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dissertation entitled

Community Health Organizing and the Political Economy of Health Care in Morelos, Mexico

presented by

Suzanne D. Schneider

has been accepted towards fulfillment
of the requirements for the

Ph.D. degree in Anthropology

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April 21, 2006
Date

COMMUNITY HEALTH ORGANIZING AND THE POLITICAL ECONOMY OF HEALTH CARE IN MORELOS, MEXICO

By

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A DISSERTATION

Submitted to
Michigan State University
in partial fulfillment of the requirements
for the degree of

DOCTOR OF PHILOSOPHY

Anthropology

2006

ABSTRACT

COMMUNITY HEALTH ORGANIZING AND THE POLITICAL ECONOMY OF HEALTH CARE IN MORELOS, MEXICO

By

Suzanne D. Schneider

This dissertation analyzes the emergence of a community-based alternative health care movement in Morelos, Mexico, and its local expressions among health groups in the *mestizo* town of Zarragoza. Influenced by self-help approaches, cultural revitalization efforts, and the global alternative medicine movement, health groups in this study run community clinics, natural pharmacies, and health promoter training programs in order to make the health care alternatives they offer accessible and affordable to community residents. This study explores the work of three health groups in Zarragoza and examines the practices they employ in their community clinics and the discourses that their participants advocate.

The study situates local health organizing efforts in the context of global and national health policies that influence paradigms governing formal health care distribution and health sector reforms in Mexico. Specifically, it explores the strategies of local health groups as a response to the government's inadequate efforts to provide "health for all" and to alleviate health care shortages in the face of socioeconomic challenges that many Mexicans experience. The study also examines health organizing as a response to perceived limitations of biomedicine as the population ages and the burden of chronic illnesses accelerates the deterioration of an underfunded public health system. As health care protection decreases under neoliberal state reforms, health groups advocate a new way of "doing" health care that emphasizes patient participation in illness

prevention, health education, and the attainment of medical care outside of government health structures.

This dissertation merges critical and political economy approaches in medical anthropology with actor-oriented frameworks. By considering how the agendas of health groups reflect local and global trends, the study contributes to the medical anthropology literature by furthering our understanding of the global and syncretic nature of medical pluralism. This dissertation also contributes a case study to the scarce literature on social movements in health, offering new perspectives on how communities, most specifically women, are interacting with a myriad of global and national pressures to contribute solutions to local problems concerning health care. By detailing local perspectives and grounding the project in issues of political economy, this research offers new insights into local understandings of health care that may be overlooked in government health planning and the implementation of development programs.

For my parents

ACKNOWLEDGEMENTS

So many people played an essential role in the many phases of this dissertation. Linda Hunt, my dissertation advisor, invested an enormous amount of time and energy in my training. She provided me with invaluable direction through her guidance, coaching, and feedback on the many dissertation drafts I produced. Ann Millard, my graduate advisor from 1999 to 2003, guided me through the conception of and data collection for this project. Her encouraging mentorship, strategic advice, and visit to the field helped to make this project possible.

I am thankful for the mentorship and support of my dissertation committee members. Anne Ferguson helped me make sense of the macro-level forces that play out in my study and guided me toward essential literature to help frame the project. Laura DeLind pointed me toward broader implications of my findings and contributed much insight into my work. Scott Whiteford helped guide the initial stages of this project, contributing his expertise on Mexico. Thanks to Margaret Holmes-Rovner for her useful comments on the dissertation. Lynne Goldstein deserves recognition for her helpful advice and ongoing support. Thanks to my colleagues Keri Brondo and Suzanne Kent for providing critical feedback at pivotal stages of the writing process.

At Michigan State University, I received support, assistance, and funding from the Department of Anthropology, Center for Latin American and Caribbean Studies, Center for Advanced Studies on International Development, Women and International Development Program, College of Social Science, and the Graduate School. The

research for this dissertation was funded by a U.S. Department of Education Fulbright-Hays Doctoral Dissertation Research Abroad Fellowship. The write up phase of the project was funded by an American Association of University Women American Fellowship with funds also provided by Michigan State University.

There are many people who assisted me with my field visits and research in Mexico. First, I would like to thank Dr. David Robichaux who allowed me to participate in the Universidad Iberoamericana Ethnographic Field School in Tlaxcala during the summer of 2000. Jeannie Andersen at *Encuentros* Spanish language school in Cuernavaca organized my language training and connected me with invaluable contacts in Morelos during the summers of 2000 and 2001. Many teachers at *Encuentros* were essential to this project. Elba Stephens Wulfrath first introduced me to numerous health groups throughout Morelos. Graciela Velásquez assisted me with my interviews in Cuernavaca and contributed her keen anthropological insights to my work. Both she and Paloma García transcribed my interviews and offered their helpful perspectives on the project. Guadalupe Mainero at CIDHAL allowed me to observe her work and offered helpful insight into women's health issues. Paquita Liceaga and her family shared their home, food, and festivities with Brendon and me while we stayed in Cuernavaca.

This dissertation would not have been possible without the generosity and kindness of many people in Yautepec. I owe much gratitude to all of the members and participants of the *Comité Cultural y Desarrollo Integral* and the *Dispensario Paroquial* who accepted me as a researcher and student. Clara Inez Pérez Pastrana first agreed to introduce me to the members of the CCDI and opened up many doors for this project. Angelica Reynoso took me in as a daughter, guided and protected me, and shared so

much about her life with me. Mago Ramírez, Brigida Espinosa, Josefina Garcia, Luz Martinez supported me in countless ways during my stay in Yatepec. Special thanks also go out to Joaquín Acosta and Yolanda Masse Cruz for incorporating me into the Parochial Dispensary group. This project could not have been accomplished without the help of so many La Gemma and La Cajigal residents, health administrators, and municipal officials in Yautepec who generously agreed to interviews. My two research assistants – Alma Delia García Lira and Avigail Gil Acevedo – were immensely helpful in arranging interviews, conducting surveys, and teaching me about daily life in Yautpec. Thanks to Alberto Becerril Montekio and Nora Alvarado Colle for opening their homes and hearts to Brendon and me during our stay in Yautepec.

My family provided me with unwavering support and encouragement throughout this process. My mother carefully mentored me through every stage of graduate school and provided me with the confidence to make it through the next challenge. My father instilled in me a tremendous amount faith in myself, a gift that has made this entire journey possible. My husband Brendon has been a key source of my strength. He accompanied me physically and emotionally in this journey, joining me in Mexico, sharing in the vistas of knowledge, and accepting the struggles as well. His unconditional love and support and the many sacrifices he made so that I could follow my dreams are always close to my heart. Sammie, my most faithful companion throughout this process, has been a constant reminder of the simple joys that life holds.

Muchas gracias por todo – to everyone I mentioned here and many more who contributed to this project. Indeed, it takes a village to raise an anthropologist.

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CHAPTER ONE: INTRODUCTION AND BACKGROUND

In the summer of 2001, I first traversed through the mountainous Wolves Canyon that separates the outskirts of the city of Cuernavaca from the town of Zarragoza. I was going to meet a group of women who had formed a health collective and were gathering on that day for a class on alternative medicine. After a forty-five minute bumpy ride in a VW bug with my Spanish teacher who had graciously agreed to introduce me to the participants of the Committee for Cultural and Development (CCD)[1], we finally arrived at the working class neighborhood of La Rosa which houses the community center in which the CCD works.

Walking into the La Rosa community center, we were greeted with brightly painted children's pictures and murals. One of the members of the cooperative introduced herself and proudly showed us the group's most recent innovation – a large bowl of an herbal ointment for relieving bronchial congestion (natural "Vaporub"). When the other women arrived for the class, they immediately began pulling out the medicinal plants that they brought to share with one another – fresh herbs collected from the countryside, prepackaged herbal combinations bought from the market, and fresh bark from a neighbor's tree. The bark was passed around so that we could taste its bitter flavor while the women discussed the uses for the herbal plants that they had brought to the gathering. They also discussed the books that they brought which included "The Therapeutic Guide to Herbal Remedies," "Medicine for the New Millennium," and "Herbalism for Health and Wellbeing."

[1] To maintain the anonymity of the participants of this study, I have replaced the names of all participants, groups, neighborhoods, and community settings with pseudonyms.

The instructor Maria arrived a few minutes later. She carried in two large white sheets of paper which she taped to the wall. One had an outline of the front side of a woman's body and the other had an outline of a women's back side. Maria noted various pressure points on the figures while the women replicated these points on their notebooks in front of them. Maria then explained how the pressure points coordinate with specific parts of the body as determined by meridians described by Chinese medical therapy. She demonstrated how to determine if an organ is strong or weak by pressing a pressure point and pulling apart the thumb and first finger of the patient. Maria instructed the class to make large drawings like hers when they got home and to hang them in their houses and study the pressure points. After the "theoretical" portion of the class ended, the women gathered around the table to make herbal tinctures using alcohol and some of the medicinal plants that they had brought.

This brief description of my earliest observations of the CCD illustrates the diverse range of health practices that are being incorporated into the health organizing strategies of local groups in Zarragoza. The activities of such groups incorporate global ideas about health and healing while seeking to "rescue" traditional medicine practices that have been used for centuries in Mexico. The health groups that I detail in this study are not working alone. Indeed, many similar groups throughout the country are also educating community members on natural health care options and providing low-cost health services to those in need.

This dissertation analyzes the emergence of a community-based alternative health care movement in Morelos, Mexico, and its local expressions among health groups in the *mestizo* town of Zarragoza. Influenced by self-help approaches, cultural revitalization

efforts, and the Western alternative medicine movement, the health groups in this study run community clinics, natural pharmacies, and health promoter training programs, in order to make the health care alternatives they propose accessible and affordable to community residents. This study explores a sample of health groups in Zarragoza, their participants, the practices they employ in their community clinics, and the discourses that they advocate.

Taking a political economic approach, the study considers local health organizing efforts in the context of global and national health policies that influence paradigms governing formal health care distribution and health sector reforms in Mexico. It explores the efforts of local health groups as a response to the government's inadequate efforts to distribute "health for all" and alleviate health care disparities in the face of socioeconomic challenges that many Mexicans endure as they attempt to procure sufficient and necessary health resources. The study also examines health organizing as a response to perceived limitations of biomedicine in the context of epidemiological shifts that are taking place as the population ages and the burden of chronic illnesses accelerate the deterioration of an underfunded public health system. As a result of the many forces that have negatively impacted low-income populations' access to health care in Mexico, this study examines how communities, most specifically committees of women, are contributing solutions to local problems concerning health care. Drawing from 15 months of ethnographic research carried out in the state of Morelos, this study offers an example of how local groups are utilizing both global and local resources to organize from the "bottom-up" in order to participate in and redefine the health care process, outside of formal government institutions.

The decline of formal health care and the rise of civil society organizing

The Mexican health system as it stands today, had originally been established in the early 1940s with the goal of meeting the health care needs of all Mexicans, including the working classes and the poor. As demand for biomedical health services grew in the 1960s and 1970s, the government began a process of reforming the health system to better meet the needs of all Mexicans; particularly the most geographically and economically marginalized groups. After decades of health system reforms that have introduced a myriad of programs designed to address the nation's health care disparities, local health systems still struggle to meet the basic needs of their patients. The challenges are mounting as health services decline under state reforms while population demand grows and new health problems emerge. The national government's acceptance of neoliberal policies that emphasize less government intervention in health care, greater decentralization of health resources, and the expansion of the private sector's participation in health care have left communities facing a gap between the retracting state and inaccessible market (Laurell 2001). As a result of these shifts, individuals are left to fill the gap, help finance the health sector, and manage health resources through increased participation in health care.

Responding to this "call to service," civil society groups (i.e., nonprofit, nongovernmental, or voluntary organizations) have grown in number since the 1980s. Many civil organizations advocate community-based approaches to health care to help meet the needs of rural and indigent populations (Jareg and Kaseje 1998). Women are the primary participants in organizations that seek alternative means of distributing health

services. According to Petchesky (2003), a transnational women's health movement has surged in the last two decades with much involvement from women in developing countries who are responding to the harsh economic conditions they face due to structural adjustment policies and declining access to health care services. In Latin America, women's health organizations have most commonly organized around issues of reproductive health and access to quality health care as part of a broader movement towards democracy (Cardaci 1995).

A growing "Third Sector"[2] literature reflects this shift, shedding light on the political-economic forces that have galvanized the emergence of civil society groups in the context of declining national health programs (Isaacs and Solimano 1999; Jareg and Kaseje 1998; Salamon 2001). However, as Lewis (1999) argues, there has been little research on the everyday interactions, organizational culture, and micro-politics of civil society organizations. Little is known about the efficacy and sustainability of civil society organizations or the impact that they are making in health care delivery, particularly in the context of health system reform. This dissertation offers a case study that considers how communities organize from the bottom-up to address their health care limitations and examines the specific alternatives that they propose.

Theoretically, I am concerned with the tension between policy and practice and between structure and agency in the context of persistent poverty and declining government intervention. While the dissertation highlights how social, economic, and political processes shape and inform individuals' health seeking options, it also reveals how individuals negotiate (adopt, resist, and restructure) these forces through health

[2] The term "Third Sector" refers to civil society organizations that include nonprofit, nongovernmental, or voluntary organizations.

organizing. In spite of growing recognition that many developing countries face mounting health and health care problems on account of failed development and neoliberal policies (e.g., Castro and Singer 2004; Kim et al. 2000), few social scientists have explored how community groups are responding to these problems.

The impetus for studying health organizing

The idea for this project was generated from pre-dissertation fieldwork that I conducted in a rural village in the state of Tlaxcala during the summer of 2000. My project titled "Household Medical Knowledge in Tlaxcala," investigated the knowledge and resources that women draw upon in their efforts to maintain household health. The only formal health care option available to residents in this community is one irregularly operated health post. The women I observed were quite resourceful in the health needs this left unaddressed. Growing their own herbal gardens and relying upon neighbors and kin networks for assistance with health problems are two concrete examples of this resourcefulness. I became interested in learning if women were formally organizing around health care in order to share their knowledge and health services with each other and with others in their community.

When I returned to Mexico the following summer, I visited five women's health collectives in the state of Morelos. One of the groups I was introduced to was the Committee for Cultural and Development (CCD), a grassroots group that organized health training programs and a women's cooperative in Yautepec. At the time of my initial visit, the CCD consisted of about 20 active members and was the largest and most active group that I had visited. The group was meeting weekly for health classes that

focused on traditional and alternative medicine (e.g., Mexican herbalism, massage therapy, acupressure or the stimulation of pressure points for healing purposes). During their "theoretical" sessions, the group learned various concepts of the body; its organs and systems; illness etiology; diagnostic techniques; and illness prevention. During the "practical" sessions, the women would practice diagnostic and therapeutic techniques on one another and produce herbal remedies which they would bring home to try out on their families and neighbors.

I soon learned that Yautepec is brimming with alternative medicine practitioners and groups. For example, I visited another group that works out of the Catholic Church in Yautepec and shares many practices in common with the CCD, including running a health promoter program and offering clinical services such as nutritional counseling, acupuncture, therapeutic massage, homeopathy, and herbal therapy along with other healing modalities described in Appendix A. When I returned to Morelos to conduct dissertation research, I observed numerous similar efforts in the state. I also learned that this movement has a relatively long history that can be traced back to the late 1960s when researchers and community organizers began to develop projects in rural communities to deliver traditional medicine in the absence of formal health services (see Magdaleno Mora and Guillén Magdaleno 2002).

What I found to be interesting about this movement is the way in which global medical practices and discourses are being adopted and reorganized to fit with local cultures and community needs in Mexico. For example, the health groups that I observed are taking up practices of traditional Chinese medicine and integrating new ideas about health and healing into their repertoire based upon Chinese medicine theory. In fact,

health group participants view some of the central concepts of Chinese medical theory as analogous to local Mexican ideas about health and healing such as the notion that a state of health reflects balance between the body and its environment. Moreover, Chinese medical ideas about balancing corporeal characteristics of hot and cold are similar to the characterization of foods and healing states as "hot" or "cold" among some Mexicans, which has received much attention in the anthropological literature (e.g., see Foster 1978, 1987; Messer 1987). Thus, as this self-help movement continues to evolve, it takes on different forms and meanings through its interaction with different bodies of knowledge and through its "transformative engagement with modernity" (Escobar 1995).

This ethnographic study is concerned with this health movement as a social response to the current context of health care in Mexico rather than with the medical efficacy of alternative treatments. The dissertation attempts to answer a range of social questions including: Why are health groups emerging at this time? What specific conditions give rise to them? Who is participating? What impacts do they have on health and well-being? How do they transform local understandings of health and sickness? How do they contribute new visions of community health?

Background and literature review

International development and global health policy

International health programs have drastically improved health standards throughout the developing world over the last century. Improvements in sanitation, the extension of vaccination coverage, increased accessibility of antibiotics, and improved health care access have helped to reduce deaths from common infections, decrease infant

and maternal mortality rates, and increase the overall lifespan. However, fundamental health problems that are linked with persistent poverty and a lack of basic sanitation are far from being eradicated. Moreover, failed development efforts have been blamed for the persistence of infectious disease and have caused enormous social, ecological, and health costs at the local level (e.g., see Lane and Rubinstein 1996; Simonelli 1987).

Since the 1950s, international development agendas have aimed at relieving the suffering of people in developing countries. In order to achieve this goal, development programs have emphasized economic growth and spreading the benefits of growth through high levels of industrialization, urbanization, technological improvements, increased material production, and the adoption of Western "modern" education and cultural values (Escobar 1995). Although development efforts intend to improve people's living standards in poorer nations, research documents how the socioeconomic status of the majority has worsened, not improved after decades of development (Escobar 1995; Rist 1997). Women in particular have born the brunt of failed development efforts as their "relative access to economic resources, income, and employment has worsened, their burdens of work have increased, and their relative and even absolute health, nutritional, and educational status has declined" (Sen and Grown 1987:16; see also Brodie 1994; Marchand and Parpart 1995).

The global economic crisis of the 1980s deepened these and other problems that earlier development efforts had been seeking to resolve. For example, structural adjustment programs (SAPs) were put in place to ensure that poorer nations repaid their debts to lending agencies like the World Bank. Budget austerity and market liberalization involved in adjustment policies resulted in drastic cuts in public services, a

reduction of all types of subsides, and a steep decline of health and education benefits (Rist 1997). As a result, the amount that developing countries could invest in health care services began to greatly decrease and the conditions of health care provision deteriorated along with the decline in financial resources (Evers and Juárez 2003).

In the aftermath of "the decade of structural adjustment," standardized health sector reforms were applied across low- and middle-income countries. Health reforms have generally been part of a larger development assistance package (loans and aid) that supports health sector programs. In return for funding available for health programs, developing countries have followed mandates of bilateral and multilateral agencies (i.e., the IMF, World Bank and Interamerican Development Bank) (Morgan 1991). Driven by models of neoliberal globalization as defined in the West, such mandates have most recently included the adoption of market oriented strategies to offset the contraction of public spending and decentralization strategies aimed at "modernizing" the health system and addressing the inefficiency, inequity, high costs and low coverage of health care associated with centralist governments and approaches.

Health planning has largely occurred from abroad mirroring economic development strategies that reflect the political agendas of powerful nations rather than the interests, needs, or realities of developing societies (Castro and Singer 2004). While numerous parties are involved in health planning (e.g., international agencies, government officials, pharmaceutical companies, health personnel, NGOs, and civil society organizations), the most influential actors are international donors, international agencies, and national governments (Zaidi 1994). Moreover, the implementation of health programs in developing countries has followed a "one size fits all" prescription,

meaning that similar reform packages are applied in countries throughout Latin America and Africa for example, which have starkly different historical and cultural backgrounds (Whiteford 2000).

