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A Balanced Approach to Health: Understanding the Health Care Practices of Guatemalan Maya in the United States

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A BALANCED APPROACH TO HEALTH: UNDERSTANDING THE HEALTH CARE PRACTICES OF GUATEMALAN MAYA IN THE UNITED STATES

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Introduction

Since their first encounters with Europeans in the fifteenth century, the indigenous Maya of Guatemala have confronted colonizing forces in a variety of ways. Through isolation, syncretism, and resistance, generations of Maya have worked to preserve the traditions and beliefs of their ancestors while also incorporating new ideas and technologies into their cultural framework. Present-day Maya culture continues to adapt to new ideas, but retains strong elements of its ancient beliefs, particularly about health and medicine.

In Guatemala, laws and regulations continue to alter ethnomedical health practices, while a history of violence and severe economic hardship drive many Maya to leave the country and seek a better life in *El Norte*.[1] Cultural influences persist in the United States, where Maya immigrants experience complex barriers to receiving adequate health care.[2] The health care practices and concepts of Maya immigrants continue to evolve as consequences of their traditional beliefs, their postcolonial cultural identity, the experience of diaspora, and their ability to access care in the United States.

Although Maya culture includes a developed system of ethnomedical care, a legacy of postcolonial oppression and racial discrimination in Guatemala greatly influence Maya perceptions of what makes healthcare good or bad. Their conceptions of power and authority also affect their interactions with the US healthcare system and its providers, often leading them to question or reject their own cultural practices in favor of the biomedicine practiced in the

[1] "Ethnomedicine" refers to the local ideologies and practices of individual groups. *El Norte* means "the north" and is a term generally used to describe the United States and sometimes Canada.
[2] Health care refers to the care given to a patient by a provider. Healthcare refers to the system that provides health care.

United States. Maya health beliefs are transmitted and reinforced within these transnational communities through the process of diaspora, but beliefs and practices may change in the host country. At this intersection of cultures, it is possible to examine how a particular group of Mayas perceives their own traditions in contrast to postcolonial pressures.[3]

The Maya Heritage Community Project (MHCP) at Kennesaw State University (KSU) recognizes the unique situation of Guatemalan Maya in the United States. The MHCP collaborates with Maya communities in Georgia and throughout the nation to address Maya-specific issues. Its mission is, "To link the academic mission of the university with the economic and social interests of Georgia while serving the local community of Guatemalan Maya immigrants."[4] Faculty, staff, undergraduate and graduate students, and Returned Peace Corps Fellows all contribute to this interdisciplinary group. Since 2001, the MHCP has developed relationships with local Maya, organized Maya conferences, participated in Maya festivals, and developed and facilitated programs such as the Georgia Governor's Office of Highway Safety "DUI Education for Hispanics in Cobb and Cherokee Counties" program, which won the prestigious Zero Deaths Award in 2008.[5] By fostering long-term reciprocal relationships with Maya throughout the country, the MHCP has made a name for itself as a model of service learning and a vital link between academia and the Maya community in diaspora.[6]

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[3] The Maya are not a homogeneous group and I wish to be clear that my interpretations are based on my interactions with the Maya Heritage Community Project's partners in developing the toolkit. This project was conducted with approval from the KSU Institutional Review Board. My closest partners were a group of Maya women who live in Canton, Georgia. All of the women who participated are from Santa Eulalia, Huehuetenango, Guatemala, and have lived in the United States for anywhere from 3 to 12 years. My impressions from my interactions with these women, my conversations with other Maya whom I have met from around the United States, and my friendship with my interpreter and his family, shape my understanding of Maya culture in diaspora, but may or may not represent all Maya living in the United States or elsewhere.

[4] Maya Health Toolkit for Medical Providers Information Pamphlet, Folder 2011, Maya Heritage Community Project File, Burruss Institute, Kennesaw State University, Kennesaw, GA.

[5] "List of Projects," Folder 2008. MHCP Archives. Burruss Institute. Kennesaw State University. Kennesaw, GA.

[6] Nance Lucas, "The Influence of Integrative and Interdisciplinary Learning on Civic Engagement," in *Civic Engagement in Higher Education*, ed. Barbara Jacoby and Associates (California: Jossey Bass, 2009).

In 2010, the MHCP was contracted by the United States Conference of Catholic Bishops (USCCB) to construct *The Maya Health Toolkit for Medical Providers.*[7] The Robert Woods Johnson Foundation funded the project. The purpose of the Toolkit is to educate medical providers and other caregivers about the Maya, their cultural practices and history, and to enhance communication between providers and Maya patients. As a Graduate Research Assistant with the MHCP, I was actively involved in the Toolkit's creation as a researcher, developer, writer, and editor.[8] I worked closely with an interpreter, Gilberto Simon, conducting interviews and focus groups with eight Maya women in Canton, Georgia, to gain an understanding of how the Maya engage with and regard the US healthcare system. I also met with medical professionals in the area to ascertain their views of their Maya patients. By working with the community, the Toolkit team attempted to take our scholarly knowledge of culture and intercultural interactions, "beyond the academy . . . into the applied field of clinics, health education, and community based agencies."[9] We developed the Toolkit based our interviews and focus groups, as well as information we received from our Maya contacts throughout the United States.

The *Maya Health Toolkit for Medical Providers* set out to understand the many obstacles Maya immigrants face in receiving adequate care in the United States.[10] We developed methods, tools, and actions to be effective in overcoming communication and cultural barriers between

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[7] Henceforth referred to as "the Toolkit."

[8] I worked closely with Peace Corps Fellow and MBA candidate, Krista Czerwinski, in data collection, synthesis, and tool development. We are listed with Dr. Alan LeBaron, MHCP Director, as Principal Authors of the Toolkit.

[9] Merrill Singer, "Beyond the Ivory Tower: Critical Praxis in Medical Anthropology," *Medical Anthropology Quarterly* 9 (March 1995): 81-82.

[10] To identify and understand these obstacles, focus groups were held by Maya leaders in California, Colorado, Georgia, Nebraska, Oregon, and South Carolina. I was present at the focus group meetings in Georgia and South Carolina and attended the national Pastoral Maya leadership meeting at Kennesaw State University in 2010. Whereas general health care information was gathered from throughout the United States, the focus groups in Canton, Georgia, were only attended by women and were geared at understanding health issues specific to women because they are less likely to speak Spanish or English and are more likely to receive care in a hospital (i.e. childbirth).

Maya immigrants and their biomedical providers. Using a qualitative ethnographic approach, I shared the Toolkit with the group of women who were involved in its creation to gauge their initial reception of it. I also met with a Certified Nurse Midwife in Canton, Georgia, to obtain her impressions of the Toolkit. I discovered from these meetings that regardless of the quality and usability of the tools, some of the obstacles inhibiting Maya health care conditions cannot be overcome with a toolkit alone.

As the health traditions of their homeland are supplanted by biomedical practices in the United States, the Maya are slowly losing touch with their cultural roots in exchange for a system that they do not fully understand. This is not to say that ethnomedicine or biomedicine is better. As Catherine Ceniza Choy warns, "[Criticizing] the benefits of Western medicine," is not a popular position. She goes on to say that there is a, "pervasive cultural association of Western medical reforms with universal humanitarianism [that makes] questioning such reforms a risky endeavor."[11] Choy's warning is apt, and shows how the presence of postcolonial imperial attitudes in the realm of healthcare and health care practices is pervasive. The assumption that Western biomedicine provides the best possible option for all people all of the time is probably false, but few dare to say so. Though the Maya do benefit from biomedical practices, in many cases their cultural traditions can be as beneficial to their overall health and should not be disregarded.

The Maya worldview is constructed on the concept of balance. Their traditional beliefs emphasize balancing the spiritual and physical forces in their lives to maintain equilibrium and thus, health.[12] Nevertheless, outside forces have impinged heavily on this worldview, often shifting Maya views on health. My discussions with my Maya partners revealed that though they

[11] Catherine Ceniza Choy, "The Health of a Nation: Race, Place, and the Paradoxes of Public Health Reform," *American Quarterly* 55 (2003): 141.
[12] Juanatano Cano (Maya leader, Los Angeles, California), in discussion with the author, April 2011.

do utilize ethnomedicine in the United States, they tend to overvalue biomedical techniques and caregivers—even if they do not seek care from them. Maya history, cultural identity, and the experience of diaspora shape the way Maya immigrants view their health and their health care options, often leading them to devalue their own cultural practices. The MHCP and the Toolkit can help the Maya construct a more balanced approach to health care in the United States by encouraging them to value both ethnomedical and biomedical practices. We, as scholars and partners to the local Maya community, can assist in reinforcing the value of Maya cultural traditions in the eyes of the people themselves. This will increase the likelihood that the Mayas' beneficial practices remain a part of their transnational culture, while also helping them to understand valuable biomedical knowledge and incorporate it into their cultural framework. As Maya in diaspora and their biomedical providers become informed of one another's practices, they can begin to appreciate the benefits of both ethnomedical and biomedical systems.

Maya History

First Encounters to La Violencia

Present-day Guatemalan Maya are the descendents of the ancient Maya civilization of Central America and Mexico. During the last five hundred or so years of the Preclassic Maya period, which lasted from 1800 BCE to 250 CE, Maya civilization became more complex.[13] This emerging complexity resulted in the intricate written language, breathtaking architecture, incredibly accurate system of mathematics, sophisticated understanding of astronomy, and complex calendar for which the Classic Maya (who thrived from 250 CE to 925 CE) are best known.[14]

When the Spanish, Hernandez de Cordoba, specifically, first entered Central America in 1517, Maya civilization had been in decline for almost five hundred years.[15] In 1528, Adelantado Francisco de Montejo arrived in the Maya area and began its colonization.[16] The Spanish began enslaving indigenous Americans, forcing the Maya into servitude, and recruiting groups to fight against one another during this time.[17] Many Maya were also the victims of European diseases, which ravaged Maya communities, sometimes before the indigenous peoples had ever encountered Europeans directly. Widespread epidemics killed many within a few years.

