchy, and these are enduring today. For example, Spanish colonial constructions of masculinity and femininity, often referred to as *machismo* and *marianismo*, idealized men as authoritative heads of household and women as selfless and moral familial nurturers. While these mythic gender tropes are increasingly dissented by many, they often persist and perpetuate gender divisions among Indigenous communities, effectively disempowering entire households. In Guatemala, the deep-rooted social inequality of Maya people, as discussed in detail in Chapter 3, is amplified for Maya women who often experience reduced power over economic resources, few social and political opportunities, and limited decision making in their interpersonal and community level relations (Green 1999). In Maya communities, gender inequality of women often manifests in many ways. Mayan women, for example, especially experience lower status and reduced social mobility due to incomplete primary education. Roughly 48 percent of Indigenous Mayan women are illiterate, averaging only three years of primary schooling (UN Women 2021b). As a result, women are unequally represented in the labor market, with only 40 percent of women working paying jobs, most of

which are in the informal job market sector as household employees, agricultural workers, and informal retail workers which provide no social security or benefits (UN Women 2021b, Vásquez 2011). In addition, Guatemala has one of the highest fertility rates in Latin America at 2.87 children per woman (World Bank 2019). Although data is lacking, this number has tended to be much higher among Mayan women for many reasons, including lack of access to family planning methods and education, religious and sexual conservatism, and distrust for biomedical practitioners (Metz 2001). As a result, Mayan women often find themselves as primary domestic and child caretakers. Adolescent pregnancy, especially among Indigenous girls is also high. About 41 percent of adolescent girls either have given birth or are pregnant with their first child by the age of 19, a rate which has remained relatively stagnant since 2008 (USAID 2018). Women and girls over 15 years of age are estimated to spend nearly 18 percent of the (UN Women 2021a).

This disempowerment of women is further compounded by additional social subjugation, including high rates of domestic violence and femicide, or the killing of women and girls particularly by men on account of their gender (Menjívar 2011). Of the top 25 countries experiencing high rates of gender-based violence, the majority are Latin America countries. Guatemala ranks third behind El Salvador and Honduras in femicide, at a rate of about 9.5 per 100,000 women (The Geneva Declaration 2011). As a result of such socially disempowering conditions, many women in Maya communities also have a tendency to primarily speak one of several Mayan languages instead of Spanish often limiting their abilities to function independently; wear traditional clothes; informally sell produce and handicrafts, and stay close to home rather than travel to major cities for work. In the past, ethnologists and anthropologists studying in Latin America had often interpreted some of these practices as cultural resilience

(Schevill, Berlo, and Dwyer 1991, Tarlo 1996, Little 2004). Yet, these practices and preferences are generally not expressed in similar ways by men in Maya communities who tend to be more educated, fluent in Spanish, and work outside of the community. An alternate interpretation considers these preferences, as a reflection of ways Mayan women, have been victimized and excluded from opportunities typically accessed and enjoyed by men (Bennett 2015, Hansen 2004).

Anthropologists and feminist scholars have been critical of women's empowerment interventions (Barrig 2016, Beck 2017b, Bernal and Grewal 2014a, Moore 2016, Schild 2015). The Latin American feminist scholar Maruja Barrig (2016, 1991) has specifically criticized NGOs involved in interventions with Indigenous women, arguing that organizations are often preoccupied with alleviating the conditions of women, while leaving their disempowered social position and experience of gender-related issues, such as sexual and domestic violence, division of labor, and limited power over reproduction, intact. Barrig argued that such organizations run the risk of maintaining the status quo of gender relations under the presumption that they are cultural traditions which deserve protection.

In the context of this study, however, NGO staff members at ANDI located gender inequality and subordination of Maya women not as a cultural predisposition worthy of being protected and maintained, but as the central contributing factor for health disparity among all Indigenous communities. While many Guatemalan NGOs focused on women's rights have premised their interventions on the idea that Indigenous traditional "culture" is "sexist and in need of reform," most rarely support Maya women as economic actors or as community leaders and organizers (Copeland 2019b:144). I found the programs at ANDI to be an exception in that they trained entire communities in women's rights along with human rights, economic

sustainability, capacity building, and the formation of women community leaders. At ANDI, NGO staff members mobilized rhetorics of women's empowerment in every aspect of their organizational model and structured approach for health intervention.

Organizational Rhetorics of Empowerment and "Doing Good" at ANDI

ANDI describes themselves to the public on their website as a "largely-indigenous organization" that lends "a community-led integrated approach" to the intricate problem of chronic childhood malnutrition through a focus on health, environment and empowerment. To reiterate, as previously described in Chapter 3 ANDI is supported financially by a U.S.-based funding institution and board of directors under the premise of carrying on the mission of community health purported by Dr. Marcelin, the U.S.-born physician who first established Fundación Maya Salud (FMS) in Chimaltenango in the 1960s. In 2005, the board of directors managing financial support for FMS severed ties with the organization and founded ANDI with the intention to advance the original community-led health intervention approach of Dr. Marcelin.

This approach, as outlined on their website, employs three mutually reinforcing arms: community mobilization, infrastructure, and nutrition; each managed by NGO staff specializing in those respective areas. The NGO field staff are described as coming from the same areas in which they work, and who can offer "intimate knowledge and connection to the language and culture" of local communities. The organization touts that this approach focuses on "community-driven solutions" that mobilize Maya communities to acquire skills necessary for advancing their own development processes where the state is notably absent. The first arm, community mobilization, involves a program for the empowerment of women and youth through trainings, leadership building, and communal activities. The infrastructure arm involves increasing water

access and sanitation by assisting with community drafted proposals that seek the support of local municipality officials to plan and coordinate communities' specific self-identified projects. ANDI staff supervise and mentor community members leading these infrastructure projects until their completion. Lastly, the nutrition arm involves improving food security through programs for sustainable agriculture techniques and storage, nutrition and health education, and family planning education and methods. Through these three strategies, ANDI describes their overarching goal as tackling the "root causes" of malnutrition while asserting that 'empowerment' is the central unifying component to the success of all of their integrated programs.

Empowerment is described as the guiding framework for the NGO's work. In a strategic plan report outlining their organizational projections for 2018-2023, drafted in English with their board of directors, ANDI administrators define their organizational understanding of empowerment as such: "Empowerment takes place in the personal, social, political, and economic spheres. For our purposes, we may define empowerment as "[T]he process by which those who have been denied the ability to make strategic life choices acquire such an ability." Yet while ANDI represents this approach to health as empowering whole communities, within this same document it is evident that their focus is primarily centered on the empowerment of Maya women, as the report describes:

> *When we talk about the empowerment of women and youth, it can be first understood in the context of their homes where the power generally resides with the husband/father. Empowering women in this context can include the dimensions of resources (pre-conditions), agency (process), and achievements (outcomes). These dimensions address the questions of: (pre-conditions) equal power and access to or control over material, economic, and social resources within the home which may take the form of mobility and shared decision-making for major issues such as the care of children; (agency) decision-making powers over household expenditures and reproduction, as well as addressing gender rights and domestic violence; and (outcomes) the ability of women to make choices, whether that be in the form of determining how to use their free time, advocating*

> *for their needs to be met at the community level, and/or participation in local committees. Women's empowerment will be integrated into activities related to improving the nutritional situation of the family and will include topics such as gender equity and self-esteem. The goal is for women to realize their agency so that they can be primary actors of change in their own communities through attaining and exercising shared power within the public and private spheres.*

ANDI's goal is to address the "root causes" of malnutrition and, as evident in the above excerpt, promoting agency, personal autonomy and improving outcomes for Indigenous women are at the heart of each of the three arms of their strategy. The empowerment of women is thus what glues each NGO worker's respective "integrated" work together. This is further echoed on their public website:

> *When women achieve autonomy in the home, and when a community has a sense of power over its future, then the integrated components come together. This paradigm shift in the minds of the women, youth, and men in the community is what results in long-term improvements to the health and wellbeing of the community.*

Moreover, as a largely Indigenous organization with staff members from the very communities in which they work, ANDI situates this need for empowering women within the historical context of the marginalization of Maya peoples in Guatemala. With undertones of solidarity and activism, the organization wrote publicly:

> *Centuries of social, economic, and political exclusion have left Mayan communities in a disadvantaged situation of chronic, grinding poverty. As people organize, they become agents of change in their communities: they can create effective relationships with their local governments, address their lack of access to basic health services, and stimulate environmental changes that impact their health and well-being. The ability of women to control the number and spacing of their children is an example of powerful decision-making that results in autonomy for women and creates healthier families.*

Thus, ANDI's organizational understanding and framework for empowerment intervention is not only steeped in the enduring institutional legacies of women's empowerment within the NGO and development sector, but also within the specific historical context of marginalization of Indigenous peoples in Guatemala. Yet, *how* empowerment interventions are

enacted at ANDI, is arguably intimately tied to individual field staff who typically spend at least a year working in their partner Kaqchikel communities. Their everyday work in rural and highland Chimaltenango is the site in which their own subjectivities as both Indigenous Maya citizens and as NGO workers coalesce to shape their understandings and applications of empowerment.

Subjectivity and Feminist Solidarity in Empowerment Work

In my interviews and observations at ANDI, I found that NGO workers frequently invoked aspects of personal identity, indigeneity, and institutional legacy in relation to their everyday work and understandings of empowerment. When asked questions about their own motivations for working at an NGO most described how their positionalities as members of Indigenous Maya communities influenced the work they do in their respective organizations. Some staff used the term "activist" when describing themselves and their work at the NGO. They described feeling like "experts" from their personal experiences and from the enduring specter that poverty, sexism, and disempowerment has had on their lives.

Inez, who has worked in the NGO sector since 2007, described to me how her experiences as a Mayan woman influenced her work in women's empowerment. Her job as a health educator at ANDI is to design health education trainings for women, men and youth in ANDI's affiliated communities covering topics related to nutrition, women's health and human rights. Sitting in a tiny school classroom after one of her training sessions with women from the village of Palima, she told me, "This work has always been important to me. I'm from a community like Palima. It's so important for me to do this. I came from this. If not me, then who?" Like many women who attend her trainings, she grew up speaking only Kaqchikel Maya

and wanted to learn Spanish but said her father was not willing to permit her to attend school as a young girl. She told me,

> *My father was not okay with it. But I told him repeatedly, 'I want to go to school. I want to study. … [Education] changed my life. …. And now my dream is that women participate, that women are activists, that they know they are powerful. I imagine them speaking out and making decisions without fear. … My experiences made me passionate about my work. Life is for developing, life is for growing.*

Similarly, when asked why her job in health education at ANDI was important to her, Sofia, a 34-year-old Kaqchikel family planning coordinator told me: "…The farthest communities… are very poor. There's no medicine. There's only one nurse covering [the health post]. This shouldn't be. She said that as an NGO worker and as a Mayan woman, "I've lived it in my own flesh," emphasizing to me, "[I have] more resources and a better chance of reaching communities [than the state.]" She went on,

> *No one else does it if I don't. No one else does. … [Women] are the ones that suffer the most. My main goal is to support them so that they can change their lives one day and have a better future for their growing daughters, because without anyone to give them this education… all their offspring can be said to follow the same path. … One of the main challenges I have is to empower women well, because in them is the change. Women are the main actors within the community in the sense that a whole family depends on them. We* [pointing to herself] *are not just one person.*

Beyond such a sense of community obligation, others also described feeling compelled to take on roles outside of their ascribed job duties. As Paola, a 39-year-old social worker and health educator described, "I'm [also] being a psychologist, a doctor, a marriage counselor, I'm everything." She continued, "it brings me closer to communities … Because women create a bond with someone who they feel confident to talk to about things, and who also gives them confidence." Feeling like a 'psychologist' was echoed by Inez, who told me,

> *When I talk about abuse and violence against women, I always play the role of the psychologist. Women talk to me, they show me their bruises, they cry with me, they tell me everything. It's good that they have the group and feel that they can talk about it in*

> *front of them. They cry in front of each other about what has happened to them. Sometimes for the first time ever. It's hard. They are always silenced. They can't speak about these things*.

Inez tells me that during one of these training sessions a woman came up to her and told her "You made me value myself and now I'm changed. I express myself. I talk. I care about myself. I am who I am." Inez went on, "hearing words like 'you are beautiful' 'you are valuable' 'you are strong' 'you are intelligent' animates them. They never hear those things from anyone. You have to have passion, you have to care. That's all it takes."

For these women and others, their everyday work and applications of empowerment were intimately tied to their personal identities and manifested in feelings of responsibility. Echoed in the words of the women above, is a strong sense of obligation and responsibility, especially toward other women. In the accounts discussed above it is evident that they see themselves in the women living in their partner communities. The concept of subjectivity thus illuminates how individuals, like Inez, are concurrently agents of knowledge and of action. For these women, enacting and designing meaningful empowerment interventions draws from their knowledge and personal experiences as Mayan women. Yet more than this, their connection to other Indigenous women, reinforced by their own self-reflections and actions, permeates a logic of feminist solidarity; that they, as women who have lived similar realities to those they serve, are uniquely qualified to do this work.

Subjectivity and Institutional Legacies of Empowerment

While workers unique subjective experiences imbued them with feelings of responsibility, they also came to understand themselves as potent transmitters for the rhetoric of women's empowerment. As previously described, for many years the NGO sector in Guatemala has been inundated with imported "Women in Development" initiatives, promoted by various

funding agencies, and international development institutions like the UN and WHO, that locate women at the center of sustainable development. In this study, this institutional legacy of "empowering women" was clearly evident within the strategic intervention models at ANDI, merging with worker's subjective and personal experiences to shape their understandings and enactments of empowerment.

As mentioned above, ANDI most often works with partner communities and villages for a year working toward improving chronic malnutrition through a multi-faceted approach that focuses on health education, women's empowerment, and community infrastructure changes in water and sanitation. It is this "integrated" approach, as staff members at ANDI would often stress to me, that makes the difference. While these various programs are envisioned by leadership at ANDI as a mutually reinforcing approach that empowers communities to reduce chronic malnutrition, I found that the emphasis of these interventions is quietly directed at women and their place in the community. While discussing her health education trainings with me, Inez described this process to me, saying,

> *This is a slow process. It takes time. To be honest, one year isn't enough with these women. When I first start these trainings and I ask women 'Do women have rights?' All of them say, 'Yes!' But when you ask what those rights are, the women don't have an answer. They don't know what they are. … I do an activity where I ask the women what happens to kids if you have a boy versus a girl. They respond that boys can get professional jobs. But when it comes to girls, they say 'girls make tortillas.' I always question them, 'why do you think girls can't get professional jobs too?' The trainings have to be participatory otherwise women will be worrying about all the things they have to do at home. All of their responsibilities. If I am just lecturing at them, they will begin to think about these things. Or focus on how tired they are. You can't just do speeches at them.*

As a Kaqchikel woman, Inez is able to recognize the quiet, underappreciated labor and subjugation of the women she convenes with in her training sessions every week and her participatory approach to designing her educational intervention reflects this. As her words

illuminate, Inez acknowledges that simply telling women they have "rights" to health and equality means little in relation to the realities of their everyday lives, where the odds of realizing these rights is largely unfeasible.

It was not only women like Inez who felt such obligation to Maya communities, these feelings of responsibility were also expressed by men working at ANDI as well. Omar is a 30-year-old Kaqchikel Maya health intervention project manager whose job is to ensure that various projects at ANDI, including women's health education like trainings provided by Inez, men's masculinity training, and food and sanitation projects, are "integrated" to empower women. When asked if he felt obligated to do this work, he said,

> *Yes. Very responsible. … I grew up in a humble family, a poor family. So I have felt the same limitations that exist within these families and the few opportunities for development that can come. I identify with them, with the people that have needs, and I have to help them. You have to help them see what they could be.*

For Omar, his experiences growing up in a poor Kaqchikel family solidified his connection to the communities he serves, while instilling an urgency to help Mayan families "see what they could be" and change their socio-cultural and economic circumstances. At ANDI, this resolve to transform communities in this way is grounded in Guatemala's realities of gender-based social and cultural inequality. For example, Martín, a 32-year-old who works with Omar designing men's masculinity trainings told me that, "in the patriarchal system of Guatemala, we men are taught to make the decisions, [and] women are on a second level." He said that his job is to help men unlearn this. When asked why this work was important to him, Martín immediately linked his work to the disenfranchisement of Maya women. He said:

> *Women haven't been empowered. To empower is to give power to people who don't have it, and equity, and balance. … So now all NGOs are 'empowering' women, for example, in economic power, but that's all. But imagine, if we do not sensitize the man who comes from a culture of decision-making, and that no one comes for him in his house—she is*

> *empowered, but he doesn't change his attitude. So we are also neglecting the other part. In health it is the man who decides. They say "yes" or "no" to everything.*

Here, Martín critiques existing institutional legacies within the NGO sector of empowering women as inadequate. By focusing on economic and financial interventions, such as the increasingly popular cash-transfer programs or microfinance initiatives, they fail to address enduring colonial legacies of *machismo* and patriarchal socio-economic control. For him, addressing these factors is essential for empowering women, and it is the driving force behind how he designs his masculinity trainings. While men attending Martín's trainings cover a range of topics including, health education, learning valuable skills, and establishing localized leadership, the undertones of these trainings is often subtly oriented around women.