As a result of international health planning, nations and communities must navigate the effects of policy shifts that may take little consideration of local needs and realities. In its local application in Mexico, health reforms have resulted in the commoditization of social services and benefits, reduced the state's direct responsibility for the implementation of sufficient social assistance programs for the poor, and required that families and communities bridge the increasing gap between the retracting state and the inaccessible market (Laurell 2001). To bridge this gap, the government has implemented numerous participatory initiatives to facilitate the involvement of individuals and municipalities in achieving the goals of "health for all" and "healthy municipalities" as proposed by international bodies. However, scholars have argued that despite their rhetoric of empowerment, such initiatives have been primarily implemented for their utility in reducing government spending, rather than for their democratic or intrinsic values (Zakus 1998).

Participatory approaches to health in historical context

The concept of community participation was first formalized at the Alma Ata conference sponsored by the WHO and UNICEF in 1978 which set the Primary Health Care movement into motion. Community participation quickly became an essential element of community health and development programs under a variety of names including "popular participation," "social participation," and "community involvement"

(Morgan 2001). The World Bank later adopted the concept and institutionalized participation in mainstream development discourse (particularly in rural development). Broadly, participatory approaches recognize the shortcomings inherent in top-down development approaches and make people's knowledge, skills, and priorities central to development as an alternative to donor-driven and outsider-led development (Cooke and Kothari 2001). Participation is still a central component of community health and other international development efforts sponsored by NGOs and international donors (Morgan 2001).

According to Morgan (2001), participatory approaches have historically been driven by two models. The utilitarian model suggests that donors or governments implement participatory programs to offset the costs of providing services. The empowerment model takes the perspective that local communities are empowered by taking responsibility to work towards resolving their own health and development problems. As Morgan (2001) explains however, neither of these widely applied perspectives calls for participatory initiatives to be implemented fully by community members. Even proponents of the empowerment approach acknowledge that marginalized communities are ultimately incapable of instigating participation precisely because they have no power. Instead, each requires some degree of outside impetus.

Participatory initiatives in health were initially established around primary health care (PHC) programs. In the context of PHC strategies, community participation came to be viewed as the "magic bullet" for resolving problems relating to both health and political power (Rifkin 1988 in Morgan 2001). However, participatory initiatives were largely motivated by ideological and political factors and had little relationship to

improving health. For example, the Ministry of Health in Mexico organized a program of community participation in the late 1970s as a means to help staff government health posts and deliver health care services and education in rural areas. Only through the use of "voluntary labor" could the government reach its goal of extending health care to rural communities (Stebbins 1986; Zakus 1998). As a result, citizens were required to contribute free labor through formal government structures without having input in the design of participatory initiatives. Morgan (2001) argues that, as a result of such realities, many participatory efforts in Latin American are patronizing to local communities, reflecting developers' views of them as passive and unable to organize themselves.

While participatory initiatives in health were initially established around PHC, development practitioners soon came to understand that health was defined more broadly by community residents than had been previously acknowledged. For example, communities viewed that housing and employment were as closely linked to health as were health services. Donors and governments also recognized that they could only make significant impacts in improving health by involving diverse stakeholders (i.e., local governments, NGOs, private sector groups, community residents) in addressing multiple areas of development including water, infrastructure, education, sanitation, and economic development (Morgan 2001). Thus, the World Bank began advocating an "intersectoral" approach to encourage the collaboration of various sectors of society to address the many impediments to health (Morgan 2001).

In theory, participatory initiatives reflect an effort on the part of international bodies and national governments to democratize social programs. Participation,

particularly under the empowerment model, has the potential to increase community residents' status, self-sufficiency, leadership, and awareness of the causes of structural subordination. However, true participation is also a threat to those holding power (Zakus 1988 in Hersch 1995). While in certain cases participation may have the potential to challenge patterns of dominance, scholars argue that it is more likely to be a means through which existing power relations are entrenched and reproduced (Nuijten 2002; Smith 2002; White 1996). As Nuijten (2002) argues, external interventions are always embedded within wider fields of power and local organizing capacities can not change those established power relations.

Smith (2002) suggests that in the same way that people in the traditional sector have been the "problem" for development and modernization efforts to resolve, those who talk about participation are in fact the people who are participating. Since those who are not participating are the ones targeted for participation, it is clear how discourses of participation are embedded in paternalistic ideas of development (Smith 2002). As a result, the acts and processes of participation (that are un-opposable) can easily conceal and reinforce oppressions and injustices (Cooke and Kothari 2001). As researchers have well documented, participatory development may result in political co-option in the form of labor or cash contributions and the transfer of project costs onto beneficiaries. Such strategies have been known to mask or enforce centralist structures in the name of decentralization (Cooke and Kothari 2001).

In the case of Mexico, the government has attempted to achieve decentralization by developing local political power structures through individual participation and the participation of community organizations (Contandriopoulos 2004). The discourse of

participation has also revolved around the idea of citizen repayment to the state in acceptance of the social goods it provides (Smith 2002). In this sense, community participation is viewed as an even trade for the services provided by the state. However, since Mexico has historically been a "welfare-type paternalist state" residents may not easily accept their role as active participants in the management of services that have historically been provided for free (Smith 2002). Thus, the logic of participation as imposed by the government may not be easily acceptable for those who understand their relationship with the government in a specific way.

Researchers suggest that there are a myriad of reasons why citizens may not be open or amenable to participatory approaches advocated by their government. For example, Sanchez (1988 in Hersch 1992) argues that in the case of Mexico, new concepts of participation conflict with the traditional culture of politics which is more passive than the modern "participative" culture. Jelin (1998 in Morgan 2001) suggests that in Latin America, the commitment of political parties to institution building guided by the logic of "governability" often clashes with less institutionalized collective means of expressing social demands. She argues that citizen participation may stall for numerous reasons, such as when there is little general participation in public life, when reformist governments channel dissident voices into political parties, or when residents have yet to organize themselves around the apathy and disillusionment that accompanies the deepening spiral into poverty. However, the literature is rife with examples of how organizing emerges "from below," particularly as a result of the "crisis of development," neoliberal policies, the rise of the global economy, and the growing poverty and social

inequalities within the developing world (Escobar and Alvarez 1992; Marchand and Parpart 1995; Ong 1996; Safa 1995; Sen and Grown 1987).

Poverty, gender, and "participation"

As researchers have well documented, poor women in the developing world have born the brunt of this deepening spiral into poverty. Under structural adjustment, increasing numbers of women had to look for income-generating work, more women than men became unemployed, working conditions for women deteriorated, and women became poorer (Sparr 1994). With the declining economy, deep cuts in household budgets and in public services increased pressure on women as they administered households (Bakkar 1994). Women have been the least likely to be able to afford private health services and fees associated with privatization within the public health sector (Standing 2002). Yet, as they have been forced to take on a greater burden under structural adjustment, they have also been the most vocal in criticizing a system that is failing them.

Women in Latin America specifically have a long history of social activism on account of the persistent inequalities they have faced due to the contradictions of capitalist development and globalization (i.e., see Sen and Grown 1987; Brodie 1994; Marchand and Parpart 1995). In Mexico, the devastating impacts of the economy and social policies have reinforced the need for collective action, particularly among poor, urban women who have organized "urban survival movements" focused on procuring land, housing, basic resources, and infrastructure (Safa 1995; Stephen 1997). Jaquette (1994) argues that without strong parties that can deliver on their promises and with

states in permanent fiscal crises and unable to provide social services, self-help via relatively autonomous organizational strategies are "practical and effective responses to survival needs" (p. 227). For decades, women throughout Mexico have been active in organizing food cooperatives; health committees and nurseries; campaigning for improved work conditions, safe water, and better sanitation; and mobilizing for greater representation, economic independence and access to information (Bose and Acosta-Belen 1995; Escobar and Alvarez 1992; Jaquette 1994; Stephen 1997; Torres Martinez 1992; Whiteford and Whiteford 1998).

While the devastating impact of the economy has propelled women into collective action, demographic changes have also facilitated women's participation. For example, as fertility declined, women's participation in the labor force as well as their education levels increased (Jaquette 1994). Although higher educational and occupational levels have primarily impacted women's movements among the middle classes, lowered fertility rates and changes in women's social roles have helped increase women's participation among the lower social classes. Furthermore, Azripe (1993) points to the prolongation of human life, the spread of contraception, and the decline of women's biological reproductive role to explain women's increasing participation in social movements since the 1980s.

Neoliberal reforms and the subsequent withdrawal of social services and the public institutions meant to distribute them have also propelled women into action to resolve community-level problems through self-help solutions (i.e., unpaid, voluntary work). With the rise of non-governmental organizations (NGOs) in the 1980s, women gravitated towards organizations with participatory programs that helped with service

delivery. While women's involvement with NGOs have allowed them to attend to the effects of growing social inequalities generated by market liberalization, women's groups have also been used as channels through which to implement development strategies that seek to "incorporate" women into development (Alvarez et al. 1998; Udvardy 1998).

Scholars viewed the neoliberal agenda as both an obstacle to and a facilitator of group solidarity. For example, Fleury (2000) suggests that the individualist system of values prompted by the neoliberal agenda is a barrier to solidarity because it destroys the political and familial ties that have traditionally provided the poor with social and economic support. On the other hand, Nash (2001) argues that cross-border coalitions and alliances between citizens groups, facilitated by the anti-globalization movement (and aided by the internet) have strengthened group solidarity and social networks. In this sense, neoliberal policies have "breathed new life" into Mexican NGOs and popular organizations since they now have a common platform to stand on with their counterparts in the U.S. and Canada (Cook 1997).

Health organizing and women's health

Health care became a focus of women's grassroots activity in Latin America in the 1980s as a result of economic recession and structural adjustment policies. Furthermore, the politicization of women's health by the World Health Organization (WHO) helped to bring women's health issues into the international spotlight. As a result, women's voices and their health campaigns, which have largely been focused on reproductive health and health care access, have become increasingly vigorous over the last two and a half decades.

In the mid 1970s, the WHO development agenda included two central goals: 1) the improvement of women's health and 2) the extension of health care coverage to the poorest citizens. As a result of the first goal, the WHO declared the year 1975 to be "The International Year of the Woman." In the same year, the general assembly of the United Nations proclaimed the period of 1976-1985 as the UN Decade for the Advancement of Women. While this attention helped to move women's health issues into the spotlight, the process has been slow to materialize. It was not until the 1995 United Nations International Women's Conference held in Beijing that women's health and reproductive rights were placed on UN's international agenda.

A second important shift that facilitated the increased politicization of women's health occurred in 1978 at the International Conference on Primary Health Care (PHC), sponsored by WHO and UNICEF in Alma Atta (USSR). At this event, primary health care was proclaimed to be the key to achieving "health for all by the year 2000." The PHC approach was unique to earlier approaches because it offered a socio-political perspective on the causes of poor health, more specifically, a critique of poverty and the global maldistribution of social and economic resources (Foley 2001; Jareg and Kaseje 1998). Couched in a language of social justice, the PHC movement promised to address gender inequalities in health and health care. Importantly, it helped to establish the themes of women's health, primary care, and community participation as national health priorities of developing countries by the 1980s (Cardaci 1995).

Since PHC strategies were considered possible only through community based health workers, non-governmental organizations (NGOs), which were most accustomed to working with communities, quickly became essential to the WHO goals since

governments could not accomplish them on their own. NGOs quickly embraced the PHC strategy since it aimed to tackle the social causes of ill-health. As a result, NGOs have since formed networks throughout the developing world to advocate for or campaign against particular health policies and actions (Jareg and Kaseje 1998).

In Latin America, where women's health networks are especially strong, women have opened clinics offering women-centered care to address expensive and male-dominated health care. While women's collectives and health centers may have the goal of creating independent, alternative institutions that make women's interests visible, health groups have also been an important source of social support for women. Women's health networks provide an avenue through which women may gain information and solidarity and increase the energy around specific health objectives (Doyal 1995). As I describe in this manuscript, grassroots women's health networks in Morelos, Mexico, address these issues by creating an environment for "women-centered care" and offering health services outside of formal institutions.

Theoretical concerns of the dissertation

Structure, agency and social change

In this study, I am concerned most broadly with the tension between policy and practice and structure and agency, or more specifically, how macro-level social, economic, and political processes shape and contribute to the contours of individuals' lives, and how individuals actively negotiate these structures, creating new "hybrid" forms of culture, knowledge and practice. In order to address these tensions, the

dissertation interlinks political economy (i.e., Morsy 1996) and actor oriented approaches (Long and Long 1992).

Political economy approaches have evolved out of theoretical traditions seeking to explain the structural condition of subordination and economic marginalization. The work of Eric Wolf (1959) was particularly significant to the evolution of a political economy perspective in anthropology as it helped to move anthropology away from modernization and "world-system" theories which viewed global changes as emanating primarily from the "core" or developed regions of the world, to a more globally interrelated and historically constructed view of the world. A more historically-oriented political economy understands "the Other" to be a product of a "particular history that is intertwined with a larger set of economic, political, social, and cultural processes" to the extent that the histories of "us" and "them" are analytically inseparable (Morsy 1996: 22).

While political economic approaches have been praised for including macro-level perspectives in anthropological analyses of the particular, they have also been criticized for their tendency to overstate the relevance of historical processes and global forces in shaping social and cultural process. As Roseberry (1988 in Morsy 1996) argues, scholars face a challenge in attempting to understand the situation of anthropological subjects at the intersections of local and global histories; they must avoid "making capitalism too determinative, and they must avoid romanticizing the cultural freedom of anthropological subjects. The tension [in oppositions like global/local, structure/agency] defines anthropological political economy, its preoccupations, projects, and promise" (p. 21).

Heeding such critiques in this analysis, I apply actor oriented approaches to consider how local actors mediate social structures. While acknowledging the social

structures and asymmetries in which actors are immersed, this approach emphasizes individuals' ability to evaluate, contest, and appropriate social rules, thus actively contributing to processes of social change (i.e., see Long and Long 1992; Arce and Long 2000). Arce and Long (2000) suggest that theories which deny the force of people's own capacities and abilities to intervene and shape the contours of social life are "simplistic and reductionistic diagnoses of the modern condition" (p. xv). Instead, they recognize the need for a reflexive anthropology of modernity and development which accounts for "localized modernities" and the means by which actors manage them which may include "deferral, accommodation, negotiation, selective appropriation, and distantiation or absenteeism" (p. 3).

Actor oriented approaches reflect the shift within anthropological theory from analyses of actors responding to inflexible structures and class relations, towards a consideration of the multiplicity of social actors contributing to social change (Escobar and Alvarez 1992). Such approaches do not conceptualize change as emanating from a linear locus of power nor do they deny the active or intentional subject (for which modernization and development theories have been widely criticized). Instead, actor oriented theories propose a world that is "multivocal, multi-sited" and concerned with modes of authority and power that "open up and are consolidated in the re-directing of social change" (Arce and Long 2000: 19).

In extending the notion of agency beyond individuals to social groups, I examine how participants of health mobilizations simultaneously face constraints within social and political fields of power, and negotiate, adapt to, and transform their constraints. As participants draw from global and local discourses and practices in proposing a different

way of "doing" health care, their efforts represent a form of resistance and a challenge to the current social order where health and disease are defined and managed by dominant institutions (i.e., Ministry of Health) and discourses (i.e., biomedicine). As Escobar (1995) argues, "changing the order of discourse is a political question that entails the collective practice of social actors and the restructuring of existing political economies of truth" (p. 316).

Theorizing about social movements

This study is informed by a voluminous social movements literature that spans anthropology, sociology, and gender studies among other disciplines. I am most concerned with women's involvement in social movements since women constitute the majority of participants in the health groups in this study. In addition to exploring how women in health groups organize to seek practical solutions to their health care problems, this case study also raises a series of questions that that requires consideration of the social movements literature. For example, to what extent are women taking advantage of the social spaces available to them through health organizing in order to chip away at hegemonic discourses and practices pertaining to gender and health care? To what extent do women directly or indirectly challenge everyday social structures and "reconfigure values and change the status quo," through their participation in health groups (Gallin 2002: 73)? Does their participation engender a "feminist" experience? A consideration of the insights of social movements scholars helps to provide a framework for examining these questions.

Over the last 30 years, the social movements literature has shifted from analyses rooted in terms of modernization and dependency to analyses of a multiplicity of social actors enacting a plurality of struggles (Escobar and Alvarez 1992). This shift is reflected in the distinction between "old" and "new" social movements. "Old" movements, as defined by Escobar and Alvarez (1992) include the urban, peasant, labor, and neighborhood movements, or "traditional actors who struggled for the control of the state, particularly the working class and revolutionary vanguards" (pg. 3). In contrast, they define "new" movements as largely identity focused, including indigenous, ethnic, ecological, women's, gay, and human rights groups which are expected to bring about "a fundamental transformation in the nature of political practice and theorizing itself" (Escobar and Alvarez 1992: 3). While many now recognize this distinction as arbitrary since it is one of many ways that social movements can be categorized, the shift in theoretical focus demonstrates how social movement scholarship has moved from Marxist concerns with material realties to postmodern concerns with the nature and politics of representation.

In addressing why social movements have proliferated in Latin America, particularly in the last three decades, many scholars have examined the "crisis of development" and economic crises that plagued developing countries in the 1980s and 1990s and have contributed to a rise in social activism (Escobar and Alvarez 1992; Safa 1995). Scholars also scrutinize neoliberal policies and the rise of the global economy, which have led to increased class differentiation, social upheaval, and political unrest (Ong 1996). In explaining women's participation, scholars point to the growing poverty and social inequalities in the developing world that have made social movements

especially transparent due to the contradictions of capitalist development and globalization (Brodie 1994; Marchand and Parpart 1995; Sen and Grown 1987). Researchers also points to the feminist movement which has influenced the rise in women's social activism over the last three decades (Jaquette 1994).

Researchers generally agree that women's social movements emerge out of material needs, usually in relation to resource access issues and economic problems, and/or out of women's exclusion from the public, political, and dominant realms of social life. Maxine Molyneux (1985) in her article "Mobilization without Emancipation? Women's Interests, the State and Revolution in Nicaragua," first made the distinction between women's "practical" versus "strategic" interests. According to Molyneux, practical interests underlie a women's fulfillment of traditional gender roles associated with the sexual division of labor, while strategic interests develop from gender subordination and challenge gender inequalities. Scholars have heartily debated if "practical" and "strategic" interests are dichotomous or if they represent a continuous spectrum of gender interests.

Some recent scholarship suggests that this distinction is not useful in understanding women's concerns, interests, and organizing activities (Alvarez et al. 1998; Escobar and Alvarez 1992; Jaquette 1994; Stephen 1996, 1997; Radcliffe and Westwood 1993). As Stephen (1997) suggests, women's concerns around issues such as access to resources, domestic violence, and gender subordination represent a continuous spectrum rather than a dichotomy. Furthermore, Stephen (1996) points out that women may have interests that are simultaneously strategic and practical, and that these interests change over time. She argues that categorizing women's movements in this way tends to

homogenize differences among women and simplify how gender is constructed in relation to other social hierarchies such as race, class, and ethnicity.

On the other hand, Jaquette (1994) argues that "resource mobilization" models of social movements are still as relevant as any theory that begins with "women's natural or socialized differences from men" (p. 227). She states that "in the absence of strong parties that can deliver on their promises, and with states in perennial fiscal crises and unable to provide social services, the self-help, relatively autonomous organizational strategies that characterize the *movimientos de mujeres* are practical and effective responses to survival needs" (p. 227). Jaquette argues that resource-based, self-help mobilizations may also make demands on the state.

As Alvarez et al. (1998) suggest, women and "their issues" have too often been consigned to the "sidelines of would-be structural-institutional transformations" (p. 96). Many scholars agree that this exclusion is the very governing mechanism of domination and is at the heart of women's political unrest in Latin America. As a result, women are choosing to engage in "democratic struggles" that are encompassing a redefinition of economic, social, and cultural practices through an array of public spheres (Alvarez et al. 1998). This redefinition necessarily includes the practical concerns that are part of women's democratic struggles.