To avoid the diseases they associated with the colonials, some Maya moved to isolated highland villages where they might minimize Spanish influences and continue practicing their traditional cultures. Victor Montejo, Walter Randolph Adams, and John P. Hawkins argue that

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[13] Michael D. Coe, *The Maya,* 8th ed. (New York: Thames and Hudson, 2011), 48, 61.
[14] Ibid., 10, 61
[15] Ibid., 10, 210.
[16] Adelantado is a Spanish title bestowed by the monarchy.
[17] Coe, *Maya,* 210-211.

removing themselves to these remote communities aided the survival of Maya cultures. European ideas did influence some Maya beliefs, but ultimately Maya isolation helped the people retain much of their cultural traditions and knowledge.[18]

Over time, the relationship between the indigenous Maya and the Europeans' descendents became more fixed, resulting in the labels *Indio* and *Ladino*. In Guatemala, Maya who live a traditional lifestyle and speak their indigenous language are often called Indios—a pejorative term that conveys a lower social status in the country. The term Ladino refers to three groups of Guatemalans: non-Indians, *mestizos,* and "Maya who no longer participate . . . in their community life."[19] Ladinos hold almost all positions of power in Guatemala. From the time of the earliest Europeans, Maya were delegated to the roles of producers—laborers for the Ladino elites. Discrimination against the Maya and a stratified social class system that placed indigenous people at the bottom became the standard in Guatemala and my interpreter, Gilberto, asserted that it remains that way.[20]

The Maya remained subjugated to Spanish and Ladino power for over four hundred years. The October Revolution of 1944 promised Guatemalans that governmental reforms would recognize the civil rights of all citizens, but this Guatemalan Spring only lasted for ten years and little long-term change resulted. In 1951, Jacobo Arbenz was elected president. He attempted reform measures that gave state-owned land to poor farmers, but in 1954, he was overthrown in a coup that was orchestrated by the US Central Intelligence Agency.[21] The collapse of the Arbenz

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[18] Walter Randolph Adams and John P. Hawkins, ed., *Health Care in Maya Guatemala: Confronting Medical Pluralism in a Developing Country* (Norman: University of Oklahoma Press, 2007), xvi.; Victor Montejo, *Voices from Exile: Violence and Survival in Modern Maya History* (Norman: University of Oklahoma Press, 1999), 35.
[19] James Loucky and Marilyn Moors, "The Maya Diaspora: Introduction," in *The Maya Diaspora: Guatemalan Roots, New American Lives,* ed. James Loucky and Marilyn Moors (Philadelphia: Temple, 2000), 1.
[20] Loucky and Moors, *Maya Diaspora*, 1; Gilberto Simon, Interview with Amanda McGrew, September 16, 2011.
[21] Richard N. Adams, "Ethnic Images and Strategies in 1944," in *Guatemalan Indians and the State: 1540 to 1988,* ed. Carol Smith (Austin: University of Texas Press, 1992), 155-157.

government began an outbreak of violence in Guatemala that lasted for over thirty years.[22] A plethora of anthropological and historical works address this period of Guatemalan history, commonly known among Maya communities as *La Violencia.*

The prominence of racism against the indigenous people contributed to the Guatemalan government and paramilitary groups targeting the Maya during the war. The fighting was at its most intense between 1978 and 1984. The Guatemalan Commission for Historical Clarification (CEH) estimated that, of the approximately 200,000 Guatemalans killed or disappeared during this time, at least 83% were indigenous Maya.[23] Furthermore, over 90% of the human rights violations that occurred, including massacres and tortures, were found to be committed by state-related groups. After the peace accords were signed in 1996, the CEH stated in its report, *Guatemala: Memory of Silence*, that the Maya were the victims of genocide because the acts against them, "were committed 'with intent to destroy [them].'"[24] These events affected generations of Maya and their repercussions continue to reverberate through the Maya community.

Personal testimonies of the violence and atrocities committed can be found in ethnographic works, histories, and the commission's report.[25] Victoria Sanford writes that the memory of *La Violencia* "is a contested terrain upon which the shifting tensions and allegiances of all sectors of Guatemalan society create, adapt, and lose control in their conflicting struggles

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[22] Greg Grandin, *The Last Colonial Massacre: Latin America in the Cold War* (Chicago: University of Chicago Press, 2004), 4-5.
[23] Commission for Historical Clarification (CEH), *Guatemala: Memory of Silence*, "Conclusions II," February 1999, accessed October 30, 2011, http://shr.aaas.org/guatemala/ceh/report/english/conc2.html
[24] CEH, "Conclusions II," Number 109, accessed October 30, 2011, http://shr.aaas.org/guatemala/ceh/report/english/conc2.html
[25] Montejo, *Voices from Exile;* Victor Montejo, *Testimony: Death of a Guatemalan Village* (New York: Curbstone, 1987); CEH, *Memory of Silence*; Beatriz Manz, *Paradise in Ashes: A Guatemalan Journey of Courage, Terror, and Hope* (Berkeley, Los Angeles: University of California Press, 2004).

for domination, liberation, and peace."[26] Although some scholars such as Beatriz Manz and Sanford agree with the CEH's conclusions that the Maya were targeted in these atrocities, others argue that the Maya were simply in the wrong place at the wrong time and were merely caught in the middle of a horrific fight between insurgents and the Guatemalan military.[27] Regardless of the reasons why, hundreds of thousands of Maya were killed during *La Violencia* and others were forced to seek refuge in Mexico, the United States, and Canada. [28] As they did when the Spanish arrived in Central America, the Maya developed strategies for cultural survival in exile. Victor Montejo says, "The socio-cultural institutions they adapted give evidence that the heart of the Maya culture continues and transforms to meet the problems of the present."[29]

The Maya in Diaspora

During the 1980s and 1990s, Maya coming to the United States sought asylum and protection from their country's military which was especially aggressive in the departments of Huehuetenango, El Quiche, and Alta Verapaz.[30] Montejo considers Maya who fled Guatemala due to the violence and trauma of the Civil War as refugees and their movement into Mexico and the United States as a forced migration.[31] Alejandro Portes and Ruben Rumbaut define refugees as "involuntary and relatively unprepared migrants 'pushed out' by coercive political conditions," whereas immigrants are "voluntary and better-prepared movers 'pulled in' by

[26]Victoria Sanford, *Buried Secrets: Truth and Human Rights in Guatemala* (New York: Palgrave Macmillan, 2003), 16.
[27] David Stoll, *Between Two Armies in the Ixil Towns of Guatemala* (New York: Columbia University Press, 1993).
[28] CEH, *Memory of Silence*; Allan F. Burns, *Maya in Exile: Guatemalans in Florida* (Philadelphia: Temple University Press, 1993), 23; Paul Spickard, *Almost All Aliens: Immigration, Race, and Colonialism in American History and Identity* (New York: Routledge, 2007), 378.
[29] Victor Montejo, *Maya Intellectual Renaissance: Identity, Representation, and Leadership* (Austin: University of Texas Press, 2005), 144.
[30] Loucky and Moors, *Maya Diaspora*, 4.
[31] Montejo, *Intellectual Renaissance*, 29.

perceived opportunities."[32] According to this definition, the Maya who fled Guatemala during *La Violencia* should have been considered refugees (or asylees once they reached the United States), but newcomers in recent years might be considered immigrants. However, the label "refugee" is granted by the host government—it is not self-assigned.

Even during the height of the violence, Guatemalan asylum-seekers in the United States were unlikely to receive asylum. At the time, the United States had economic, agricultural, and political interests in Guatemala.[33] Between 200,000 and 600,000 Maya refugees fled Guatemala during the Civil War. Forty-two thousand Maya were granted refugee status in Mexico.[34] Though some Guatemalan asylum-seekers in the United States were accepted, many were denied. Throughout the 1990s, 165,000 Guatemalans applied for asylum or refiled their asylums requests, but US immigration authorities granted less than ten percent of these requests.[35]

After the Guatemalan peace accords in 1996, Maya continued to immigrate to the United States. This new wave of Guatemalan Maya immigrants came seeking "economic and social improvement."[36] Many of these Maya immigrated to *El Norte* to send remittances back to their families in Guatemala. In 1995, the small town of Santa Eulalia, Guatemala, where most of my Maya partners are from, received $3 million in remittances.[37] Many of these newer arrivals were born after the height of the violence in Guatemala had ended. In recent years, the educational

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[32] Alejandro Portes and Ruben G. Rumbaut, *Immigrant America: A Portrait*, 3td ed. (Berkeley: University of California Press, 2006), 179.
[33] Portes and Rumbaut, *Immigrant America*, 179; Spickard, *Almost All Aliens*, 378.
[34] Burns, *Maya in Exile*, 24-25.
[35] Portes and Rumbaut, *Immigrant America,* 33.
[36] Christopher H. Lutz and W. George Lovell, "Survivors on the Move: Maya Migration in Time and Space," in *The Maya Diaspora: Guatemalan Roots, New American Lives*, ed. James Loucky and Marilyn Moors (Philadelphia: Temple University Press, 2000), 33.
[37] Ibid., 33.

opportunities for Santa Eulalians have improved somewhat, particularly concerning the teaching of Maya culture and language.[38]

The success of immigrants in their receiving country is often dependent on their class of origin in their sending country.[39] Thus, these younger immigrants may have an advantage over their refugee predecessors. However, many Maya are limited by the "collective expectation that new arrivals should not try to surpass . . . the status of older migrants."[40] Thus, even though some Maya groups feel kinship with others in the development of a Maya identity, others (mainly older, earlier arrivals) may feel resentful of newcomers who have immigrated to the United States for economic opportunity, rather than to escape violence.[41] This demonstrates how individual Mayas' pasts shape their view of life in the United States and their opportunities.

In their book, *The Maya Diaspora*, James Loucky and Marilyn Moors refer to the movement of Maya people as a diaspora, but they do not indicate how a diaspora is different from the similar concepts of exile, refugeeism, and immigration.[42] Whether US Maya are true refugees or economic immigrants, the group fits Kim Butler's definition of a diaspora. She asserts that four criteria must be met for a movement of people to be identified as a diaspora. First, "After dispersal, there must be a minimum of two destinations." The Maya who have traveled to *El Norte* have settled in Mexico, Canada, and throughout the United States. "Second, there must be some relationship to an actual or imagined homeland." Maya often maintain active ties with Guatemala, sometimes travelling back and forth between the two countries or having immediate family members living across borders. Those who cannot remain in contact with family and friends in Guatemala usually interact with other Maya who live near them. Third,

[38] Gilberto Simon, Interview with Amanda McGrew, August 26, 2011 and September 16, 2011.
[39] Portes and Rumbaut, *Immgirant America*, 178.
[40] Ibid., 95.
[41] Maria Andrea Miralles, *A Matter of Life and Death: Health-seeking Behavior of Guatemalan Refugees in South Florida* (New York: AMS Press, 1989).
[42] Loucky and Moors, *Maya Diaspora*, 10.

"There must be self-awareness of the group's identity." This is evidenced by the Maya community groups that have organized around the nation, such as Pastoral Maya and Corn Maya.[43] The fourth characteristic of diaspora is that the dispersal of the people last at least two generations.[44] Therefore, the Maya meet all the criteria of a people in diaspora. However, diaspora is not an ethnicity; it is a way of understanding how a community formed and how it functions.[45]

As Stuart Hall argues, the diaspora experience focuses on "narratives of displacement."[46] The Maya in diaspora have been displaced and this affects their contact with their homeland, but diaspora does not define who the Maya are, rather it is one of many complicated influences impacting Maya cultural identity. In the case of the Maya, diaspora can be viewed as a means of dealing with other pressures—a result and a cause of cultural change. According to Hall, "Diaspora identities are those which are constantly producing and reproducing themselves anew, through transformation and difference."[47] The products of this diaspora are not always clear in the written records and therefore we have to look elsewhere—to the lived experiences of immigrants, in this case, their health care behaviors and ideas—to find evidence of how diaspora affects culture.[48]

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[43] Pastoral Maya Inc. http://www.pastoralmayausa.org/ and Corn Maya USA, Inc. http://cornmaya.web.officelive.com/default.aspx
[44] Kim D. Butler, "Defining Diaspora, Refining a Discourse," *Diaspora* 10 (2001): 192.
[45] Butler, "Defining Diaspora," 194.
[46] Stuart Hall, "Cultural Identity and Diaspora," 223.
[47] Hall, "Identity and Diaspora," 235.
[48] Butler, "Defining Diaspora," 212.