I observed one of Martín's masculinity education trainings in Tecpán with a group of fifteen Kaqchikel men who were near the end of their year of interventions with ANDI. He asked them to develop a strategic "action plan" for community development projects respectively related to water, youth, women health promoters, and boys and girls, that they wanted realized in their community (see Figure 2). Martín asked them, "What do you plan to do as leaders in the community? What do you think you can do together?" He then asked the men to fill out a large sheet of paper answering questions like, "What can we do? From whom do we need support? What do we need? [and] When can we accomplish this?" As the men worked in groups to brainstorm their ideas for a strategic plan, Martín tells me, "The idea is to get them to continue to be community leaders and support women after ANDI is gone." In instructing men to assign important leadership tasks to women and youth, Martín told me he hoped the activity would instill in the group the value of perspectives outside of the male leaders of the community. In this example, Martin's approach toward training Mayan men illuminates his centralized goal: improving the outcomes and status of women in the community.

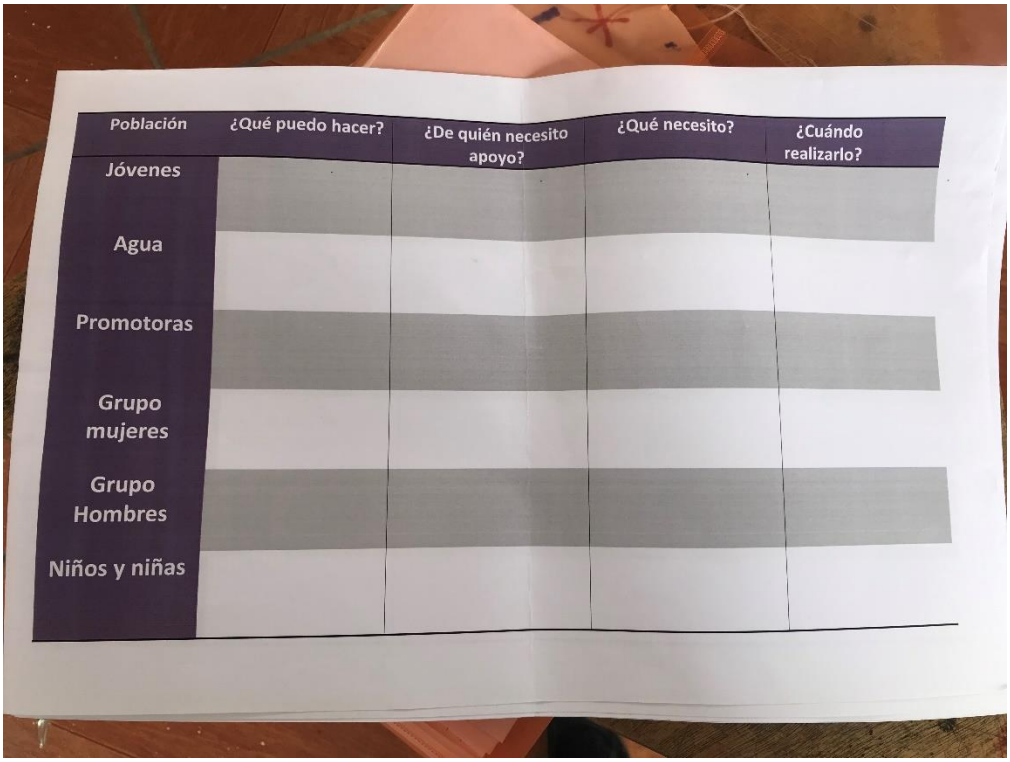

Figure 2. Men's "Action Plan" Activity
Image of Martín's strategic "action plan" shared with the men's group during a masculinity education training in Tecpán in 2019. "Youth, Water, Health Promoters, Women's Group, Men's Group, Boys and Girls" (left column). "What can we do? From whom do we need support? What do we need? When can we accomplish this?" (top row).

Getting community support for the empowerment work at ANDI that Martín and Omar felt was important "took years," explained Nicolás, ANDI's executive director. Nicolás had worked in the NGO sector for nearly 20 years, including working for major institutions like the United Nations. He told me that getting their board of directors and funding agencies to support empowerment interventions beyond direct health interventions with women and communities was extremely hard. He went on,

> *I had to explain why. Most NGOs go to the communities, and if they are focused on malnutrition, they provide food. Or they leave the skills with women to feed their children properly. But you need that part of empowerment, that means that women feel responsible for the community development and for resolving all the problems that they have in the community. … Not that they feel that they have to do it because [we are] in the community saying, "Look you should be doing this." So that women, after our*

interventions are over, feel very empowered about nutrition. … Women are still doing [it], chronic malnutrition is being reduced, even without our support.

In the same vein as Martín's critique of NGOs, ANDI's director, Nicolás notes that institutionalized legacies in the sector, that simply provided women with nutritional supplements and knowledge, are unsustainable because they fail to tackle chronic malnutrition. He told me stories about when ANDI was first founded, critiquing his own tendency to do whatever the board of directors and funders suggested, saying: "It wasn't clear what our main focus was, and our staff were quite lost. … And when [things] didn't work our donors complained … So we changed our board's mind about this and then we really focused on what we know how to do," which he identified as health education and community empowerment. For the director of ANDI, the empowerment of women is the glue that truly "integrates" the programs at his organization. Thus, while the NGO sector at large may maintain particular problematic legacies toward women's empowerment, for Nicolás, the skills, insights and personal sense of responsibility from his NGO staff make the difference in doing sustainable empowerment work.

While these NGO workers clearly buy into the overarching rhetorics of women's empowerment within the NGO sector, their understanding and enactments of what it means to do empowerment work is filtered through their own subjective realities. For these NGO workers, empowerment is intimately tied to their own personal experiences that challenged legacies of women in development strategies which they felt were insufficient. For the NGO staff members at ANDI, designing health interventions for Mayan communities entails the acknowledgement of the social inequality of rural Maya peoples. But more specifically, it entails acknowledging the subjugation of Indigenous women, and recognizing women's central role in the wellbeing of future generations, and "empowering" both women and men to make inclusive decisions about their community.

Discussion

In this chapter, I have demonstrated that NGO workers can simultaneously operate as individuals with personal and lived connections to the communities in which they work and as actors engrossed in institutionalized rhetorics of empowerment prevalent within the NGO sector. In understanding these characteristics as unique and competing subjectivities, I have argued that such subjectivities impact how workers enact their roles in health intervention and shape their understandings of empowerment. Thus, subjectivity is a valuable site for understanding processes of development "from below."

Subjectivity is the site in which historical processes and social moralities meet, merge, and blend. Not only is subjectivity an empirical reality but a means for understanding the ways in which culture is "constantly remade through social encounters, ethical deliberations, [and] political processes" (Biehl et al. 2007:7). As Biehl, Kleinman and Good suggest, "the subject is at once a product and agent of history; the site of experience, memory, storytelling and aesthetic judgment; an agent of knowing as much as of action; and the conflicted site for moral acts and gestures amid impossibly immoral societies and institutions" (2007:14). While it is widely accepted that NGOs' activities are intimately shaped by external forces, such as state policies, global development agendas, and funders and donors, as outlined in a previous chapter, NGO workers should not simply be understood as neutral vectors at the whims of such forces. Instead, they possess varying skills, experiences, identities, and understandings of social problems, that ultimately shape how interventions are implemented from below.

In trying to understand the ways worker's competing subjective realities shape their understandings and enactments of empowerment, I've found that NGO workers in this study take up institutionalized rhetorics of women in development yet do so through the lens of their own

lived experiences and identities. As Bourdieu (2003) would argue, to be a collective part of an institution, like an NGO, requires one to "become what you are'" (2003:122). Yet Bourdieu argues that individuals become who they are not based on "personal conviction or pretension… "but rather on the collective belief, guaranteed by the institution" (2003:125-126). Yet, I would argue that in the context of this study, personal convictions merge with the convictions of the institution of the NGO to shape worker subjectivity and identity. These subjectivities ultimately shaped NGO understandings of empowerment, and in the context of this study, specifically toward a notion of empowerment invested in feminist intervention that aims to render poor and Indigenous women as targets for self-advancement. Yet the application of this notion of empowerment was rendered complex by the fact that workers were simultaneously products of the realities they felt responsible for altering. Thinking back to the vignette at the beginning of the chapter, Inez's human rights puzzle training demonstrated her belief in the message of the NGO—that women should be empowered to recognize their "rights"—yet her application for doing so was immersed in her own personal experiences as a woman who lived situations without those rights. NGO workers like Inez are entangled in a context that merges her competing institutional and individual subjectivities. Women's empowerment has been a longstanding primary objective of the UN development goals for years, which is rhetoric the NGO sector has been immersed in for decades. Utilizing puzzles in her training that underscore the notion that women have fundamental human rights aligns with such institutional discourse. Inez never told me where she got these puzzles from, but I assumed they came from these agencies. Nonetheless, she filtered their utility through her own subjective interpretation in ways that spoke truth to the realities of the Indigenous women in the school classroom, including herself.

Studies in the anthropology of development have notably focused on notions of agency, wherein the mundane everyday activities of development actors, must balance the social logics of their development interventions with that of their target groups or communities (Kalman 2017, Mosse 2005, Pigg 1992, Shepard 2003). As Veronica Schild (2014) suggests, health interventions—like those described at ANDI—"target families" or communities, "but focus on women" and the ways gender inequality can be remediated on an individual level (2014: 285). The "catch" she proposes, is that such approaches play to women's commitments as caregivers and mothers and that "women are appealed to as autonomous citizens and expected to continue to provide care plus bear the responsibility for pulling their families out of poverty" (Schild 2015: 558). Yet, while some may sum up such interventions as reflections of social policy trying to make impoverished women over as "neoliberal citizens," a consideration of the subjectivities of local actors involved in implementing such interventions illuminate that the enactment of empowerment work is much more nuanced than that. The feelings of responsibility that can emerge from the subjectivities of local actors who see themselves as fighting at the side of those who have been unjustly dealt, to transform their objective reality, also begs to question if such applications of empowerment should also be understood as reflections of social solidarity.

Anthropologists' work in NGO studies have shed light on how these organizations increasingly play important roles women's rights, and how they operate as gendered spaces wherein women are fashioned as subjects for intervention (Bernal and Grewal 2014b, Beck 2017a, Merry 2016, Bernal 2017, Ong 2011, 2006). Yet, attention to those involved in designing such interventions considers the roles that personal experience and subjectivity may have in why NGOs can become so intimately engrained in gender issues. Costa (2014) questions how and

why NGOs serve women, calling for more nuanced understanding of "feminist solidarity" (2014:186).

Subjectivity can play an important role in how NGOs are reshaping feminism in the context of development. NGO workers balancing their own personal socio-cultural experiences with institutionalized rhetorics of empowerment ultimately influences how women's empowerment is enacted. It is worth questioning how much of ANDI's feminist empowerment framework is truly "Indigenous" and Mayan, and how much of it emerges from larger institutional and international development discourses about gender inequality. For workers at ANDI, their approach demonstrates the specific ways that community mobilization is interpreted as empowerment. This contrasts with women in development initiatives that tend to focus on women's entrepreneurship or individual improvement through education as core tenants of what it means to "empower" women. At ANDI, community mobilization entails an interrogation of the domestic power and decision-making dynamics within the Maya community. Moreover, ANDI's approach may be a vestige of community participatory and self-reliance frameworks supported during the Pan-Maya Movement, a movement in which the original founder, Dr. Marcelin, was engaged. As discussed in Chapter 2, the movement had significant influence on the NGO sector, as Mayan intellectuals found places of leadership among grassroots organizations and non-profits. Dr. Marcelin's long history in the Kaqchikel Maya community during this time period likely influenced his view that 'development' requires "measures that create and activate a community, rather than leave it passive and waiting." Such understandings still permeate the overarching mission of ANDI today. While the decision to focus on gender inequality is in line with larger institutional models and rhetorics of empowerment with which

contemporary NGOs like ANDI are immersed, ANDI's work is arguably more a manifestation of the Mayan reality, history, and the experiences of the NGO workers themselves.

It is through such reflexive forms of intervention—where individuals negotiate and apply the competing realities of their lives—that solidarity emerges. Paulo Freire (1970) would describe individuals like those in this study as "converts"—those who take up particular ideals about supporting the oppressed, and who believe enacting those ideals to be acts of solidarity. Yet, individuals do not take up certain social and institutional rhetorics, discourses, and calls to action in and of themselves. People take up these messages because there is something about them that speaks truth to who they are. In interventions like those at ANDI that are education-based, such solidarity emerges because such approaches contain a socio-political essence—what Freire calls "politicity". As Freire describes,

> *Education cannot be just technique because education has as a characteristic, another quality, that I call politicity. The politicity of education is the quality that education has of being political. And one principle related to this quality is that education never was and never will be neutral.* (Freire 1970: 25).

For the individuals at ANDI, the enactment of empowerment work and their focus on Indigenous Maya women is thus not a neutral decision. Instead, it is based in their own lived experiences, identities, abilities, and their subjectivities as Indigenous citizens and actors operating in the institutions of NGOs. Merging notions of solidarity with subjectivity may help us to understand why individuals can become so convinced that their beliefs and actions constitute true social goodwill—that they are, in fact, "doing good."

This chapter has described the ways in which doing good at ANDI's involves a distinctive focus on empowerment, that is both engendered and endorsed by the unique subjectivities of their NGO staff members, their organizational approach, and their funding

structures. In the next chapter, I contrast this social justice approach to health intervention against the context at Fundación Maya Salud.

Chapter 5: “If There is an Activist Here, I'll Fire Them!”: Managerialism and Bureaucracy at Fundación Maya Salud

Sitting in the medical director's office at Fundación Maya Salud, Dr. Chavajay tells me that after the cancellation of the Ministry of Health (MSPS) contracts with NGOs, "the people were abandoned. They have no options but to go to the public hospital for care." "But [the system] is in crisis," he says, expressing it is not just the lack of resources and medical supplies, but a lack of knowledge about the pervasiveness of health inequalities among Indigenous communities that contributes to the crisis. Dr. Chavajay tells me most people think doctors and nurses are at the top of "the pyramid" when it comes to the structure of the health system. He draws a triangle on a piece of paper with different levels: Doctors at the top, followed by professional nurses, technicians, and auxiliary nurses. Pointing firmly at the top of the drawing he says, "most doctors and nurses don't have interests in changing the inequalities of the system, they just focus on doing their jobs. They aren't political." Sounding very frustrated he says that even his own medical staff, "don't really know. They know the general problems in communities, but they don't know the public health statistics. They go to schools that are so specific. They don't learn all the requirements to understand the social issues. There is so much corruption in these schools. The government doesn't want medical personnel to question social problems." Dr. Chavajay goes on, "People tell us all the time 'Help the poor! Go to the rural areas!' But that was a reality when [our founder] was alive and FMS had international donors." He says back then, during the 1970s until the early 2000s, FMS had lots of volunteers working on community participatory health interventions, water, and agricultural projects. "We can't do that now," he says, telling me that currently they are solely concentrated on maintaining "financial stability," focusing their energies on performing surgeries, selling pharmaceuticals, renting out unused areas of their medical complex, and seeking financial partnerships with state institutions. Looking up at a black and white photo of the founder, Dr. Marcelin, on the wall behind him, Dr. Chavajay reflects on his former medical director, who died in the 1990s, telling me he is the last person here to have known him personally. "He would die of a broken heart" he tells me, "the Doctor was adamant about not doing surgeries at all. He always said, 'it's the responsibility of the state to do this, they have plenty of resources." But, he explained, because of privatization the government diminished money for healthcare many years ago. With bloodshot eyes welling with tears, Dr. Chavajay tells me defeatedly, "this is where we are now. How the times have changed."