Other attempts to explain women's participation in grassroots efforts have followed Temma Kaplan's (1982 in Stephen 1997) theory of "female consciousness." Kaplan proposed that women internalize their roles as domestic providers and caretakers. If they are unable to complete these roles, then they feel they must complete their social duties through other avenues. Women's participation in groups such as the *Madres de la*

Plaza de Mayo in Argentina has been explained on account of this theory. Yet critics of this theory suggest that it tends to homogenize women since it simplifies their identity solely based upon motherhood. As Molyneux (2000) suggests, women have not learned so much to challenge as to "deploy the language of difference in ways that destabilize the traditional binaries that served to disqualify them from full citizenship...they used ideas of domestic and maternal virtues as a basis for activism and to create ties of female solidarity" (p. 69).

The theory of "female consciousness" is also criticized for contributing to the feminist/feminine dichotomy as well to approaches that reinforce the separation of the "public" and "private" domains (Stephen 1997). Alvarez et al. (1998) elaborates upon the divide between "feminism" and women's movements or groups considered to be "nonfeminist." She explains that in the Latin American women's movement, an early distinction between feminists and nonfeminists related to "political" verses "cultural" interests where feminists were viewed as politically motivated to change the status of women even though they refused to participate in the conventional political arena. Class was also a central issue in the divide between feminist and nonfeminist movements since feminist movements have been largely propelled by middle-class interests while the base of women's popular movements have been lower-class urban women (Jaquette 1994). During the 1970s in Mexico, young professionals, students and middle-class women came together through the feminist movement to question the role of women and expose inequalities in everyday life. These consciousness-raising groups focused on raising awareness of the problem of women's double exploitation due to domestic duties and

economic work (Escandon 1994). Although this was a largely middle class movement, these women were eager to build alliances with lower-class women.

The interests of the middle and lower classes became more closely interconnected in the 1980s when the debt crisis became an everyday fact in Mexico. As a result, popular protest and social movements increased with women at the forefront, demanding housing, education, health care, and a variety of other services and challenging the Mexican political system, national economic policies, and state bureaucracy. These demands did not include proposals for structural changes necessary to advance the position of women in Mexican society (Craske 1993). However, according to Craske (1993), the combination of the growing feminist movement and the increasing activity of urban movements had the effect of expanding women's political participation in Mexico.

In the same way that scholars have demonstrated how the boundaries between "practical" and "strategic" interests and feminist and nonfeminst movements have blurred, so too has the distinction between the social and political aspects of social movements faded under scrutiny. Slater (1998) explains that social movements have often been interpreted as phenomena that occur within society, "existing in juxtaposition to those key political structures that give them their essential meaning – namely, states and the state system" (p. 383).

Addressing this dichotomy, Alverez et al. (1998) suggest that the struggle against any form of domination or conflict among social actors reflects a political process. Further, all social movements are "bound up" with culture and thus share a continuous struggle against dominant politics and projects such as nation building, development, and globalization. As cultural meanings are involved in the process by which actors seek to

redefine social power, culture is itself political. The authors state that "cultural politics" is enacted "when movements deploy alternative conceptions of women, nature, race, economy, democracy or citizenship that unsettle boundaries of dominant cultural meanings" (p. 7). As social movements challenge boundaries of dominant political culture, they modify social power, reconfigure practice, and foster what Alverez et al. (1998) call "alternative modernities."

Despite the scholarship that has led to more theoretically complex understandings of women's participation in social movements, there has been a striking lack of "micro accounts" of "everyday life situations" that contribute to actors' involvement in social movements, nuanced accounts of how people strategically organize themselves in their everyday lives, and theoretical considerations regarding the outcomes that organizing strategies may achieve (Lewis 1999:73; Menéndez 1997, Nuijten 1992; for exceptions see Foley 2001; Gallin 2002). Furthermore, few ethnographic accounts have been written about women's participation in movements that address health care inadequacies, particularly in response to neoliberal globalization (for an exception see Doyal 1995). This study attempts to fill in these gaps by expanding our theoretical understanding of health movements through an ethnographic analysis of the everyday practices, strategies, and concerns of health group participants in Yautepec, Morelos.

Theoretical concerns within medical anthropology

Critical medical anthropology. In this study, I draw heavily upon critical medical anthropology (CMA) to analyze the implications of health policies, practices, and inequalities that impact women as they manage household health. The label CMA

represents a broad spectrum of work that encompasses political economic approaches in medical anthropology (PEMA) (see Morsy 1996; Singer 1990). Scholars in this field understand the relevance of culture to extend beyond ethnomedical conceptions of illness and healing to include issues of power, resistance, control, and defiance that are intertwined with health, sickness, and healing.

CMA emerged as a reaction to earlier interpretive approaches of the 1970s that privileged cultural meaning without accounting for the social distribution of sickness or examining larger political-economic forces that contributed to suffering (Baer et al. 1997; Morsy 1996). As Hahn (1995) argues, interpretive, hermeneutic, and phenomenological approaches that attempt to explain social and cultural phenomena can be credited for moderating ethnocentrism, but they go too far in cultural relativism when they posit that "what other people believe about their circumstances fully accounts for these circumstances" (p. 54). In contrast to "meaning centered" approaches, critical medical anthropologists turned a critical lens on power relations and political economic influences shaping the production of health, illness, and healing. Thus, while interpretive anthropologists view culture as a "web of significance" that can explain interpretations of suffering, illness, and healing, CMA theorists argue for a greater understanding of the ideological webs spun by actors involved in shaping health practice and discourse (Singer 1990).

CMA scholars also consider the power relations at play within institutionalized health care settings and the role that biomedicine plays in sustaining dominant political and economic systems. Researchers applying the CMA approach problematize research concerned with clinical situations (i.e., the doctor-patient relationship, the "culture" of

biomedicine) that interprets relationships and clinical experiences within biomedical terms without examining biomedical knowledge itself as culturally constructed (Rhodes 1996). CMA researchers also apply a critical lens to the examination of international health discourse and practice (i.e., Foster 1999). Critical studies in international health scrutinize the ideological thinking that promotes biomedicine as the salvation of people in developing countries. Anthropologists have illuminated the positivist value orientation and social evolutionary thinking that guides the universal application of biomedicine based upon "Western" notions of progress and development (Kleinman 1995).

Pointing to dichotomies such as local/global and traditional/modern that have become reinforced through such positivist thinking, critical medical anthropologists illuminate the implications for privileging scientific medicine in health interventions. For example, when biomedical doctors are viewed as the medical experts, other forms of therapeutic knowledge are viewed as flawed or incomplete (Foster 1999). Moreover, "local" knowledge becomes perceived as a barrier to the adoption of biomedically-based public health interventions and irrelevant to public health interventions rather than an asset to the community (Yoder 1997). By focusing on "local" knowledge and "culture" to explain unfavorable health behaviors, governments may overlook the structural inequalities that are at the source of widespread health problems among poor, marginalized, and disenfranchised members of society (Conners 1996; Menendez 1997).

Drawing on the contributions of critical medical anthropologists, this dissertation addresses questions regarding who controls the therapeutic process, how power and authority structure health care, and how local interests are represented in or excluded from the health sector. By detailing the perspectives of local residents, considering how

"local" knowledge and practice is central to health group efforts, and grounding the project in issues of political economy, this research seeks to offer new insight into local understandings of health care that may be overlooked in the medical anthropology literature as well as in government health planning. Much of the existing literature in the field of international health presumes that increasing medical technology and creating costly new health establishments will necessarily improve community health prospects. This perspective does not consider the number of local responses to health care that include but extend beyond biomedical solutions, such as the traditional and alternative medicine practices promoted by the health groups described here. Particularly as international health policies shift the responsibility for health management from the state to the community, this study offers a timely ethnographic depiction of how individuals are participating in the health care process.

Medical pluralism. This dissertation also draws on medical pluralism literature within medical anthropology (e.g., Janzen 1978; Worsley 1982) to examine how health groups appropriate different types of medical knowledge and resources to develop new health strategies. The medical pluralism literature addresses numerous issues relevant to this study, including how medical beliefs influence health seeking behavior (Young 1981), how therapeutic choices are made within specific cultural and social contexts (Nigenda et al. 2001a), and how health systems change in the context of state interventions and development projects (Low 1985).

In Mexico, many diverse and historically significant traditions inform contemporary understandings of health, disease, and healing. While biomedicine is well entrenched in Mexico, it coexists with a diversity of practices with indigenous roots to

the region (i.e., *curanderismo*, herbalism) and with others that were more recently imported from other countries (i.e., homeopathy, Chinese medicine). Influences such as the humoral system and Catholicism have become well integrated with certain biomedical and indigenous practices, exemplifying a process of medical hybridization that continues today (Foster 1987; Ortiz de Montellano 1989). Medical traditions are also transforming as a result of processes of globalization that increase the flow of ideas and services between borders. The state of Morelos is particularly permeable to these processes because of its geographic location (sharing a border with Mexico City, high immigration rates from neighboring states) and because tourism is central to its economy. Just as products and services flow between its borders, so too, do health practices and philosophies.

The health groups I describe are enmeshed in processes of globalization as they work to "rescue" health practices native to Mexico and adapt alternative health practices from as far away as China for their needs. The global alternative medicine movement is particularly influential to their work. New ideas and practices are introduced to health groups as participants attend different health workshops and courses, bring ideas back from their travels, and incorporate foreigners into their work. Health group participants also seek information on herbal remedies from the internet, and they purchase books on Chinese medicine or other alternative modalities from roaming vendors and in city book stores.

By examining practices used by health groups (i.e., herbalism, acupuncture), I explore the ways in which global medical practices become "localized" and incorporated into local healing traditions and how local practices become commoditized and

"globalized" as they assert themselves into the market. Taking into account the processes of globalization that are central to the local expression of health groups, I examine how groups accommodate or resist local and global expressions of culture available to them. I seek to understand how health groups influence local understandings of health, sickness, and healing and contribute to the changing nature of health care in Yautepec.

As Escobar (1995) suggests, rather than being eliminated through development, "traditional" culture survives through its transformative engagement with modernity. In this case, health practices are being continually reworked and applied to resolve problems that biomedicine cannot remedy. In many ways, "traditional" medicine may stand as symbol of defiance and renewal for populations that are enmeshed in the contradictions of modernity. As Bastien (1998) argues "inventive aspects of culture" take place as local traditions negotiate changing social contexts. I suggest that knowledge and practice that emerge from this engagement can be useful tools for individuals to sustain their participation in social change and to maintain their integrity in a rapidly globalizing world.

Organization of the dissertation

The dissertation is organized into ten chapters. The first two chapters provide the context and setting for the study. In this current chapter, I have provided background information on the study and reviewed pertinent literature. In Chapter 2, I explore the research setting (the state of Morelos and town of Yautepec) and describe the methodology I used to collect and analyze the data. The next three chapters describe the national and local contexts for the distribution of health care resources. Chapter 3

describes Mexico's national health system in historical context, explores health sector reforms since the 1970s, and examines the case of Healthy Municipalities to illustrate how international health agendas are applied in local contexts. Chapter 4 examines municipal "official" perspectives on health service delivery and health reforms and Chapter 5 explores health seeking behaviors in Yautepec.

The remaining chapters address health organizing in Morelos. Chapter 6 traces the roots of traditional and alternative medicine movements in Mexico. Chapter 7 examines the history and organizational structures of three Yautepec health groups. Chapter 8 explores the perspectives of a sample of women who are participating in these groups and Chapter 9 examines the discourses and health practices utilized by the groups. In Chapter 10, I conclude the dissertation by offering reflections on the study and recommendations for further research.

CHAPTER TWO: RESEARCH SETTING AND METHODS

Morelos State

Morelos is located in central Mexico. It is bordered by the states of Mexico to the north and west, Puebla to the east, and Guerrero to the south (see Figures 1 and 2).

Figure 1. Map of Mexico

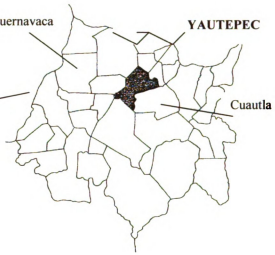

Figure 2. Map of Morelos State

With a population of over 1.5 million inhabitants, Morelos is the third smallest state in the Republic (INEGI 2001). However, it ranks third nationally in population density with only the Federal District and Mexico City housing more inhabitants per square kilometer (Sarmiento Silva 1997). Most of the state is located between 2,900 and 9,800 feet above sea level. Morelos has a very diverse topography as 42% of the land is mountainous, 16% is hilly land, and 42% is flat terrain. The mountain peaks of the Sierra Ajusco in the north of the state divide Morelos from the neighboring Valley of Mexico. The state is ideal for agriculture (especially sugar cane) since 70% of the state has a subtropical climate. Farmers in Morelos grow a large variety of fruits and vegetables

year round including bananas, chimoyas, mameyes, melons, and tomatoes (Schmal 2004).

Like other rapidly urbanizing states in Mexico, Morelos's growth has been characterized by uneven development resulting in an enormous concentration of wealth in its metropolitan zone while significant poverty and inequalities exist in the surrounding towns and rural areas. In fact, Morelos has been described as an "experimentation laboratory for diverse processes of development" due to its geopolitical and historical importance, its proximity to the nation's capital, its importance as a center of industrial production for the country, and its ideal climate and diversity of natural resources (Oswald 1991: 224). The state's industrial sector has played a particularly important role in the state's development. The economically active population involved in the industrial sector grew from 6.8% to 12.7% between 1950 and 1970 as the state's political economy favored industrial and agroindustrial development over agricultural activity (Rounds 1987; Subsecretaria de Cultura 1988).

In 1963, the state's largest urban industrial park (CIVAC, the Industrial City of Cuernavaca Valley) was built in Cuernavaca. CIVAC was later followed by two other industrial parks developed in Cuautla and Emiliano Zapata. Guided by the logic of modernization, the development of CIVAC responded to the federal government's interest in decentralizing financial and industrial capital to entities close to the Federal District. Although many had hoped that CIVAC would ensure the economic integration of the state, it became apparent by the middle of the 1970s that the majority of its products were destined for the national and international markets (Saramiento Silva 1997). By the middle of the 1980s, chemical-pharmaceutical and automobile production

accounted for 60% of the state's industrial exports (Becerril Straffon 2001). These industries replaced the more traditional textile and food industries and have created enormous levels of environmental contamination (Sarimiento Silva 1997). Problems relating to property and the distribution of services have followed the growth of the industrial sector.

The growth of industry is also responsible for the complete revision of the state's economic orientation (Becerril Straffon 2001). For example, the shift from agriculture to industry led to the process that Rounds (1987) calls "*discampanización*," or the abandonment of the primary activities of farmers. The industrial sector has failed to absorb an adequate share of the labor force no longer employed in agriculture. This failure has contributed to the emergence of an informal economy that by some estimates constitutes up to half of the state's working population. These informal laborers face significant job instability and are excluded from the benefits of social security programs like the Mexican Institute of Social Security (IMSS).

The growth of industry also facilitated rapid migration towards the capital and surrounding areas leading to massive population growth in the state's urban centers. By 1995, 44.8% of the state's population had settled in Cuernavaca[1] and the surrounding municipalities of Juitepec, Emiliano Zapata, and Temizco through permanent and temporary migration (Moctezuma 2001). The majority of migrants have settled into the "urban corridor" that runs through Cuernavaca, Yautepec, and Cuautla (see Figure 2 above). This corridor contains 74% of the working force for the state and houses the majority of commercial and service activities (Subsecretaria de Cultura 1988).

[1] The city of Cuernavaca has a population of 338,706 (INEGI 2000) and is relatively affluent with a large middle-class sector. However, a sizable squatter settlement exists in the center of the city, and a growing working-class population tied to the industrial sector reveals its socioeconomic diversity.

By 1990, the rural-urban shift had created a largely urban state, with only 14% of the population considered to be living in rural areas. What Becerril Straffon (2001) calls "municipal marginalization" has occurred as a result of this shift. This refers to the process whereby industrial centers of the state (i.e., Cuernavaca, Cuautla) absorb neighboring municipalities along with the majority of the resources and services designated for the state's population. For example, in 1997, seven out of 33 municipalities (Cuernavaca, Jiutepec, Temixco, Emiliano Zapata, Cuautla, Jojutla, and Yautepec) were granted 74.34% of federal funds (*participaciones*) designated for the state. Cuernavaca alone accounts for 38.22% of these financial resources (Becerril Straffon 2001). As a result, vital resources such as public services, health care, and education are inequitably distributed throughout the state and are particularly lacking in municipalities that lie outside of the urban corridor.

Municipalities also struggle with resource shortages and with managing public services through decentralized forms of governance. With the municipal Reform of 1983, the Mexican Constitution formally guaranteed municipalities fixed sources of revenue which would allow them to provide public services and strengthen their political independence (Rodríguez 1997). Municipalities thus legally became autonomous administrative units ("*municipio libre*")[2] even though they historically evolved as subordinate entities to federal and state governments. Despite such national efforts to decentralize resource management to the municipal level, a centralist culture of governance still makes states and municipalities fully dependent on the distribution of federal earnings (Beccerril Straffon 2001). For example, federal and state entities

[2] The current organization of the thirty three autonomous municipalities of Morelos was achieved through the Municipal Organic Law of Morelos State in 1992 in accordance with Article 110 of the Political Constitution of Morelos State.

calculate municipal budgets based upon the number of citizens and taxes collected (Rodríguez 1997). Yet municipal authorities minimally enforce tax collection because increasing tax rates and revising property values are not politically attractive options. As a result, municipal budgets are chronically insufficient to provide for the needs of the municipality.

Municipal spending priorities compound the problems associated with limited tax collection. For example, municipalities have historically favored spending on public works (i.e., development infrastructure) rather than social services. Furthermore, increases in public funding are often channeled into municipal government elections. For example, in 1999 Yautepec increased its public spending on municipal elections by 35%. The municipalities of Coatlan del Rio, Ocuituco, and Temoac increased their election spending by 547%, 522%, and 417% respectively in this year (Becerril Straffon 2001). Such irresponsible spending siphons away money that could be spent on public services. These issues play out the complicated arena of politics that guide development priorities, economic growth strategies, and resource prioritization.

The municipality of Yautepec

A municipality is a politico-administrative unit roughly equivalent in size and function to a county in the United States (Rodríguez 1997). Yautepec is the fifth largest municipality in the state of Morelos with a population of 84,405 in 2000 (INEGI 2001). The municipality is situated between the two largest cities in the state – 27 miles to the southeast of Cuernavaca and 20 miles to the northeast of Cuautla (see Figure 2). It is largely an urban municipality; only 13% of its population lives in rural areas (Miranda et

al. 2002). Almost half of its population lives in the town of Zarragoza[3] which is the municipal county seat of Yautepec.[4] The municipal population is primarily *mestizo* or of mixed European and indigenous ancestry.

Yautepec: A land of contrasts

In many ways, the municipality of Yautepec is a land of contrasts. Yautepec has a "semi-humid" climate with two seasons; the dry season (October-May) and the wet season (June-September). During the wet season, lush greenery covers the mountains that surround the Yautepec valley. All of this transforms during the dry season, when the mountains become brown and dry as they are baked by the sun. This changes once again when the rains return in June, providing relief for the residents and nourishment to their land. Stark contrasts also exist between urban and rural communities. For example, the town of Zarragoza bustles with activity, cars, and commerce in contrast to more remote villages like La Nopalera where the main road has only recently been paved and where residents must climb steep hills by foot to reach their homes and fields.