Maya Ethnomedical Traditions

Anthropologist, Merrill Singer writes, "Critical medical anthropology can be defined as a theoretical and practical effort to understand and respond to issues and problems of health, illness, and treatment."[49] In this framework, understanding the cultural and historical influences that affect Maya health beliefs and decision-making is crucial to the development and analysis of the Toolkit. Taking a cultural approach to medical anthropology means understanding how different cultures view health and healing. In order to identify the motivations and influences the Maya are experiencing, there must be a clear understanding of the variety of beliefs one may encounter. This requires, as Singer states, "Recognition of the historic role of culture in the shaping of human behavior and social configuration on the one hand, and the contribution of social relations to the generation of culture [on the other hand]."[50] History, culture, and identity affect health care choices and those choices and behaviors in turn affect culture.

A complex system of diagnosing and treating illnesses exists in traditional Maya culture.[51] Some of their practices involve partaking in rituals or saying prayers to heal individuals, but the Maya also utilize herbs and plants as medicines. Plants like *apasote* (also called *sk'aj*) have been used by Maya healers for hundreds of years to cure stomach cramps, vomiting, and diarrhea. This plant has amoebicidal properties that are recognized by modern clinicians, illustrating that there are scientific bases to at least some Maya ethnomedical

[49] Singer, "Ivory Tower," 81.
[50] Singer, "Ivory Tower," 99.
[51] Alejandro Murguia, Rolf A. Peterson, and Maria Cecilia Zea, "Use and Implications of Ethnomedical Health Care Approaches Among Central American Immigrants," *Health and Social Work* 28 (February 2003): 44.

practices.[52] Sandra Orellana also details the many plants used by the Maya during pre-Columbian times to treat illnesses.[53]

In recent years, globalization, urbanization, and biomedical health care access have negatively affected medicinal plant use and its transmission to younger generations by stigmatizing traditional healers and fostering a negative perception of traditional medicine in some parts of Maya society. Environmental pollution and land loss have further contributed to the demise of indigenous Maya healing by making it more difficult for curers to access and use healing herbs.[54]

Maya healers play a different role in their communities than most caregivers in US hospitals, especially because of the Maya connection between medicine and spirituality. Thomas Hart, Jolene Yukes, Jason Harris, and Adams and Hawkins, all emphasize the importance of Maya healers to their communities in Guatemala. For the Maya, becoming a healer is not a choice; rather, it is a spiritual calling. This calling presents itself in a variety of ways, sometimes curers even learn their craft through dreams.[55] Often, the person called to heal will become very ill for unknown reasons and the illness will last until they accept their role as a healer. Once the healer takes on the responsibilities of their calling and begins learning and practicing their craft, they will get better.[56]

There are several different types of Maya healers including *comodronas* (midwives), *curanderos* (healers), *hueseras* (bonesetters), and *cura los ojos* (eye specialists). They do not

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[52] Adams and Hawkins, *Health Care,* xv.
[53] Sandra L. Orellana, *Indian Medicine in Highland Guatemala: The Pre-Hispanic and Colonial Periods* (Albuquerque: University of New Mexico Press, 1987).
[54] Jolene Yukes, "'No One Wants to Become a Healer': Herbal Medicine and Ethnobotanical Knowledge in Nahuala," in *Health Care in Maya Guatemala: Confronting Medical Pluralism in a Developing Country,* ed. Walter Randolph Adams and John P. Hawkins *(*Norman: University of Oklahoma Press, 2007), 44-46, 50.
[55] Thomas Hart, *The Ancient Spirituality of the Modern Maya* (Albuquerque: University of New Mexico Press, 2008), 130.
[56] Hart, *Ancient Spirituality*, 119.

attend school to learn their craft, though. Parents or established local practitioners usually train new Maya healers; some are even self-taught.[57] Sometimes Maya women become midwives by successfully delivering their own baby by themselves without a comodrona, most likely because none was available. That woman's successful experience results in other women seeking her advice and help when they deliver their own babies. Thus, she becomes a Maya midwife.[58] Because access to health clinics and hospitals is limited in highland Guatemala, many Maya babies are delivered by comodronas. Maya midwives are best known for their practice of *sobada* or prenatal massage.[59]

Traditionally, the care given by a Maya healer is more than physical. Their methods of curing can involve medicinal herbal treatments, physical treatments like massage, and prayer or rituals.[60] Maya healers also provide social, moral, and spiritual guidance by sharing testimonial stories or folktales with their patients. [61] Montejo explains that curers can personalize stories to bring the listeners into a "direct experience of contact with their roots."[62] Because the Maya worldview sees life and existence as cyclical, ancient stories can plausibly be set in the current time and place—and conceivably may happen again in the future.[63] This holistic view of the universe pervades every aspect of Maya life, including their health beliefs, and this has been true since ancient times. Rigoberta Menchu and others emphasize the Maya belief that all life and

[57] Yukes, "Herbal Medicine and Ethnobotanical Knowledge," 45.
[58] Focus groups with Maya women.
[59] Sheila Cosminsky, "Maya Midwives of Southern Mexico and Guatemala," in *Mesoamerican Healers* ed. Brad R. Huber and Alan R. Sandstrom (Austin: University of Texas Press, 2001), 188.
[60] Adams and Hawkins, *Health Care*; Hart, *Ancient Spirituality*.
[61] Sheila Cosminsky, "Childbirth and Midwifery on a Guatemalan Finca," *Medical Anthropology* 1 (1977): 69-104 and Cosminsky, "Maya Midwives," 188.
[62] Montejo, *Maya Intellectual Renaissance*, 141.
[63] Ibid.

nature are interdependent in a physical and spiritual sense. These ancient Maya beliefs continue to this day.[64]

In their ethnomedical framework, the Maya often view each symptom of an illness as having its own cause. This is different from the biomedical view of symptoms as indicators of underlying disease.[65] This ideology can have a great effect on how a Maya person perceives their diagnosis.

The idea of balance plays a prominent role in humoral medicine, an aspect of Maya health tradition. Humoral practices are based on the principle that hot and cold elements are at work in the human body. In order to sustain or restore health, one must find a balance between these two elements. To maintain this balance, the Maya eat certain foods with hot or cold properties to achieve the desired effect. For example, the Maya in Canton told me that when a woman has just given birth, they believe she is in a very cold state because of blood loss during delivery. Therefore, she must receive only hot food and drinks until her body is back in balance and this can take a few days. Ideas about what kinds of foods are "hot" or "cold" varies among the different Maya groups, but the general belief is common to all Maya.[66] In Guatemala, Maya also take hot steam baths in a type of sweathouse called a *tuj* or a *temascal* to adjust their body temperature and maintain humoral balance.[67] These are not available in the United States, though.

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[64] This perspective has been voiced by Maya whom I have spoken with including Gilberto Simon, Karin Ventura, and Juanatano Cano; Rigoberta Menchu, *I, Rigoberta Menchu: An Indian Woman in Guatemala* trans. Ann Wright (London, New York: Verso, 1984); Adams and Hawkins, *Health Care*; Hart, *Ancient Spirituality*; Montejo, *Maya Intellectual Renaissance.*

[65] Harris, "Conceptions of Disease," 27-28.

[66] Adams and Hawkins, *Health Care*; Miralles, *Life and Death*; Hart, *Ancient Spirituality*, 119; Sheila Cosminsky, "Changing Food and Medical Beliefs and Practices in a Guatemalan Community," *Ecology of Food and Nutrition* 4 (1975): 183-191.

[67] Steven Shem Rode, "'If We Do Not Eat Milpa, We Die': The Cultural Basis of Health in Nahuala," in *Health Care in Maya Guatemala: Confronting Medical Pluralism in a Developing Country* ed. Walter Randolph Adams and John P. Hawkins *(*Norman: University of Oklahoma Press, 2007), 70-71.

Related to the concept of balancing temperature, Stephen Shem Rode writes that to the Maya, balance is the basis of health.[68] According to ethnomedical health researchers Alejandro Murguia, Rolf Peterson, and Maria Cecilia Zea, the Maya attribute health to maintaining, "equilibrium between forces of nature and illness is attributed to the disequilibrium of these forces."[69] Maya I spoke with have also expressed this belief in maintaining balance in one's body and one's life. To be healthy, one must maintain or "restore balance to the relationship between the self and the whole."[70]

The traditional Maya worldview revolves around the idea of the community, not the individual, and that community can affect one's physical health.[71] Although the Maya view some illnesses as having a cause in the physical world, others are thought to have a fundamentally spiritual cause. Jason Harris says that these illnesses are called *k'oqob'al*, a K'iche' word which means, "Someone is making you sick."[72] One such illness is *mal de ojo* "the evil eye." *Mal de ojo* occurs in infants and young children when they are looked at by someone with "strong blood." The child may become sick in a variety of ways. Sometimes the "giver" of the illness causes it intentionally, but usually not. Different Maya communities view *mal de ojo* differently, but the concept of "the evil eye" is common among the Maya and throughout the world.[73]

In the Guatemalan village in which he studied, Harris argues that *k'oqob'al* illnesses serve to regulate behavior with fear. If the Maya believe that committing a crime or behaving immorally will cause them physical pain, they are less likely to engage in those activities. In this way, Maya medical beliefs play a social role in their communities. It is unclear how this belief

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[68] Ibid., 76.
[69] Alejandro Murguia, Rolf A. Peterson, and Maria Cecilia Zea, "Use and Implications of Ethnomedical Health Care Approaches Among central American Immigrants," *Health and Social Work* 28 (February 2003): 43.
[70] *Maya Health Toolkit for Medical Providers*, 16.
[71] Ibid.
[72] Harris, "Conceptions of Disease," 28.
[73] Clarence Maloney, "The Evil Eye in a Quiche Community," in *The Evil Eye* ed. Clarence Maloney (New York: Columbia University Press, 1976); Harris, "Conceptions of Disease," 36.

affects Maya life in the United States. However, if Maya health beliefs fall out of practice, the social role of illness will be affected by this culture loss.

In recent years, fewer Mayas have chosen to become healers. Many are dissuaded from the career because healers are often paid in kind.[74] In the past, some healers, such as the bonesetter Anton Luk who was interviewed by Victor Montejo, never accepted payment for services.[75] The dwindling numbers of traditional healers is a distressing trend; Yukes shared that only one of the 23 healers in her study was passing on their knowledge to the younger generation.[76] Furthermore, recent studies claim that there are only about 600 midwives left in Guatemala with knowledge of traditional *sobada* massages.[77]

Ethnomedical healers may be the only source of medical care within reach for many Maya, but the Guatemalan government now mandates that medical providers attend certain training sessions or have an accredited education before they can practice. The required education classes have resulted in many of these healers (midwives especially) synthesizing modern biomedical practices into their ancient traditions.[78] For example, midwives in Guatemala are using pitocin injections to speed up labor more often. This can be a problem if the drug is not administered perfectly or if there are certain pre-existing conditions because pitocin could harm the mother or baby. Maya midwives have also adopted the practice of performing vaginal examinations to determine the mother's progress toward delivery. These examinations enhance the possibility that an infection could occur.