-Field notes, from an interview with Dr. Chavajay at Fundación Maya Salud (FMS), May 2019

Introduction

In so recounting the complex history of the organization, Dr. Chavajay, the director of Fundación Maya Salud (FMS), describes its trajectory over time with both a feeling of heartfelt nostalgia for a past long-gone, and a sense of irrevocable change. In my meetings with him, the 78-year-old Kaqchikel doctor would often weave together stories of the Fundación's original work in rural communities in Chimaltenango, his favorite memories of the founder, and his "big ideas" for community projects that never seem to become a reality. It was evident in our discussions that Dr. Chavajay imagined an ideal version of his organization, one that realigned with community participation and empowerment work. Instead, the realities of how FMS had evolved in relation to their complex relationship with the state and funders, made realizing this ideal unattainable. While the administrators and NGO workers at Asociación para Nutrición y Desarrollo Integral (ANDI) have carried on the community empowerment focus of Dr. Marcelin, the original founder of both of these organizations, FMS bears little resemblance to the original organization once founded in the 1960s. In comparing the work conducted at both NGOs, I found myself asking: How can two organizations with the same founder, the same foundational missions and goals, serving the same communities, and who both employ Indigenous staff from the very communities in which they work, approach health interventions in such different ways? In trying to understand the central question of this dissertation—how NGOs continue to perform health interventions amidst a shifting socio-political climate—this chapter focuses on where the community empowerment and health activism at FMS has gone and why.

As discussed in detail in Chapter 3, ANDI and FMS share a unique history in that they both claim to share the liberationist vision of Dr. Marcelin, the U.S.-born medical doctor who first established FMS in Chimaltenango in the 1960s. Shortly after FMS pursued PEC contracts

in 2005, the board of directors managing financial support for FMS, decided to create ANDI. Essentially, ANDI emerged as a new take on FMS, founded under the notion of advancing the original principles and empowerment vision of Dr. Marcelin. As such, both NGOs lay claim to Dr. Marcelin as their "founder" and originator of their liberationist agenda. While, (as discussed in Chapter 4), ANDI's focus on empowerment is generated and endorsed by the unique subjectivities of their NGO staff members, their organizational approach, and their funding structures, FMS' approach to health intervention is quite different. Unlike ANDI, which is privately funded, FMS relies on pay-for-service revenue and state institutions for funding. In this chapter, I argue that as a result FMS is defined by a complex relationship with state institutions, which have immersed the organization in a context preoccupied with bureaucratic tendencies that over time have valued managerialism over a social justice focus on community empowerment.

Managerialism and Bureaucracy in the Context of NGOs

In the context of NGOs, managerialism refers to practices of organizational governance that are marked by concepts such as accountability, transparency, project evaluation, extensive bookkeeping, strategic planning, and self-assessment (Roberts, Jones, and Fröhling 2005). Some have argued that these practices can become the focus of the organization such that "managerialism has become a central daily concern for staff" (Roberts, et al. 2005:1849). The result is often the creation of a "report culture" (Mawdsley, Porter, and Townsend 2000) burdened by bureaucratization, accompanied by a retracted focus on the missions and objectives on which the NGOs may have been originally founded. Anthropologists studying NGOs have shown how relationships with the state can instill bureaucratic practices within the NGO sector (Bernal and Grewal 2014b, Bawole and Hossain 2014, Vannier 2010, Lewis 2014, Alvaré 2010). Bernal and Grewel (2014a) have argued that collaboration and relationships between government

institutions and NGOs highlight the "trevails of the state in the neoliberal present" as they manipulate NGOs to possess more professional "state-like" bureaucratic practices (2014a:302-303). Bureaucratic managerial practices and knowledges associated with organizational management have also become a means for NGOs to demonstrate greater legitimacy and show that their actions are necessary, important, and validated by the state (Appe 2016, Bawole and Hossain 2014). Managerialism in this sense reflects the Weberian notion of bureaucracy wherein "the advance of the bureaucratic structure rests upon 'technical' superiority" evidenced by "a 'rational' character: rules, means, ends, and matter-of-factness" (Weber 1946: 228; 244). Individuals in this study at FMS, who may very well want to initiate social change or social justice, operate in a context that is resistant and even repressive to that change as business-oriented bureaucratic tendencies have withdrawn their institutional focus on community empowerment.

Organizational Structure and the Shift Away from Liberationist Agenda at Fundación Maya Salud

In order to understand the shift away from a community empowerment focus at FMS, it is first essential to explore the historical legacy and framework of the liberationist agenda that had been at the heart of the organization. The central mission of community empowerment can be traced back to the original founder, Dr. Marcelin. What follows is a discussion of the history of empowerment work and ideology at FMS, and how the NGO had been able to maintain this vision.

"Into the Hands of the People": A Brief History of Community Empowerment at FMS

In 2014, a community health project coordinator at FMS gifted me a copy of a publication from the 1990s curating a collection of personal essays, drafts, photographs, journal entries, and transcribed interviews and lectures from their original founder, Dr. Marcelin. The

entries in this text are dated from 1962-1990, and primarily center around reflections of their interactions with Kaqchikel Maya communities, the meaning of "development," and the role of the NGO as a healthcare provider. This collection provided me with the original ideological foundations upon which both FMS and ANDI stand. In analyzing this collection, I will focus primarily on how the founder framed empowerment and community participation in health as the central goal of FMS.

In an entry from 1974, Dr. Marcelin writes that the Kaqchikel "are a very biophilic race." This word choice connotes the image of a people who are innately tied to their environment around them; a people who are deeply and emotionally bonded to nature and their community. This somewhat romanticized notion of community and Indigenous connection the earth is consistent throughout the collection and is a reflection of social thought of the time. The Kaqchikel Maya communities are consistently represented as being entirely community-driven. With attention to repetitive descriptors, I found frequent use of phrasing including: "community participation," "doing things together," "community oriented" and "community involvement" to describe Maya communities affiliated with the NGO. For example, an entry from 1971, the founder writes,

> *…[Kaqchikel Maya] understand and love themselves, know and care for one another, and have a natural sense and feeling for the web of life that binds the earth, humans and God together. Though these qualities are socially acquired, they seem almost natural and often appear to exist as do the digestion of food, the rising of the sun and the flowering of the bud.*

The founder contended that because of their cultural disposition of connectedness to nature and to each other, Kaqchikel communities are "capable of resolving their own problems if given the opportunity." In his vision Dr. Marcelin implored those at FMS to understand "patients as agents" of their own health and development. This view of Maya subjectivity as having a

community-oriented approach towards life was influential on the NGO's original vison of what improving health and enacting "development" should entail: a dedication towards community empowerment. As such, the organization long supported a social and economic justice and empowerment focus, centering their efforts on integrated community-led development projects in agriculture, water infrastructure, and land reform, as well as training community health workers in preventative medicine. As Dr. Marcelin wrote in 1990,

> *Many health programs look good on paper but fail because they have been designed solely by professionals. It is different when the indigenous people work on their own terms, learn from their own failures and build on what they themselves have done. This is what "development" is all about.*

For the founder, "development" was intimately tied to community participation, involving "learning," "building" and "failing" alongside communities. It also entailed bring critical of "professionals" and "experts" implementing decisions "from above." In a lecture from 1982, he stated,

> *The concept of "development" should be reexamined. Great allotments of time, paper, food and jet fuel have been expended in development efforts, often with little lasting effect. Clean water and malaria control may help diminish diseases but do not in themselves furnish the tools and procedures for building a health promoting society. Genuine development requires creative processes that encourage both self-reliance and a sharing of available resources. The point is to seek measures that create and activate a community, rather than leave it passive and waiting.*

From excerpts like these, it is evident that Dr. Marcelin, whose liberationist ideals shaped both FMS and later ANDI, had a deep understanding of how community empowerment was an imperative approach for providing health interventions in Kaqchikel communities. The founder understood their role, as well as the roles of NGO health promoters and medical staff, as enablers of self-reliance who passed "basic knowledge and initiatives, tools, decision making and organization… into the hands of the people." In its early days, FMS operated under the belief

that merely providing curative medicine and biomedical services did little to address the deep-rooted cultural and socio-economic factors underlying poor health in the Maya community. Yet while this organizational legacy has continued at ANDI as evident in Chapter 4, at FMS this dedication to community participation and empowerment today exists mostly only on paper, as a nod to the legacy of their original founder.

Figure 3. Community Health Training with Dr. Marcelin
Image of Dr. Marcelin, the founder of FMS, meeting with Kaqchikel community leaders during a health promoter training, circa 1970. Photograph from FMS.

"Maintaining the Vision": PEC Contracts and the Managerial Shift at FMS

Sitting in a conference room at FMS one morning, Juan Luís, a Kaqchikel project manager who has worked at the organization for over 10 years, told me FMS has tried its best to maintain the "vision" of the founder over the years. However, he said that the NGO today is predominantly focused on its financial stability and now depends on pay-for-service care, saying: "currently most of our resources, our funds, are from the consultation services, hospitalizations, drug sales, laboratory and x-rays." Notably, some of these services were not offered by FMS in the past, or when they were, patients were never charged for them. When asked if he felt the organization had changed much over the years since it was founded, Juan Luís smiled and sighed while looking up at a large map of the Indigenous villages of Chimaltenango saying, "Not philosophically, but practically. The institutional philosophy, the goal, is the same. It's the same vision that [our founder] had, it has not changed much."

The practical changes that Juan Luís alluded to, I had learned, stemmed from the organization's association with the Ministry of Health via the *Programa de Extensión de Cobertura* (PEC) contracts they received from 2004 to 2014. As previously described in Chapter 3, the PEC was a health policy for delivering a basic healthcare package to the most marginalized via state contracted NGOs. During this time, the NGO received numerous PEC contracts from the Ministry of Health to monitor and provide health services to rural regions in the departments of Chimaltenango and El Quiche. By the end of the PEC program, FMS was one of only 11 NGOs in Chimaltenango, receiving contracts for 20 municipalities. While many of the current staff were not employed at FMS during this period, long term administrative staff and board of director members I interviewed indicated that during this time FMS maintained their core mission of empowering Indigenous communities by bringing health services and health

education to rural Indigenous communities. Juan Luís saw value in this approach, saying that with the PEC contracts,

> *...We were committed to serving the most needy population. It was a good program because we brought health to children, to women, and we had cases where the patient was not allowed to die. The team monitored and took women to the hospital, even from the mountains; …. If children and women did not reach the Centros de Salud or Centros de Convergencia, our staff's obligation was to go to their home and make it possible, to give control to the pregnant woman, to give her vaccines; to go to their homes*.

The notion that the PEC contracts allowed FMS to continue the vision of their founder was echoed by others including, Faustino, a Kaqchikel community health project coordinator, who had worked at FMS throughout its PEC contracts. On multiple occasions, Faustino described the PEC as a "beautiful program." He told me, "[Dr. Marcelin's] vision of being able to support Guatemala's most needy people, that is the strategic planning of the foundation, that approach. So that's why we do a lot of coordination with state institutions to be able to support them." When pressed as to whether he felt this vision was still being realized during their years with the PEC, Faustino replied enthusiastically that this was the so-called 'beauty' of the contracts, saying "Yes, entirely, because we did reach the communities most in need."

For these NGO workers, maintaining the vision of Dr. Marcelin entailed providing services to Indigenous communities. Yet, bringing a basic package of curative and preventative services into communities is notably a transmuted application of the empowerment and community participation work the organization once performed. This was likely due to the managerial and bureaucratic control placed on them by the Ministry of Health (MSPS). As told to me by multiple staff, the PEC contracts demanded significant MSPS oversight and required transparency of NGOs receiving the funds. As Juan Luís explained, "if the Ministry gave us

100,000 *quetzales*[7], we executed it with transparency and with all the supporting documents; and of those 100,000 *quetzales* we were entitled to 10,000." In addition to transparency and detailed accounting, I was told that each month FMS was also required to monitor and enumerate numerous public health goals related to reducing childhood malnutrition, improving child growth rates, increasing vaccinations, and reducing maternal mortality.

These goals were in line with multiple health campaigns triumphed by multiple presidential administrations over the years which PEC-contracted NGOs were required to work toward, including *Plan Hambre Cero* (Zero Hunger) and the *Thousand Days Initiative*, aimed at reducing childhood malnutrition and maternal mortality, and *Mi Familia Progresa* (My Family Progresses) a conditional cash transfer program aimed at improving women's abilities to "act on behalf of their children's health" (Dasgupta-Tsinikas and Wise 2015: 23). The organization was responsible for facilitating health teams in rural communities, utilizing *Centros de Convergencia* where auxiliary nursing staff could provide maternal and infant care, emergency care, medicines, and vaccines, and monitor health conditions and improve access to preventative services. Celso, an accountant who has worked for FMS for twelve years, recalled that part of his job during this time with the PEC contracts was to "go into the communities as such, but rather just for supervision of the teams assigned in those areas." Yet these activities and interventions were a far cry from the original community empowering types of health interventions undertaken by the founder and their health team.

In his ethnographic research on the PEC, medical anthropologist Jonathan Maupin (2015) points out that the minimal health package offered by PEC-contracted NGOs failed to address

[7] About $12,500 USD. At the time of this research, the value of one U.S. dollar in Guatemalan Quetzales was about 8Q.

underlying causes of morbidity and mortality, arguing that "the focus on preventative services, increased surveillance, and basic curative services effectively diverts attention away from identifying the social, economic, and political structures that create and sustain systemic inequalities causing poor health in rural areas" (2015:15). As described in more detail in Chapter 3, the political supports for the PEC program waned over time, and the program was ultimately cancelled in 2015. After the cancelation of their contracts and their funding in 2015, FMS' ability to carry on these activities in any form was greatly diminished. Juan Luís told me that by canceling the PEC contracts, "[the government] is not hurting NGOs but the most deprived population, the most distant population who are not served by the Ministry of Health. …We catered to approximately 100,000 people, and our staff was roughly, including volunteers, about 750." He tells me volunteers typically were local community health "facilitators" and "watchdogs" but that by 2016 most of these groups were completely disbanded. He went on to say, "Now everything is different. A team may arrive once a month to be able to attend to [rural communities], if they have the willingness to do so and if they have the resources, otherwise there is nothing."

Others also seemed to question the shift in 'willingness' and motivation for community health interventions among staff at FMS toward the end of the PEC. Celso the accountant, explained to me that he felt "in the end the staff were being compromised" because their sense of "obligation" to communities was based in their being "accustomed to being supported." When the resources for doing community work diminished, "those services could no longer be carried out," he said. Similarly the director, Dr. Chavajay, said that NGO workers seem to have a sense of 'responsibility' for Indigenous communities only if they receive incentives to do so. He told me, "only if they have financial compensation, but of their own free will, they don't. Only if they

have a salary. Only if they have a salary, because these same workers who, even if they have a social conscience, have no economic resources."