In Zarragoza, the past and the present intermingle and expose further contrasts within the region. One of the largest pre-Hispanic pyramids in the state sits partially excavated on the road leading out of town in the direction of Cuernavaca, reminding residents of its ancient history. In contrast, the present town square is organized around an aging *zocalo* (plaza), where tired farmers rest to escape the mid-day sun while vendors conduct business.

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[3] The formal name of the town is "Yautepec de Zarragoza." However, locals refer to it only as "Yautepec." So as not to confuse the town with the municipality of Yautpec, I will refer to it only as "Zarragoza".
[4] The municipal county seat (*cabacera*) is the administrative center of the municipality. It houses the municipal council (*ayuntamiento)* which holds the top ranking municipal officials.

A walk around the town center during a weekday reveals the diversity that exists in Zarragoza. Many people come from smaller towns and villages throughout the municipality to shop at the market, pay bills, address a concern at an administrative office, or receive their pension check. Many come to Zarragoza to shop at the municipal market, which offers a dizzying array of stalls with fruits, vegetables, meats, dairy products, herbs, flowers, tortillas, clothes, music and household items as well as many small *fondas* or restaurants that serve quick meals. The municipal's administrative buildings lie behind the *zocalo,* housing municipal officials that are responsible for public services, culture, education, and the health and well-being of municipal residents.

Small businesses line the streets in the center of town where one can find almost anything including pizza, furniture, stereo equipment, roasted chickens, and children's toys. Most residents however, travel to the nearby cities of Cuernavaca and Cuautla to purchase larger and more expensive items that are sold more inexpensively in these cities. Three national bank offices – Bancomer, Banamex, and Bital – as well as Tel-Mex (Mexico's national telephone company) are all located near the *zocalo*. Behind Banamex is Viyautepec, one of the few wealthy "gated" communities in Zarragoza.[5] Wealthy Mexicans from Mexico City and Cuernavaca have purchased weekend homes in neighborhoods like Viyautepec as the cities become increasingly expensive. The stark contrast between some of these wealthy homes (most of which are adorned with swimming pools) and the average one-room block home of poorer residents is striking.

Zarragoza's town center becomes a hub of activity during the afternoon when residents conduct their business and return home for *comida* (the main meal that is usually taken around 2 to 3pm). Buses noisily move people into and out of the town

[5] By gated, I mean that the neighborhood is guarded by a single chain, one watchperson, and his dog.

sharing the congested streets with cars and mopeds. Leaving the busy town center, farm lands and fallow fields stretch for miles running into the mountains that surround the Yautepec Valley, exposing its history as an important agricultural center. While urban development moves towards these mountains, funded by remittances from migrants living in the United States, the vastness of open land still remains visible today in the outskirts of town. Papaya, mango, lime and banana trees stand in stubborn confrontation of the development that is soon to encroach upon these open spaces. For now, there is always fruit to be picked from the trees.

The local economy of the municipality of Yautepec

Until the Revolution of 1910, Yautepec's economic well-being centered on *haciendas* (large land holdings that originated with the land grant system used by Spanish conquistadors) as did much of the economy of Morelos. The Hacienda System had thrived in Morelos since the 16th century and the great *hacendados* (*hacienda* owners) were a powerful economic and political force that reaped huge profits from the harvest of the sugar cane (Schmal 2004). Prior to the Revolution, the only significant industry in operation in Yautepec fed off of the sugar mills that depended on the sugar cane of the *haciendas* (Miranda et al. 2002). Yautepec played a significant role in this operation since the *haciendas* at Atlihuayan, Oacalco, and San Carlos produced a significant amount of the state's sugar. However, this industry locked the general population into a position of dependency on the industry resulting in economic subjugation.

By 1910, Yautepec found itself in the center of a Revolution that absorbed the country until 1917. Located in the heartland of Emiliano Zapata's territory (an important

revolutionary leader), Yautepec joined the pursuit of "land and liberty" to end the long standing subjugation under the powers of *hacienda* owners. The war took a significant toll on the country and Yautepec faced tremendous loss of life and destruction. Although it recovered a good deal after the war, Yautepec did not surpass its pre-war population of 8,141 until 1950 (Rounds 1987). Despite the many sacrifices that were made during the war, the land that so many fought for ultimately remained in the hands of large land holders while the government gained the power to control it. By the 1940s, the majority of the land within the municipality was *ejido* property (communal landholdings). Yet the landholders did not control this land. Instead, it was distributed by the central government who also controlled access to irrigation water and allocated agricultural credit (Rounds 1987). Farmers had no choice but to plant sugar cane even as their returns stagnated.

In the 1950s, the expansion of commercial cultivation and new technology, industrial development, and tourism propelled the state of Morelos towards "modernization" (Subsecretaría de Cultura 1988). By the 1970s, Yautepec farmers were planting more market and industrial crops on their land such as sorghum, tomatoes, onions, and rice along with corn and beans. However, modest returns on their crops required them to seek employment as day laborers at the sugar mill or in other capacities. However in 1989, the sugar cane refinery, which was the largest employer in the region closed due to "political motivations" (Conchiero Borques 2001: 190). With the closing of the mill, the hydraulic network and much of Yautepec's infrastructure were lost. Yautepec residents were devastated by the mill closing. Coupled with the economic fallout of the 1980s and 1990s and growing pressures towards urbanization, Yautepec

residents have become more dependent on work in Cuautla, Cuernavaca and Mexico City.

According to a municipal report (Miranda et al. 2002), only 34% of Yautepec's population is formally employed while a large portion of the population participates in the informal economy. Among the formally employed population, 56% work in the commercial and service sector; 30% work in mine extraction, the manufacturing industry, or construction; and 12% work in agriculture, livestock, fishing, and gaming[6] (Miranda et al. 2002). More than 1000 commercial and service establishments exist in the municipality including restaurants and *fondas*, *tortillarias*, lumber mills and furniture manufacturers. The majority of these establishments are located in Zarragoza and the Oaxtepec-Cocoyoc area. After commerce, tourism is the greatest source of income for the municipality. The Oaxtepec Vacation Center, which is a swimming park that opened in 1966, brings in an average of one million visitors a year. Additionally, many resorts, swimming parks, and historical buildings throughout the municipality draw over 100,000 visitors to the region (Miranda et al. 2002). The service sector of the local economy also provides a vitally important source of income for the municipal residents of Yautepec.

Industry is largely absent from the municipality although a few factories have been established in Yautepec including a lime factory ("*Purísima,*"), a livestock food factory ("*Campi*"), a concrete tube producing factory ("*Tubocreto*"), a poultry incubator, a bottled water purifying plant, and a few minor workshops (Miranda et al. 2002). Many residents who live in the town of Zarragoza commute to work in the industrial parks in Cuernavaca and Cuautla. Zarragoza can thus be considered a "bedroom community" for factory workers as well as for residents who work in Mexico City. As these cities have

[6] Two percent of the population's work activities are unspecified.

become increasingly expensive and overcrowded, Zarragoza has expanded its housing available to the working class. In fact, seven working class neighborhoods in the town accommodate residents who have access to credit from INFONAVIT, a government subsidized social security program (Miranda et al. 2002). Largely due to this influx of people within and around Zarragoza, the municipal population growth of 5.59% between 1990 and 1995 has far exceeded the state average of 3.8% (Miranda et al. 2002).

The large majority of workers in the municipality participate in the informal sector of the economy. This sector includes street vendors, domestic servants, pieceworkers in small establishments, agricultural day laborers, and construction workers. Women contribute to the informal sector as domestic workers, vendors in the municipal or city markets, and street vendors. They also work in *tortillarias*, *fondas* and other food establishments, in vacation centers and tourist establishments, and in the greenhouses in the municipality. While this employment is irregular, it provides an economic basis for those otherwise unemployed (Rounds 1987).

Most of the residents I spoke with in Zarragoza agree that most the pressing social problem that needs to be addressed is the lack of businesses and formal employment options. These residents used the phrase "*no hay fuente de trabajo*" (there are no sources of employment) time and time again to describe this pressing problem. In discussing the lack of employment opportunities, the municipal president explained in an interview that local, national, and foreign investment in the municipality is lacking, which prohibits the establishment of new businesses. He suggested that this lack of investment relates to protests on the part of local residents when new businesses threaten to siphon off resources such as water and electricity. Local residents have also protested when

investors from outside of the municipality proposed business plans. In this way, locals are protective of their municipality, sometimes to the exclusion of outside investment.

These struggles are important factors in explaining the employment shortage in the municpality, but they do not tell the whole story. Limited education also appears to be a central factor contributing to the scarcity of employment options available to Yautepec residents. For example, 14% of the population older than 15 years old is illiterate and 38% do not have secondary school education (Miranda et al. 2002). The municipal education system is struggling with "extraordinarily insufficient" resources. Only 50% of the teachers in Yautepec have basic high school education. Complicating matters, teachers are considered the "worst paid professionals in Mexico" with little possibility to improve their economic position (Miranda et al. 2002). While teachers are paid substandard wages, many families can not afford to pay the basic costs of school (supplies, clothes, etc.). Limited education means that many individuals have no other choice but to work in low-skilled, low-wage jobs. Sine the minimum wage in Morelos is approximately $40 pesos or $4 USD a day, there are grave economic consequences for a lack of education.

Because of the difficult economic situation in Mexico, many of those who are formally employed must hold multiple jobs. This includes doctors and factory workers alike. Moreover, most families have at least one relative who has migrated to the United States for work, and these families rely on remittances for help. While I could not locate statistics regarding U.S. migration rates among Yautepec residents, migration is quite visible throughout the municipality since the construction of new homes, paid for slowly by remittances, are markedly different (in construction and size) than older homes.

Migration affects economic stratification among neighbors as well as household composition. Many families become temporarily or permanently dependent on the income sent from male relatives abroad since far more men than women migrate. Moreover, since it is not uncommon that men do not return from the U.S., female headed households have become an increasingly common phenomenon. In fact, the rate of female headed households throughout the state of Morelos (23.3%) is higher than the national rate of 20.4% (Becerril Straffon 2001). Because it is difficult for these women to find permanent, formal work, most end up subsisting on petty sales, domestic work, and other low paying jobs.

Municipal health indicators

In the first half of the 20th century, Mexicans were most frequently affected by water- and food-born illnesses and many people died from preventable common infections. Although many Mexicans still suffer from malnutrition and common infections, the Ministry of Health reports that less than 15 percent of the nation's illness load is caused from these preventable sources of illness (Secretaría de Salud 2004a). Moreover, maternal mortality rates have fallen from 150 per 100,000 live births in 1950 to 65 per 100,000 in 2003, and they fell by almost 10 percent between 2000 and 2003. Infant mortality rates have also sharply declined. Today, the probability that a child will die in the first year of life is less than half of what it was 20 years ago. With the reduction of mortality, life expectancy has increased by more than 25 years during the second half of the 20th century. Now, the average age that women can expect to live is 77.4 years, while men can expect to live 72.4 years (Secretaría de Salud 2004a).

Despite these achievements, the burden of disease tends to fall disproportionately among the urban and rural poor who also have less relative access to quality health care than more economically solvent Mexicans. The conditions of poverty and lack of sanitation in which large groups live have ensured the persistence of infectious diseases among the poorer populations (Carolina and Gustavo 2003). Accordingly, the "double burden" of both communicable and non-communicable diseases is concentrated among the most disadvantaged socio-economic groups in the country (Carolina and Gustavo 2003).

While fewer people die from infectious diseases today, there is a notable increase in deaths caused by non-communicable disease. Mexico's epidemiological transition is occurring at a notable pace – in the period between 1990 and 2002, deaths caused by non-communicable diseases grew by 35%. During the same period, the percent of deaths from infectious diseases (or diseases that can be transmitted from one person to another) decreased from 26% to 14% (Secretaría de Salud 2004a).[7] This transition can be seen most clearly in the case of diabetes which contributes to the largest number of deaths in Mexico today (Secretaría de Salud 2004a). Deaths due to complications from diabetes are increasing at a rate of 3 percent per year. Moreover, cancer now causes more than 10 percent of the deaths in the country. Pulmonary cancer is the most frequent (and most evident in men older than 65 years of age) while cervical cancer is the most frequent cancer suffered by women (Secretaría de Salud 2004a).[8]

Many health indicators in the state of Morelos fall within the range of national averages. For example, in 2003 both the national and state life expectancy averages were

[7] The rate of external causes of death has remained relatively stable, at 5% a year, following a similar pattern observed in other parts of the world (Secretaría de Salud 2004a).
[8] Mortality for breast cancer has remained stable during the last 10 years (Secretaría de Salud 2003).

75 years. Infant mortality rates in Morelos averaged 19.67/1000 while the national average was 21.34/1000 (Secretaría de Salud 2004b). In 2000, the average number of children born to each mother was 2.5 while the national average was 2.6 (INEGI 2001).

Still, certain health indicators in Morelos are far below national averages. For example, in 1999 maternal mortality rates were the second highest in the nation at 86/1000 while the national average was 65/1000 (INEGI 2001). According to the Ministry of Health, hepatic cirrhosis rates among both women and men in Morelos are the fifth highest in the country; AIDS mortality rates among 25-44 year old males are the sixth highest in the country; and diabetes and heart disease rates among women rank eighth in the country (Secretaría de Salud 2004b). The state of Morelos also has the second highest cervical cancer mortality rates in the nation with 16 per 100,000 women dying every year from the disease (Gómez-Jauregui 2001). In 2003, the principal causes of mortality in Morelos were 1) heart disease, 2) malignant tumors, 3) diabetes mellitus, 4) liver disease, and 5) accidents (INEGI 2005).

Yautepec closely follows many of these state trends. As Table 1 illustrates, heart disease, diabetes, and malignant tumors are the principal causes of mortality among the general population.

Table 1. Principal causes of mortality, Yautepec general population, 2001

Cause	Cases	%	# per 100,000
Heart disease	49	15.86	50.4
Diabetes mellitus	47	15.21	48.3
Malignant tumors	37	11.97	38.1
Accidents	25	8.09	25.7
Cerebrovascular disease	18	5.83	18.5

Total Population: 97,233
Source: Servicios de Salud de Morelos. Dirección de Planeación Departamento de Estadística. In Diagnostico de Salud 2000 Yautepec, Morelos (Miranda et al. 2002).

The most common causes of cancer among individuals of productive age include cervical and stomach cancer. In fact, cervical cancer is the forth cause of general mortality among women of reproductive age in Yautepec. Yautepec ranks second in the number of HIV/AIDS cases in the state. Another disconcerting problem for the municipal health system relates to chronic alcoholism which, linked to hepatic cirrhosis, is one of the top five priority community health problems in Yautepec (Miranda et al. 2002; *H. Ayuntamiento Municipal* 2003).

As Table 2 illustrates, the principal causes of morbidity (incidence of disease) among the general Yautepec population include respiratory infections, intestinal infections, scorpion bites, and urinary tract infections.

Table 2. Principal causes of morbidity, Yautepec general population, 2000

Cause	Cases	%	# per 1,000
Acute respiratory infection	11,236	59.4	119.3
Intestinal infections (non-amoebic)	1,885	9.9	20.0
Intoxication by scorpion bite	1,377	7.2	14.6
Urinary tract infections	1,049	5.5	11.1
Intestinal amoebas	608	3.2	6.4

Source: SUIVE 2000. Sistema Único de Información de Vigilancia Epidemiológica 2000. In Diagnostico de Salud 2000 Yautepec, Morelos (Miranda et al. 2002).

In a Municipal Health Diagnosis of Yautepec, Miranda et al. (2002) point out that problems relating to respiratory infections, intestinal infections, and diarrheic illnesses cause the most persistent strain on the local health system. This report suggests that these health problems "evidence a lacking culture of sanitation and non-healthy lifestyles" (p. 85). Other public health problems that are linked with sanitation in this report include dengue fever, chagas disease, typhoid fever, and cholera which can be prevented by drinking clean water, eating clean food, and eliminating the breeding of mosquitoes and

other insects within the household. Yautepec has the highest rate of scorpion bites in the nation. While municipal health programs have been put into place to address these public health challenges through prevention, they have had limited degrees of success for reasons that will be discussed in Chapter 3.

In addition to the concerns raised by infectious diseases, the municipal government is also concerned about the increase in chronic degenerative diseases (i.e., diabetes, heart disease, cancers). According to the Municipal Health Diagnosis, these diseases are increasing on account of lifestyle changes, longer lifespans, and exposure to pollutants and toxins. To further complicate matters, newer public health challenges are emerging which include the HIV/AIDS epidemic and the resurgence of infectious diseases such as tuberculosis. As we will see in Chapter 5, municipal clinics in Yautepec are struggling to effectively address the growing and changing health care demands of its population.

Conducting research in Morelos

I conducted research for this project over the course of 15 months in central Mexico. I conducted pilot field research during the summer of 2000 in Tlaxcala and the summer of 2001 in Morelos and dissertation research from December 2002-November 2003 in Morelos. While carrying out research in Morelos, I lived in the capital city of Cuernavaca for six weeks in 2001 and from December-February 2003. I lived in the town of Zarragoza from March-November 2003. The ethnographic methods that I used to collect data for the project include participant observation, semi-structured interviews,

informal conversations, and ethnographic surveys (Schensul et al. 1999). I recorded my general observations and experiences in the field into daily fieldnotes.

I chose to conduct research in Cuernavaca and Zarragoza for two reasons. First, I was interested in understanding the politics of health care distribution on both the state and municipal levels. Cuernavaca is the administrative seat for Morelos State and houses state-level government health officials who work in the social assistance and social security branches. As I mentioned above, Zarragoza is the head township for the municipality of Yautepec and houses the municipal administrative offices. In addition to facilitating access to health officials, living in these two locations allowed me to observe how clinics and health programs are run on the state and municipal levels.

Second, I chose these sites because of the proliferation of health groups and alternative health practices that exist both in Cuernavaca and Zarragoza. Cuernavaca is the home to a large number of non-biomedical health practitioners and civil association groups to which I had access while living there. Although Zarragoza is a small city, it boasts many similar activities. I wanted to study the Committee for Culture and Development (CCD) after my initial visit in the summer of 2001 and soon after learned about the other groups working in Zarragoza. I lived in Zarragoza for the majority of this research period, and I traveled back and forth to Cuernavaca to conduct interviews, visit health groups, and attend health-related events. I also traveled throughout the state to observe numerous health groups, health fairs, and health campaigns.

Most of my time in the field was spent with women. As a female researcher I had greater access to women's than to men's lives and activities. Furthermore, women are the primary household health managers. They utilize health services more often than

men, and they represent the majority of participants in health associations. A few men play an active role in the groups that I studied, and I include their perspectives in the work that I describe. I also interviewed several men in administrative health posts on the state and municipal level.

My husband, Brendon, accompanied me in the field during the summer of 2001 and during the entire dissertation research period. Since we are both unmistakably foreign, we stood out as obvious outsiders, particularly when we lived in Zarragoza, which has few foreigners. At 6 feet 3 inches, Brendon especially stood out and his presence often led to great befuddlement. His primary reason for being in Mexico was to accompany me and to learn from the opportunity to live abroad. Since he took on many "domestic" duties for our household, like shopping at the market, his presence created even greater curiosity. These experiences in "alternative manhood" as he chose to call it, as well as the lessons learned doing "masculine" things like working out at the gym and hanging out at a friend's workshop, were enlightening for me as they revealed cultural insights about masculinity that I otherwise would not have been able to achieve. His view of Mexican culture greatly enhanced mine, and his thoughts and experiences are deeply embedded in the way that I eventually came to view life and health in Zarragoza.

Data collection methods

Data for this study was collected during two phases: the Cuernavaca phase and the Zarragoza phase. In Cuernavaca, I examined the distribution of state-sponsored health services, the availability of non-biomedical health care options, and the proliferation of health associations. In Zarragoza, I observed three civil association

health groups; interviewed municipal authorities, health officials, and medical practitioners; and surveyed community residents regarding their health seeking behaviors.