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[74] Yukes, "Herbal Medicine and Ethnobotanical Knowledge," 44-46, 50.
[75] Montejo, *Maya Intellectual Renaissance*, 143.
[76] Yukes, "Herbal Medicine and Ethnobotanical Knowledge," 63.
[77] Kevara Ellsworth Wilson, "'Your Destiny is to Care for Pregnant Women': Midwives and Childbirth in Nahuala," in *Health Care in Maya Guatemala: Confronting Medical Pluralism in a Developing Country* ed.Walter Randolph Adams and John P. Hawkins *(*Norman: University of Oklahoma Press, 2007), 135.
[78] Wilson, "Midwives and Childbirth," 135-137.

In her study of Guatemalan Maya midwives in 2001, Sheila Cosminsky noted that Maya women in Guatemala seek out midwives who use these new biomedical techniques over ones that do not.[79] This behavior shows that Maya women may value their ethnomedical practices less than biomedical practices, even though they may contribute to complications during labor. When colonial powers share new information with traditional practitioners or require them to utilize new practices, it is not necessarily complementary to existing practices. They may actually corrupt ethnomedical practices and threaten patient health in the homeland and patient perceptions of health care practices in diaspora.

[79] Cosminsky, "Midwives and Menstrual Regulation," 179, 193-194.

The Maya Health Toolkit for Medical Providers

Culture and Health Care

Understanding how history and culture affect health care decisions is an important aspect of Medical Anthropology—an interdisciplinary branch of social and cultural anthropology that examines how different groups develop and maintain ideas about health and healthcare systems. Catherine Bernosky de Flores and Murguia, Peterson, and Zea explain that often it is not understood how specific immigrant groups manage their health care needs in relation to the customary local practices of their new destination communities.[80] Medical anthropologist James Morrissey details why issues of migration and refugeeism are relevant to the field, stating, "The domain of medical anthropology extends to all issues of health and health-related behavior . . . Its contribution . . . lies in its efforts . . . to relate cultural factors to health behavior."[81] Studies show that when working with indigenous populations and refugee communities (the Maya in diaspora fit both descriptions) clinicians can provide better quality care by considering the cultural perspective of their patients. Historically, the Maya people are open-minded and eager to incorporate new methods into their cultural framework, but to do this they must trust their providers and feel respected by them. This trust and respect must be cultivated through clear communication and cultural congruency.

The *Maya Health Toolkit for Medical Providers* addresses the issues that occur when Maya culture and US healthcare meet. Cultural congruency resources like the Toolkit can aid

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[80] Catherine H. Bernosky de Flores, "Human Capital, Resources, and Healthy Childbearing for Mexican Women in a New Destination Immigrant Community," *Journal of Transcultural Nursing* 21 (2010): 332-341; Murguia, Peterson, Zea, "Ethnomedical Health Care Approaches."

[81] James A. Morrissey, "Migration, Resettlement, and Refugeeism: Issues in Medical Anthropology," *Medical Anthropology Quarterly* 15 (November 1983): 3, 11.

clinicians in providing treatments that are more effective to minority patient populations.[82] As we can see from their cultural history, the Maya are a unique group in the United States and the multitude of factors that impact their health and their health care decisions need to be addressed specifically.

The MHCP (Maya Heritage Community Project) was contracted to achieve four main objectives in the completion of the Toolkit. We aimed to, "Minimize barriers between patients and medical professionals in order to enhance the health of the Maya community. Identify the major health care barriers both from the provider and patient's perspective. Create a variety of tools to help providers and patients communicate better. [And] Create a National Network of Maya Interpreters trained and certified in the knowledge and methodology contained in this toolkit."[83] Focusing on the first three of these objectives, my role in the Toolkit's development was to gather data from the Maya people, review the literature on cultural congruency and Maya health beliefs, and to use this information to develop tools that could be used by providers and patients to enhance communication and improve health outcomes.

The Mayas' negative experiences with authority in Guatemala and their immigration status in the United States can make trust across cultures very difficult to develop. Local health care providers may be unfamiliar with the traumatic histories and cultural traditions of the Maya.[84] Cultural competency can help relieve these issues by improving communication,

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[82] Murguia, Peterson, and Zea, "Ethnomedical Health Care Approaches."
[83] *Toolkit*, 10. National US Maya leaders are currently working with the MHCP and the USCCB to develop and implement the Interpreters Network. Because of this, I did not incorporate it into this study. Future research on this network would be beneficial to understanding how properly trained interpreters benefit Maya health. National Pastoral Maya Leadership Meeting Notes, KSU, October 9, 2010, in author's possession.
[84] Miralles, *Life and Death,* 34; Burns, *Maya in Exile,* 47.

developing trust, expanding cultural knowledge, and increasing the effectiveness of treatments.[85] The Toolkit aims to alleviate these problems.

Community-Based Participatory Research

In order to make the Toolkit applicable and usable to the Maya and their providers, the Toolkit team embraced a, "commitment to the principle of self-determination"[86] Throughout this multiple phase project, I utilized the method of community-based participatory research with my partner community of Maya immigrants to achieve a deeper understanding of Maya health beliefs, practices, and needs. The idea of community engagement in scholarship has become more popular in recent years, but it is particularly applicable in projects such as this one where the ideas and experiences of the Maya people formed the basis of the products of the research and later, Maya opinions were the basis for analysis.

According to Nina Wallerstein and Bonnie Duran, community-based participatory research (CBPR), "is an orientation to research that focuses on relationships between academics and community partners, with principles of colearning, mutual benefit, and long-term commitment and incorporates community theories, participation, and practice into the research efforts."[87] For a study in the medical field to achieve its highest quality within this framework, four goals much be reached in the design and execution of the project. First, each partner must learn from the other for the relationship to be truly reciprocal. Second, a commitment must exist on the side of the academics to advance community members' capacity to help their communities themselves. Third, the results of the research should be beneficial to everyone involved, and

[85] Cindy Brach and Irene Fraser, "Can Cultural Competency Reduce Racial and Ethnic Health Disparities? A Review and Conceptual Model," *Medical Care Research and Review* 57 (November 2000): 190, 194.
[86] Singer, "Ivory Tower," 98.
[87] Nina B. Wallerstein and Bonnie Duran, "Using Community-Based Participatory Research to Address Health Disparities," *Health Promotion Practice* 7 (July 2006): 312.

fourth, the project should include a long-term commitment to aid the community in achieving better health care.[88] The Toolkit team embraced these goals sincerely and wholeheartedly.

CBPR is a complex and sensitive process because of the level of trust involved between the community members, their representatives, and researchers. This is particularly true in a vulnerable community such as that of Maya immigrants where the primary researchers must handle the project design and implementation deftly. Researchers must recognize that they have power and privilege due to their education and affiliation with the university. This position must be tempered with the voices of the community participants so the project is truly reciprocal and the Maya have a say in the types of questions that are addressed and the outcomes that result. Our Maya partners told us what issues were of importance to them and asked for specific and general tools to assist them in their communication with doctors.

During this process, the Toolkit team maintained a mutually beneficial relationship with our Maya partners. The Maya community would voice their needs to us, we would devise and compose aspects of the Toolkit, and then the Maya would comment and make recommendations. This cyclical method assured that the Maya community was involved in all stages of the research project and fostered a long-term relationship between the research partners. Reciprocity and relationship-building have been found to enhance the outcomes of researchers working with other indigenous communities.[89] Providers, specifically nurses and midwives who work often with Maya patients and health clinic staff members also provided information to the Toolkit team.

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[88] Wallerstein and Duran, "Community-Based Participatory Research," 312-313.
[89] Julie Baldwin, Jeannette Johnson, and Christine Benally, "Building Partnerships Between Indigenous Communities and Universities: Lessons Learned in HIV/AIDS and Substance Abuse Prevention Research," *American Journal of Public Health* 99 (March 2009): S77-S81.

In conducting CBPR, there is also the question of "Who represents the community?"[90] In the case of the Toolkit, members of the national Maya organization, Pastoral Maya, who were already familiar with and had previously worked with the MHCP, took an active role in the project. These Maya leaders from throughout the United States conducted focus groups and individual interviews with their local Maya about their health traditions and their health needs. Others served as interpreters for English-speaking researchers such as myself.

Building on the work of Mary Odem and Belsie Gonzalez, I attempted to understand the medical concerns of Maya immigrants in Georgia at a deeper, more personal level.[91] During this process, I worked closely with several Maya families—young mothers, in particular, who had delivered babies in the local hospital system. My interpreter arranged for Maya women who had expressed a desire to participate in the study to meet with us at his home. Between four and seven women attended each meeting. The women were all of child-bearing age and usually brought their children with them to our discussions. The children would play together and graze on the refreshments I provided, contributing to the casual, low-pressure atmosphere I wished to maintain. This setting allowed me to see how the women interacted with their children and, I believe, helped them feel more comfortable sharing sensitive information with me. Each woman shared her general comments and concerns about health care in the United States and the healthcare system. After the open forum, I asked more specific questions, which were then answered by some or all of the Maya in attendance. This series of focus groups occurred between September 2010 and September 2011.

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[90] Wallerstein and Duran, "Community-Based Participatory Research," 314-315.

[91] Mary Odem and Belsie Gonzalez, "Health and Welfare of Maya Immigrant Families: Perspectives of Maya Parents and County Agencies," in *Maya Pastoral 2004-2005: National Conferences and Essays on the Maya Immigrants,* ed. Alan LeBaron, (Kennesaw: Kennesaw State University Press, 2005), 187-195.

During this time, I developed a trusting relationship with my interpreter, Gilberto Simon, which allowed me to ask questions and engage in discussions with him about sensitive subjects that I would not have been able to broach otherwise. Gilberto's role became one of a cultural broker as well as an interpreter of language. Aside from organizing and facilitating meetings of researchers and Maya women, Gilberto also agreed to share his personal story in a series of oral history interviews that I conducted and recorded. Gilberto's retelling of his life experiences enhanced my understanding of Maya health beliefs and practices and his insight and perspective as a Maya and an immigrant to the United States was invaluable in developing my forthcoming arguments about postcolonial Maya identity. This partnership made the rest of my project possible.

Health Care Barriers Experienced by the Maya

The Toolkit team identified fifteen "Barriers to Care" commonly experienced by our Maya partners and their health care providers. These issues can be divided into two categories: logistical obstacles and cultural barriers. Though both categories impact how Maya experience the healthcare system in the United States, the sources of these problems are very different. Examining these barriers to determine what causes them and how they can be overcome is crucial to assisting the Maya in obtaining adequate health care.

Difficulty obtaining transportation to a doctor's appointment and the inability to find childcare are among the logistical barriers. Another logistical problem is the high cost of health care in the United States. This leads many to delay seeking care, which puts the Maya at further risk for health complications, especially in the area of prenatal health. Many US patients experience problems such as these, along with the long wait times in emergency rooms and

public health clinics—two other barriers mentioned often by the Maya with whom I spoke. However, because they are unfamiliar with US healthcare procedures, they often feel they are being discriminated against when they encounter these hurdles to receiving care, rather than feeling solidarity with US patients who may also face these obstacles at one time or another.

The other group of barriers identified by the Toolkit team is rooted in the differences between Maya and US culture. Identification is a problem. Often providers and receptionists are unable to distinguish between Latino and Maya patients, or they are unaware of the difference. In the healthcare system, there is also confusion surrounding the use of last names among the Maya who generally take the name of each parent, therefore having two "last" names. This can make record keeping and tracking difficult and confusing for hospital staff.