After the cancelation of their PEC contracts, health interventions with rural Indigenous communities in Chimaltenango continued to diminish significantly at FMS. In interviews with staff, I found this fading sense of responsibility for rural communities coincided with a sense of feeling like communities were "abandoned." As the director, Dr. Chavajay explained,

> *We saw that the populations in need were left abandoned without that program. But, the Fundación did not have the financial capacity to continue working with communities. It is sad. It is very sad because they arose again, the diseases, increased malnutrition, increased various gastrointestinal diseases, lung diseases. Yes, it is sad.*

The diminished community work was evident in the NGO's bi-annual fiscal and activities reports. Dr. Chavajay shared with me some of these financial reports from the last 10 years or so. These reports spanned the organization's years in which they held PEC contracts, and the years following its cancellation. The reports highlighted the NGO's income and activities throughout the year. The oldest report I was given was from early spring 2008 and indicated that with their PEC contracts FMS conducted a range of work involving community-based health interventions. For example, in early 2008 the NGO reported that in addition to consultations and hospitalizations at their clinic, teams performed surgery *jornadas* (health fairs) in communities in the departments of Chimaltenango and Sacatepéquez, and the northern departments of El Quiche and Baja Verapaz. They also worked in eight jurisdictions in Chimaltenango and El Quiche, totaling 101 unique communities, where they provided maternal and child healthcare services, nutritional supplementation and growth monitoring, family planning methods, and reproductive health services to thousands of people. They also reported training 511 community members as health "facilitators" to provide health information on topics including vaccines, child growth and malnutrition, and communicable diseases like measles and rubella. Notably, of these community

health facilitators, 122 were Indigenous *comadronas* (midwives), local women leaders who have been shown to hold considerable influence over Indigenous health in some rural communities (Berry 2006, Cosminsky 2016, Cosminsky and Scrimshaw 1980, Chary et al. 2013, Maupin 2008). The remaining reports for 2008 indicated additional sustained community work especially oriented around the empowerment of women and girls, including establishing school scholarships for rural girls and a microcredit and rural banking system in order to "grant loans to organized women to contribute to their family finances." The 2008 reports also indicated that FMS collaborated with other NGOs to construct safer and hygienic homes in rural communities, and was seeking to establish as sustainable community development project "based on law, equity of gender interculturality, local management of risk, agricultural production and improvement of minimum infrastructure housing" that would bring together Indigenous community leaders and local institutions to improve local agriculture. The majority of this work at FMS was made possible because it was financially supported and mandated by the terms of their PEC contracts.

In contrast, the most recent bi-annual financial and activities reports I received were from 2018, ten years later and after the cancellation of the PEC. These reports likewise outlined the NGO's work and income throughout the year. Pouring through the recent reports, I noticed that FMS reported largely providing curative and diagnostic services in-house, with limited *jornadas* in communities outside of their immediate city of Chimaltenango. In the second half of 2018, for example, FMS reported providing consultations, specialist care, hospitalizations, general surgery, and general medicine to a total of 5,706 people. The largest proportion of these patients came from the immediate surrounding urban area of Chimaltenango, while patients coming from highland and rural communities were significantly smaller. While this can be attributed to their

vicinity in the heart of Chimaltenango, the smaller patient numbers in other regions may also reflect the physical inaccessibility of their clinic as well as the NGO's limited health interventions in neighboring local communities. For example, FMS reported conducting only 16 community-level *jornadas* in the department of Chimaltenango: 10 *jornadas* at schools in Tecpán to provide hygiene education and training, and 6 *jornadas* in San Juan Comalapa, to provide nutritional supplements to young children and mothers. In both of these regions, these *jornadas* were performed in collaboration with other NGOs. Beyond these regions, the annual report described no other events or activities that directly brought health services, interventions, or preventative health education to other local Indigenous communities, aside from *jornadas* at the organization for reproductive services, diabetes, osteoporosis, and high cholesterol, in which rural community members would have had to travel to on their own. The report also indicated that FMS no longer assisted in organizing or training community members or *comadronas* as health facilitators in rural Indigenous communities as it once had 10 years prior. Surprisingly, in 2019, when I asked about these community-level health interventions, none of the staff interviewed, aside from the community health project coordinator and the Director, were aware that FMS even performed *jornadas* in these areas.

While the 2008 reports indicate the staff at FMS continued community health interventions at the coordination and behest of the Ministry of Health in accordance with their PEC contracts, by 2019 the majority of staff at FMS did not realize that interventions in community health was one of their main objectives. By the end of my fieldwork in May 2019, the director, Dr. Chavajay expressed that his main goals for FMS were to increase monetary revenue by expanding the pharmacy, renting unused offices as storefronts to the public, and establishing their own private health insurance scheme for the community to buy into. While

their founder, Dr. Marcelin, organized FMS under the notion that curative biomedicine and clinic-based services did not address the roots of poor health in the Maya community, maintaining this vision faded amidst the organization's funding structure and relationship with the state. This irrevocable change over time, shifting attention away from community activism and empowerment, was further reflected in my interviews with staff at FMS.

"When Will NGOs Return?": Financial Constraint, Responsibility, and Anti-Activism

In contrast to ANDI, in my interviews with administrative staff and medical personnel at FMS, I found that discussions about empowerment and activism were notably absent from our conversations about their everyday work despite the organization's long history in community participation in health and many years of PEC contracts. Here NGO workers instead described in great detail the mundane activities of their everyday work, from nursing duties, to filling prescriptions, to accounting. By and large, staff at FMS understood their role in the community as limited to their specific job duties within FMS. In essence, they understood themselves as healthcare providers to citizens of Chimaltenango, namely those who had the physical, logistical, and financial ability to walk through their doors for consultations, emergencies, and other health services. Although they had originally operated similarly to ANDI many years ago, FMS now resembles a health clinic operating as a business more than an organization focused on community participation in health. At FMS I found that while staff and administrators possess the experience and skills to do community level health interventions, they overwhelmingly described being constrained by the NGO's financial structure and by the state.

From interviews, I learned that many of the staff at FMS had had experience working on community level projects elsewhere, either in past jobs with other NGOs or with municipal health institutions, and many of them described feeling like experts in the field. However, at

FMS, this experience and ability to conduct community level work was limited by the current demands of the NGO structure and funding, and by limitations imposed by the state.

Juan Luís, the health project manager, was particularly well spoken in terms of how the change in funding affected FMS' ability to continue supporting Indigenous communities. In relation to his job designing community health interventions and *jornadas* he described how this shift in funding impacted his capacity to design and direct meaningful preventative community health projects like he had in the past. Like other administrators, he described that after the cancelation of their PEC contracts with the Ministry of Health, FMS's work in Indigenous rural communities largely ceased altogether. Only a small fraction of the organization's finances were allocated to his work, and Juan Luís told me multiple times how much he and local community members wished the PEC would come back. He told me,

> *In communities, people ask us "when will NGOs return?" In Chichicastenango, in Chupol, San Pedro la Laguna, San Martin Jilotepeque; San Andrés Itzapa; Tecpán Guatemala. We've been called by the community. "When will they start the program again?" they ask. Unfortunately, there is no political will. The current government does not know 100% of the benefits of this program. To the government and the Ministry of Health, NGOs are cardboard… Our program was a preventive program. When prevention is over in communities, they no longer arrive at the health center, but come to fill hospitals instead…. There are no resources, so we left our communities, with great sadness. Children and mothers were neglected.*

Like Juan Luís, many other staff described feeling like Maya communities were "abandoned" in the aftermath of the PEC cancellation, yet when pressed about their feelings of responsibility for these communities the NGO once helped serve, most of the staff expressed that it was not their responsibility to continue to provide services, and that it was the obligation of the Ministry of Health and local municipalities to safeguard their health and wellbeing. Dr. Chavajay and Faustino, the community health project coordinator at FMS, both told me the organization does not have the resources to visit communities beyond a few *jornadas* unless they can

collaborate with another NGO who may have more means to do so, which was evident in the organizational activities reports discussed above.

This reduced sense of responsibility for local Indigenous Maya communities brought on by limited funding was repeated in interviews by other staff at FMS. This was articulated particularly well by Celso, the accountant who worked at FMS during and after their PEC contracts. As Celso explained,

> *We do not have enough income. So even if you want to support the community with some health projects, you can't do it because you don't have the backing to do it. … I think there are 11 specialists here…There are practically several services that can continue to be deployed in communities. But … it will depend very much on the specialist, on their social vision. Because you're not going to be paid much here as you are for attending someone in your clinic, for example. Your clinic might be Q500 or Q600 for your appointment. And here about Q200 or Q300. So it's going to depend a lot too on whether the specialists have any social vision. I think most specialists here have a social vision, but have to come and accept the terms of the foundation.*

The sentiment of staff having the moral will to do community level health interventions yet being constrained by the funding limitations of the NGO was echoed by Faustino, the community health coordinator, who told me, “There are many workers, many NGO staff who are experts in health, in education. There are a lot of [people] with experience in the NGO sector on the topic of health, health and nutrition, and education that are working here.”

However, Faustino tells me he feels their staff only work on at business level, “they don’t work at the level of a community-level study.” Faustino expressed with great frustration how NGO professionals at FMS could have a real impact on health policy because of their experiences, but the Ministry of Health is “closed” to them. He told me, “there is no opportunity to present a project, or that there is an alternative and a solution” and that if any NGO proposals for policy change or health projects go through to the Ministry of Health, “it is a political action that we get there, not because of our experience.” As Faustino articulates, NGO workers may

have the experience and skills to conduct community health work or even influence health policy change, but understand their roles as actors within a business who are constrained by the whims of the state.

Within this context of limited administrative funding and diminished support from state institutions, the notion of being an activist in health, once a foundational principle of FMS, was notably absent. In contrast to ANDI, staff interviewed at FMS largely did not, or were careful not to, describe themselves as health activists or as engaged in empowerment work. This likely stems from anti-activism sentiments of administrators at FMS. The director, Dr. Chavajay as exemplified in the opening vignette of the chapter, often articulated a conflicted conceptualization of his organization in our meetings, where he reflected fondly and at times nostalgically on the FMS' earlier days when community participation and health promoter activism was the central focus. Yet, he told me adamantly that he would not support activism from any of his staff at FMS. Dr. Chavajay told me,

> *The government doesn't like that there are NGOs in charge of justice, the government doesn't want those NGOs that are telling the truth to the government. … I am not an activist. I'm not an activist in that I'm going to protest the government, no. But there are a lot of NGOs that are activists and that's not what the government wants. … If there is an activist here, I'll fire them!*

For Dr. Chavajay, activism brought fear of repercussions from the state, yet he never articulated what such repercussions would be, simply citing ominously that when the NGO had community health promotors and activists in the 1980s, they "disappeared". Yet, as noted by Nicolas Copeland (2019c) Guatemalan NGOs that received public funding for service provision were prohibited from publicly criticizing the government, or even discussing "politics" including the historical and systemic causes of abject poverty encountered in their beneficiary communities. Hopeful that "inter-institutional" collaboration and financial support from the Ministry of Health

or other state institutions could still be on the horizon for FMS, Dr. Chavajay described himself as reluctant to be publicly vocal against issues within the Ministry of Health or within the healthcare system. Yet, Faustino, the community health project coordinator, told me he feels like somewhat of an activist in his position at the FMS "because of what I'm doing in seeing how to bring some health services to communities" like *jornadas*. He told me there should be more health-related activism at FMS, saying "there needs to be those kinds of workers innovating some health program." As evidenced by the sentiments of Faustino, NGO workers may have personal convictions about initiating social change, yet the managerial aspects of their everyday roles within the organization, compounded with the NGO's tenuous relationship with the state, have worked to dull their attention to community empowerment and activism.

Discussion

As this chapter has indicated, "maintaining the vision" of the original liberationist community empowerment approach to health intervention diminished over time at FMS. This occurred in relation to the ebb and flow of funding, an increased focus on curative biomedical healthcare services, and increased monitoring and surveilling of public health goals specified by the state. This trajectory led the organization down a path positioned toward managerialism and business-oriented bureaucracy over empowerment and activism. The logics of reporting requirements to the state and adhering to advancing specific health initiatives in return for funding through the PEC effectively shaped the nature and content of community health interventions that FMS performed. Extending a "basic" healthcare package that focused largely on women and children, arguably left out a large portion of Indigenous communities in need of health services, namely men, youth, and the elderly. Increased focus on preventative and curative healthcare which manifested in enumerating health indicators for vaccines, nutrition, birth, death

and growth rates, did not address the underlying socio-cultural and systemic inequalities producing health disparities in Maya communities. Once the financial support for community work was removed with the cancellation of the PEC, the staff at FMS had been so far removed from addressing the real needs of communities—which had been effectively "rendered technical" (Li 2007) by this process—that today their limited community health interventions and occasional *jornadas* scarcely resemble the empowerment work envisioned by their original founder. As James Ferguson (1990) argued, development in this sense serves as an "anti-politics machine," reinforcing the power of the state by blanketing its bureaucratic practices over systemic inequality and structural violence experienced by the poor and most marginalized.

I have sought to understand why ANDI and FMS are so different given their shared community empowerment history. This chapter demonstrates that their orientation to the central purpose of their work is quite different at each of these organizations. Despite both having staff with experience, knowledge, and the will to provide community level health interventions, the path toward continuing empowerment work versus pursuing business-oriented managerialism is mediated by funding. At ANDI, their funding authorizes and encourages them to serve in the arena of human rights and social justice. At FMS, constraints and limitations of funding from the state transmuted such liberationist agenda by instilling adaptive bureaucratic tendencies which effectively rendered technical the original mission of the NGO: to empower communities to address the root causes of health inequality. Yet, while the work of activism and community empowerment has largely been abandoned at FMS, for staff and administrators the rhetoric and philosophy of these ideals has simply been ascribed to a new set of bureaucratic processes which they do not see as contradicting the history, legacy, and vision of the organization.

In trying to understand the central question of this dissertation—how NGO workers continue to perform their roles in healthcare for the underserved despite shifting policy and political sentiments toward NGOs—in the context of FMS this entails taking on a managerial service-focused approach to health and letting activism and community participation work fall by the wayside. As evident in the case from FMS, the social justice focus and strategy of an NGO can change amidst shifting socio-political climates. The abilities of NGOs to maintain agendas of social change are not only dependent on funding, but on their ever-evolving relationship with state institutions. While instances of strategic collaboration with local government, or "pull down-devolution" (Markowitz 2001: 11), can allow NGOs to create and strengthen ties with local governments while continuing to advocate for and strengthen civil society from the bottom up, in the case of the PEC such collaboration had the opposite effect. Audit culture imposed on FMS through the PEC represented "a particular exercise of power–from a direct authoritative and supervisory power to an indirect exercise of power through a new form of bureaucracy" (Vannier 2010: 282). Organizations like FMS may be negotiating between their institutional philosophies and financial stability when seeking "strategic alliances" to survive and continue serving their beneficiaries (Maupin 2015:7-8). Yet, in pursuing such strategic alliances, NGOs can in return be "harnessed by the state" and used to further neoliberal reforms and state agenda, compromising NGO core missions and objectives (Gideon 1998: 304).

In the next chapter, I further turn to such "harnessing" of NGOs by the state. As NGOs continue to perform their roles in health intervention amidst Guatemala's shifting healthcare context, a major factor impacting their abilities is state socio-political discourse and discursive framing whereby NGOs have become sites for criticism, suspicion, and control by the state.

Chapter 6: "NGOs Shouldn't be Doing Advocacy Work, That's Terrorism": Discourses of Corruption, Enduring Trauma, and the State

It's a dark, rainy day in Antigua, and I am meeting with Dr. Flores, a pediatrician and former Ministry of Health (MSPS) official to discuss the history of the Extension de Cobertura (PEC). Excited to speak with me, she explains she devoted many years of her life on a team designing and evaluating the PEC contracting program with NGOs. She tells me that when the PEC first started the idea was to begin with a basic care package that would be "tailored" overtime to the needs of each particular Indigenous community. She said, "This didn't end up being what happened. This was a big criticism." Dr. Flores tells me earnestly that the goal of the PEC was to identify which NGOs were most capable of working with the MSPS, telling me "they had to have great administrative skills; have someone who tracked spending; have additional means to support themselves; be officially registered; and show they were capable of being transparent." Dr. Flores pulls out a document listing 42 NGOs who still had PEC contracts in 2013 and tells me these are the NGOs her team wanted to "certify" for a "PEC Plus"—a new, strengthened and ultra-transparent version of the PEC that her team had worked hard to design a certification process for. "We felt the remaining NGOs were the experts," she said with a hint of resentment, "we wanted to prove these NGOs were in good standing, doing everything legally, and that they were valuable." Slamming her fist onto the document, Dr. Flores exclaimed with great frustration, "These were the best of the best!" Looking down at her shaking hands, I see that Fundacion Maya Salud (FMS) was included in this list of certifiable NGOs. Dr. Flores explains that NGOs have become "incredibly politicized" and her hard work had been taken over by political interests. She explains that the main reason leading to the cancellation of the PEC was that in 2013 the government "was looking for corruption everywhere" honing in on all the money being passed to NGOs without any cost-benefit analysis, as "corrupt" and "too expensive." Defeatedly, she told me, "our certification process would have helped dispel the idea that NGOs were corrupt." Dr. Flores explained that this culminated in a "death sentence" for any fortification of the PEC with the passing of a 2015 amendment prohibiting the government from contracting NGOs altogether. She said, "The government saying the PEC was too expensive was not based in evidence. They didn't analyze anything. Honestly, the results would probably indicate the opposite." She says there is a large database of PEC-contracted NGO health data spanning many years, but it was never really analyzed beyond statistics for nutrition and maternal mortality. She laughs and leans toward me, "if I gave it to you, would you analyze it?" I could tell Dr. Flores was very attached to the PEC but asked if she thought it would even make a difference for someone to analyze this data. Dr. Flores responded, with a hint of sadness in her voice, "Contracting is good practice, but Congress banned it anyway. NGOs are like a bad word. The PEC is like a bad word. The PEC was innovative. The PEC was hope."