Cuernavaca phase

During the Cuernavaca phase of the research, I interviewed health officials and medical practitioners and conducted clinical site visits to gain perspective on the distribution of health resources, programs that target the poor, and viewpoints on "official" health discourse (the interviews are summarized in Table 1). I conducted open-ended interviews with the Coordinator of Reproductive Health and the Director of the Healthy Municipalities program at the Ministry of Health office in Cuernavaca. The goal of these interviews was to learn about the objectives of the programs, the process of implementing health programs, and the effects of health reforms on these programs. I attended a Healthy Municipalities community meeting, conducted site visits at the Institute for Mexican Social Security (IMSS) general hospital and at two social assistance (SSA) clinics, and interviewed doctors at each of these health centers regarding what they see as the most pressing health problems and the resources available to them. I also interviewed four Community Programs staff at DIF (*Sistema Nacional para el Desarrollo Integral de la Familia*), the national system for social assistance to better understand the range and nature of the services provided to the poor and their perceptions of needs within different municipalities in the state.

Using a purposive sampling method during the Cuernavaca phase, I purposely selected a sample intended to provide me a range of perspectives on health resource delivery there (see Bernard 1994). Table 3 summarizes who was interviewed in this

phase. I supplemented these interviews with observations in a range of settings including public health fairs, national health day events, community workshops, public clinics, and private doctors' offices.

Table 3. Cuernavaca phase interviews (N=18)

Interviewee group	Number
Ministry of health officials (SSA)	2
Social assistance officials (DIF)	3
Medical doctors	3
Non-biomedical practitioners	7
Health organization directors	3

I interviewed three medical doctors and seven non-biomedical practitioners. One doctor specializes in treating patients with AIDS and is the director of COESAMor (*Comisión Estatal de Arbitraje Medico de Morelos*), a public organization created to help arbitrate problems between users and public health services. The second doctor specializes in gynecology and is the director of health programs for a non-governmental organization called CIDHAL (*Comunicación, Intercambio y Desarrollo Humano en América Latina A.C.*) that runs a community health clinic and an early cancer detection program. The third doctor practices biomedicine and homeopathy in Cuernavaca and Mexico City. I also interviewed a range of non-biomedical practitioners in Cuernavaca including two herbalists, one traditional healer, and four traditional midwives. The goal of these interviews was to learn: 1) how practitioners address the needs of low-income clientele, 2) what has changed in health care over the course of their professions, and 3) the most pressing problems they face as they practice health care.

I conducted observations with three organizations in Cuernavaca that work in the area of traditional and alternative medicine. I carried out three interviews with the

director of the *Instituto Mexicano de Farmacofitoterapeutica "Tlahuixcalpantecuhtli" A.C.* which is a civil association that has been involved in establishing community clinics in Morelos and training health promoters in alternative and traditional medicine since 1967. I conducted two interviews with a biologist at the *Instituto Nacional de Antropología e Historia en Morelos, (Centro INAH-Morelos)* who has spent over 20 years working with community health groups and traditional healers. Finally, I conducted interviews and observations with CIDHAL members (mentioned above) over the course of three months. During this time I traveled throughout the state with a group of midwives who conduct early cancer detection campaigns, and I also observed the clinic at the main office. These interviews and observations helped to provide context for understanding the trajectory of health organizing in Morelos, how health groups organize themselves, and the interaction between civil associations working in traditional and alternative medicine and government institutions.

Zarragoza phase

Health care and local government. Table 4 summarizes the interviews that I conducted with health care officials, physicians, and local government officials while living in the town of Zarragoza.

Table 4. Zarragoza phase interviews (N=12)

Interviewee group	**Number**
Municipal health clinic directors (SSA, IMSS, ISSSTE)	3
Municipal government officials	4
Community leaders	2
Medical physicians	3

I made numerous visits to the three public municipal health clinics in Zarragoza. These are the largest health services available in the municipality since there are no hospitals. These clinics include the SSA "Urban Health Center," which is run by the Ministry of Health and is open to all residents; the Mexican Institute for Social Security clinic, which is open to formal workers insured by IMSS; and the Institute for Social Security and Social Services for State Workers (ISSSTE) clinic, which is open to government workers. I conducted semi-structured interviews with the directors of these three clinics regarding the structure and functions of each clinic, the populations they serve, the resources they offer, key challenges they face, and perspectives on local effects of health reforms.

I also conducted interviews with three members of the *ayuntamiento* (the governing council of the municipality), including the Municipal President, the President of the Municipal Health Committee, and the incoming alderman *(regidor)* of Public Health and Wellbeing. I asked these individuals questions regarding public health priorities of the municipality, strengths and weaknesses of health programming, and levels of community participation in health. Additionally, I interviewed the Municipal Director of Education, the President of the Ejido Commission, and the Parish Priest, to get a sense of how other community leaders perceive health priorities and participation in Yautepec. Finally, I interviewed three medical physicians who operate private clinics to learn more about the private health sector, the types of patients that use this sector, and the health problems that doctors address. I also interviewed one physician who worked at the "*Similares*" Pharmacy described in Chapter 5.

I brought a specific set of questions to each interview but allowed the conversations to follow their natural course. Because these interviews took place over about six months, I was able to utilize the insights that each offered to pursue further (and different) questions. As I typed up the notes from each interview, I would draw up a list of questions or clarifications that I needed and would discuss these with my research assistant, Alma, the following day. Alma was immensely helpful in explaining to me the nuances of the health care and local political system.

The outgoing *regidor* of Public Health and Wellbeing in the municipal council was extremely helpful in providing me with documentation regarding public health matters in Yautepec. She gave me a copy of the 2002 Yautepec Health Diagnosis (Miranda et al. 2002), a demographic survey and analysis of the factors that contribute to health and wellbeing in the community. The study was led by the Ministry of Health and involved the Municipal government of Yautepec, the Health Jurisdiction Number 3, and different public and private sectors that form the Municipal Health Committee. The study is rich in history, statistics, and detail of various social, political, and economic aspects of the municipality.

Local perspectives on health care. I developed a 16-question survey regarding local health care perspectives, which I administered to 100 residents of Zarragoza. I chose two neighborhoods to administer the survey, which were selected because they represent two prominent socioeconomic segments of Zarragoza society. La Rosa is a working class community, and El Bosque is a farming community. I conducted 50 surveys with female heads of households in each of these two neighborhoods. The survey includes questions about health seeking behaviors, prevention actions, illnesses

suffered by immediate family members, perceptions of community health problems, and participation in community groups. The survey also includes questions regarding perceptions of social problems and potential solutions to these problems.

Two research assistants, Alma and Avigail, helped me to gather the survey data by asking the questions during interviews and recording short answers on the questionnaire while I took detailed notes of the informants' answers. The surveys were collected face to face with the most senior females of the households. After mapping out the two neighborhoods, I designated an equal number of surveys per street for each neighborhood. We knocked on every third door until we had fulfilled the number we needed for each street. Only two people declined to answer the survey. The survey took between 20 to 40 minutes to administer. Demographic information on this sample is included in Chapter 5.

After completing the surveys in each neighborhood, I selected a sub-sample of 15 women per neighborhood for in-depth interviews (N=30). I selected these interviewees to capture a cross-section of illnesses and health care experiences and participation in community groups. I asked them to elaborate on specific issues that were brought up during the survey interview and asked about their experiences and perspectives on health care, community participation, gender relations, work, and other social issues. I asked women questions about their histories, families, and life events. These interviews lasted anywhere from one to four hours each and were tape recorded. I conducted each of the 15 interviews for the La Rosa sample, and Alma conducted 12 of the 15 interviews for the El Bosque sample. I include demographic information on this sample in Chapter 5.

Health group data

Three civil association health groups were operating in Zarragoza during the time of my study. I focused the majority of my observations on two of the three groups – the Committee for Culture and Development (CCD) and the Parochial Center for Health Promotion (PCHP). I participated in their classes and workshops, observed their clinics, and informally spent time with their members. I visited a third organization, the Center for Traditional and Alternative Medicine (TAM Center), on two occasions when I received a tour of its school and clinic, briefly interviewed its director, and spoke with two other staff members and two students. I did not conduct participant observations at the TAM Center.

During the time of my study, the CCD had six active participants, although upwards of 15 women were involved peripherally in CCD classes and activities. The core group accepted me as a "seventh member" and included me in much of what they did, from planning meetings to family fiestas. I developed close relationships with each of the six women and became involved in their lives. I conducted life history interviews with each of the six women. However, I gained the most insight into their worldviews through the informal conversations that we had over the course of my time in Zarragoza.

As a "member" of the group, I participated in the CCD's weekly classes which they offered to the community. This included an eight-month therapeutic massage class and a three-month herbalism class. These classes were often conducted more like social gatherings than formal classes, and I learned a lot about the participants through these weekly meetings. The group also ran a community clinic during part of my research period. I observed the clinic one day a week and had access to the medical records that

were kept at the clinic during its intermittent operations from 2001 to 2003. By simply hanging around the clinic and asking questions, I gained access to a larger network of people throughout the state working in alternative and traditional medicine in a similar capacity as the CCD.

The second group that I closely observed is the Parochial Center for Health Promotion. This group works out of the Catholic Church in the center of town. I had the good fortune that the health promoter training program was just beginning a new three-year cycle. After meeting with the organizers of the group, I enrolled as a "student" of the health promoter training program and began the program with the rest of the new cohort. This allowed me to establish relationships immediately with other students and to learn in the greatest detail about the philosophies and practices applied in the dispensary.

Four months prior to my arrival in Zarragoza, there had been a falling out between members of the Parochial Center for Health Promotion (PCHP). As a result, it split into two separate groups. One group packed up all of the center's property (beds, medicines, supplies) and moved to another location where it opened a new school and clinic under the name of the Center for Traditional and Alternative Medicine (TAM Center). The other group that remained in the church, with whom I later became affiliated, began the process of registering as a new civil association. By February, when I began attending classes at PCHP, the group was organizing its first cohort of health promoter students. Thus, I was able to observe how the group reorganized and re-established itself in the community.

Because I was actively involved with the group, I had the opportunity to attend its opening ceremonies and its first "health fair." Besides attending all of the Monday night

classes and events, I went on medicinal plant collection outings with the class and spent a week working with the "emergency health brigade" following a flood that hit Zarragoza on July 4. I also conducted observations at the clinic one day a week for four months. This allowed me to get a feel for the types of people who use their services regularly, how the community clinic operates, and what techniques are used by health promoters. I interviewed four active participants of the group and kept notes on informal conversations that I had with most students in the program. I came to understand the work of the dispensary through these diverse experiences and through the personal relationships that I developed with the participants and group leaders.

Because of my close ties with the Parochial Center for Health Promotion, I was hesitant to pursue close contact with the group that split from them, the TAM Center. The participants of the Parochial Center for Health Promotion I interviewed painted a very ugly picture of the conflict that had occurred, and I felt that my participation in the TAM Center could jeopardize my relationship with the leadership of the Parochial Center for Health Promotion. Thus, I collected information about this group mainly from secondary sources. However, since these sources were often very negative in describing the group, I use this information only to contextualize the events leading up to the split up of the groups (see Chapter 7). I visited the TAM Center twice, where I received a tour of their facilities, spoke with two staff members and conducted a brief interview with the director.

I handed out a nine-question survey to the students who were present at the CCD and PCHP schools. Nine women at the CCD and nine women with the PCHP completed the survey, four of whom belong to both groups (N=18). The survey includes questions

regarding students' histories of studying traditional and alternative medicine; other types of health programs in which they are involved; if they provide health consultations to family members, friends, or neighbors; and the types of illnesses they have suffered, along with basic demographic information.

All of the interviews I conducted were tape recorded, and they were transcribed by a research assistant in Cuernavaca. Upon returning to the U.S., I entered the interviews and fieldnotes into the computer using the software Atlas.ti 4.2, and I assigned codes to the data that enabled me to locate patterns. I generated documents based on this coding system and reviewed these documents to identify patterns in my data. I organized interview information into four categories: 1) state and municipal health care; 2) health practitioners; 3) health care users; and 4) health group participants. From these categories, I made data charts that were organized around specific topics such as traditional and alternative medicine, gender, health care reform, illness prevention, etc. I elicited patterns from these documents and continued to make more refined matrixes. I made data charts of the survey information which I used to make comparisons between different variables.

In sum, the quality of my data reflects the degree to which I was integrated into health groups and social networks, had access to health administrators and officials, and gained permission from community residents to conduct surveys and in-depth interviews. My methodology reflects careful consideration of the elements of health care and health organizing which I was studying. I also achieved much of my understanding of the lives and experiences of women through more informal means.

CHAPTER THREE: NATIONAL HEALTH CARE AND HEALTH SECTOR REFORMS

Mexico's national health system in historical context

As it stands today, Mexico's national health system is composed of two branches: a social security branch and a social assistance branch which are both coordinated by the Ministry of Health (SSA, *Secretaría de Salubridad y Asistencia*). The social security branch is designed to address the needs of the working class and serves formally employed workers, production cooperatives, organized groups of agricultural workers, and small landowners. The most important institutions within the social security branch are the Mexican Institute of Social Security (IMSS, *Instituto Mexicano del Seguro Social*) which provides health care and retirement funds to salaried workers of private companies and the Institute of Social Security and Services for State Employees (ISSSTE, *Instituto de Seguridad y Servicios Sociales de los Trabajadores del Estado*) which provides health and retirement services to public servants at both the federal and state levels. Social security recipients have access to free services at public clinics and hospitals run by IMSS and ISSSTE.

The social assistance branch is designed to respond to the needs of the rural poor and urban uninsured. The Ministry of Health (SSA) is the primary provider of preventative and curative health care (e.g., vaccination, diagnosis and detection of disease, care of healthy children, etc.) for the uninsured population. Although SSA services have historically been free to the public, the SSA implemented user fees in the 1980s at clinics and hospitals. Although these fees are minimal for many Mexicans (e.g., $2 - $4 USD for a clinical visit), they have been found to deter the most impoverished

segments of society from seeking health care (Laurell 2001). The two branches of the public health system were designed to ensure that all Mexicans have access to at least basic health care. However, according to some estimates, under current conditions, up to 10% of Mexicans do not have access to any health services. These are primarily the rural and urban poor (Laurell 2001).

The antecedents of Mexico's National Health System developed early in the century. Mexico's first modern medical establishments were created between 1901 an 1910. This period corresponded with the last ten years of Porfirio Diaz's dictatorship, during which Diaz resolutely pursued an agenda of modernizing the nation. As a result, the government developed and financed general, civil, military, and rural hospitals throughout the country (Fajardo Ortiz 2002). With the onset of the Mexican Revolution (1910-1917), civil wars, economic disasters, epidemics, and a deteriorating public infrastructure, the need for emergency services escalated. Between 1911 and 1930, emergency medical services were developed to service sites of combat and attend to people affected by the epidemics. The services were sustained by a combination of public and private funds and by the work of volunteers (Fajardo Ortiz 2002).

During the presidency of Lázaro Cardenas (1934-1940), public medical programs flourished, primarily focused on rural populations (Fajardo Ortiz 2002). Cardenas promoted innovative programs, such as the establishment of a mandatory year of social service required of fifth-year medical students who worked as *pasantes* in rural clinics. This is still required today. Health services were organized into medical districts where officials could coordinate regional areas in an effort to meet local needs. Leyva Flores (2000) argues this was a precursor to today's decentralization strategies. The government

also instituted social participation programs where individuals were encouraged to contribute volunteer work to the health sector through campaigns such as the Rural Medical Cooperative Service which functioned like a labor cooperative (Leyva Flores 2000). As we will see in this chapter, social participation programs have been implemented in the Mexican health care system over the last three decades as a means to leverage government resources.

After the Second World War, the demand for industrialization grew. Utilizing the opportunities offered by technology and economic development, the Mexican government created the Ministry of Health (SSA), the Mexican Institute for Social Security (IMSS), and the Children's Hospital in the early 1940s (Frenk et al. 2003). The social security branch (IMSS, ISSSTE) was designed to address the needs of the working class and the public assistance branch (SSA) was designed to respond to the needs of the rural poor and urban uninsured. The specialized hospital-centered care was expensive and based mostly in urban areas, and thus most directly benefited urban populations. By the late 1960s, the cost of health care was rising as a result of the growing demand and services were not adequately reaching impoverished rural populations (Frenk et al. 2003). The health care distribution model was ripe for change.

The 1970s: The primary health care movement

Responding to the demand to extend health services to rural and poor urban populations, a new generation of reforms were under way by the late 1970s, guided by the principals of primary health care set forth by the World Health Organization. The WHO established the goal of "Health for All" by the year 2000, setting into motion a

global movement designed to erase the enormous health and health care disparities in developing countries. The PHC model was different from earlier international health efforts because it articulated a critique of poverty and maldistribution of social and economic resources (Foley 2001). Based upon the premise that health care is a fundamental human right and that national governments are responsible for providing primary health care, the WHO's declaration proposed that governments expand their primary facilities to meet the basic health needs of every individual.

Taking up the challenge of "health for all," the Mexican government built 2100 new rural health clinics between 1978 and 1980, extending basic health service access to its more impoverished communities (Stebbins 1986). A government subsidized national program for depressed areas and marginal groups (COPLAMAR) was also established to coordinate the health programs for the poor. Because of grave restrictions in federal spending, a program of community participation was instituted in the health sector as a means to sustain the new clinics. This program mandated that each clinic be operated by a community volunteer and a health committee, and that each household in the community contribute 10 days of labor a year towards the clinic's operations (Stebbins 1986).

The new health clinics indeed expanded health care coverage for rural populations. However, the PHC program was limited in many ways. The clinics were still too distant from many users; they were poorly staffed and underfunded; they were administered by personnel that had little technical skill and who were principally trained to administer birth control programs; and they ignored local health knowledge and local practices (Leyva Flores 2000; Stebbins 1986). The community participation program

also had limited success. Critics suggest that the Ministry of Health failed to involve citizens in decision making process and expected individuals to perform health related services that the government was unable to supply (Stebbins 1986; Zakus 1998).

Many scholars point to the relationship between the Mexican government and international bodies to understand the limitations of the PHC movement. Mexico's implementation of PHC programs was influenced by and dependent upon international health agencies such as WHO, UNICEF, and USAID. Scholars argue that international agencies mandated PHC strategies, including community participation programs, throughout the developing world without consideration of the diversity of local needs and realities (Crandon 1983; Lane and Rubenstein 1996). Critics suggest that local residents were to be used as a means to accomplish PHC projects affordably and affectively. While in theory, PHC encouraged community residents to help diagnose and solve health and development problems, scholars point out that in practice, residents were not always provided with sufficient training, tools, or participation in the decision making process to allow their contributions to be integral (Morgan 2001; Stebbins 1986).

PHC was ultimately a short lived strategy, although some of its components have been recycled in more recent "health for all" efforts, such as the emphasis on collective decision making and community participation that were central to the decentralization programs of the 1980s and 1990s (Jareg and Kaseje 1998).

The 1980s: Decentralization and poverty programs

Mexico's health care policy abruptly changed as a result of the nation's economic crisis in the early 1980s. Responding to its debt crisis in 1982, the government

implemented austerity measures that involved radically reducing health spending. As the crisis deepened, the government's attempts to increase health care coverage benefits failed. International creditors pressured the Mexican government to reduce unemployment and welfare benefits while multilateral and bilateral agencies (e.g., World Bank, Interamerican Development Bank) pressured the government to reorganize its health system.

At the same time, a profound demographic and epidemiological transition was occurring in the country where new and serious problems were being affecting health care delivery. For example, while the national health care model was designed to address acute, communicable diseases, the nation was seeing an increase in chronic and degenerative diseases. The limited availability and expense of high tech and long term treatments, and their concentration in the largest (and most politically influential) cities and towns resulted in great resource inequality for marginal social and geographic groups (Hunt 1995).