It was also discovered that some Maya hesitate to identify themselves as indigenous people because of the history of discrimination they have encountered in Guatemala and in diaspora. This discrimination, which has resulted in Maya being less able to access education in Guatemala, also contributes to the low literacy levels of many Maya immigrants. Not being able to read or write in any language makes completing paperwork and understanding health materials very difficult for Maya in this situation. Limited use of interpreters in any language further contributes to misunderstandings. Mayas sometimes use their children as interpreters, but this practice can lead to other serious problems within families.[92]

[92] Aside from cultural issues, language is a major obstacle for Maya people seeking healthcare, but one that cannot be adequately addressed in this paper. Utilization of services, satisfaction with care, and adherence to treatment plans are all adversely affected by language barriers. Using children as interpreters is a common practice in Maya immigrant communities, but there is much research that shows this can be detrimental to the mental health of the child and the relationship between the child and parents. The following sources address language concern, including why trained interpreters are so vital. Brach, "Cultural Competency;" Nancy H. Hornberger, "Language Policy, Language Education, Language Rights: Indigenous, Immigrant and International Perspectives," *Language in Society* 27 (December 1998): 439-459; Anna M. Napoles, Jasmine Santoyo-Olsson, and Leah S. Karliner, "Clinician Ratings of Interpreter Mediated Visits in Underserved Primary Care Setting with Ad Hoc, In-person Professional, and Video Conferencing Modes," *Journal of Health Care for the Poor and Underserved* 21 (February 2010): 301-317; Tilly A. Gurman and Allisyn Moran, "Predictors of Appropriate Use of Interpreters: Identifying professional

The history of *La Violencia* in Guatemala has also contributed to the Maya's difficulties in accessing health care in the United States. Some Maya patients have difficulty identifying their exact date of birth because records were not kept at the time or were lost. Others may be unable to complete a family medical history or even their own medical history accurately. This might occur because the persons' parents were displaced or killed, or because they have lost contact with their home community.

Finally, Maya traditional healers who may be practicing in the United States can affect the way Maya behave with regard to health care. The Maya conception of health also greatly affects how they perceive biomedical care. It is possible and common for their holistic ethnomedical traditions to conflict with biomedical practices.[93]

The women who participated in our focus groups in Canton expressed that these obstacles prevent them from seeking care, and other studies report similar findings. Anthropologists and sociologists recognize that immigrants experience barriers to accessing health care in the United States and a few studies have addressed the Maya population specifically. In 2009, Colleen Supanich examined Guatemalan Maya women seeking prenatal care in Palm Beach County, Florida. In her study of Indiantown, Florida, during the 1980s, Maria Miralles examined the barriers to health care that many Maya immigrants faced at that time. In 2002, Cecilia Menjivar analyzed how Guatemalan women in Los Angeles, California, utilized complex social networks to access health information and traditional treatments because of the barriers they faced in trying to receive biomedical care. With few health care opportunities for undocumented immigrants, access is limited and alternative treatments are often sought first. Preventative care is uncommon and Maya in immigrant communities usually wait until a

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Development Training Needs for Labor and Delivery Clinical Staff Serving Spanish-Speaking Patients," *Journal of health Care for the Poor and Underserved* 19 (November 2008): 1303-1320.

[93] *Toolkit* , 20-23.

problem becomes serious before they seek medical treatment.[94] Menjivar also found that sharing prescription medications was common among friends and family members in the L.A. community.[95] Language, cost, and culture were recurring barriers in all of the above-cited studies.[96]

Medicine is often thought of as a hard science that can be applied across the board regardless of a patients' culture. However, Pertti Pelto and Gretel Pelto argue that medical knowledge is a cultural belief in and of itself and must be viewed in anthropological terms as a belief. Unfortunately, in the United States, most health care providers view "knowledge" and "belief" in contrast with one another and therefore give "knowledge" a higher position in their personal health care hierarchy. This view is in contrast with the Maya tendency to integrate knowledge and belief into one holistic system. While researchers find that groups, such as the Maya, who practice ethnomedical traditions, may easily incorporate biomedical practices into their traditions (through syncretism), it is much more difficult to convince Western medical practitioners to give credence to traditional healing methods. [97] Therefore, it is important for providers to understand the cultural and historical influences that determine the kind of care Maya seek, their perception of biomedical care, and their understanding of biomedical practices. Hence, the need for the *Maya Health Toolkit for Medical Providers* is clear.

Case studies contained in the Toolkit exemplify how these barriers affect US Maya and complicate their understandings and experiences in the healthcare system. The examples highlight situations in which Maya patients received substandard care because of the identified

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[94] Cecilia Menjivar, "The Ties that Heal: Guatemalan Immigrant Women's Networks and Medical Treatment," *International Migration Review* 36 (2002): 442.
[95] Menjivar, "The Ties that Heal," 441-442, 453.
[96] Colleen Supanich, "'You're Too Late!': Prenatal Health Seeking Behaviors of Guatemalan Mayan Women in Palm Beach County," Master's Thesis, Florida Atlantic University, 2009.
[97] Pertti J. Pelto and Gretel H. Pelto, "Studying Knowledge, Culture, and Behavior in Applied Medical Anthropology," *Medical Anthropology Quarterly* 11 (June 1997): 148-149.

barriers. In one case, a Maya patient underwent surgery for reasons she could not explain and did not understand at the time. Another Maya woman who lives in South Carolina took her daughter to the emergency room after the child was in a car accident that the woman was not involved in. Because the mother could not communicate with the emergency room staff, they treated her as if she had been involved in the accident and billed the family accordingly. A young Maya man working as a landscaper cut his finger and developed a minor infection. Because he lacked access to affordable, culturally appropriate care, he delayed treatment until the injury became life threatening and resulted in surgery.[98] These examples highlight how these obstacles translate into real-world problems with which the Maya have to cope with on a regular basis.

The Tools

The Toolkit team developed a set of tools to assist providers and Maya patients in overcoming the identified obstacles. These resources are rooted in Maya history and culture, and the principles of cultural congruency in health care. The resulting tools focus on meeting "the specific and unique needs of the Maya community."[99] Some of the tools, such as the Pain Scale, Happiness Scale, and Body Charts are versions of existing aids commonly found in doctors' offices and hospitals. The Toolkit team changed these instruments slightly to make them more appealing and relevant to Maya patients. The charts are especially helpful in bridging the literacy gap but aim to do so without treating the Maya as childlike in their intellectual capacity. Because some Maya have witnessed the deaths of loved ones, the trauma of war and migration, extreme poverty, and great uncertainty and discrimination in the U.S., they experience the health care system as a vulnerable population and many suffer from anxiety and depression because of this.

[98] *Toolkit* , 24-27.
[99] *Toolkit* , 32.

The Mental Health Assessment tool was adapted from other mental health questionnaires to be more sensitive to Maya cultural stigmas often associated with mental illness. Understanding and accounting for cultural sensitivities is important when working with vulnerable communities, such as the Maya.[100] The Identification Card, Key Medical Terms in Translation, Herbal Medicine Chart, and Audio-Visual presentations address ways to overcome barriers particular to Maya patients.

To address the communication barriers between Maya patients, receptionists, and caregivers, the Toolkit team developed a patient identification card for the Maya to use when seeking care. This card identifies the person as Maya and contains spaces for a photo, address, phone number, preferred language, medical conditions, and current medications. Ideally, this informational identification card would be completed prior to the patients' visit to the clinic or hospital by accessing the website, completing the form, and printing out the card. It can also be printed and completed by hand. Maya can fill out the information in comfortable, low-stress settings such as churches or schools, where friendly interpreters may be more accessible. This would be an improvement over the high-stress, unfamiliar environment of a doctor's office or clinic. Using the identification card increases the likelihood that the information shared between patient and caregiver remains consistent. Consistency allows providers to access the correct hospital records, decreases the confusion surrounding multiple last names and unknown birthdays, and offers a more complete medical history of the patient. It also directs the provider to the Toolkit's web site where he or she can find more information about the Maya and other communication tools.[101]

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[100] Mary De Chesnay and Barbara A. Anderson, *Caring for the Vulnerable: Perspectives in Nursing Theory, Practice, and Research* 2nd ed. (Sudbury, Massachusetts: Jones and Bartlett, 2008), 25.
[101] *Toolkit*, 33.

Medical professionals and Maya health educators helped create a list of medical terms that are commonly used in patient-provider encounters. The Maya partners involved in the Toolkit translated these terms into four of the Mayan languages. These languages were chosen because they are commonly spoken in various parts of the United States. This "Key Medical Terms in Translation" tool is helpful for providers who are trying to convey specific diagnoses to patients, but are especially useful for Maya interpreters who may have limited knowledge of medical terminology.[102]

The Natural Remedies Chart lists herbs that the Maya may use to treat illnesses—their Maya medicines. The chart includes the name of each herb, a photograph of the plant, and the reasons for use to help alert providers to possible drug interactions. It also serves as a tool for Maya patients to help identify supplements they have been taking to their doctors if they cannot communicate this verbally. However, because of the diversity among the Maya community, different Maya groups may use herbs in different ways.[103]

Conveying medical information to this group is difficult. The audiovisual tools were created to educate non-English, non-Spanish, low-literacy Maya patients on key health issues. Clinicians in the United States often distribute written educational materials to Maya patients in English or Spanish and assume that they will be able to read and understand it. This is not always the case; hence, the audiovisual tools. Two videos were created, one covering prenatal care and the other diabetes, with the intention that they would be shown by providers to patients with whom they were having difficulty communicating. These two health issues were chosen as pilots because they affect many Maya living in the United States.

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[102] *Toolkit*, 35-45.
[103] *Toolkit*, 50-55.

Each audio-visual tool is a video similar to a slideshow that displays photos of Maya people in biomedical health care settings. The photos are accompanied by a voiceover in one of four Maya languages presenting health information on the specific topic. The videos include captions in English for providers so that they may assess the relevance, accuracy, and applicability of the information and fill in gaps where necessary. These tools allow illiterate or low-literacy Maya to hear—in their first language—important health information without relying on written material to educate Maya patients.

The Toolkit team integrated their understanding of Maya health beliefs and practices with the needs and practices of biomedicine in the United States to educate providers and assist them in helping Maya patients overcome obstacles to care. We designed the tools with guidance from the Maya community and the health care community to bridge the gap between these two groups. The Toolkit was designed to enhance the health outcomes of Maya patients in the United States, but for that to happen, the Maya and their providers must access and utilize the tools in health care settings.

Toolkit Reception

The MHCP recognizes that the *Maya Health Toolkit for Medical Providers* will continue to evolve. After the completion of the Toolkit, I scheduled further focus groups with the Maya women who participated in its development to see what they thought of the products of our collaboration. The Maya women shared their impressions with me and thus, the Toolkit team (meaning the academic and community partners together) will continue to hone the tools to meet the needs of Maya and their providers. To ensure that we also considered a provider's perspective on the tools, I met with Certified Nurse Midwife, Jody Toledo, to share the Toolkit and to obtain her opinion of its usability and effectiveness for providers. The reactions shared with me at these meetings will allow us to shape the tools in culturally sensitive, yet practical ways. Though positive overall, the responses demonstrated that regardless of the Toolkit's content there will continue to be logistical and cultural hurdles hindering Maya health care access.