-Interview with Dr. Flores, former MSPS official, Antigua Sacatepéquez, May 2019

Introduction

Dr. Flores' discussion of the history of PEC and its cancellation underscores an important theme I had been hearing from many NGO workers in interviews, observations, and casual conversations: politically charged "corruption" discourse was affecting the work of NGOs across Guatemala. Not only had such discourse culminated in the permanent cancellation of the PEC—a program Dr. Flores dubbed as "hope" for delivering healthcare to the Indigenous poor—but it began to sow seeds of public and political stigmatization within the NGO sector. As briefly mentioned in Chapter 2, the popular anti-corruption movement has emerged in Guatemala over the past decade. The movement, led by anti-impunity activist groups, NGOs, and bodies of law, has targeted numerous politically and socio-economically powerful individuals, and came to a head during the course of my fieldwork with the unprecedented persecution of high-profile individuals, further amplifying the anti-corruption movement's message over the hearts and minds of citizens, civil society, and politicians (Flores and Rivers 2020, Hite and Montenegro 2020). In this chapter I will examine ways in which discourses of "corruption" have been turned against the NGOs, becoming a powerful tool for advancing state interests in controlling the NGO sector. In this chapter I will examine the power and impact of this discourse on NGO workers' ability to continue to serve the health needs of Indigenous communities.

The goal of this dissertation is to understand how NGOs continue to perform their roles in health intervention amidst Guatemala's shifting socio-political healthcare context. A major factor impacting NGO's abilities in this context how the sector has increasingly become "harnessed by the state" (Gideon 1998: 304) as subjects of social criticism and increased state control. This chapter asks, how have public and state discourses of corruption impacted how these NGO workers understand and implement their work in health, and how are their political

subjectivities impacted. I will argue that NGO workers in this study have internalized the larger discourse and labels of corruption in a variety of ways manifesting in fear, stigmatization, and social distrust, and that these internalizations manipulate their ability to serve Maya communities. Moreover, I will argue that corruption discourse in this context is a political tool deployed by the state that stands to re-articulate the subjectivities of NGOs and those who work for them.

"Looking for Corruption Everywhere": How NGOs Became Targets of Discourses of Corruption

The internalizations of corruption discourse as articulated by NGO workers must be understood and contextualized in relation to Guatemala's broader anti-corruption movement and how this powerful discursive force has shifted to target NGOs. The popular anti-corruption movement in Guatemala has enjoyed unprecedented social and political support for the past decade (Flores and Rivers 2020, Burrell, El Kotni, and Calmo 2020). This was due largely in part to the UN-backed International Commission against Impunity in Guatemala (CICIG) in 2006, an independent body supporting the Guatemalan Public Prosecutor's Office, recognized as one of the most effective anti-corruption bodies in all of Latin America at rooting out corruption among politicians and private industry (Human Rights Watch 2018, Hite and Montenegro 2020, UN 2021a). Famously, this resulted in the *La Línea* corruption scandal in 2015. This high-profile scandal involved the former President Perez Molina and Vice President Roxana Baldetti who were found by CICIG to be involved in a scheme in which customs agents gave importers reduced tax rates in exchange for millions of dollars in bribes sent directly to the former President and Vice President (CICIG 2017, Taub 2015). CICIG helped lead investigations convicting hundreds of other high-profile individuals on a variety of charges of corruption (Hite and Montenegro 2020).

CICIG's important work leading the front on corruption and impunity in Guatemala was supported by many sectors of Guatemalan civil society, NGOs, and activists. The NGO sector had been especially skilled at affixing labels of corruption to state officials, influential business leaders, and other powerful state and private institutions. However, over time, as Dr. Flores explained in the opening vignette, this spirit of corruption rhetoric and accusations was turned on the NGO sector by the state.

In the aftermath of the 2015 *La Linea* scandal, the popular anti-corruption movement further embroiled the nation, and as a result the subsequent presidential administration under Jimmy Morales was, as Dr. Flores aptly described, "looking for corruption everywhere." NGOs became entangled in this discourse of corruption as targets of conservative political scorn stemming from critiques of the early days of the PEC. In one influential report on the PEC, Cardelle (2003) identified what he termed "astroturf" NGOs. These were organizations that had emerged simply to obtain government contracts and funding, effectively taking advantage of the government economic incentive. Such NGOs were often fronts for non-healthcare activities, and did not have the capacity or facilities necessary to carry out the healthcare agenda and basic healthcare services required of them under the contract (Cardelle 2003; Maupin 2009). This discovery called into question whether policy makers should reexamine the relationship between NGOs and the state, and to what extent decentralization has impacted the actions and functions of NGOs. As a result, in a subsequent World Bank report about the PEC, La Forgia, et al. (2005) argued for stronger transparency and oversight measures, many of which were subsequently adopted into the NGO PEC contracts. A majority of the NGO workers I spoke with made reference to these scandalous NGOs that cropped up during the early years of the PEC, telling

me that nearly all of them were money laundering fronts owned and organized by politicians, not non-profit workers. For example, Nicolás, the executive director of ANDI told me,

> *For many many years [Guatemala] had the PEC—the healthcare was provided by the NGOs in the rural areas because the government recognizes that they do not have the capacity to do it. … for many years in the NGOs, there has been corruption too. You know, that the congressmen started their own NGOs to give that money to big projects, like construction of roads with millions of dollars and everything. What they did was actually give the money to their own NGO, to administrators, millions of dollars. Then they re-hire a construction company and they kept—like if the road was 100 million dollars, they kept 10% for 'administration.' But they didn't administrate anything, they just kept the money.*

For Nicolás, the culprits responsible for the stain on the PEC and the NGO sector, were actually political officials and big businesses. Others told me that these NGOs that Nicolás described were just a few "bad apples" that made the NGO sector look bad, but that most involved with the PEC were actually doing what they were contracted to do. Dr. Flores also mentioned this issue, telling me that after discovering these money laundering fronts, "there was an overgeneralization that all NGOs who had the PEC were corrupt", so the Ministry of Health instituted stricter regulation on the use of PEC funds and mandated NGOs report every month on health outcomes. For Dr. Flores, these additional transparency measures are what made the remaining PEC-contracted NGOs "the best of the best…who do good, honest work!" Yet, the stain on the reputation of NGO sector remained, providing a perennial for continued critique by the political right and justification for control by the state.

In a dramatic turn of events, and contrary to the anti-corruption platform he ran on, during my fieldwork the 2016 incoming President Jimmy Morales, supported by Congress and invested interests in the economic sector, initiated a what has been labeled a "pro-impunity campaign" (Monzón 2020, Hite and Montenegro 2020). In 2018, Morales' administration expelled CICIG investigators from the country, and denounced social justice leaders, passed

impunity laws that protected government officials from prosecution, and silenced media, organizations, and businesses supporting the anti-corruption movement (Abbott 2019, Amnesty International 2019b, a). One strategy of this pro-impunity campaign was to turn discourses of "corruption" toward silencing criticism of the government's agenda, according to several of the workers I interviewed at ANDI, FMS, and other NGOs. According to them, this discourse was particularly powerful when targeted toward NGOs, a sector that had been especially skilled at criticizing the actions of the state.

Between 2015 and 2019 changes to the original 2003 *Ley de ONGs* (NGO Law) and additional associated laws were enacted which resulted in the prohibition of state contracting of NGOs altogether. These changes also redefined the registration process for non-profits, categorizing them intro three classifications: associations, foundations, and NGOs. Under the NGO Law, an "association" is a not-for-profit organization promoting trade unions, socio-political and economic interests, as well as religious, cultural, and professional interests. "Foundations" are defined as entities formed by the public with a principal of at least 50,000Q (approximately $6,300 USD), who must disclose the source, purpose and intention of their assets. The third classification, "NGO," is defined within the law as a not-for-profit entity with objectives in providing social services, assistance, aid, and charity, by engaging in development, economic and social-cultural objectives. Notably, associations and foundations qualify for tax exemptions, while "NGOs" do not. Instead, organizations registered as NGOs are recognized as the only entities permitted to receive government funds, face heightened surveillance measures, and can be taxed at 12% for activities deemed "non-exempt" under the law. (Tucker 2019, Council on Foundations 2021, Ministerio de Finanzas Publicas 2021).

As the above discussion has shown, NGOs have been caught in the push and pull of politically-motivated policy change in both a shifting healthcare context and an increasingly pro-impunity political climate. In a political context where those in power are "looking for corruption everywhere," the cancellation of the PEC and changes to NGO Law effectively and permanently dismantled a healthcare program that had long provided care to the Indigenous Maya communities most in need. As NGOs like ANDI, FMS, and others continue to provide health interventions in Maya communities in spite of this environment, discourses of corruption have nonetheless become an internalized aspect of their everyday work. In what follows, I will theorize how discourses of corruption, like the process discussed above, comes to hold power over the political subjectivities of such individuals.

Discourses of Corruption and their Relation to Political Subjectivity

In order to better understand how discourses of corruption can impact the work of NGOs, I turn to discourse theory. (Johnstone 2018) argues that discourse is both the source of knowledge and the result of it, writing that "discourses are ideas as well as ways of talking that influence and are influenced by the ideas" (2018:3). The power of particular discourse comes from "delegated power" vested in authorized and authoritative actors such as state institutions (Bourdieu 2003). As Fairclough (2001) points out, "power in discourse is to do with powerful participants controlling and constraining the contributions of non-powerful participants" (2001:38-39). Discourses of corruption in the context of this study can be understood as what Fairclough calls a form of "ideological power" whereby the belief and practice of applying corruption labels to NGOs is increasingly naturalized and held as "common sense." (2001:27). Discourses of corruption reflect the Foucauldian notion of a "regime of truth," as they operate in a society as mechanisms for producing and regulating subjective views of reality (Foucault

1979). As Fairclough argues, discourse creates "social subjects" who are simultaneously under the jurisdiction of political authority and shaped and implicated into action (2001:32). As such, discourses of corruption have important implications for understanding subjectivity. Such discourse can reconfigure the political subjectivities of NGO workers, whose work is deeply embedded in culturally constructed and ever-changing systems of power.

Understanding discourses of corruption as a tool for re-configuring subjectivities involves "interrogat[ing] the social life of corruption as a concept-in-the-world that simultaneously transforms—and is transformed by—the particular social worlds in which it finds fertile soil" (Muir and Gupta 2018 S6). Anthropologists studying corruption seek to draw attention to how corruption is "lived out" in particular contexts, as it "haunts modern politics and economics, threatening the legitimacy of states and markets while simultaneously animating repetitive, incomplete attempts to cleanse and legitimate the political economic order" (Muir and Gupta 2018). Political subjectivities are sites where corruption discourse can realize and live out its power. Subjectivity is the culmination of personal experience, beliefs, agency, and personhood that can influence and inform an individual's view of truth and reality. Discourses of corruption stand to transform that truth and reality, through the mixture and use of legal, moral, economic and political rhetoric to depict the enemies of the state as "corrupt" (Zhang and McGhee 2017). In relation to the presumed purpose of NGOs—that is, to accomplish some form of societal good—political subjectivity matters in that the morality of what NGO workers do can be transmuted and even silenced.

"The System of Corruption is From the State": NGO Worker's Views of the State

In order to understand how corruption discourse has been internalized to shape NGO worker's understandings and implementation of their health intervention work in Indigenous

communities, it is first important to note that NGO workers in this study overwhelmingly did not view themselves, or the NGO sector at large, as corrupt. When asked if they were aware of corruption discourse being applied to NGOs, the majority of NGO workers said they had heard such negative depictions of NGOs in the news, on social media, and from state officials. While some agreed that Guatemala's NGO world was not perfect, most were adamant that corruption was increasingly the status quo of multiple government institutions, including the presidential administration, the Ministry of Health, the Institute of Social Security, and even the police. It was their belief that NGOs and the private sector served as scapegoats, diverting public attention away from endemic lies and manipulation by the state which they felt were underlying poor healthcare access and health inequity. Many believed state corruption is at the root of health inequities experienced not only in their target communities, but by many across the country. This was particularly well explained by Martín, the masculinity health educator from ANDI who told me,

> *The first crisis we have in the health system is corruption. … And not only in the health system, our government is corrupt. I'm disgusted with the system because it's so big and abysmal that a person who comes to the health system to place change, the system absorbs them, absorbs them or runs them out of work … they become corrupt in the same way, and they don't care about anything. … they are losing their sensitivity… they don't put on the shoes of the people and see that the government is to blame. Because there is no access to education. Because there are miners who are benefiting from wages without paying taxes to the country. Because the African palm is leaving them without water. Because we are diverting their rivers. Because there is stigma and discrimination toward the Indigenous population. … No one else is going to get us out of this hole, just us.*

For Martín and others at both ANDI and FMS, corruption is at the root of processes that keep individuals from enacting meaningful change within the healthcare system that attends to the social determinants of health. He said the phrase "just us" referred to NGOs, implying that NGOs like ANDI hold considerable responsibility and ability to address health inequity in a context where the state is notably absent.

Feelings of corruption's impediments to addressing the social determinants of health in Guatemala were also pointed out by Dr. Chavajay, who felt that the government was invested in preventing medical students from learning about the cultural and social determinants of health. He described his own doctors and nurses this way, telling me "the [medical staff] here know there are not enough [healthcare] resources. But I don't think they know the reasons or the causes of this." For Dr. Chavajay, the cause stems from corruption within the taxation system. He tells me,

> *The reasons for the state of the healthcare system have to do with allocation of state funds and issues in the taxation system. Guatemala is a country with the least coverage for health. We spend the least on health and education. … 75% of the [household] spending goes to personal costs, not to food and healthcare. In addition to this, 70% of the Guatemalan population have informal jobs, meaning they don't pay taxes. They go to the public hospitals. But they don't pay their taxes!" Only 30% of the population have a formal job. Only the middle class and the lower middle class pay state taxes.*

Martín and Dr. Chavajay's connections between processes of corruption and the healthcare system crisis that disproportionately affects Indigenous communities, was echoed by others in the NGO community. Aria, the director of an NGO focused on curative and preventative healthcare for Indigenous Maya communities in Sacatepéquez, told me that she felt that the government is not lacking in the ability to support the Ministry of Health and the healthcare system infrastructure, but that state corruption prevents allocation of funding to these areas. As Aria explained to me,

> *What's interesting about Guatemala is its not a poor country. Its GDP is quite high, it's one of the highest in Central America, yet it is one of the most unequal countries in the world. If you look at the middle-high income families in this country they are doing quite well. Living quite good lives, no problem. But in Guatemala, the poorest of the poor are the poorest in this hemisphere. No questions asked. Poorer than Haiti, I mean, countries that have much lower GDPs. It is so unequal in this country. Could real change happen in this country? You bet. There is so much corruption. There is not trickle down here. Those funds are diverted somewhere else. Always.*

Similarly, Dr. Flores, the former Ministry of Health official, even expressed that annually the Ministry claims it does not have the financial means to address critical issues in healthcare access and infrastructure for the rural Indigenous poor, telling me "yet they don't even use the entire percentage of their annual budgets and that money ends up going back to the state!"