Beginning with Miguel de la Madrid's presidency (1982-1988), the Mexican government responded to these pressures and challenges by embarking upon a process of political and economic decentralization. State reforms emphasizing decentralization were designed to address the growing concentration of economic power, population, and governmental authority in Mexico City (Rodríguez 1997). Arguably, the Municipal Reform of 1983 initiated the development of a "decentralization culture" in Mexico (Rodríguez 1997). Changes in Article 115 of the Constitution guaranteed municipalities fixed sources of revenue which would allow them to provide public services and

strengthen their political independence (Rodríguez 1997). The health and education sectors were most specifically targeted for decentralization.

Multilateral agencies like the World Bank promoted decentralization strategies as the panacea for developing countries like Mexico to address the inefficiency, inequity, high costs, and low coverage of health care. Advocates of decentralization suggested that health sector improvement is possible if centrist governments better involve diverse social actors in health resource management. A central aspect of decentralization is the transfer of functions and power to local level governments and the privatization of services to non-governmental entities (including private businesses and NGOs) (Evers and Juárez 2003).

The Pan American Health Organization (PAHO) has been particularly influential in the introduction of decentralization programs in Latin America. In the 1980s, PAHO recommended that governments organize health services into "Local Health Systems" (SILOS, *Sistemas Locales de Salud*) where local authorities were given greater decision-making power regarding health service operations and the delegation of funding. In this way, municipalities could more effectively run community health care and prevention programs, coordinate and mobilize resources, and organize the community to participate in health (Sotelo and Rocabado 1994).

At the same time that PAHO was encouraging decentralization programs like Local Health Systems, the 1983 Mexican constitutional amendment to Article 4 which effectively raised the right of health protection for every person to the constitutional level (Frenk et al. 2003; Tamez and Molina 2000). This was a pivotal amendment asserting that the state was responsible for fulfilling this constitutional right. To better achieve this

responsibility, the federal government formally created the National Health System (NHS) to harmonize federal and state programs and the social security and private sectors. The NHS's explicit purpose was to extend coverage to the whole population, prioritizing the least protected and to improve the quality of health services (Tamez and Molina 2000).

In order to reorganize the national health system, the Ministry of Health was placed in charge of coordinating all federal health care institutions, including the social security branch (IMSS and ISSSTE). Protests against the new power structure erupted from workers within the Mexican Institute of Social Security (IMSS) because it had been the most powerful health sector institution since the 1970s. Under IMSS leadership, an organized labor movement formed a vetoing coalition which interrupted the process of decentralization. As a result of this obstacle, health services of only 14 out of 32 Mexican states were decentralized in the 1980s (Gonzalez et al. 1995 in Tamez and Molina 2000). The decentralization process was not completed until the late 1990s (Frenk et al. 2003).

Decentralization did not occur in some of the poorest states and instead selective programs were developed for the most indigent populations (Tamez and Molina 2000). For example, the federal government established the National Solidarity Program (PRONASOL) in 1989. Co-financed with federal resources and a loan from the World Bank, PRONASOL was established to help meet the health care needs of the most impoverished population groups, particularly in rural areas. However, like the COPLAMAR program of the 1970s, scholars explain that PRONASOL / IMSS-

Solidaridad[1] followed the policy priorities of international agencies which were not always representative of local needs (Tamez and Molina 2000). Laurell (1991) suggests that by only targeting extremely poor Mexicans, PRONASOL effectively ignored the poorest half of the population as well as the vast majority of the working population. She argues that the program undermined the very constitutional standards on which the reform stood since "targeting, rather than a policy of social justice, is an ideological pretext to justify the state's disregard of its constitutional obligation to guarantee the social rights of all Mexicans" (p. 462).

Mexico's shift towards decentralization grew out of an economic and political crisis that required a "profound transformation of the relationship between state and society" (Tamez and Molina 2000: 150). Like earlier PHC efforts, the national government was encouraged by international bodies like the World Bank and the World Health Organization to adopt decentralization strategies. However, as scholars have pointed out, governments' adoption of health policies "from above" have the effect of diminishing the importance of local needs "from below" (Castro and Singer 2004). Another profound shift was on its way. Like in the 1980s, this shift was again propelled by severe economic crisis.

The 1990s: Neoliberal health reforms

Funding for Mexico's poverty programs was in decline by the mid 1990s. The peso devaluation crisis of 1994 required the largest International Monetary Fund (IMF) bailout in Mexican history, with strings of structural adjustment attached. Mexico fell

[1] PRONASOL took over the structure of the IMSS COPLAMAR program which kept its government subsidy but changed its name to IMSS-Solidaridad (Gonzalez et al. 1995 in Tamez and Molina 2000).

into its most serious depression since the 1930s, requiring a further reduction in social welfare programs to help pay off the growing debt. In response to its economic predicament, Mexico accepted the terms of state reform that accompanied neoliberal globalization as defined by international institutions such as the World Bank and the IMF. These terms required that the Mexican government adopt market oriented strategies to offset the contraction of public spending and to improve the nation's competitive position in the world market. As Evers and Juárez (2003) explain, market liberalization policies emphasized by the World Bank and the IMF call for the "deregulation of world and domestic markets, while placing restrictions on individual country governments' ability to control and direct foreign investment and to influence flows of imports and exports" (Evers and Juárez 2003:10).

As a result of the IMF bailout and growing pressures to liberalize its market, Mexico opened up its economy to external competition through free trade agreements. The signing of the North American Free Trade Agreement (NAFTA) in 1994 allowed international companies to participate in private insurance. Furthermore, international economic and legal incentives favored the growth of an industrial medical complex based on high technology service networks and pharmaceutical consumption (Tamez and Molina 2000).

The move towards a market-based economic system affected Mexico's public health institutions in other ways. For example, user-fees were instituted at public assistance institutions following on the heels of the World Bank's 1987 publication, *Financing Health Services in Developing Countries.* In this publication, the World Bank proposed that patients pay more for their health care and encouraged the development of

private health insurance schemes, the expansion of the private sector's participation in health care, and the decentralization of government health services (Isaacs and Solimano 1999). As a result, Mexican public assistance health services that were once free now required payments, which have been increasing since the 1980s (Tamez and Molina 2000). According to critics of this system, charging fees for services is another example of shifting the cost of health care from governments to citizens and is a step closer to privatization (Laurell 2001). Laurell (2001) argues that such shifts further polarize wealthy and poor health service users and make the goal of equitable health care increasingly unattainable.

The social security branch of the public health system (particularly IMSS) has historically provided high quality medical care. However, IMSS was affected by the economic crises of the 1980s and 1990s. IMSS lost 106 billion pesos between individual dues, employer fees, and the state budget between 1983 and 1994. At the same time, it reduced the payment contributions it collected from individuals and employers. IMSS physicians lost 80% of their salary during these ten years. These cuts had a severe impact on the maintenance of equipment, provision of work materials, supply of drugs, and the quality of care and working conditions, resulting in its deterioration and the erosion of IMSS' reputation (Laurell 2001).

To address the growing problems within the National Health System, President Ernesto Zedillo set out the objectives of a Health Sector Reform Program 1995-2000 in his national development plan. Zedillo proposed to diversify health care services and financing schemes (Tamez and Molina 2000). His reform program set out to complete the process of decentralization that was begun in the 1980s, extend coverage for the poor

through a basic Essential Health Package, increase the quality and efficiency of health services, and involve greater municipal participation in health care through a program called Healthy Municipalities, which will be discussed in detail later.

In order to extend coverage to the poor, the Zedillo administration implemented the basic Essential Health Package. This package includes 12 basic health and health promotion measures that are to be offered in public clinics, including basic household sanitary measures; family planning; prenatal, perinatal, and postnatal care; nutrition and growth surveillance; immunization; diarrhea treatment; treatment of common parasitic diseases; treatment of acute respiratory infections; prevention and treatment of tuberculosis; prevention and control of hypertension and diabetes; prevention of accidents and basic injury treatment; and community training for health promotion (Frenk et al. 2003). The package establishes a set of basic services that are to be provided free of charge to every Mexican. For the poorest segments of society, Zedillo also introduced an incentive-based welfare program called PROGRESA (Program for Education, Health, and Nutrition). PROGRESA offers monthly cash subsidies to poor people in exchange for adhering to several education, health, and nutritional interventions (Frenk et al. 2003).

In a separate program, Zedillo set out a series of social security reforms. These reforms are aimed at addressing the growing problems faced by IMSS relating to the increase in the aging population and the institution's difficulty in collecting payments. A new financing scheme that will be fully implemented by 2007 establishes "equal pay for equal services" in which the insured will all pay the same premium regardless of income. Previously, individuals paid a fixed percentage of their income, thus, those that earned more paid more. This new scheme will affect the poorest members of society who will

be paying a sum equivalent to what wealthier Mexicans pay. State funding will increase from 5 to about 30 percent of the total premium, reversing the policy of state withdrawal from funding the public sector adopted in the 1980s. At the same time, the changes favor big companies that pay higher wages leaving small and medium companies at a disadvantage in premium payments (Laurell 2001).

In 1998, the Mexican government accepted a U.S. 700 million dollar adjustment loan from the World Bank. The conditions accepted by the government in return for this loan involve a "profound corporate reorganization of IMSS health services" that follows a market logic (Laurell 2001: 306). As outlined by the World Bank document, *Mexico: Health System Reform*, this reorganization involves transferring health insurance fees to individual accounts managed by private financial institutions, rather than by IMSS. It also involves the transfer of health funds to public and private managed care organizations (MGOSs which are copied from U.S. health maintenance organizations, HMOs). MGOs will eventually organize health care for the insured population and provide services directly or purchase them from other providers (Laurell 2001). As Fisk (2000) suggests, social security institutions in Mexico are moving towards the competitor model of privatization and will eventually provide vouchers for workers who want to buy private insurance. Thus private insurance will inevitably replace public insurance, yet another sign of the entrenchment of health system inequalities.[2]

In spite of the government's efforts to extend health services to the entire population, an estimated 10% of the Mexican population was without access to any kind

[2] An estimated 2% of Mexico's population carries private insurance. Private medical insurance did not exist until 1985 and its emergence coincided with the steep decline in social security spending. By 1995, private insurance covered 1.67 million families. Of these families, 71% had a group insurance that generally came from employment benefit. Thus, a growing number of Mexicans have both public and private medical insurance, while the large majority has none (Laurell 2001).

of formal health care in 1996 (Laurell 2001). The current administration of President Vicente Fox (2000-2006) has sought to address this problem through his National Health Program Plan 2001-2006 which is in accordance with the WHO framework on health system performance. It seeks to provide universal health insurance through a "Social Protection in Health" system, which will cover people who have been excluded from the formal insurance system because they are self-employed, unemployed, work in the informal sector, or are out of the work force. Individual health care will be financed by Popular Health Insurance *(Seguro Popular)* which is funded by tax-based contributions from federal and state governments to subsidize family contributions on a sliding scale. This program is to subsidize up to 99% of the benefits for the nation's poorest families. A pilot program was underway in 2003, at which time 614,000 people in 24 states participated in the program (Secretaría de Salud 2004a). Its goal is to reach all uninsured citizens by 2010 (Frenk et al. 2003). It remains to be seen how well this system will improve health care access and if it can address the multitude of health care problems present within the national health system.

Decentralization and municipal participation in health: The case of Healthy Municipalities

As I describe above, Mexican health system reforms since the 1980s have emphasized decentralization strategies that involve the transfer of health resource management responsibilities from the federal and state governments to municipalities. Because of its proximity to the population, the municipality is considered by development practitioners to be best informed about local needs and the availability of

health resources (Sotelo and Rocabaldo 1994). As a result, National and State Health Laws define the municipality as the axis for the development and implementation of health programs (Sotelo and Rocabaldo 1994).

To facilitate the process of decentralization, President Zedillo proposed greater "intersectoral" involvement in health among diverse sectors of society, including municipal authorities, civil society organizations, and community residents. The intersectoral approach was first advocated by the World Bank in its redefinition of participation to focus more directly on stakeholders (Morgan 2001). The approach seeks to generate solutions to community problems through the collaboration of distinct social sectors. The Healthy Municipalities program, as proposed by the Pan American Health Organization, is meant to facilitate intersectoral involvement at the level of the municipality.

Following PAHO's definition of health, Healthy Municipalities proposes that the well-being of municipal residents follows a series of conditions. These conditions include sufficient education, employment, nutrition, health care, housing, a stable ecosystem, social justice, and equality. Municipal governments are charged with identifying and remedying their most persistent public health problems with the support of diverse sectors of society. Healthy Municipalities' projects most typically focus on sanitation and infrastructure, promoting healthy lifestyles, social and economic projects, and projects directly related to the quality and orientation of health services (Sotelo and Rocabaldo 1994). The program works under the logic that community participation is essential in the determination of each municipality's priorities and in the design, implementation, and evaluation of local health programs (Tamez and Molina 2000).

The ideological basis of Healthy Municipalities

Healthy Municipalities places the responsibility for improving community health largely in the hands of municipal officials and community residents. As Dr. Vargas, the Morelos Healthy Municipalities director explained to me, the program is essential for generating the political will of municipal authorities to make health and well-being a priority of the municipal government's political agenda. He said:

> There are 1437 municipalities that exist in the country. And realistically, I believe that none, or very few can be described as "healthy." Obviously, we, Health Services of Morelos, cannot certify a municipality as healthy if it has problems with street dogs, if it has the problem of contaminated streams and ravines, if it is without recreation spaces. But what we, Health Services of Morelos, can guarantee is for those municipalities that have decided, through the political will of their political authority, of their municipal authority, to say *yes* I am interested in the health of my population, *yes*, I am interested in including health and well-being in my political agenda. A healthy municipality does not exist, a healthy municipality is constructed; it is a process that is attended to every single day.

Healthy Municipalities is well-situated within a national discourse of social development where health is understood to be "an expression and synthesis of development which is a strategic objective of municipalities" (Sotelo and Rocabado 1994). Dr. Garcia, a Ministry of Health official suggested that "if we want to have social development, we have to participate and assist in health." According to this logic, health and development can only be achieved if citizens are willing to share in the responsibility. Accordingly, Dr. Vargas explained that:

> ... health is a constitutional right, it is consecrated in Article 4 of our constitution. And also, it is a social right that *cannot* be granted to all citizens by the federal government, or by the state government, or by the municipal government. Therefore, we, as a government, as an institution, have to give the tools to the population so that the people take responsibility to care for their own health.

The Healthy Municipalities program promotes the idea of citizen repayment to the state in return for the social goods it provides (Smith 2002). It encourages citizens to become less dependent on the government to resolve health problems. Dr. Garcia elaborated on this focus.

> Many years ago, we stopped saying that the government is responsible. If we want to demand from the government, then we have to contribute much will, much participation. In other words, everyday, the government, citizenship, social organizations, religious organizations work to seek out a common benefit. If we want only the government to do this, it is not going to work. If we want only residents to do this, it is not going to work either. Citizens are the engine of this program. Without you, if you do not help us, we can accomplish absolutely nothing.

As Dr. Vargas said, "the institutions and the *ayuntamiento* (municipal government) can not resolve the problems. The problems have surpassed us and it is necessary that citizens are incorporated in the solutions and strategies to resolve these problems." Healthy Municipalities requires municipal governments to organize communities and to incorporate citizens in public health solutions.

Local applications of Healthy Municipalities in Morelos State

Municipalities that agree to enroll in the Healthy Municipalities program are expected to fulfill certain functions. First, they are to organize municipal and local health committees that are in charge of developing and running health projects. Second, they are to conduct a "health diagnosis" of their municipality to identify key public health problems and develop a "work plan" to resolve these problems. Third, they agree to take part in a workshop that includes diverse sectors of the municipality, identifying the top five public health priorities for their community. Municipalities that choose to participate in the program are coordinated by the state-level Ministry of Health department. There

are no formal "incentives" for municipalities to join the program beyond receiving training for municipal officials and improving the health standards and conditions within the municipality.

The goal of the Ministry of Health is to enroll every municipality in the program. However, not all municipalities choose to become involved. In 2003, 13 of the 33 municipalities in Morelos State (40%) were participating in the program.

Municipal health committees. The backbone of the Healthy Municipalities structure is the municipal health committee. The committee is comprised of officials working in the municipal council (*regidores*, department directors), along with local health district directors, health center directors, and other local officials. The committee conducts the health diagnosis which informs their work plan. The committee is responsible for carrying out the work plan in partnership with state agencies like the National Water Commission, the Ministry of Social Development, and the Ministry of Health. The committee is also expected to involve public and private institutions, NGOs, and community residents in carrying out the work plan. The municipality is to provide the economic resources for the projects.

A third function of the committee is the vigilance, observance, and enforcement of general public policies. Municipal health committee members are expected to educate others on and enforce health regulations. Finally, the committee is responsible for the follow through and evaluation of health projects determined by an intersectoral workshop (see below).

The municipal health committee organizes "local health committees" which are constituted by community residents and are managed by municipal-level Ministry of

Health officials. Participants of these local committees are to be the conduit between municipal representatives and local communities. They are to present residents' concerns to the municipal health committee, develop local projects, and organize community efforts to accomplish these projects. In this way, the population's needs are given voice by the local health committees which are part of a chain of representation organized through the Healthy Municipalities program.

The state-level Healthy Municipalities director, Dr. Vargas, explained that the municipal and local health committees are at "the center of the most substantial strategy of the entire process towards a healthy municipality." In my research, however, I observed very little committee activity and no knowledge among local residents about the committees or their functions. For example, the president of the municipal committee in Yautepec explained that the committee met only once or twice a year. She said, "We are supposed to meet every three months, but a lot of times the municipal president does not show up, so the meetings don't happen." It appears that this situation is the norm, rather than the exception. Dr. Vargas explained that in 80% of the cases, municipal committees form "but there are very few participants and it is rare that they actively fulfill all of their functions."

The local health committee in Yautepec was equally inactive. The officials who were involved in the program were not even sure how many people were members of the committee. One official thought that six people were involved while another said, "there are no volunteers because people don't want to participate." I was told by the president of the municipal health committee that in the past, the Ministry of Health had a budget to administer to the committee and when this budget was available to them "they didn't

behave like volunteers. They administered things and to administer they took part of the resources for themselves and they paid themselves salaries." The president told me that there is no budget now. Throughout the course of my research, I did not locate a single committee volunteer. Even though these committees are expected to be the "backbone" of the Healthy Municipalities effort, it appears that in Yautepec at least, they are generating little active participation or involvement.

In the 100 surveys I conducted in Yautepec, I did not find anyone who knew of the health committees. I specifically asked those surveyed if they knew of any means through which they might channel their complaints regarding the health system. The large majority mentioned the *ayuntamiento* as the source through which to channel their complaints. Since the committees are to be the conduit for local residents' participation in health structures and a channel for their concerns and interests, their absence left a void for channeling local interests and community voices.

Intersectoral workshop. Municipalities that agree to join the Healthy Municipalities program commit to organizing workshops to elicit community feedback on priority public health issues. These "intersectoral" workshops are intended to directly involve community residents, non-profit organizations, municipal officials, and business leaders in devising a work plan around priority health issues. The workshop is organized once during every three-year presidential term for the municipalities enrolled in the program. It follows the municipality's completion of its "health diagnosis," which is a formal study of various social and health indicators. The workshop intends to bring about a commitment by the parties present to prioritize and resolve the problems they

identify. I attended a workshop in the town of San Lucas.[3] My observations of this workshop suggest that it provides little space for genuine citizen input.