The Maya Women

When I met with the women after the Toolkit's completion, I showed them the tools and asked their opinions of each one. They were pleased, but characteristically reserved in their comments. I was particularly interested in getting their opinions of the video on prenatal care since that topic directly affects them. After watching the video, the women said that they liked it very much. They said that they learned things from it. For example, now they know they should go to the doctor as soon as they think they are pregnant. However, they all stated that even

though they know this now it will not affect their behaviors because there are still obstacles for them.

They cannot go to the doctor earlier in their pregnancies because they cannot afford to do so. An initial visit to the county health clinic is around two hundred dollars. Several of the women expressed that they would go if they could afford it, but instead they pay a lay Maya midwife five dollars per visit and postpone seeing a biomedical provider until closer to the baby's birth. Susan Griggs, a Certified Nurse Midwife practicing in Cherokee County, Georgia, told me that sometimes her Maya patients bring an older woman with them when they deliver babies in the hospital. It is always the same woman even though the mothers identify her as a sister, aunt, or other family member. Susan assumes that woman is the lay midwife because she is repeatedly in attendance at births and appears to give the women directions and encouragement in an unidentified Maya language and with gesticulations.[104]

Some of the women also learned from the video that they should tell their doctor about the herbs they are taking. Others in the focus group knew this already, but had chosen in the past to withhold the information from their doctors. They told me they are hesitant to tell their providers about herbal supplements, "because then the doctors ask lots of questions they do not understand."[105]

The Maya women answered my questions candidly for the most part. For example, focus group participants were not pleased with some of the photographs used in the prenatal video. As the information about symptoms that should alert a pregnant woman to call her doctor, the screen showed Maya women and families. The Toolkit team had thought that this would be acceptable as an alternative to a list of risk factors, but it was not. The Maya women were bothered by the

[104] Susan Griggs, Interview with Amanda McGrew, November 20, 2010.
[105] Focus Groups with Maya Women.

disconnect between the photographs and the content and felt that the images should directly match the dialogue.

As our discussions of the tools continued, I mentioned to the Maya women that I would be meeting with a midwife the next day. The women and Gilberto became confused and wondered who the midwife was and where did I meet her. They thought I knew a Maya midwife who they did not know existed. When I explained that I would be meeting with a Certified Nurse Midwife who works in a hospital, they were shocked. They thought that their comodronas were the only "midwives." They had no idea that many of the "doctors" who deliver babies in the hospital are technically midwives.[106]

Ultimately, the Maya women expressed great pleasure and satisfaction with the Toolkit text and tools. At the end of our meeting, I asked the women if there was anything else they would like to share with me. Their answer was a collective, "Thank you." The Maya women said that it makes them feel good to see the Toolkit that has been made just for them. Being a part of this project has made them feel like they are not alone and that someone in the United States cares about them and wants to help them.[107] As Butler writes, "Articulations of diasporan identity by disempowered peoples suggest a quest for new alliances that might potentially confer more autonomy."[108] I hope that this project encouraged the Maya women to feel more confident when seeking health care. I was very glad to form an alliance with them and hope to continue our work together in the future.

[106] Focus groups with Maya women.
[107] Ibid.
[108] Butler, "Defining Diaspora," 213.

Provider

Jody Toledo, the certified nurse midwife who discussed the Toolkit with me, expressed similar feelings toward the Toolkit. She told me that she had studied cultural congruency in school, but has not taken any continuing education classes on the subject. She is very interested in learning more about Maya culture, though, especially their health culture because such a large proportion of her patients are Maya—she estimates about thirty percent. Furthermore, Jody said, "We treat them like the queens they are."[109]

Jody feels that providers in the Canton area will definitely use the Toolkit because there is a great need for it. She felt that providers could greatly benefit from the cultural and historical background information presented in the body of the Toolkit. She also expressed that there is nothing like it in use in the hospital system and that it could greatly improve communication and understanding between providers and Maya patients. When I expressed concern that hospitals would need to approve the tools before they could be utilized by providers, she dismissed my concerns, saying, "If avenues of communication fail or are not available, we have to think outside the box and use whatever tools are available to us."[110] Jody's assessment of the tools themselves was equally positive.

[109] Jody Toledo, Interview with Amanda McGrew, September 21, 2011.
[110] Ibid.

Discussion

A Culture in Flux

Stuart Hall asserts, "Identity [is] a 'production', which is never complete, always in process, and always constituted within, not outside, representation."[111] Maya identity is constantly in flux as are all cultural identities. They adapt to new discoveries, ideas, and influences, but build upon their ancient and solid foundational beliefs. John Watanabe stresses the importance of allowing for the possibility of change within cultures without stripping them of their authenticity. Culture is meaningful, contextual, and emergent.[112] Nevertheless, how does a culture balance the two conflicting ideas of advancement and cultural preservation? The Maya people have a right to advance technologically along with the rest of the world, especially in the realms of health and medicine. It is my understanding that the majority of Maya do not necessarily understand or utilize medical technologies as they are intended, though. Rather, they tend to value any concept or practice of US-origin as superior to their traditional way of doing things.

The history of Maya oppression in Guatemala has contributed to the group maintaining a postcolonial mindset in diaspora and this was evident in my discussions with my Maya partners. Postcolonial theory emphasizes the long-term effects of the European colonization of the Americas and "studies how subaltern practices and productions in the non-Western peripheries respond to Western domination."[113] An aspect of this study was to examine how this peripheral

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[111] Hall, "Culture and Identity," 222.
[112] John M. Watanabe, *Maya Saints and Souls in a Changing World* (Austin: University of Texas Press, 1992), 11.
[113] Revathi Krishnaswamy, "The Criticism of Culture and the Culture of Criticism: At the Intersection of Postcolonialism and Globalization Theory," *diacritics* 32 (2002): 106.

community of Maya respond to Western biomedical care. What I found was that Maya often place Eurocentric practices above their own traditional practices regardless of the actual physical benefits. There is evidence that the Maya live with postcolonial repercussions on their culture.

If given the choice to deliver at home with a Maya midwife or in the hospital with a US medical doctor who does not speak their language and who they have never met before, the Maya women I interviewed all claimed they would choose the doctor and the hospital over the comfort of their home. They said they feel safer at the hospital because of the doctor's education and the access to equipment and medication. The women told me that it is easier to have a baby at the hospital because they give you "vitamins" there and "they have good medicines."[114]

When compared with the lengthy education of US medical doctors and nurses, self-taught Maya midwives lose prestige in the eyes of US Maya. Even though Maya healers provide more holistic care, many Maya do not find these traditional caregivers as appealing or comforting a presence as medical doctors. This is compounded by the Maya belief that their traditional ways lack the sophistication of modern medicine.[115] Questioning the value of Maya culture, rejecting it due to hardships experienced in the United States, and a history of being devalued and denied agency by the portion of society in power have all contributed to the Maya perception of their traditional health care practices in direct comparison with US biomedical practices. Their unclear conception of what a midwife is and what she does is an example of how the Maya do not fully comprehend the intricacies of the US medical system. The Maya women told me that they do not even have conversations with their doctors.[116]

The Maya in diaspora carry with them not just the problems of their generations, but also a long cultural history of suffering under and resisting colonial rule. It is evident in studies of

[114] Focus Groups with Maya women.
[115] Yukes, "Herbal Medicine and Ethnobotanical Knowledge," 47; Focus Groups with Maya Women.
[116] Focus groups with Maya women.

other indigenous groups that after many years of discrimination and oppression, it can be difficult for Indians, like the Maya, to appreciate the richness of their culture, including the benefits of their health practices.[117] A Maya person's legal status in the United States further impacts their ability to maintain their cultural ties to their homeland. An immigrant with documentation can travel between their host country and their home country more easily than an undocumented person who prefers to avoid the risk of traveling across the border.[118] Therefore, undocumented immigrants are at much higher risk of losing contact with their homeland and thus rely on connections with their diaspora community to retain their culture.

When I asked Jody, the Certified Nurse Midwife, what I could tell the Maya that might help them in the hospital, her answer was, "Tell them to keep doing what they are doing. They are perfect." She told me the Maya are her healthiest, most prepared patients, but that she worries fast food and a sedentary lifestyle could change their health outcomes in the future.[119] Susan Griggs also said, "You should be proud of your girls. These tiny four foot eight women deliver ten pound babies like it's nothing."[120] Biomedical caregivers appreciate the traditional Maya health practices that lead to healthier people and hope the Maya retain their good eating and exercise habits.

Research shows that Maya immigrants do experience a higher standard of health in the United States if they receive adequate information about nutrition and healthy life choices. In a series of studies conducted by Patricia Smith, Barry Bogin, Maria Ines Varela-Silva, and James Loucky, Maya immigrants to the United States, children in particular, were found to benefit greatly from immigration. These researchers used height, weight, and body composition—

[117] Teresa Evans-Campbell, "Historical Trauma in American Indian/Native Alaska Communities: A Multilevel Framework for Exploring Impacts on Individuals, Families, and Communities," *Journal of Interpersonal Violence* 23 (2008): 320-321.
[118] Cecilia Menjivar, "Guatemalan-origin Children," 549.
[119] Toledo, interview.
[120] Griggs, interview.

commonly used factors to determine health status—to examine the effects of immigration on Maya children. US Maya children were found to be taller than their Guatemalan counterparts are and to have longer legs indicating their superior health. However, they are more likely to be overweight or obese, perhaps because of diet and a reduced activity lifestyle.[121] These findings suggest that even though Maya children living in the U.S. are receiving better nutrition than those in Guatemala, education is needed to inform parents and children about the risks of obesity and a sedentary lifestyle on long-term health. Therefore, it is important for US Maya to receive culturally specific information on certain health issues, especially nutrition.