Moreover, in addition to the misallocation of state funding, multiple NGO workers also told me that they believe the government lies about health data and public health statistics. As Omar, a fieldwork supervisor at ANDI described it, such manipulation is an extension of state power. He explained,

> *Because of the high corruption that there is, all these systems are manipulated. In press conferences they say, "The health system has improved by 20%. We now have 80% good health care. We have medicine. We have good attention, good service of disease specialties. Children's nutrition has improved. We now have fewer malnourished children." But these don't happen. That's what [the president] says. But within the field, we [at ANDI] don't see that. So all that information that health centers handle is manipulated. … It is manipulated for money and power.*

Others expressed that the alterations of health statistics by the Ministry of Health is linked to the state receiving abundant financial support from USAID, and from other international sources of aid and loans. This was particularly well explained by Nicolás, the executive director at ANDI who told me,

> *Some state health centers lie about the growth and nutrition numbers that they have to present to the Ministry of Health periodically. All data at the national level is totally false. If health workers at the health centers don't get the chance to check a child's growth progress, they add centimeters to the child's growth chart. [ANDI's] information is real. Our information is better!*

Nicolás went on to say that when ANDI has presented their health statistics on child malnutrition from the Indigenous communities they work with—the major health focus of their organization—the local Ministry of Health officials labeled them as "liars." He told me they

disbelieved that ANDI could have possibly improved child nutrition and growth rates at the numbers that they claimed. He told me,

> *Our programs have reduced malnutrition in the communities by 8%. Especially with babies. However, other organizations and the Ministry of Health do not believe that we could have reduced it by this much. They claim [ANDI] is not doing the evaluation right. They don't believe us. I know we are doing everything right. It's just impossible for others to believe it.*

Curiously, when asked what he thought analysis of the health data collected by PEC-contracted NGOs would indicate, Nicolás replied—just as Dr. Flores speculated at the opening of this chapter—that the data probably would show those contracted NGOs were doing a good job at achieving numerous health goals, especially for the *1000 Days Initiative* and *Plan Hambre Zero*. He noted, however that the Ministry of Health refuses to analyze it. When asked why the MSPS would be invested in concealing health data, altering growth and nutrition statistics, and denying the positive improvements accomplished by NGOs, Nicolás exclaimed with great frustration, "For funding! For money!" USAID and the European Union, for example, give money every year to support the health system. The government is lying to them."

As the above narratives have laid out, not only was the work of NGOs being rejected and denied by the state, the processes of corruption impacting the healthcare system silenced the meaningful and positive societal impacts of NGOs from being recognized by the state. As these examples highlight, NGO workers identify state corruption as the root cause of the healthcare system crisis. Furthermore, as evidenced by the controversy over health data, the everyday context of corruption can lend power to authorized discourse, silencing the truth and reality of those working to address development and enact change in the health system.

"I Never Say I Work for an NGO": Internalizing Discourses of Corruption

Despite being able to articulate their critiques of the state and locating processes of corruption within state institutions impacting healthcare, I found that the discourses of NGO corruption were also internalized by NGO workers. The internalizations of this discourse, manifest in a variety of ways including feelings of stigmatization, criticism of others, fear, and efforts to increase organizational managerialism.

Stigma was an especially common theme within NGO workers' responses when asked questions about the anti-corruption movement in Guatemala. Many workers described working for NGOs as a stigmatized occupation, internalizing the critical discourse surrounding their work. As Rafael, the director of a reproductive health NGO in Sacatepéquez explained,

> *Libertarians hate NGOs. Liberals tend to be more supportive of NGOs. So it really depends. I don't think those corruption cases and all those politicians that used their own NGOs to win contracts made any of us any favors. You say "NGOs" and in some parts or some groups it's almost like a bad word.*

Rafael notes that there are distinct sectors of society that take up the discursive notion that NGOs are corrupt, yet like others, fears that NGOs are increasingly a buzzword for taboo topics in everyday conversation. Nicolás, the executive director of ANDI, expressed such social stigma, telling me,

> *If you come to Guatemala and you ask anybody who is not involved in development work, "What do you think about NGOs?" They are all going to tell you, "Oh! They are corrupted people! They only look to get money from the government! Blah, blah, blah." I feel sometimes, even ashamed when I talk with somebody who is not part of the development world, and they ask me, "What do you do for a living?" (Laughs). Because they are probably going to think that I'm involved in all this corruption and things. So I never say I work for an NGO. I say, "I work for an association." They don't see the connection. You know?*

For Nicolás, the disconnection between the idea of being an "NGO" versus an "association" stemmed from fear of changes in the NGO Law discussed previously above, which

created new categories within the non-profit sector making registered "NGOs" more likely to be controlled and monitored by the state than organizations registered as "associations" or "foundations." Nicolás tells me that they purposefully register themselves as an "association" with the state for this reason. In a similar fashion at FMS, Dr. Chavajay and the community health project coordinator Faustino, both stressed to me on multiple occasions that their organization is a "foundation" and not an NGO. However, this distinction only goes so far in dispelling negative views about non-profits, as Faustino explained,

> *Here in Guatemala there are associations, foundations and NGOs. They're different. We are under the 'foundation' regime. … but by "NGOs," they still include all of us. So, if you say "NGO," Everyone will say, "Ah, that's a corrupt NGO." This has been discussed at the level of an NGO council to Congress to raise awareness on what organizations, foundations, and associations do. We are not corrupt, but this is a popular position, [NGOs] are not transparent, they are corrupt, that is to say, a bad word.*

As Faustino eludes, the word "NGO" remains a monolithic category in the public and political purview, despite the sector's attempts to distinguish and define these legal categories to dispel blanket notions that all non-profits are corrupt.

Yet while most NGO workers I interviewed expressed that they don't believe the NGO sector to be blanketed in corruption as the popular discourse might suggest, many had internalized a critical view of the NGOs that had or continued to be associated with the state. Aria, a health NGO director, was particularly well spoken about this. She told me she is especially wary of NGOs after the PEC, telling me she feels NGOs who worked with the state became "arms of government." She explained,

> *There was no way to empower the NGOs to do any real outcomes. They just became arms of the government. … There was so much regulation placed on them by the government and I understand those were the [PEC] funds they were receiving but… they were not actual independent thinking organizations. … they weren't organizations that could do advocacy, or policy, or respond to the government, or talk about the government, or say "Well, we received 90% of funding from you, but 10% we don't, so we can do some*

> *outside thinking." The majority of these groups, not all of them but a lot of them, were 100% funded by the government so they had no way to do anything but exact government work. That's where you lose—there's no autonomy there. You are just a government agency with the title of NGO. When you receive 100% of the funding you can't technically, literally speaking—you can't bill your time to advocacy or anything else."*

Uncannily, Aria's cynicism for former PEC-contracted NGOs endorsed the very situation that developed at FMS during the years in which they held PEC contracts with the Ministry of Health. As discussed in detail in Chapter 5, FMS' focus on community health advocacy greatly diminished under the careful eye of the state and has continued to remain transmuted even years after the cancellation of the PEC.

Aria's discussion above speaks to the ways in which transparency measures undermined the ability of PEC-contracted NGOs' to partake in social activism, while at the same time, in the context of increasing discourses of corruption, transparency was also had being internalized at NGOs. This is illustrated by the comments of Nicolás, the director of ANDI, who told me about an NGO he knew was breaking the law, and the influence this has had on his oversight at ANDI. He said,

> *In Guatemalan law, NGOs are prohibited from paying money to a business. This NGO is paying money under the table to their staff. This is illegal. The business is paying 40% more salary under the table to the workers. The NGO workers are getting paid way more than they claim they are. … For them to get audited and disappear from the communities will be a tremendous loss. The community will have no healthcare. … Now I know you can't trust anyone, even if they are close to you like family… I tell my staff to keep themselves clean about everything.*

Nicolás explained that being "clean" meant that his staff needed to be as transparent and honest as possible about their work in order to retain their private funders. He told me he even has tracking devices on the association's vehicles to monitor where staff are in the communities each week, and that he hires an independent auditor to evaluate the organization's activities and spending every year. Rodrigo, a Kaqchikel water project technician at ANDI, expressed the

importance of these transparency measures, telling me it not only ensured funds are allocated to communities, but it also trains him and his co-workers at the NGO to be "professionals." As Rodrigo explained to me,

> *Here, about a month or two ago, there was an audit that graded the quality of work that the organization does. Its inspected. And if there is any anomaly, it is immediately reported, and then letters are taken on the matter and proceeded. Thank God for the audits… the supports go directly to the beneficiaries. … Within the organization, there has been no anomaly. So, it's a very important thing, as professionals, that we know and understand that we shouldn't fall into that. We should do our job as professionals. I have to do my job and do the best I can.*

However, at ANDI, where their programs rely predominantly on international funding and donors, some staff still feared the effects of the corruption discourse on their funding despite such transparency measures. When asked whether or not they felt discourses of corruption were directly impacting the association, several NGO workers reported feeling worried or concerned that the larger corruption discourse around NGOs will turn away international funders from continuing to support their work. As Martín expressed to me, "Every time organizations disappear, non-governmental organizations, it is because international financial institutions – that is, international aid, is going away because of the levels of corruption we are having."

In addition to these transparency procedures, Nicolás told me that he has refrained from any financial relationship with state or municipal institutions, and does not collaborate with other NGOs, out of fear of potentially "losing credibility in the communities." He tells me, "[ANDI] can't ever be connected to any of these corruption situations. We are not involved at all with the government or big companies or whatever. We are totally independent, and we want to keep it like that." For Nicolás, and other NGO workers at ANDI, increased transparency measures were necessary in the context of larger corruption discourse in order to ensure they could continue to conduct their empowerment and community health programs.

At FMS, where the notion of transparency was an integral part of their PEC contracts for many years, for staff and administrators the powerful discourses of corruption encircling the NGO sector further drove home the idea that the organization should continue to maintain utmost transparency. For example, when asked about how the corruption discourse has impacted FMS, Faustino, the community health project coordinator told me,

> *[FMS]has been impacted because the funding system has been decreased. There's not many funding opportunities at any level. From international funds it has declined due to the issue of corruption. It affects the healthcare system. There are no resources where they need to go. It is a common discourse, because there are NGOs that were not transparent in their opportunity, who had the resources but did not work them with transparency*.

As Faustino explained, lack of transparency within the NGO sector is one of the main reasons for the stigmatization of the NGO sector. Moreover, the popular notion that NGOs are corrupt was reducing the amount of state and international funding available to them. I pressed Faustino further, asking him how NGOs might push back against this corruption discourse. He replied,

> *What the NGO sector has to do is to publicize what the work is [and] the impacts that arise at the community level. It's a lot of effort to make the NGO's work known, because it is a populist discourse in which they believe there are many corrupt NGOs.*

For Faustino and Nicolás, the powerful discourses of corruption at play in this context solidified notions about maintaining administrative transparency and accountability at their respective organizations. For them and others, efforts to be as transparent as possible to the state and to their funders was a way of ensuring their health interventions and work within the Indigenous Maya communities they serve could continue unscathed.

Yet the notion of continuing work in community-based health interventions, empowerment, and advocacy for Indigenous communities still provoked unsettling feelings among some NGO workers for whom the discourse of corruption surrounding NGOs had

internalized an enduring sense of fear of the state. Dr. Chavajay, the medical director of FMS, who expressed in the previous chapter that he would "fire" any staff member who took an "activist" role within the organization, framed his anti-activism stance as not wanting to attract any government attention to the organization whatsoever. The state's targeting of FMS health workers during the Guatemalan Civil War was repeated to me by Dr. Chavajay on more than one occasion, as if there is always a looming possibility that, as NGO workers, the state could at any time mark them as extremists, jail them, or make them disappear as had once happened in the recent past. This enduring fear of the past-in-the-present was also echoed by Nicolás, the director of ANDI who told me,

> *All the soldiers, that during the war, killed many indigenous people. You have all these people from the army moving the engine—they are experts at convincing public opinion about how bad the NGOs are. It's something I find is like from the movies. You know, like spies. … if you go to Facebook to some specific pages that have to do with the army they have very powerful people who don't want to change the situation about education, for example. That way they can hire very cheap labor. If people study they are going to fight for their rights. They want to keep the population with no education. They start moving all of this to make sure that the media, that the TV, that the newspaper talk about NGOs and how corruption affects them, that we are ALL corrupted. You see almost every week a column in the main newspapers talking about corruption and NGOs … Somebody is moving everything from hiding. Moving the public opinion to where they want it to be.*

From both Nicolás and Dr. Chavajay came the idea that the discourses of corruption targeting the NGO sector are influenced by individuals and sectors of Guatemalan society that have had vested interest and practice in silencing the work of advocacy NGOs. Nicolás further expressed this sense of fear when discussing recent changes to the NGO Law, which, as before mentioned, would change the non-profit registration process, allowing the state to tax, monitor and control NGOs. Nicolás told me,

> *The new registration process is trying to redefine what it means to be an NGO. To the government, NGOs can receive money from the government. And they can tax you for it. The new registration process is a way to control all NGOs. The government wants control of all their accounting, what they use their money for, where it comes from, and*

> *they want to tax NGOs on this money. The government wants to give a very hard life to some NGOs, especially political and advocacy NGOs. From the point of view of the government, NGOs shouldn't be doing advocacy work, that's terrorism. Everything is left or right in Guatemala. If you support labor rights and reducing chronic malnutrition, you are from the left. You are communist.*

As Nicolás indicates, labels of "terrorism" and "communism," as crafted by sectors of society with the power to sway public and political opinion can stand to significantly impact the empowerment work of NGOs like ANDI, and keep others like FMS from continuing to pursue community health advocacy altogether.

Discussion

As this chapter has demonstrated, while NGO workers in this study largely did not take up the notion that the NGO sector is corrupt and instead located corruption as the status quo of the state, the discourse as targeted toward NGOs continued to impact the political subjectivities of NGO workers themselves. As the narratives in this chapter have shown, such powerful discourses of corruption can be internalized in various ways. In the Guatemalan context, corruption discourse not only has the potential to transmute NGO advocacy agenda through an admixture of legal, fiscal, and fear tactics, but it also has the power to impact the subjectivities of the individuals enacting such work, manifesting in the internalization of stigmatized identities. Applying the concept of political subjectivity draws attention to the reasons why individuals do what they do. For NGO workers in this study the powerful corruption discourse within Guatemalan's shifting socio-political context, worked in ways that shaped their understanding and applications of their work.

As these examples have shown, NGO workers targeted with discourses of corruption, do internalize the rhetoric in varied ways, but notably it hasn't created a monolithic effect in

silencing NGOs' advocacy work altogether. This is especially evident with ANDI, whose empowerment work as discussed in Chapter 4 continues despite this context, with the support of their international donors and funders. Yet, organizations like ANDI and FMS, also continue their work in their current forms due to the ways in which the larger discourses of corruption have re-articulated the political subjectivities of their staff. NGO workers found new ways to adapt and adjust in this context. This was manifest in increasing efforts to show transparency, accountability, and auditing. NGO administrators also adapted by trying to reclassify their organizations within the politically-motivated and revised legal definitions, making space to counter blanket notions of the sector as corrupt.

Some argue that these changes in practices exemplify an increasing trend in professional managerialism within the NGO sector, where an increase in techniques to make themselves accountable to local communities, government, and transnational development agencies are envisioned as processes of professionalization (Eagleton-Pierce 2020, Fernando 2011, Vannier 2010). While that may be true, attention to the context in which these professionalization practices emerge adds nuance to understanding why such practices are invoked and valued. As this chapter has shown, corruption rhetoric is not a neutral discourse. Instead, it can be understood as a tool of the pro-impunity state for forcing individuals away from advocacy and action, re-configuring their political subjectivities in the process. The larger discourse of corruption entrenched managerialism out of fear and stigmatization, effectively persuading NGOs to begin to police themselves. This was accomplished through self-auditing, closely monitoring their staff, and increasing transparency measures. Such self-policing had additional effects, in that it muted socio-political advocacy and discouraged associating with other NGOs, effectively discouraging inter-institutional collaboration and solidarity among the NGO sector.

Through socio-political and legal tactics designed to induce fear and stigmatization, discourses of corruption exert their power within the subjective experiences, agency, and personhood of individuals' views of truth and reality. In a context where enduring historical trauma of state violence exists as a reality among the NGO sector, the manipulation of the political subjectivities of NGO workers may in fact be an enduring trauma and quiet continuation of such violence.