The workshop that I observed was led by five representatives of the Ministry of Health's Department of Health Promotion. It was organized into a presentation session and then a workshop session. The presentation session was attended by approximately 60 people, half of whom were school-aged children. More than one-third of the adults departed after the two hour presentation. Twenty five people remained, children included, to participate in the workshop portion of the day. We were divided into five groups to work on a worksheet that was to guide us in identifying the health problems. The worksheet asked us to rate each public health problem that we identified using a very detailed and confusing set of criteria.[4] My group was comprised of one middle-aged housewife, one elderly farmer, two children, both under 12 years of age, and myself (an outsider). The woman in my group was the most (and sometimes only) vocal representative in our group.

A Ministry of Health official sat at each table, rotating periodically. Our representatives didn't just observe what we were doing, but they often made suggestions and guided our ranked answers. The following excerpt, taken from my field notes, describes the extent to which our group was guided by our first representative:

> The official sitting at our table asked us to write down the first health problem that our group viewed as a priority. The elderly man in my group said that he lives on a hill and that Chagas disease is a huge problem. He said that his wife died a year ago from the disease. The official asked the man, "Is that a problem that affects the whole municipality?" The man meekly shrugged and said no. So the official asked, "What about the problem with trash?" The woman in the group

[3] San Lucas is a pseudonym for the town in which the meeting was conducted.

[4] The criteria included frequency, seriousness, solution characteristics (i.e., easy or difficult solution), extent to which the problem is worsening or improving, extent to which the problem is modifiable, its level of importance relative to other problems, the ease by which it occurs, the level of resources that exist to attend to the problem, and accessibility to the place where the problem manifests itself.

> wrote "trash" down on our form and then the official read off each variable for which we were to rank the trash problem.

Ultimately, the majority of the "community problems" that we ended up listing on this form were suggested by an official who was sitting at our table. Besides the obvious implications of our "answers" being offered by the health officials, I wondered to what extent the conclusions drawn by a small handful of adult participants could be representative of this municipality. When I posed this question to the director of Healthy Municipalities during an interview, he responded somewhat evasively saying that the idea behind the workshop is that participants:

> ... diffuse (the information) ...that they go to their municipal *aydantes* (helpers) or the municipal aids, that they do something in their *colonia* with health advisers, that they bring it to that level. For example, if the most pressing problems that are prioritized are street dogs and trash, the job of the municipality is to develop projects that can be done in their *colonia*, in a barrio with their *ayudantes* and their neighbors.

This response indicates that in his view, the number of people that attend the workshop is less important than the actions taken by the attendees after the workshop. The attendees are to diffuse the ideas that are generated at the workshop and initiate projects in their neighborhoods based upon the conclusions arrived at during the workshop. While this is logical in theory, no concrete projects were ever mentioned during the meeting. Nor were any next steps defined in terms of diffusing the workshop information. The director further explained the purpose of the workshop:

> What we offer through this exercise is education – first, it is that planning is broad, democratic, it includes all sectors. Second, that the people perceive first, that it is not easy to plan, and second, that real needs are one thing and perceived needs are another. The people can say –the problem is that there are many dogs in my *colonia* – when the real problem is not the dogs, it can be contamination of the river, the deficient potable water chlorination. Real needs are one thing and perceived needs are another.

This comment raises a contradiction within the goals of the program. While the goal of Healthy Municipalities is to involve "all sectors" in democratic planning, health officials have the power to determine which are "real" and which are "perceived" needs. This troublesome distinction is illustrated in the example above, where one participant in my group identified Chagas disease as a priority health problem and the health official challenged him. Chagas is caused by a parasite that thrives in substandard housing structures usually in rural areas. The disease clearly posed a real health problem for the man in my group, since his wife died from it. Furthermore, in the public health centers I visited throughout the state, preventing Chagas is listed as a priority health issue on the posters that hang in these clinics. Moreover, in a neighboring municipality, the "proliferation of deadly fauna" (which includes scorpions, mosquitoes, and the parasite, T. cruzi, which causes Chagas disease) is listed as one of the top five health priorities in its health diagnosis. Yet, the health official at our table dismissed this suggestion in favor of the trash problem.

I wondered to what extent the top five priority health problems had already been identified and that this gathering was a mere formality, a symbolic gesture, or a stamp of approval under the guise of "community participation." For example, at the beginning of the workshop, the following statement was made by one Ministry of Health official:

> The health diagnosis of San Lucas found that among others, the principal problems that demand the population's attention are related to aspects of trash, lack of potable water, combating addictions, combating domestic violence, improving the attention provided at the health centers, lack of public recreation and cultural spaces, and rehabilitation of drainage networks and sewers. Probably these are not all. And we have to develop a work plan so that we detect which are the most important for the municipality, the institutions, and the population. We have to confront them and try to offer short-term, medium-term, and long-term solutions. This is the justification behind this workshop.

Although Healthy Municipalities "includes participation in its definition, priorities, design and evaluation of local health programs," (Sotelo and Rocabaldo 1994), the intersectoral workshop example suggests that residents may not be truly encouraged to participate. Like the health committee structure, here again we see a "top-down" approach to organizing the community where health officials maintain the power to determine project priorities and outcomes.

Reflections on Healthy Municipalities

From this brief description of the local application of Healthy Municipalities in Morelos, we can see how the program does little to share or transfer power and instigate genuine participation. Indeed, the political will of municipal-level officials is weak, municipal committees are all but absent, and residents' contributions in public forums like the planning workshop are sparse. If community residents' perspectives are not given serious consideration then the program is, in fact, not based on mobilizing people from "below."

A problematic feature of the program is that while promoting "self-representation" for community residents, it operates through a "top-down" approach from which power is appointed from the Ministry of Health to municipal officials to community residents. While my observations suggest that community residents have little input in the priorities and design of health programs, the success of the program seems to depend on residents "participation" not only on a community level but on an individual level – in illness prevention and improving health behaviors. As the director of Morelos Healthy Municipalities points out:

> I think that they (the people) need to be given tools so that they can be responsible for their own health. And at times, health services or institutions give them these tools, but you have to have more participation from other sectors like the communication and education sectors. And I think that with these steps, you will have a more educated and health-oriented population, and you probably will have more awareness of the problems and their possible solutions. For example there is Chagas, there is dengue, there are scorpion bites. But what happens? The mosquitoes, the parasites don't walk around in the street. These are in peoples houses. People store water here uncovered in tanks, bottles, and tires, and at times they have them in their houses. These are issues that require direction and education.

Here we see how political discourse points to the behaviors of individuals to explain the source of community health problems. The director of Healthy Municipalities goes so far as to suggest that residents lack "aspiration" to achieve a better quality of life. He emphasizes health education and promotion as the means through which behavioral changes may be made to improve quality of life. However, this model neglects the structural factors that prevent people from maintaining clean water sources and the housing structures that aggravate problems with mosquitoes, scorpions, and parasites. Rather than addressing socioeconomics of health disparities, victim-blaming seems to justify the increased role that citizens are expected to play in resolving community health problems. Yet victim-blaming might have the potential to cause individuals to circumvent programs like Healthy Municipalities rather than to participate in them.

The discourses of prevention and participation applied by government officials through Healthy Municipalities are in direct contrast to earlier discourses of community participation generated from the primary health care movement of the 1970s. As discussed in Chapter 1, "participation" in past decades centered on mandatory citizen assistance in health clinics and neighborhood committees with the goal of increasing the

number of clinics and patient access to biomedical health services throughout the country (Stebbins 1986; Zakus 1998). Participation was thus elicited to help the government *expand* public health services throughout the nation, albeit through the mandatory contributions of residents.

In the current era of neoliberal globalization, community participation programs are encouraged by the national government as a means to develop local political power structures that involve the participation of individuals and community organizations (Contandriopoulos 2004). Intersectoral programs like Healthy Municipalities help to advance decentralization policies that shift the responsibility for health resource management from the state to municipal governments. Participation and prevention discourses thus help to facilitate the *contraction* of the state's provision of public health services.

As radical changes take place in political discourse where the meaning of "participation" and the role of the state transforms, community residents must alter their expectations of the government and accept their new roles within the shifting context of the state. I suggest that low participation rates on the part of community residents could reflect a limited understanding of what is expected under neoliberal health reforms. Low participation rates could also signify residents' refusal to accept or conform to these new responsibilities as defined by the government.

When I asked the director of Healthy Municipalities about the lack of citizen participation in municipalities like Yautepec, he suggested that it relates to apathy or residents' expectations that the government will resolve their problems for them. He explained:

> At times it is very much an issue of initiative – there is much apathy, there is much disinterest, there is much laziness. Maybe the people don't feel that their government listens to them or cares about them. They say, "I went and placed a complaint at the *Ayuntamiento* and nothing happened so I am not going again." In other words, the expectation is that the *Ayuntamiento* firmly seizes the responsibility of generating important actions.

As we will see in Chapter 4, "apathy" towards community health programs is not just limited to community residents. Municipal authorities also face obstacles that prevent their vigorous engagement with the new responsibilities dictated under decentralization policies. As we will see, apathy and lack of political will on the part of municipal authorities is rooted in resource shortage, residents' resistance to participate in government health structures, and local politics that enforce the exchange of public services for political support. Lack of political will may thus contribute to the absence of voluntary participants in the Healthy Municipalities program.

Even though one goal of the Healthy Municipalities program is to generate better intersectoral coordination, my observations suggest that a significant disconnect exists between the authorities, institutions, and the population. For example, Dr. Vargas commented:

> These types of programs (Healthy Municipalities) function very well if there is good communication between the authorities, the institutions, and the population. If the three are in tune with each other, things improve. But many times what happens is that the work of the departments overlap or each one does their own thing in an isolated way. Or at times the people say - we are going to do this our own way.

All factors considered, Healthy Municipalities may not be equipped to generate the solutions necessary to overcome these barriers.

According to Sotelo and Rocabaldo (1994), local Healthy Municipalities projects tend to be selected because they are easy to execute, have low cost, provide quick results,

and have the capacity to mobilize people (Sotelo and Rocabaldo 1994). During the time that I conducted fieldwork in Yautepec, the municipal administration completed the following health projects as an outcome of the program – they opened up a canine unit, fumigated the market for rats, conducted sanitation inspections in the market, promoted house cleaning to prevent the proliferation of deadly fauna, gave talks in schools about canine responsibility, and organized trash collection with private services. These projects are typical examples of what Rodríguez (1997) defines as "lightweight activities that require no lump sum investment and that fall unequivocally within the aegis of the municipal president" (p. 120). Such projects involve little community participation and only address the surface of community health problems. Until residents see that the government is taking their "real" concerns seriously, it is possible that Healthy Municipalities will continue receiving little support from the population.

Conclusions

The Healthy Municipalities case study illustrates how international health agendas are imposed on local populations via government bodies with little consideration for their interests, needs, or realties. This disconnect between government officials and local populations calls into question decentralization strategies that are viewed by international health agencies as the panacea for adjusting the organization of health systems to be in line with local social needs (Evers and Juárez 2003). Furthermore, the limited power that municipalities have despite reforms that have created the "autonomous municipality" ("*municipio libre*") reveals the die hard nature of centralism in Mexico. As Laurell (2001) argues, even though decentralization theoretically allows local governments to

have more autonomy, in reality the basic conditions of centralization have not changed – the federal government continues to control health program content, investments, size of the budget, the hiring of new staff, and collective bargaining agreements. Rodríguez (1997) goes as far as to assert that contrary to the priorities of state reforms, decentralization is used as a strategy to not have to democratize.

Just as decentralization strategies are situated within a deeply rooted centralist culture, so too does the rhetoric and practice of community participation exist within wider fields of power. As scholars point out, while "participation" may have the potential to challenge patterns of dominance, it is more likely to be a means through which existing power relations are entrenched and reproduced (Nuijten 2002). As the case of Healthy Municipalities demonstrates, rather than motivating genuine citizen involvement in health, the program instead appears to reproduce government power structures while persuading and indoctrinating citizens in a neoliberal discourse that justifies state withdrawal and emphasizes citizen over government responsibility for the management of health resources. Thus, while the right to social security and health care declines, the timely rhetoric of prevention and community participation places the burden on municipalities and citizens to resolve emerging health problems despite the fact that neither the municipality nor its citizens have the power to determine community priorities or the resources to address them. It is not surprising then that many individuals are organizing outside of formal health structures, often through grassroots groups, and taking part in a growing movement that critiques "top-down" approaches of government health care while striving for more horizontal means of involving participants.

CHAPTER FOUR: THE PUBLIC HEALTH SECTOR: A VIEW FROM "ABOVE"

> "Everyone knows that if there is health, there is progress. And if there is not health, well, there is no progress. Here in Mexico health system reform is urgent." – Director of ISSSTE, Yautepec

Mexico's public health care system has weathered a myriad of economic challenges and political shifts over the last decades, as discussed in Chapter 3. New challenges continue to emerge as the user population grows, the disease burden shifts, and funding is increasingly insufficient to meet the country's health needs. In this chapter, I explore a range of perspectives expressed by municipal government officials and health care authorities regarding the current status of public health care in Yautepec and challenges that public institutions (IMSS, ISSSTE, SSA) face. I consider how structural problems are overlooked by government officials who focus largely on individual prevention efforts. The chapter suggests that shifting the blame for health care decline from the state to the individual may help perpetuate, rather than resolve, the conditions that maintain inefficient and inequitable health service delivery.

An overview of government-sponsored health care in Yautepec

As I described in Chapter 3, the social security system (specifically IMSS and ISSSTE) is designed to meet the health care needs of the working class. IMSS and ISSSTE operate from individual dues, employer fees, and state budgets. Enrollment in a social security institution means that the individual and his/her immediate family have free access to health care at primary-, secondary- and tertiary- level social security institutions. Members are also eligible for a wide array of benefits including pension, disability, and maternity coverage. Currently, the insured pay a fixed percentage of their

annual income to be enrolled in a social security institution. Although individuals who do not qualify for IMSS through their employer may purchase IMSS insurance at a cost of about $2300 pesos per year ($230 USD), few people choose this option. While IMSS and ISSTE health care facilities only serve social security members, physicians have an obligation by law to attend anyone in the case of emergency.

In Morelos, 45% of the population is insured by the social security system. In contrast, only 22% of Yautepec's population is enrolled with IMSS (15%) or ISSSTE (7%) (Secretaría de Salud 2003). The low enrollment of Yautepec residents in social security institutions (IMSS and ISSSTE) means that most of the population must rely on either social assistance facilities or pay out of pocket for private health care. The Ministry of Health (SSA) provides health care for the uninsured population through its social assistance system (although the insured may use SSA facilities as well). The social assistance system is funded by taxes and more recently by user fees. Thus, all Yautepec residents have access to SSA clinics, from which they will be referred for secondary or tertiary care if necessary. The user fees charged at each clinic are firm, although they may vary from clinic to clinic. Hospitals require that patients pay but base the fee on a sliding scale.

In the public health sector, 12 primary care units are located in Yautepec, including nine SSA clinics, two IMSS clinics, and one ISSSTE clinic. The three largest public municipal clinics – the "Urban Health Center" (UHC-SSA), IMSS Yautepec, and ISSSTE – are located in the town of Zarragoza. The nearest secondary hospitals are located outside of the municipality, in the cities of Cuautla and Cuernvaca. The Morelos Children's Hospital, located 20 miles away in Cuernavaca, is the only tertiary-level social

assistance hospital in the state. Many Yautepec residents travel to Mexico City for tertiary care, which is about 60 miles north of Yautepec.

According to the director of the Urban Health Center, the UHC-SSA serves a population of about 90,000 people since it is open to all residents. However, not all residents of Yautepec utilize the UHC-SSA as we will see in Chapter 5. Yet, as the population increases, so too does the demand on the UHC-SSA. Many municipal residents travel to the town of Zarragoza to seek care at the UHC-SSA because the smaller municipal health posts, particularly in rural areas, are often understaffed and lack basic supplies. For example, seven of the eight other SSA clinics in the municipality are run by one *pasante* (fifth year medical students completing their year of social service), assisted by a nurse or nursing student. In contrast, the UHC-SSA employs four doctors, five contracted doctors, three dentists, nine nurses, five contracted nurses, and two health promoters (Miranda et al. 2002).

According to its director, the IMSS Yautepec clinic serves a population of 18,000 to 20,000 people. His staff includes six general practitioners, six medical assistants, six nurses, four pharmacy assistants, one dietician, two social workers, and one emergency doctor. The Yautepec IMSS clinic was recognized on a national level in 2003 as one of the top clinics in the nation for its high quality of service (Secretaría de Salud 2004a). The ISSSTE clinic serves a population of approximately 8000 people and employs three doctors, two nurses, and one social worker.

Relative to the populations they serve, the IMSS unit is far better staffed than the UHC-SSA facility. Whereas the UHC-SSA employs 29 medical staff members for 90,000 people, the IMSS employs 26 to cover less than one-forth of the population served

by the UHC-SSA. The ISSSTE clinic is less well-staffed, relative to IMSS, with only six staff members to cover a population of 8000.

Although in theory, all Yautepec residents have access to at least minimal services, a recent Municipal Health Diagnosis that was conducted by the Ministry of Health and the municipal government of Yautepec (Miranda et al. 2002) suggests that "medical coverage is insufficient for the population." The report states that clinic hours are irregular; supplies (particularly medicines) are in short supply; and medical personnel are without professional development options "which has caused an exodus from professional activity in search of a more lucrative living" (p. 72). It also states that the accessibility of services are limited, particularly during the middle of the night when even in the case of emergency, a resident may wait until the morning to receive the necessary medicine and treatment. The report details the lack of emergency services in the municipality, specifically the absence of any general hospital or specialist working in public facilities. Because emergency resources are absent, patients must travel outside of the municipality to search for a solution to their health problem. Moreover, five pueblos in the municipality are without the most basic health care services.

Some of Yautepec's health care shortcomings reflect resource shortages on the state level. For example, in a ranking of health resource availability among the 32 states in the country, the Ministry of Health ranked Morelos second to last in terms of the number of hospital beds available to the population (Secretaría de Salud 2004b). On a national level, there are 84 hospital beds available for every 100,000 residents while Morelos has 55.7 beds for every 100,000 residents. While nationally there are 111 doctors for every 100,000 residents, in Morelos there are 96 doctors for every 100,000

residents. In an analysis of health services in Morelos, Beccerril Straffon (2001) concludes that health services are not accessible to all sectors of the state's population, reflecting the large economic inequalities that exist between population groups. Furthermore, local clinics and state hospitals do not have access to the equipment and technology that is needed to respond to current health problems. He suggests that because of their small size, hospitals in Morelos do not have the necessary technology to effectively attend to current needs, much less future needs.

To better understand the challenges that Yautepec faces in attempting to distribute sufficient health care to the municipal population, I now turn to examine perspectives of some of the officials who manage health care units for the municipality and administer the local health sector. I conducted interviews with the clinical directors of the SSA Urban Health Center, IMSS clinic, and ISSSTE clinic; three Yautepec municipal council officials (the municipal president, the health coordinator for the municipal council, and the president of municipal health committee); and three state-level Ministry of Health officials (in the departments of health promotion and reproductive health) to explore a range of perspectives on these and other challenges, particularly as they relate to the national health reforms discussed in Chapter 3 (see Chapter 2 for details regarding data collection methods).

Health service delivery and health sector reforms in Yautepec

A view from IMSS and ISSSTE

The social security and social assistance branches of the public health sector are undergoing significant change in response to policy, demographic, and epidemiological

shifts. The social security branch (IMSS, ISSSTE) is arguably in the midst of its most profound transformation in decades, given the national efforts to privatize the system. As I discussed in chapter 3, the Ministry of Health was placed in charge of coordinating the public assistance and social security branches in the 1990s. This has limited the power and regulating abilities of IMSS which was once the most powerful public health institution. Health sector reforms have also stimulated a gradual process of corporate restructuring in IMSS which has meant that health funds are to be handled by private managed care organizations (MGOs) which will eventually provide direct services to the insured populations.