As Gilberto and I worked together, we came to know each other well and trust grew between us. It became more common for him to talk candidly about sensitive issues. However, the extent of my interactions with the women was much more limited. Because I do not speak their language, Q'anjob'al, my words and theirs were filtered through Gilberto. The women were comfortable enough with our relationship to disapprove of the photographs in the prenatal video, but I doubt they were always completely forthcoming with relevant information that I did not specifically request. I hope our relationships become more open and trusting as the Toolkit team persists in using CBPR to craft a product that will truly benefit Maya in diaspora and their medical providers. This mutual relationship is the key to developing a product that will enhance Maya self-worth while helping them to overcome barriers to biomedical care. Just as the Maya syncretize biomedical practices into their health repertoire, it would be beneficial for US

[121] Bogin, B., P. Smith, A.B. Orden, M.I. Varela Silva, and J. Loucky, "Rapid Change in Height and Body Proportions of Maya American Children," *American Journal of Human Biology* 14 (2002): 753-761; Patricia K. Smith, Barry Bogin, Maria Ines Varela-Silva, and James Loucky, "Economic and Anthropological Assessments of the Health of Children in Maya Immigrant Families in the US," *Economics and Human Biology* 1 (2003): 145-160; Patricia K. Smith, Barry Bogin, M. Ines Varela-Silva, Bibiana Orden, and James Loucky, "Does Immigration Help or Harm Children's Health? The Mayan Case," *Social Science Quarterly* 83(2002): 994-1002.

providers to attempt to do the same with some Maya traditions. Often biomedical practitioners are resistant to do this.[122]

As a researcher subjectively examining the qualitative information that the Maya have shared with me, it seems that many Maya seek to use their indigenous status to gain prestige, privilege, and social capital, but others wish to blend in with the larger Latino community in the United States. It seems *possible* to me that the Maya manipulate their identity strategically to maximize acceptance in the group they are in to get the best care or treatment. For example, midwives and nurses interviewed told me that patients from Guatemala emphasize that they are not Mexican; they are Guatemalan. They want it to be clear that they are different.[123] On the other hand, interviews revealed that once Maya learn to speak Spanish well, they may attempt to pass as Hispanic at work or in school. Gilberto told me, "Guatemalans and Mexicans do not get along."[124] In order to "get along" with their peers, many Maya reject their ethnicity. Thus, the Maya may leverage their Maya-ness when it suits to distinguish them from Latinos, who they perceive are disliked by the white majority. However, at other times, they may choose to blend in with Latinos, rejecting their indigeneity and adopting a Hispanic identity.[125]

Language loss from one generation of immigrants to the next was a common theme in my interviews. Rejection of the Maya indigenous language is fueled by the negative experiences of parents who could not speak English or Spanish when they arrived in the United States. Some Maya immigrant parents question the use of their indigenous language and encourage their children to learn Spanish to blend in with Latinos or to learn English and be American. It is not unusual for a child and parent to speak different languages. Gilberto told me of a friend of his

[122] Adams and Hawkins, *Health Care*.
[123] Griggs, interview; Toledo, interview.
[124] Simon, interview.
[125] Ibid.

who lamented, "'I don't know how to talk to my kids. They only speak English and I don't speak English.'' Gilberto told me that his nieces and nephews do not speak Q'anjob'al because his sister (whose house his family shares with her family) says, "'They are never going to use it, so why should I teach them Q'anjob'al?'" Though Gilberto sees this trend and is bothered by it, other Maya who work with the MHCP have shared with us that their children do speak the Maya language when they are young, but lose proficiency as they get older and enter the public school system in the United States.[126]

Another benefit of the Toolkit is that it contributes to the preservation of Maya health beliefs and language. As the Maya in diaspora encounter biomedical practices and adapt to life in the United States, their reasons for making certain health care choices may become lost. If the Maya lose touch with their homeland, they could experience culture loss because they are not able to maintain contact with their home communities. By gathering information from Maya people and publishing their 'medical' beliefs in the Toolkit, the Toolkit team documented why Maya behave as they do.

The Maya I interviewed were unaware that providers view them as such a healthy people. Therefore, they aspire to blend in with a culture that is perhaps not as physically healthy as they are. By encouraging them to conform to the US health culture (for example, urging them to go to the doctor as soon as they think they are pregnant and submitting themselves to tests and doctors' decisions that they perhaps do not understand) we may be harming their health, rather than promoting it.[127] By helping the Maya to recognize the validity of their methods of caring for themselves and the effectiveness of their traditional health care practices, especially when

[126] Conversation with Dr. Alan LeBaron.

[127] Of course, some of the Maya women experience complications and illnesses, but without statistical data on the frequency of those problems in specific populations comparable to other populations, we cannot determine if the Maya are at special risk, better off, or the same. This CBPR reception study was not able to address in depth medical data, but a larger study that considers this data would be beneficial to better understanding this situation.

incorporated with biomedical practices, providers and advocates can help level the playing field and build pride in Maya identity and culture—even as it changes to incorporate modern medical practices and knowledge of disease.

The Mayas' pluralistic, hybrid belief system exemplifies a defining characteristic of culture: the tendency toward syncretism in all things. A Maya core identity has remained intact and strong since first encounters, but has changed with new influences and hardships. The process of syncretism is a common way for Maya culture to evolve by incorporating other culture's practices into their own, often recreating the meaning of the practice at the same time.[128] This strengthens in diaspora as they encounter new ideas from US culture, but also shows some signs of resistance as some Maya recognize the colonial influence on their culture and work in resistance against this and to promote traditional knowledge and practices. Thus, "Cultural identity . . . is a matter of 'becoming' as well as 'being. . . [Cultural identities] are subject to the continuous 'play' of history, culture, and power."[129]

Perhaps this vindicates Diane Nelson's argument that "ethnicity and tradition are not always already there."[130] On the other hand, perhaps this flexibility and adaptability *is* the tradition and this has allowed the Maya culture to survive the last five hundred years. Maya identity is formed through their "persistence in some of their pre-Conquest beliefs," their development of a "'cultural cocktail,'" and their collective experience with racism in Guatemala and discrimination in the United States.[131]

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[128] Harris, " Conceptions of Disease," 27.
[129] Hall, "Culture and Identity," 225.
[130] Diane M. Nelson, *A Finger in the Wound: Body Politics in Quincentennial Guatemala* (Berkeley, Los Angeles: University of California Press, 1999), 2.
[131] Peter Hervik, "Narrations of Shifting Maya Identities," *Bulletin of Latin American Research* 20 (2001): 343; Les W. Field, "Beyond Identity?: Analytical Crosscurrents in Contemporary Mayanist Social Science," *Latin American Research Review* 40 (October 2005): 283-293.

Pressures on the Maya

The logistical and cultural barriers addressed previously place great pressure on Maya living in the United States. Researchers often view cultural beliefs in the abstract and do not take into account peoples' actual behaviors.[132] Ideally, by including the Maya people in the data-gathering process and incorporating their experiences and ideas into our products, they will be more likely to adhere to the Toolkit's recommendations because they will feel that they have a stake in the products.[133] It is evident here that though the Maya who participated in this study are pleased with the Toolkit, there is no guarantee that they will adhere to its suggestions.

Furthermore, many Maya immigrants mistrust institutions and those who appear to be in positions of power. This often happens because immigration status may cause the person to fear detainment and deportation. Experiences in Guatemala contribute to this mistrust, as well.[134] Other Maya may have had negative experiences in the United States, or have other legitimate reasons to fear the authorities.

Promoting Maya identity to alleviate cultural pressures is not a new strategy. The idea of Pan-Mayanism—the incorporation of ancient Maya-descended Central American indigenous groups into one "Maya" identity—has gained popularity since the 1970s.[135] In Guatemala, the Pan-Maya movement, *movimiento maya*, emphasizes pursuing "scholarly and educational routes to social change."[136] The movement promotes, "'reverse orientalism,' which categorically elevates the 'self' and condemns the structurally dominant 'other' as racist to promote solidarity

[132] Pelto and Pelto, "Knowledge, Culture, and Behavior," 148, 161.
[133] Baldwin, et. al., "Building Partnerships," S80.
[134] Burns, *Maya in exile*, 24-26.
[135] Paul K. Eiss, "Constructing the Maya," *Ethnohistory* 55 (2008): 503-508.
[136] Kay B. Warren, *Indigenous Movements and their Critics: Pan-Maya Activism in Guatemala* (Princeton: Princeton University Press, 1998), 4.

and resistance."[137] The potential problem with this approach is that it adopts colonial forms of repression and "othering" in reverse.

The make-up of the Pan-Maya movement suggests its possible impacts on the majority of the Maya people is limited. It is mainly composed of Maya who are educated, speak fluent Spanish, and are "economically mobile."[138] These proponents of Maya culture want to elevate the status of the Maya people in Guatemala and in diaspora, but it is unclear if their beliefs permeate throughout the entire community of Maya.[139] For example, though many Maya live in poverty and experience discrimination in Guatemala, the Pan-Maya movement, "seeks to break the association of Maya identity with abject poverty and Ladino oppression."[140] This attitude serves to ignore systemic problems, rather than confronting them and seeking ways to overcome them. There is a need to resist portraying, "'Maya culture' as a static pre-Columbian essence . . . [to] do justice to the various syntheses of Maya culture."[141] In the Pan-Maya promotion of Maya-ness, the Maya themselves risk pursuing an "oppressive authenticity" that rejects modern advances and thus, holds the Maya back.[142]

Despite the Pan-Maya movement, Maya in Guatemala are treated very poorly by the non-Maya Ladinos. "Postcolonialism strategically harnesses culture to history in the interests of deconstructing national/ethnic identity and exposing the workings of power/domination."[143] There is recognition in Guatemala that power is held by the Ladinos and that this power structure is colonial in origin. For example, Gilberto told me that when Maya babies were born in his hometown of Santa Eulalia, the parents could go to apply for a birth certificate only to be told by

[137] Ibid., 4.
[138] Ibid., 11.
[139] Ibid., 12
[140] Ibid., 21
[141] Ibid., 11.
[142] Jeffrey Sisson, *First Peoples: Indigenous Cultures and their Futures* (London: Reaktion, 2005), 37-59.
[143] Krishnaswamy, "Culture of Criticism," 107.

Ladino officials that the name they had chosen was "ugly" and that they should choose a Spanish name instead.[144] When Maya in Santa Eulalia go to the bank, they must speak Spanish or take a friend or family member with them to interpret for them because all of the bankers are Ladino. Gilberto said that the people in power are not Maya because it is not the Maya who graduate and get good, professional jobs.

Now there are very few people with Maya names left in Santa Eulalia, but some Maya who are involved in cultural revitalization efforts are reclaiming Maya names. Gilberto and I discovered that his friend Nora from Santa Eulalia had won the *Princesa Indigena Nacional* in Guatemala in May of 2011.[145] She had changed her name to a Maya name since he last spoke with her. Gilberto plans to take a Maya name himself if he returns to Guatemala.[146] Reclaiming Maya names serves as a way to take back cultural identity and resist postcolonial influence.

It is evident that some Maya are coming to recognize, question, and resent Ladino power in Guatemala, but Gilberto believes that many more fear prejudice, discrimination, and deportation in diaspora and would rather blend in with the larger Latino community. He implied that many Maya immigrants do not embrace their Maya identity because they see it as a hindrance to their success in the United States.[147] Instead, they encourage their children to learn Spanish or English, abandon their Maya language, and aspire to be Ladino themselves one day.[148] The postcolonial pressures that shape these actions change the way Maya view all of their cultural practices, including health care. Even if they live as Maya and participate in the Maya community, they may view that community as backward or be ashamed of their heritage.

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[144] Simon, interview.
[145]The Guatemalan National Indigenous Princess speaks out on behalf of Maya throughout Guatemala, promoting Maya culture and advocating for the Maya people. Carlos Ventura, "Coronan a representante de Santa Eulalia como Princesa Indígena," *Pensa Libre* May 9, 2011, accessed 11/11/11 <http://www.prensalibre.com/quetzaltenango/Coronan-Santa-Eulalia-Princesa-Indigena_0_548945291.html>
[146] Simon, interview.
[147] Ibid.
[148] Ibid.

During our initial focus groups with the Maya women in Canton, we were told that sometimes hospital staff members do not treat the Maya with respect. One woman told us of a friend who was abandoned by her husband. Left alone with four children, the woman went to the hospital to give birth to her fifth child where she was harassed and chastised by some hospital staff: "They were talking about her really bad and treating her like a dog." Despite this poor treatment, the woman did not say anything in her defense, though. Instead, she asked her friends to share this story with the MHCP researchers so that we could influence providers to treat Maya respectfully.[149] They believe they should be treated with respect. However, they do not have the confidence to demand respect from caregivers. They allow themselves to be treated poorly because they have come to believe that is what they deserve. But when given an opportunity to form an alliance (with the MHCP in this case), they happily to do so in order to advocate for themselves and the other Maya.