Chapter 7: Discussion and Conclusion: Subjectivity and Refractions of "Doing Good" in the NGO Sector

Introduction

On February 11th 2020, less than a year after returning from fieldwork, I woke up to the news that Guatemala's newly minted president, Alejandro Giammattei, adopted Decree No. 04-2020, which introduced additional reforms to the *Ley de ONGs* (NGO Law). This decree would create a legal system to impose control measures over the registration, administration, financing, and everyday operations of NGOs, limit freedom of association, and establish additional power to "cancel" and disband national and international organizations. One of the most disconcerting aspects of these changes was that NGOs could potentially be stripped of their legal status for participating in work deemed to oppose the "public order," while what constitutes violations against the public order was not clearly defined (Hite and Beltrán 2020). It seemed that the shifting socio-political context affecting NGOs in Guatemala I am documenting had abruptly come to a drastic head with the passing of Decree No. 04-2020.

I poured over news articles and social commentary, which brimmed with public objection from the NGO sector, academics, and countless international development institutions (ACNUDH 2020, WOLA 2020, Amnesty International 2020). In a joint statement signed by over 50 national and international organizations objecting the decree, the writers contended that "the approved regulation creates risks of persecution based on dissent, aims to deter public criticism and eliminates any possibility of accountability to the public, thereby perpetuating schemes of corruption and impunity" (WOLA 2020). Such criticism of the law is exemplified in an inter-institutional statement from NGOs in Quetzaltenango shared publicly and widely on Facebook in February 2020. The NGOs stated that civil society organizations were "doing what the state of Guatemala has not done in the last 50 years" including addressing vulnerable populations, chronic malnutrition, poverty, and violence against women. They explained,

> *We are the ones who ultimately finance what the state does not attend to. … The NGOs are the bridge between the community and the state, we strengthen their technical, methodological and political capacities. We play a role in favor of life and territory of the peoples, of women and men, as well as the democracy and the rule of law of the country. We have been at the front of the fight against corruption and impunity. It's also a service of human solidarity when we are the ones who immediately join to meet needs and demands. We have been in communities where the state does not have an institutional presence, serving the forgotten sectors. To date, NGOs have done serious and committed work with communities. … We publicly denounce that the freedoms and rights constitutionally guaranteed are violated, limiting citizen action, and demonstrating a government, dominated by the military, a small business sector, and corrupt politicians, who fear denouncement and action by society through NGOs in the fight against injustice, corruption and impunity.*[8]

In the face of such damning criticism on a national and international level, Decree 04-2020 was suspended by Guatemala's constitutional court a month later (Reuters 2020). However, this attempt to further reign in the NGO sector under state control was indicative of the larger socio-political shift that emerged throughout the course of my fieldwork, in which NGOs were increasingly defunded and delegitimized by state policy change and political discourse. This clearly illustrates the critical importance of contextual circumstances for understanding the ways in which NGOs serve underrepresented and disadvantaged communities. Such laws have the potential to directly shape the political subjectivities of NGO workers in ways that can influence their work by silencing social activism, community participation, and empowerment.

In this dissertation I have shown that the work NGOs perform and accomplish at the intersections of health and social justice provides a window into better understanding the dynamic interplay of cultural, political and economic factors of particular contexts. As I've demonstrated, the entanglement of the state and the NGO is made visible through attention to the subjectivities of NGO workers. The Guatemalan context has provided a salient example of this tangling process, as changes in NGO-state relationships, social policy for health, and an

[8] This is my English translation of the original statement which was written in Spanish.

increasingly pro-impunity state that protects perpetuators of corruption, have steadily impacted the subjectivities, resources, and practices of those working for NGOs. NGOs working within a social justice framework for health, such as Asociación para Nutrición y Desarrollo Integral (ANDI) and Fundación Maya Salud (FMS), are a unique area to examine this process as they continue to operate in the ebb and flow of changing fields of social power. This link between social justice and health has been an increasing trend within the NGO sector in Guatemala over the last several decades as increasing privatization and decentralization of healthcare created a hybrid landscape of private, public for profit, and non-profit healthcare that further marginalized Indigenous Maya communities (Beck 2017a, Chary and Rohloff 2015). Yet it remains unclear how the larger churn in socio-political support for non-profits may influence the work of such NGOs.

In this research, I sought to explore how recent socio-political shifts and policy change in Guatemala affected the abilities of NGO workers to continue to perform their roles in health intervention in Indigenous Maya communities. I examined this question in the context of two primary NGOs in Chimaltenango, ANDI and FMS, who share an intertwining history of social justice for health, which was molded and transmuted over time in this context. I showed how the subjectivities of NGO workers, formed through powerful personal, institutional and political forces, impact what NGOs do and how they understand their work in relation to those they aim to serve. By examining the subjectivities of NGO workers, I reveal how collective action is transformed through the social, cultural and political linkages between NGOs, local communities, and state institutions.

How NGOs Continue to Serve in Contexts of Socio-Political Change

In this study, I questioned how NGO workers at ANDI and FMS were able to continue their health intervention work in Maya communities amidst the shifts in social and political supports for NGOs in Guatemala's changing healthcare context. In examining the intertwining history between these organizations and comparing the work conducted at each, I found that this context shaped health intervention differently at these organizations. These differences were based on the varying ways that the personal, institutional and political subjectivities of NGO workers impacted their understanding of health disparities in Maya communities and how best to address them.

Although both organizations shared a unique history of social justice approaches to health intervention in Kaqchikel Maya communities, this commitment to collective action only continued to be realized in some form at ANDI and was no longer prevalent at FMS, despite both originating from the same founder, Dr. Marcelin. At ANDI, continuing to serve communities in the context of decreased social and political supports for NGOs was facilitated largely by their funding structure. ANDI relied primarily on international donors and financial institutions and foundations that fully supported ANDI's community empowerment approach to addressing chronic malnutrition in Kaqchikel communities throughout Chimaltenango. This was an approach both steeped in the institutional legacy of the founder, Dr. Marcelin's, liberationist vision of community participation in health, as well as the collective understanding of Indigenous NGO workers at ANDI who saw women's empowerment as the central contributing factor to chronic malnutrition in their affiliated communities. I discussed how many of the workers at ANDI invoked their own personal experiences as Indigenous peoples from the very communities in which they worked, as reasons for why they pursued such work, and how they

designed their approaches in health intervention. Many saw the various projects being carried out by their fellow NGO workers at ANDI—from health education, to water sanitation, to men's masculinity trainings—as intimately connected to the empowerment of women. While ANDI, like much of the NGO sector, is immersed in larger institutional and international development discourses pushing agenda concerned with gender inequality and feminist thought, workers at ANDI also demonstrated the ways they uniquely understood community participation as empowerment. I argued that through their personally and institutionally formed subjectivities, NGO worker's notions about the connection between malnutrition and the disempowerment of women mobilized a sense of feminist solidarity, where the subjugation of women was the fundamental driving force behind their everyday work.

In contrast, at FMS, continuing to serve Indigenous communities in Chimaltenango was mediated by their fluctuating relationship with the state. Through an examination of the NGO's history of community participation, their work with the Ministry of Health via state-funded PEC contracts, and their current fee-for-service financial model, I showed how the organization's approach to health intervention changed significantly over time. I discuss how in its early days, FMS oriented their work around the notion that health disparity was best remedied through the passing of knowledge and decision making to community members, and that biomedical services, while necessary, do little to address the profound social and economic issues contributing to systemic health problems in the Maya community. This community participation approach dramatically shifted when FMS began to receive PEC contacts from the Ministry of Health. I show how the stipulations and agenda attached to these contracts transformed the meaning of working with community by narrowing health intervention to the provision of basic curative and preventative services, and the surveillance of limited health outcomes. I demonstrate

how these changes simultaneously instilled managerial and bureaucratic practices within FMS such that most NGO workers no longer recognized community participation in health as the central focus of the work conducted by the organization. While NGO workers at ANDI were able to continue pursuing this legacy of community participation, at FMS financial constraints and their intimate relationship with the state made continuing such work unfeasible. I showed how even after the cancellation of the health policy supporting the PEC contracts, FMS continued to maintain the managerial practices that were engrained in them as subjects of the state. This irrevocable change over time continued to permeate FMS, manifesting in diminished preventive health interventions in Indigenous communities, the condemnation of health activism by FMS administrators, and a hyper focus on the provision of biomedical services to maintain financial stability.

As the intricate history and connection between ANDI and FMS shows, the path toward community empowerment work in health is negotiated within the intertwining context of personal convictions, funding, institutional requirements, and a fluctuating relationship with state institutions. At ANDI, the deeply personal and experiential convictions of NGO workers to pursue community empowerment was supported by the organization's institutional agenda, legacy, and financial donors. On the other hand, at FMS, community participation in health was transmuted and subdued by the organization's financial ties to the Ministry of Health which left lasting effects on the everyday operations of the NGO. The major differing factor between these two cases is notably the ways in which the state directly impacted the actions and practices of the NGO.

The Intrinsic Linkage Between the State and the NGO

As demonstrated in Chapter 6, NGOs are closely tied to the state through the effects of larger policy, law, and political discourse, regardless of whether they hold financial or collaborative ties to government institutions. While administrators at ANDI made it clear to me that they would never work for the state in the same way FMS had, the link between the state and the organization was still very real. This became apparent in relation to the politically motivated discourses of corruption emerging from powerful sectors of Guatemalan society targeted toward NGOs. As discussed, these discourses instilled fear among NGO workers and a sense of stigmatization, manifesting in increased bureaucratic transparency measures and professionalization. Despite relying on international funders and donors, NGO workers at ANDI described real fear that the notion that NGOs are corrupt has become increasingly popular and was being taken up as a societal truth. They feared that this could potentially dissolve their financial stability by turning away donors altogether. The key to ensuring that ANDI retain financial stability in this shifting context necessitated increased transparency measures with their donors. At the same time, such transparency was arguably an objective of the state as evidenced in the changes to the NGO law. In effect, discourses of corruption and changes in law essentially compelled the NGOs in this study to begin policing themselves in ways that actually aligned with the objectives of the state. Moreover, the legal, fiscal and fear tactics of the state impacted the health intervention work of NGO staff through the internalization of stigmatized identities, sowing distrust among those within the NGO sector, reducing inter-institutional collaboration among NGOs, and further transmuting NGO advocacy and social justice work.

The connection between the state and the NGO sector is thus a fundamental, intrinsic linkage, by the mere fact that NGO workers are still citizens and subjects of the state, whose

political subjectivities are continuously shaped by politically-driven policy change, authoritative discourse, popular belief, and regimes of truth. As such, NGOs are not entirely 'non-governmental,' as they are interconnected with the state (Mercer 2002). As Grewel and Bernal (2014) aptly argue,

> *If the main distinguishing characteristic of NGOs was their independence from government, then many NGOs would fall outside that designation because they are not so much separate from or dependent on states as they are entwined with states. … NGOs may become so intertwined with the state that their ideology and practice become less radical.* (Grewal and Bernal 2014: 9).

As I've shown, this "intertwining" of the state and the NGO is made visible through attention to the subjectivities of NGO workers. Yet, it is through the negotiation of their varying and competing individual, institutional, and political subjectivities, that NGO workers make decisions about how to best serve the most marginalized within a socio-political context that churns around them. It is through subjectivity that we can see the competing processes that lead to refractions of doing good within NGOs.

The Competing Subjectivities of the NGO Worker

As discussed throughout this dissertation, NGO workers possess multiple and competing subjectivities. Their unique subjectivities are constructed through the interweaving of the personal, institutional and political realms they must traverse in their everyday attempts to accomplish some form of societal good. Individual personal subjectivity manifested in the way in which personal experiences, beliefs, identity and agency led individuals to understand and implement health intervention work in particular ways. For example, this was especially apparent among NGO workers at ANDI, whose personal convictions, and experiences of disempowerment and disenfranchisement as Indigenous citizens, influenced their understanding, valuation, and implementation of their work in community empowerment for health. The

powerful discourses and practices of the state did increasingly instill fear and uncertainty among NGO workers at ANDI, steadily impacting their political subjectivities. However, this did little to transmute the central community empowerment focus of their work, likely due to their limited direct interaction with state institutions like the Ministry of Health, SIAS, or IGSS. Instead, the compounding of their individual subjectivities as members of the Indigenous Maya community, and their institutional subjectivities as employees of an NGO, carried a greater bearing upon their work, together mobilizing a paradigm of feminist solidarity within the model and approach of the NGO.

At FMS, NGO workers and administrators demonstrated a different negotiation between their competing subjectivities. Their institutional subjectivities, as employees of an organization with a historical legacy of liberationist community participation in health, combined with their political subjectivities as bureaucratic arms in contract with the Ministry of Health. I showed how the connection between the state and the NGO began to transform FMS' fundamental notion of health intervention entirely, rearticulating their central purpose toward curative biomedical care and enumeration rather than community empowerment. As the case of FMS indicates, such a dramatic change in what NGO workers do, occurs as a series of shifts over time, in which the lure of state support can come to hold significant influence over the subjectivities of NGO workers, such that professionalization, managerialism, and bureaucratic practices become marked as defining what it means to do good.

As I've argued, the political subjectivities of NGO workers are an innate aspect of their work. Their political subjectivities are continuously shaped and re-articulated by the whims of political discourse, and changes in state policy and law. As evidenced by the opening discussion of this chapter, the attempt to install additional measures of state control over the Guatemalan

NGO sector in 2020 indicates that NGO workers are continuously caught in an ever-changing field of power that is increasingly being harnessed by the state. In the shadow of Guatemala's haunting civil war, where the overt tactics of intimidation, disappearance, and murder, were employed against NGO workers and social activists, the state has instituted new ways of impacting what NGO workers do through the manipulation of their political subjectivities. Such re-articulations of NGO worker's political subjectivities have the potential to cast NGOs in an unfavorable light, sowing seeds of social distrust and anti-solidarity. Still, subjectivity in this context is the foundation where the subtleties between the self and socio-political processes converge. It is the site where individuals traverse the competing and interweaving conditions of their identity, agency, and personhood in order to do good.

This work has demonstrated that the value of subjectivity theory lies in its framework for exposing the dynamics between the self and political and social processes. Through the lens of subjectivity, the complex entanglement and intrinsic link between the state, institutions, and individuals is revealed. It is within such entanglements that individuals make decisions and choices based on the boundaries of their social and political freedoms, the limits of their knowledge and experience, and the dialectic between their ability to act and be acted upon. In short, subjectivity forms the basis for understanding the intricacies of human agency.

Limitations and Future Research: Social Solidarity and the Political Economy of NGOs

In this dissertation, I have demonstrated the ways in which relationships with funding and the state, can cause impediments for health intervention in the context of NGOs. Within this context, NGO workers negotiated their way around these impediments in ways that highlighted the various individual, institutional, and political subjectivities they possess. Yet, this analysis is limited in that it largely shows how contextual factors can be tremendously determinative in the

work conducted by NGOs. This attends to much needed documentation of the effects on NGO workers and processes within the substantial shifts in politics of the last two decades, responding to questions of how NGOs continue to serve others. However, an additional question emerges from this dissertation, which asks why NGO workers continue to serve others despite shifting (and increasingly precarious and unstable) relationships between NGOs, states, and communities. As such, this dissertation has looked at *how* NGOs persist and persevere, but not *why*.

Solidarity theory may provide an interesting framework for expanding on this limitation and understanding this question in more depth. Kolers (2016) contends that a moral theory of solidarity lies in the notion that solidarity "is working together irrespective of whether we agree" toward the "equitable treatment of those who have been treated in equitably" (Kolers 2016: 7;148). This understanding of solidarity reflects Kropotkin's (1915) notion of mutual aid in which he posits that "the conscience of human solidarity" rests on "the sense of justice, or equity, which brings the individual to consider the rights of every other individual as equal to [their] own" (Kropotkin 1915:5-6). As an outcome of this research, I question whether social solidarity may be an underlying or inherent aspect of NGO political economy. I question whether at their most basic incarnation, grassroots NGOs could be understood as reflections of social solidarity emerging in response to social injustice, systemic inequalities, and the absence of state presence, capacity, and responsibility.