Unfortunately, while receiving medical care the Maya do not ask questions very often, likely because of the language barrier and exacerbated by their perceived inferiority.[150] This leads some Maya to accept the instructions of providers who appear to have authority (meaning education, information, and power) without question and perhaps without a complete understanding of what is happening. Many of these providers are technicians, nurses, or midwives, but because they wear a uniform and represent the biomedical healthcare system, the Maya women view them as "doctors" with medicines that can help them. Hence, a technician in scrubs (medical uniform) that comes to take a patient's vital signs may exert as much power and influence over a Maya woman in labor as an obstetrician.

[149] Focus groups with Maya women.
[150] Ibid.

It is important that providers recognize their relationship with patients in order for transcultural care to be effective. Doctors and nurses are in a position of power and therefore must choose to understand and implement methods of cultural competency.[151] Fortunately, studies show that health care providers want to develop cultural competency and are seeking ways to do that.[152] Providers who I interviewed corroborate this finding. They are very interested in learning more about the Maya, their health care traditions, and ways of communicating with them.[153]

The Toolkit serves to start a dialogue about the Maya amongst health care providers. Really, the most valuable tool to providers is the knowledge of the Maya culture: their history, their uniqueness, and their current and historical experiences. Without this connection to the Maya community, clinicians have little reason to recognize the need for the tools, no less to use them in their practice. We can only make providers aware of the Maya and the tools—we cannot force them to use them. The Toolkit can enhance the health care experiences and feelings of worth and recognition among the Maya throughout the United States who see the tools created specifically for them, but will be more effective if studied and utilized by providers.

My initial belief in beginning this assessment of the Toolkit was that caregivers were going to be the biggest obstacle to implementing it because medical anthropology texts often warn that caregivers (or others in power) may be resistant to hearing outside recommendations.[154] However, in the first three and a half months that the Toolkit was available online through the Bridging Refugee and Children's Services web site, it was downloaded in its

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[151] Royal College of Nursing, "Transcultural Health Practice: Foundation Module," *Royal College of Nursing Professional Development*, accessed 11/11/11< http://www.rcn.org.uk/development/learning/transcultural_health>
[152] P. Abbot, E. Short, S. Dodson, C. Garcia, J. Perkins, and S. Wyant, "Improving Your Cultural Awareness with Cultural Clues," *Nurse Practitioner* 27 (2002): 44-49.
[153] Toledo, interview; Nancy Rappenthall, Interview with Amanda McGrew, November 20, 2010; and Susan Griggs, interview.
[154] Singer, "Ivory Tower," 82.

entirety over 12,000 times. It is impossible to know exactly who downloaded the Toolkit, but the numbers clearly show that there is a great need for this project.

Moving Forward with the Toolkit

After assessing Maya and provider's impressions of the Toolkit, it is clear that certain actions can be taken to improve the usability and efficacy of the tools. First, changing the photographs used in the prenatal education video was very important to the Maya women and must be done to ensure they feel comfortable with the images on-screen as they take in the information. Second, Jody expressed that the "Body Charts" and the "Key Terms in Translation" are excellent, useful tools, but would be difficult to access in hospitals if internet access were necessary. A way of overcoming this problem would be for these tools to be converted into smart phone or tablet computer applications that can be downloaded to a device and accessed any time. This conversion would take time, talent, and resources, but would greatly enhance the chances that providers are able to use these tools when they need them. Furthermore, presenting the Toolkit to nurses and other providers in person at hospitals and medical conferences would spread the word that the Maya are living in the United States, they have a unique perspective on health, and their needs are different from that of other patients because of their historical and cultural situation.

The positive reception of the Toolkit by the Maya and providers is encouraging, but it is unclear if the benefits of the Toolkit are as concrete as they at first appear. It is true that the tools convey information that the Maya did not know, and this is helpful for increasing their health literacy. However, it cannot solve the logistical problems of seeking care. And though it narrows the cultural divide, it cannot help the Maya completely overcome the cultural obstacles to care that have their roots in hundreds of years of oppression. For example, the Maya women know that they should tell their providers about the herbs or alternative remedies that they use, but they

do not because it results in more questions that they do not understand. The frustration (and perhaps judgment) the Maya women feel when they are unable to explain their actions is worse to them than the threat of their herbal supplements harming their baby or themselves. The risk of being honest outweighs the risk of health complications. While the herb chart attempts to address this issue it does not completely solve the conundrum.

Regardless of whether the tools will actually change Maya behaviors, the Maya people appreciate the Toolkit as an indicator of their human value. The Maya feel important and accepted when they see US material culture that has been created specifically for them. These things validate their opinions of themselves and recognize their existence in the United States. The tools give Maya immigrants social capital. Whether or not the tools actually convey medical information that will be used by the Maya or was previously unknown to the Maya is secondary to the positive emotional and psychological effects that their existence has on the Maya women. The Maya people will be more likely to retain their language and cultural traditions in diaspora if they have a better outlook on their position in the United States. If the Maya see that providers recognize and admire their culture and are attempting to communicate with them through culturally appropriate means, their frustration and shame may be lessened. Providers must also be willing to recognize and accept beneficial or neutral Maya traditional practices without being judgmental or harsh.[155]

The Toolkit can present information and serve as a communication aid, but ultimately there are great needs for interpreters and cultural brokers who can help the Maya understand and navigate the system openly and honestly. The fourth goal of the Toolkit is to develop a national network of Maya interpreters who would be trained to do just that. The MHCP is working with

[155] Cosminsky, "Childbirth and Midwifery on a Guatemalan Finca," 94-98.

Maya around the country to develop this network. When it is put into practice it will greatly enhance Maya health access.

Researchers, including the MHCP, should continue using the community-based participatory research (CBPR) model to formulate new tools and increase their own knowledge of Maya culture and health practices. It is important to continue partnerships and dialogue with the Maya people in order to foster open lines of communication and further their specific goals and needs. Though few studies have been done on whether CBPR leads to better health outcomes, it definitely leads to capacity building in the partner community and increases agency among partner community participants.[156]

[156] Wallerstein and Duran, "Community-Based Participatory Research," 318-319.

Conclusion

As the Maya encounter, conform to, and value US health care practices it is possible that they will lose their cultural traditions in diaspora. As they syncretize their own beliefs and practices with the beliefs and systems they encounter, their culture will change just as the cultures of previous waves of immigrants diverged from that of their homelands. Though this is not necessarily a bad thing, it is important that the Maya understand that their cultural traditions are not inherently inferior to the culture and practices of their host country. This false assumption could lead to the decay of traditions that could actually benefit US health care if understood and appreciated by biomedical providers. Avoiding the "oppressive authenticity" of the receiving community may allow them to benefit from biomedical health care advances when they actually are advances, but can also help them recognize and continue to practice beneficial traditional health customs.[157]

Maya immigrants have come to occupy a liminal space in the United States. They have crossed a physical border, but they remain on a cultural border by maintaining some of their traditional beliefs, but also adding US practices to their everyday lives. The Maya retain their indigenous culture as foundational beliefs, but they are open to new experiences and are likely to adopt and re-appropriate those experiences as performances of traditional, deeply held beliefs. Achieving a balance of appreciation for these modes of care would greatly benefit the Maya in diaspora. However, even as they use "Maya medicine" to cure illness, given a reasonable opportunity to pursue biomedical care, they would prefer it to their Maya methods.

[157] Sissons, *First Peoples*, 37-57.

Maya health care choices are a consequence of their beliefs, knowledge, and their means of access, all of which are affected by Guatemalan history, the experience of diaspora, and their traditional culture. Maya health in the United States is a function of all of these complicated influences.[158] These postcolonial cultural pressures exist regardless of logistical obstacles. These influences shape Maya self-perception in the United States, affecting the way Maya think about their traditions and indigenous heritage. Though Pan-Maya advocates in Guatemala promote Maya pride, the postcolonial mindset pervades the Canton Maya women's health care experiences and opinions. Maya organizations in the United States, like Pastoral Maya, are working to curb these influences, though.

Maya culture continues to transform. Stuart Hall laments that Africans in diaspora are unable to regain their past because the past is not frozen in time and cannot be reclaimed. The Maya in diaspora confront the same obstacle by creating a new Maya-ness. This evolution of Maya culture has been heavily influenced by colonial forces that have resulted in the Mayas own belief in their "other-ness."[159] The Maya are not actively questioning power and voicing resistance to postcolonial pressures in the United States because they do not recognize themselves as worthy of doing so. They continue to "other" themselves and position themselves in relation to the dominant cultures in Guatemala and the United States.[160] The Toolkit works to encourage the Maya to accept their beneficial practices, resist US power, and access quality health care.

Maya health beliefs are based on the concept of balance. Keeping one's body in balance by maintaining equilibrium between hot and cold and avoiding negative energies are two ways

[158] Though immigration status is probably also a factor, the Maya I spoke with failed to mention this as a personal barrier and I did not ask the question directly as a strategy for maintaining trusting relationships.
[159] Hall, "Culture and Identity," 231.
[160] Ibid., 233.

traditional Maya preserve balance within their bodies. Finding a balance between Maya ethnomedical traditions and US biomedicine is a key factor in providing the Maya in diaspora with adequate and culturally appropriate health care. A balance between their beneficial traditional practices and modern biomedical practices will allow the Maya to retain the culture of their homeland, but to identify and utilize advanced medical techniques available in their host country.

The tools can improve Maya knowledge of biomedical health care, but the Toolkit alone cannot change the health care system. Singer argues that, in general, many health reforms serve to continue oppressive practices, rather than alleviate them. [161] While the Maya perceive that providers have the power, they will continue to place their health at risk by mixing practices for various reasons. Changing the system to accommodate for these behaviors will be a long process that begins with recognition of the need, but continues through the development of the tools, their improvement, their utilization, and eventually generational knowledge of the US health care system and its culture. The problems of Maya health knowledge and access are not going to be solved with a Toolkit, but the Toolkit does serve to uplift the Maya community in the United States and make doctors aware of them and their specific and unique needs.

The Toolkit can ease some Maya feelings of inferiority therefore creating the opportunity for confidence and knowledge to increase agency. However, just as one obstacle is overcome, it seems that another lies in the path. Even if logistical problems were solved, Maya health decisions would still be greatly impacted by postcolonialism. Overcoming this longstanding obstacle continues to be difficult for the Maya in diaspora. They are accustomed to staying in their "place" and to seeing themselves as the "other." The MHCP and the use of CBPR in this project encourage the Maya to think in terms of their agency in the United States and the world

[161] Singer, "Ivory Tower," 88.

so that they can begin countering the arbitrary and often irrational colonizing influences of the last five hundred years. The Maya cannot, nor should they, revert to being "authentic" pre-Columbian peoples. However, they should not be ashamed of who they are and their culture's long-standing health traditions. Gilberto told me, "When they [the Maya] are proud of themselves, other people are very interested to learn about Maya culture. And if they are proud and they have a firm identity, that helps other people respect them and their culture."[162]

[162] Simon, interview.

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