As discussed in chapter 4, I posit that there is a notion of feminist solidarity that drives and shapes the work conducted by NGO workers at ANDI. There, I saw a basic human desire and sense of commitment that people have for others, especially being products of oppressed communities themselves, as if it is in the very nature of community to carry forward. At the

opening of this dissertation, I quoted a poem by Lao Tzu as recited to me by an NGO worker at ANDI who told me it rests framed on one of the walls in their office in Chimaltenango. The poem reads:

> *"Go to the people. Live with them. Learn from them. Love them. Start with what they know. Build with what they have. But with the best leaders, when the work is done, the task accomplished, the people will say 'We have done this ourselves.'"*

Recited to me as a maxim for the work conducted at ANDI, I contemplated this as a reflection of the solidarity championed by the founder of FMS echoing through time and reverberating through the collective actions of ANDI's staff and the Indigenous Kaqchikel Maya communities they work with. This tenant of collective action reflects Paulo Freire's notion of solidarity, who writes "solidarity requires true communication" that is dialogical, necessitating "action with the oppressed" to transform the structures that systemically oppress them (1970: 40; 50). Yet, as anthropologist, Mark Schuller (2017) asks, "for whom, from whom, and to what ends" are NGOs doing such work?

Future ethnographic investigations of subjectivity can begin to address such questions as a critical theoretical framework for understanding the nature of NGOs, how and why they change, and the role of social solidarity within the political economy of NGOs. In this dissertation, I have sought to reveal the process of power, agency, and negotiation that occurs when considering the competing subjective realities of NGO workers. Moving forward, anthropological and research with NGOs would do well to further examine questions of what NGOs do versus questions of what they are, through close attention to these everyday experiences and subjectivities of the workers that ultimately comprise them. In doing so, we may begin to understand the role of social solidarity within NGO practices, and how it can be transmuted, amplified, and refracted over time and space.

APPENDICES

APPENDIX A: English Interview Guide

The Relationship Between the State and Non-Government Organizations: Implications for Marginalized Communities in Guatemala

NGO REPRESENTATIVE INTERVIEW

Participant ID: _____
Participant Name: _____
Participant Title/Position: _____
NGO Name: _____
Interview Date: _____
Interviewer Name: _____
Location of Interview: _____
Additional Interview Participants: _____

STARTING TIME: _____

INTRODUCTION

This interview is part of an exploratory study examining the relationship between Guatemalan non-government organizations and state or government institutions, and how these relationships may affect NGOs and the communities they serve, especially in regards to health and healthcare services. The interview should last about 1 hour. The questions are open-ended so please answer in as much detail as you care to. Also please feel free to not answer any question you don't feel comfortable with, or to stop the interview if you no longer wish to participate. Do you have any questions before we start?

I NGO WORK, PROGRAMS, AND COMMUNITIES

1.1 First can you tell me about your main work here at the NGO?

1.1.2 When did you first start working here?

1.1.3 Has the focus of your work here changed over time? How so?

1.2 What kinds of health programs does the NGO offer?

1.3 What is your role in those health programs?

1.4 Tell me more about the patients you typically see here.

1.4.1 What communities/regions?

1.4.2 How many people does the NGO serve in an average week?

1.4.3 What kinds of health problems do you typically treat?

1.5 Do you think the patients who come here experience any obstacles or barriers to health? Like what?

1.6 For you, what does it mean to be a healthcare provider working in this community?

1.7.Do you ever do home visits with patients? What is that like?

1.7.1 IF NO, do you think bringing healthcare services to communities is important?

1.8 What would you say are your main "goals" with regards to delivering care?

II HEALTHCARE SYSTEM CRISIS, ANTI-CORRUPTION, SOCIAL MOVEMENTS

2.1 As you are probably aware, the National Healthcare system here in Guatemala is experiencing immense challenges. What do you think about the current crisis?

2.1.1How do you think the current state of the healthcare system is impacting people's health?

2.1.2 If you were experiencing health problems yourself, where would you go?

2.2 If healthcare reform happens in Guatemala, what do you think these reforms will include?

2.3 If you could imagine an ideal healthcare system for Guatemala, what would it look like?

2.3.1 What kind of facilities or services or resources do you think your patients in this community would need in this ideal healthcare system?

2.3.2 Do you think NGOs would have a place within your ideal healthcare system?

2.4 I've heard some people say that sometimes saying "NGO" is like saying a bad word. What do you think of that?

2.4.1 For you, what has been being an NGO worker meant to you? What has your work here meant to you?

2.5 You are probably aware of the anti-corruption movement that has been happening in Guatemala in recent years. Do you think this has impacted NGOs in any way?

2.5.1 Are you concerned that the anti-corruption movement may impact the NGO, or you as an NGO worker in any way?

2.6 I've talked to people who have said that some NGOs with "corrupt practices" have made other NGOs look bad. Have you ever heard things like that?

III. NGO NETWORKS

3.1 Have you worked at other NGOs besides this one?

3.2 Does the NGO collaborate with other NGOs to provide services? For what? Can you give me an example?

3.3 Is it important for you to network with other NGO workers in the community? Why?

3.4 Do you think the NGO sector can work together to help improve the healthcare system?

3.4.1 Do you think NGO healthcare workers like yourself can have an impact on healthcare policy? In what ways?

3.5 Do you see any potential problems with collaborating with other NGOs?

3.6 Do you think NGO workers like yourself have a responsibility to care for communities?

IV INFLUENCE OF THE STATE, GOV, MINISTRY OF HEALTH ON NGO

Now I want to change topics a little and talk about the NGO's relationship with the Guatemalan state and government, especially the PEC (Coverage Extension Program)

4.1 As I understand, this NGO used to collaborate with Guatemalan Ministry of Health during the PEC. What do you know about the PEC?

4.2 Were you here when the NGO received PEC contracts?

4.2.1 [IF YES] If yes, tell me more about this. What was it like during that time? Do you think the PEC affected the work you or others were able to do?

4.2.2 [IF NO] What do you think about government-NGO contracts?

4.3 Since the canceling of the PEC a few years ago, do you think things have changed at the NGO? How?

4.3.1 Do you think your work here has changed since the canceling of the PEC? In what ways?

4.4 Does the NGO still have any type of relationship with the Ministry of Health or the local government?

4.4.1 [IF YES] What kind of relationship?

4.4.2 [IF NO] If no, do you think they should?

4.5 Do you think the government should financially support NGOs? Why or why not?

4.6 If the PEC were to come back, do you think the NGO would do it again?

4.6.1 Are there things you would change about the contracts?

4.6.2 What do you think worked well with the PEC?

V FUNDING AND RESOURCES

Now I would like to talk about how this NGO is funded and how it might affect your work.

5.1 Do you know how the NGO receives most of its funding now?

5.2 Do you think funding at the NGO ever affects your abilities to do the work you need to do?

5.3 Have you ever felt that you didn't have the resources you needed to do your job?

5.3.1 Why do you think that happened?

5.4 Are there services or programs you would like to see funded here at the NGO that are not? Like what?

VI. ACTIVISM

6.1 To you, what does the word "activism" mean?

6.2 Do you think the Guatemalan government is supportive of that kind of activism? OR should they?

6.2.1 Do you think that in some places, being an NGO healthcare worker is a dangerous?

6.3 I've heard that in the past, when this NGO was founded, the workers were thought of as social activists. Do you think that is still true today?

6.3.1 Do you think the workers here should do more activism related to health? About what kinds of things?

6.4 In your work here, do you think of yourself as a healthcare activist? Why or why not?

VII DEMOGRAPHICS

This is the last section. I just have a few questions about your background that I would like to ask.

7.1 [Circle one: Male Female]

7.2 What is your title/position at the NGO? _____

7.3 What is your age? _____

7.4 Where were you born? _____

7.5 What is your race or ethnicity? _____

7.6 How much schooling have you completed? _____

7.6.1 Do you hold any degrees or certifications? _____

7.7 How long have you work at this NGO? _____

7.7.1 Do you have any other experience working with NGOs? _____

7.8 Can you tell me how many people work at the NGO in total? _____

VIII CLOSING

8.1 Those are all my questions, is there anything you would like to add that we haven't discussed?

8.2 I'm interested in doing observations here to better understand how healthcare workers deliver care to patients. Would you be interested in letting me shadow you during one of your work days?

IF NOT, Do you think there are any events or programs here that I might be able to observe?

ENDING TIME:_____

APPENDIX B: Spanish Interview Guide

La relación entre el estado y las organizaciones no gubernamentales: implicaciones para las comunidades marginadas en Guatemala

NGO REPRESENTATIVE INTERVIEW

Participant ID: _____
Participant Name: _____
Participant Title/Position: _____
NGO Name: _____
Interview Date: _____
Interviewer Name: _____
Location of Interview: _____
Additional Interview Participants: _____

STARTING TIME: _____

INTRODUCCIÓN

Esta entrevista es parte de un estudio exploratorio que examina la relación entre las organizaciones no gubernamentales y las instituciones estatales y los financiadores, y cómo estas relaciones pueden afectar a las ONG y las comunidades a las que sirven, especialmente en lo que respecta a la salud. La entrevista solo debe durar una hora or menos. Las preguntas son abiertas, así que responda con todos los detalles que prefieres. Además, no necessitas responder a cualquier pregunta con la que no se sienta cómodo, y puedes detener la entrevista si ya no desea participar. ¿Tiene alguna pregunta antes de comenzar?

I ONG, TRABAJOS, PROGRAMAS Y COMUNIDADES

1.1 Primero, ¿puede hablarme sobre su trabajo principal aquí en la ONG?

1.1.2 ¿Cuándo empezaste a trabajar aquí?

1.1.3 ¿Ha cambiado el enfoque de su trabajo aquí con el tiempo? ¿Cómo?

1.2 ¿ Este ONG tiene un enfoque en la desnutrición. ¿Cómo se relaciona su trabajo con este enfoque?

1.3 ¿Puedes decirme cómo es un día típico para ti trabajando aquí?

1.4 Puedes decirme más sobre las comunidades en las que trabajas?

1.4.1 ¿Qué comunidades / regiones?

1.5 ¿Cree que los communidates experimentan obstáculos o barreras para la salud? ¿Como que?

1.7 Para usted, ¿por qué es importante llevar estos servicios a las comunidades?

1.8 ¿Cuáles diría que son sus "objetivos" principales a tu trabajo aquí?

II CRISIS DEL SISTEMA DE SALUD, ANTICORRUPCIÓN, MOVIMIENTOS SOCIALES

2.1 Como usted probablemente sabe, el sistema nacional de salud aquí en Guatemala está experimentando inmensos desafíos. ¿Qué te parece la crisis actual?

2.1.1 ¿Cómo cree que el estado actual del sistema de salud está afectando la salud de las personas? Cómo afecta la salud de las personas en las comunidades con las que trabaja?

2.1.2 Si estuviera experimentando problemas de salud, ¿adónde iría?

2.2 Si la reforma de salud se implementa en Guatemala, ¿qué cree que incluirán estas reformas?

2.3 Si pudieras imaginar un sistema de salud "ideal" para Guatemala, ¿cómo sería?

2.3.1 ¿Qué tipo de instalaciones, servicios o recursos cree que necesitarían sus pacientes en esta comunidad, en este sistema de salud "ideal"?

2.3.2 ¿Cree que las ONGs tendrían un lugar dentro de su sistema de salud "ideal"?

2.4 He escuchado a algunas personas decir que, a veces decir "ONG" es como decir una mala palabra. ¿Qué piensa usted de eso?

2.4.1 Para ti, ¿qué significa ser un trabajador de una ONG? ¿Qué ha significado tu trabajo aquí para ti?

2.5 Probablemente esté al tanto del movimiento anticorrupción que ha estado ocurriendo en Guatemala en los últimos años. ¿Crees que esto ha impactado a las ONGs de alguna manera?

2.5.1 ¿Le preocupa que el movimiento anticorrupción pueda afectar este ONG, o a usted como trabajador de una ONG, de alguna manera?

2.6 He hablado con personas que han dicho que algunas ONG que tuvieron "prácticas corruptas" han hecho que otras ONG se vean mal. ¿Alguna vez has escuchado cosas así? Que pienses de eso?

III. REDES DE ONGs

3.1 ¿Has trabajado en otras ONGs además de esta?

3.2 En su trabajo, ¿puede hablarme de un momento en que fue importante establecer contactos con otras ONG?

3.3 ¿Es importante para usted relacionarse con otros trabajadores de ONGs en la comunidad? ¿Por qué?

3.4 ¿Cree que el sector de las ONG puede colaborar para ayudar a mejorar el sistema de salud?

3.4.1 ¿Cree que los profesionales de la salud de ONG como usted, pueden tener un impacto en la política de salud? ¿De qué maneras?

3.4.2 ¿Alguna vez has sentido tu trabajo afectado o mejorado la política social de alguna manera?

3.5 ¿Ves algún problema potencial con la colaboración con otras ONGs?

3.6 En su trabajo en la ONG, ¿se siente responsable de ayudar a las comunidades con las que trabaja?

3.6.1 ¿Crees que las ONGs, en general, han asumido la responsabilidad de ayudar a las comunidades en los ultimos anos?

IV INFLUENCIA DEL ESTADO, GOV, MINISTERIO DE SALUD SOBRE ONG

Ahora quiero cambiar un poco la tema, y hablar sobre la relación del sector de ONGs con el estado y el gobierno de Guatemala.

4.1 En su trabajo, ¿puede hablarme de un momento en que tuvo que trabajar con el gobierno o el municipio para hacer un proyecto? Cómo fue esta experiencia?

4.2 ¿Crees que es importante para el ONG a trabajar con el gobierno local?

4.3 ¿Crees que el gobierno debería apoyar financieramente a las ONG que trabajan en áreas rurales?

4.3.1 Hipotéticamente, si el gobierno financió programas en el ONG, ¿cree que su trabajo podría cambiar? ¿De qué maneras?

4.4 ¿Ha habido algún momento en el que el gobierno, el Ministerio de Salud o el municipio le dificultaron a su trabajo?

V FINANCIAMIENTO Y RECURSOS

Ahora me gustaría hablar sobre cómo se financia esta ONG y cómo podría afectar su trabajo aqui.

5.1 ¿Sabe cómo la ONG recibe la mayor parte de su financiación ahora?

5.2 ¿Cree que la financiación de la ONG afecta sus capacidades para hacer el trabajo que necesitas hacer?

5.3 ¿Alguna vez ha sentido que no tenía los recursos que necesitaba para hacer su trabajo?

5.3.1 ¿Por qué crees que sucedió?

5.4 ¿Hay servicios o programas que le gustaría ver financiados aquí en la ONG que no lo son? ¿Como que?

VI. ACTIVISMO

Ahora quiero cambiar un poco el tema para ver qué piensa sobre el activismo en la atención médica.

6.1 Para ti, ¿Qué significa el “derecho a la salud”?

6.1.1 Pienses que la salud como "derecho humano" describe el sistema de salud hoy in Guatemala?

6.1.2 Crees que el Ministerio de Salud tiene la responsabilidad de garantizar este derecho?

6.1.3 En este momento, ¿cree que las ONGs, como ustedes y otras que se enfocan en problemas de salud, han tomado la responsabilidad de garantizar la salud como un derecho humano?

6.2 Para ti, ¿qué significa la palabra "activismo"?

6.5 En tu trabajo aquí, ¿te consideras un activista de salud? ¿Por qué o por qué no?

6.4.1 ¿Crees que los trabajadores aquí deberían hacer más activismo relacionado con la salud? ¿Sobre qué tipo de cosas?

6.3 Tienes la esperanza de que algnun dia el Sistema de salud sea mas accessible a todos?

VII DEMOGRAFIA

Esta es la última sección. Solo tengo unas preguntas sobre su historia que me queria preguntar.

7.1 [Circle one : Hombre Mujer]

7.2 ¿Cuál es su título / posición en la ONG? _____

7.3 ¿Cuantos anos tienes? _____

7.4 ¿Dónde naciste? _____

7.5 ¿Cuál es su raza or ethnicidad? _____

7.6 ¿Cuánta educación has completado? _____

7.6.1 ¿Tiene títulos o certificaciones? _____

7.7 ¿Cuánto tiempo llevas trabajando en esta ONG? _____

7.7.1 ¿Tiene alguna otra experiencia trabajando con ONGs? _____

VIII CLOSING

8.1 Esas son todas mis preguntas, ¿hay algo que quisiera agregar a nuestra conversasion?

ENDING TIME: _____

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