As these shifts occur, IMSS and ISSSTE are gradually losing their wealthy clientele who can afford private health insurance. Along with their clientele, IMSS and ISSTE are losing essential financial resources (i.e., client dues) that have historically helped to fund the institutions (Laurell 2001). These problems come after a decade of financial hardship due to the economic downturn of the 1980s when a decrease in government funding caused a significant decline in social security clinics and hospitals. The resulting erosion of user support, lingering resource insufficiency, changing demographics, and shifting illness patterns are among the many problems plaguing social security clinics today. In my interviews with the directors of the IMSS and ISSSTE clinics in Yautepec, it became apparent that the everyday challenges of managing a growing and changing user population are at the forefront of their minds, while the implications of policy changes have them and municipal officials braced for the worst.

According to the director of the ISSSTE-Yautepec clinic, Dr. Avilés, the stagnant economy is forcing people who would otherwise use private services to utilize their

social security health benefits. As a result of the increasing user demands, the resources at ISSSTE are stretched to their limit. Dr. Avilés explained:

> Before in Yautepec we had fewer people that came for consultations. There were days in which we did not fill our consultation quota. But for the last year, all of our appointments have been filled. Even those in the afternoons fill up. These days, people without appointments will come and wait. Because of this population growth, we have to accomplish more with the resources that we have.

The director of the IMSS-Yautepec clinic, Dr. Palacios, pointed to similar problems within his IMSS unit in relation to the growing user demand. He not only mentioned the growth of the user population but also the problems he has tracking the changing user population because of an inefficient and outdated system. As he explained:

> This unit is small. We serve a population of 18,000 to 20,000 people, but that is growing. And it is constantly changing – those who lose their jobs, those who are discharged, those who are fired. It is a joke to try and keep track of them because we don't have an automated system. Everything is done with cards. There are no computers.

In fact, at the time of this study, none of the municipal health clinics in Yautepec had access to computers and computer systems. Instead, they utilize user access cards to admit patients and paper files to track health records. This is problematic because patients may use a variety of public facilities in both the social security and public assistance sectors. Without a central management system, these health centers have no way of coordinating patients' medical records and needs.

In addition to the challenge of tracking the changing user population within their own institutions, the IMSS and ISSSTE units have problems with being able to identify social security recipients who do not have their user access card in hand. The Yautepec residents I spoke with shared numerous stories about their fruitless attempts to be seen by

an IMSS doctor when they did not have their access card with them. These inconveniences and inefficiencies appear to contribute to the overall level of social security user dissatisfaction. However, the clinical directors and their employees have little power to resolve these systemic problems without an overhaul of the tracking system.

In addition to the problems voiced by the IMSS and ISSSTE directors I interviewed relating to increasing demand and systemic inefficiencies, social security clinics face mounting problems associated with the rapid epidemiological changes affecting their user population. Dr. Palacios of IMSS explains how the epidemiological shift has an impact on health services:

> With the population growing there are more chronic problems; as people live longer, we have more chronic degenerative problems – diabetes, hypertension, heart disease, accidents, cerebrovascular problems, hepatic cirrhosis, uterine cancer. But we have a significant lag in diseases of poverty. Although they have diminished, people still die of diarrhea and malnutrition and there are emerging problems like HIV/AIDS. Morelos has had one of the most rapidly growing HIV/AIDS rates in the nation in the past years. Health promotion is not impacting adolescents in prevention, as far as sexually transmitted diseases are concerned.

In light of this epidemiological shift, the IMSS and ISSSTE directors both explained how important prevention is within their institutions. For example, IMSS runs a program called PreveIMSS that focuses on prevention. PreveIMMS coordinates prevention activities geared toward different age groups. For example, PreveIMSS distributes health booklets and a "self-health care guide" which outlines a range of suggested health prevention actions (i.e., nutrition, breast self exams, accident prevention). Education is a central component of prevention programs. As Dr. Palacios of IMSS said, "Giving education to the people is prevention; shelter your children, give

them a lot of fruits, vegetables. Go to your doctor periodically to control a healthy child."

Dr. Avilés of ISSSTE suggested that "culturally, there is a deficiency in preventative health behaviors." Much of this, he argues, has to do with the strong transnational influences that are shaping Mexican health practices. He explained that Mexicans are being drawn to American consumer values that encourage drinking sodas and eating chips rather than relying on the plentiful local fruits and vegetables that are accessible and affordable to all residents. He said:

> We are not against these transnational influences. But imagine what you are wasting by ignoring the fallen lemons, melons, pineapple, watermelon, seasonal fruit that is not very expensive. With what you use to buy two liters of coca cola that costs $15 pesos, you can make 20 liters of prickly pear water, a million things more cheaply that are healthier. This is what we are talking about, the culture that is lacking here.

To address this "lacking culture" of prevention, ISSSTE focuses significant attention on illness prevention and health promotion programs. According to 2004 statistics, it conducted 45,057,985 "preventative health actions" in its primary care clinics throughout the country (ISSSTE 2005). For both preventative and curative services, the directors of IMSS and ISSSTE say their beneficiaries are fortunate to have access to health care that is free of charge, particularly as compared to the uninsured who must pay user fees to access SSA clinics. In fact, both directors are critical of the charges that the SSA has adopted for their user population particularly since they affect the most impoverished populations. The directors each contrasted the user fee requirement at the SSA facilities with their policies of providing free health care and medicines to their user populations. As Dr. Avilés of ISSSTE explained:

> The people here in Morelos who have the most problems are those who do not have an affiliation with any institution. They are suffering from the socioeconomic situation of the health sector. And now, because of the same economic situation that the country faces, Salubridad (SSA) charges a symbolic fee for what used to be free throughout people's lifetimes. In ISSSTE and IMSS, consultations continue being free.

Dr. Avilés explained that those with IMSS and ISSSTE are better off because they do not have to spend money on their health services – the most that they have to lose is time waiting for a consultation.

> Imagine one *campesino* who has four or five children and due to misfortune his children get sick with diarrhea, which is very common. They go to Salubridad (SSA) which will attend to them. But Salubridad, for whatever reason, does not have medicines at that moment. He will suffer because he doesn't have the money to buy medicines. Those insured by IMSS and ISSSTE do not have this problem because, for better or for worse, they will receive a consultation and medicine. Therefore, the only thing they lose is probably a few hours or a little more if they have to get up early to make an appointment. But fortunately, their health problems get resolved.

Despite the advantages that social security beneficiaries have, Dr. Avilés concedes that even the ISSSTE has problems in maintaining sufficient supplies for its patients. He explained that since there are more people coming to the clinic for consultations now, "the medicine at times runs out a little earlier than it should." Since Yautepec residents told me about chronic medicine shortages at social security clinics, I asked Dr. Avilés if he felt that there were sufficient medicines to address the health problems that he sees at the ISSSTE clinic. He responded:

> It would be very dishonest if I told you yes. But we are getting help from the authorities and we realize that we have a 20 or 15 percent shortage, but we are providing 80, 90 percent coverage of medical attention and medicines. We have a problem that the entire world is facing, but the problem would be larger if we had a deficit of 80 percent and only had funding for 20 percent of our activities. We are almost achieving our goals, and we keep trying to move forward.

When I posed the same question to Dr. Palacios of IMSS, his response was markedly different. He said, "Not that I mean to boast about the Institute, but now it is putting forth great effort to maintain an almost constant supply of medicine. Now the medicines are arriving and we have a good supply to cover the consultations." He explained that IMSS-Yautepec can draw from the medicine stock in the Cuautla and Cuernavaca IMSS facilities. He compared his steady supply with the chronic shortage in the UHC-SSA and suggested that this shortage siphons off resources from his clinic.

> For example, in the night, when Salubridad (SSA) does not have anti-scorpion serum, everyone comes here regardless of if they tell you that we don't attend to them. IMSS doesn't charge for it; emergency medicine is given out in great quantities. We don't cover anything. And when Salubridad is almost emptied out, they all come to us.

In this comment, Dr. Palacios criticized the SSA policy of charging for medicines while emphasizing that the IMSS will give them to patients free of charge. In the same conversation however, he questioned if the IMSS was "underselling" itself by not charging for medicines, especially when it serves the uninsured during emergencies. This contradiction seems to capture the dilemma that the social security sector faces as state reforms open up the health sector to greater competition and privatization. Dr. Palacios expressed this dilemma in the following statement:

> The government wants to be more like Chile with its involvement of private businesses, its increased competitiveness of services, and improved efficiency. Here we are confronting this situation of increasing competition. Social Security is one of the largest institutions with many resources for our people – structural, physical as well as human resources. But people often say – 'now IMSS is a burden. We can't use it any longer, it is better to go with a private business.'

As this comment suggests, the country's momentum towards privatization has impacted the way in which residents view "old" institutions such as IMSS. The president during the time of this study, Vicente Fox (2000-2006), a member of the right-winged

PAN party, has championed the goal of privatizing social security. The privatization of IMSS is an extremely polemic issue in Mexican politics. For example, the acting municipal president of Yautepec, who belongs to the PRI party, blames the Fox administration for pushing reforms that he feels will have a detrimental effect on his municipality. In our interview, he raised specific concerns regarding the financial impacts of the privatization of IMSS:

> We did not have problems until three years ago. Vicente Fox came into power and he wanted to privatize Social Security; he wanted to privatize the schools; he wanted to privatize electricity. If IMSS is privatized, who is going to pay for a doctor? How much does a (private) medical appointment cost when, for 200 pesos ($20 USD), Salubridad (SSA) will see a patient with a scorpion bite or a grave illness. We had an accident with a transportation police officer recently, a municipal worker. We admitted him to IMSS and they charged him $110,000 pesos ($11,000 USD). He didn't have IMSS. Imagine a person, or this guy. How is he going to go to pay $110,000 pesos? Not in 10 years could he pay it off.

This comment points to the grave concerns that some citizens and politicians share regarding the proposal to privatize social security. The most significant concern is that privatization will result in greater inequalities in access to health care than already exist. As Congress debates the privatization of social security, the public increasingly views the IMSS as a national burden. In response to this view, Dr. Palacios said that the IMSS has plenty of capacity to give the people excellent service. Yet he acknowledged the many obstacles that IMSS faces in serving the population including "the population's attitude towards IMSS services." Thus, in addition to managing the everyday problems associated with a growing and changing user population, administrators of social security facilities in Yautepec must also negotiate the political and practical implications of policy changes that are slowly shifting the way in which health care is perceived and how it will ultimately be managed in the municipality.

A view from the SSA Urban Health Center

While Yautepec health units within the social security sector (IMSS and ISSSTE) face a myriad of challenges relating to corporate restructuring, social assistance (SSA) units must negotiate a different series of challenges. These challenges relate to decentralization policies, which give the municipality greater authority in managing public health resources, while limiting the amount that local governments have to spend. The most immediate challenges that the Urban Health Center faces are due to population growth, which has placed inordinate pressure on SSA clinics which are responsible for addressing the primary care needs of the uninsured. Taking a historical perspective, Dr. Martinez, the director of the SSA Urban Health Center, reflected on the changes that have occurred over the course of 30 years. As he explained:

> The Urban Health Center has a catchment of approximately 90,000 people. Before, we were a small "casa de salud" (health post) as they called it, where there was a doctor, a nurse and an administrator. Thirty years ago, there was nothing more than us [and the clinics] in Cuautla and Cuernavaca which offered a bit more service. We are crammed now with a large number of people, and there are more and more people all the time. And here in the health center, we keep dividing ourselves internally rather than extending the facility or creating another building. The needs are surpassing our resources.

Dr. Martinez explained that the only way to cope with the problems at hand was to expand staff responsibilities and to request municipal resources when possible. He explained that because of the resource shortages in the clinic, he must ask the municipal president for personnel who can help fill in the gaps at the center. He also asks the municipal council for medicines and potable water to fill the cistern "since we provide service day and night and the water runs out rapidly." Because emergency situations require that the UHC request ambulances and drivers from the municipal council, Dr.

Martinez emphasized that the coordination with the *presidencia* must be "very strict, cordial, and rapid in order to get the wounded, gravely ill and children quickly transferred to hospitals." Thus, coping with resource insufficiencies and providing emergency care requires that the UHC rely on the local government for help. This is not the case for the IMSS and ISSSTE, who do not rely on municipal resources, but rather can count on government funding and contributions from employees and workers.

In addition to its dependency on the local government for personnel, emergency support, and medicines, the UHC-SSA also receives its operational budget from the municipality. As I explained in Chapter 3, state reforms in the 1980s guaranteed that municipalities receive fixed sources of revenue that allow them to provide public services to their communities. The resources they receive are largely dependent on state and federal entities that calculate municipal budgets based on the number of citizens and taxes collected. Municipalities rarely collect property taxes, although this is a principal source of potential income, since increasing tax rates and revising property values are politically unfavorable strategies. Thus, municipalities are ultimately dependent on the state for their budgets, which are often not sufficient to meet the needs of the community. As the municipal president pointed out:

> The money comes from the state. It is from the federal government, and it is the House of Representatives that decides how much to send, based on the number of residents. They send the resources from the taxes that we pay; this is how it is. For this reason they send very little money. There are not sufficient resources for the needs of the pueblo. They just don't exist.

The president pointed to citizen failure to make tax payments, suggesting that if more people paid their taxes, there would be more money for the municipal government to invest back into the community. A municipal council member I spoke with suggested

that the problem of resource insufficiency is aggravated by the "irresponsibility" and "apathy" of the administration, whose responsibility it is to distribute municipal resources. She pointed to two significant issues that exacerbate the resource distribution problem. First, since resources are distributed through political parties, they often follow political interests and agendas, rather than community needs. Moreover, if there are not sufficient resources to address a problem "then the problems don't matter to them (council members), they don't interest them." In other words, resource insufficiency generates a lack of political will among administrators.

From the perspective of Dr. Sotelo, a state-level Ministry of Health coordinator who works in the department of Reproductive Health, the decentralization policies that were implemented to give states the legal right to distribute federal budgets to municipalities have created apathy from above since the federal government can wash its hands of responsibility once it allocates the budget to the states. As Dr. Sotelo explained, state health programs face budgetary shortages just as do municipal programs. He said:

> The reforms say that we are decentralized. And every state can act freely for what we believe is important. But the federal government says: 'Finally they are free. Congratulations! I will send you your budgetary share. So long.' But that is not sufficient, we need more. This is the problem – the distribution of too few resources to run all of our programs.

According to Dr. Sotelo, a further contradiction of decentralization policies is that states have little autonomy to do much more than replicate national programs and invest in national priorities as identified at the federal level. Thus, even though states are theoretically given the freedom to address local needs through health programming, they must ultimately follow the guidelines of federal programs. In other words, while decentralization policies have theoretically given states and municipalities greater control

over their budgets, these policies have ultimately increased their dependency on a centralized federal government. Problematically, there is a mismatch between what the laws say and what happens on the ground. As Dr. Sotelo suggested, "Culturally, Mexico is centralized while legally, no. Legally, they say that we are decentralized."

An important component of decentralization strategies as applied on the local level is community participation in the management of health resources, as was discussed in Chapter 3. Community participation is expected by the Mexican government on various levels. The most obvious form of participation is financial, in the form of taxes and SSA user fees. Community participation is also expected in the management of health resources, through assistance in health committees, clinics, neighborhood projects, health education, and health promotion efforts. The director of the UHC-SSA feels that the implementation of user fees in the social assistance sector was an important step to help address the resource shortages in SSA clinics. He suggested that overall, people are cooperating and paying their fees and they are not "making a fuss." However, he added that the UHC is growing beyond what the fees can cover, and he hopes "the authorities" understand the extent to which the general population is demanding health care.

The municipal council health coordinator, Dr. García, who is responsible for the administration of health programs in the municipality, feels that user fees are essential for involving patients in their own health care, decreasing their dependency on public health services, and decreasing governmental paternalism. As he explained:

> I think the fees are important because we have to put an end to paternalism. Whatever you seek out, if it doesn't cost you anything, you are not going to value it. Therefore, moderate costs in accordance with what people can pay are very important. What is most important is that people get on board, that people understand how to care for their health. It is not possible to have a doctor for everyone, it is just not possible.

Each of the municipal health officials I spoke with shared this perspective– that individuals must contribute to help resolve the health care problems that plague their municipality. These health officials discussed the importance of decreasing residents' dependency on public health institutions by shifting the focus from curative to preventative health care. However this prevention discourse often took on a "blame-the-victim" tone which presented individuals as ignorant, overly dependent on government services, or uninterested in improving their own health. For example, Dr. Soltelo, a Ministry of Health official explained:

> I can tell a patient – I need you to buy this medicine – he is sick. He needs the medicine. And he says, give it to me, supply it for me. Sometimes the government does not have enough (medicine). But if you say to a patient – today the supplies didn't last, today they ran out, today I don't have any for you – the patient won't go and buy it for himself. His way of thinking does not allow him to understand that the medicine is important for him to get well. He walks in the office three days later – 'Señor, how are you?' 'Worse.'

This statement generalizes about patients' culture, suggesting that they refuse to follow appropriate health actions because of their "way of thinking." Culture is also drawn upon by health officials to explain patients' dependency on government health care. For example, one Ministry of Health official said, "We have a culture of running to the doctor when we are sick. But when we are not sick, we don't pay much attention to health." The solution, according to Dr. García, the municipal health coordinator, is prevention:

> The majority of people think that having hospitals and health centers signifies having health and this is completely false. This is having illness. I don't believe that if we fill up our health centers, or put a health center in every *colonia*, or put a hospital in Oaxtepec, another in Cuautla, another in La Joya, that we are going to resolve the problem. We need more prevention. We need to be educated, right?

Education was cited repeatedly in my interviews as a central strategy for spreading the message about prevention. All of the medical personnel I spoke with discussed the importance of preventative measures like early cancer screening and vaccinations. However, according to Dr. Sotelo of the Ministry of Health, while the doctor is an educator, patients only judge the contributions of the doctor based on the efficacy of the treatment. As he explained:

> We (the state of Morelos) have an excess of health centers according to the plans. We have more centers than necessary, but the perception of the people is that no, there are too few. Then, we come back to the concept of local illness, and we clash. The people don't understand what a health center is. A doctor in this country is seen as a healer, only to heal, but they don't see you as an educator, a teacher, someone who communicates with you. We teach our people that (health care is) not only about curing illness but about their education.

While it is logical that patients should appreciate their doctors as educators as well as healers, biomedicine in Mexico, as elsewhere, has historically focused on the curative aspects of health care to the detriment of prevention. Moreover, doctors' focus on education is not always a priority since their most immediate task is to help patients resolve their health problems. The tension between healing and education is well illustrated by the promotion of the "essential interventions package" mentioned in Chapter 3, which SSA clinics are expected to offer to their patients. This package consists of 12 basic preventative and curative interventions, including basic household sanitary measures, family planning, vaccinations, and Pap and breast exams. SSA doctors are supposed to educate their patients about these interventions and invite them to partake in them when they come to the clinic. But as Dr. García, the municipal health coordinator explained, "This is what we are supposed to do in theory, but we don't do it. They come because their throat hurts, we examine them, we give them a prescription and

– see you later. There is a lack of promotion of these programs." In other words, the curative aspect of doctors' work takes precedence over prevention.

One reason why these interventions are not proactively introduced to patients is that the SSA may not have the resources available to provide them to all of its patients. For example, according to Gómez-Jauregui (2001), the resources allocated for early cancer detection in Morelos in 1996 provided funding for less than three and a half million Pap tests, while more than 16 and a half million women were being targeted. This is a shortage of resources for over 75% of the targeted population. Thus, while doctors are expected to educate and invite clinic users to partake in preventative interventions, the system may hardly be prepared with the resources necessary to follow through with the actions. The prioritization of health programs "from above" arguably contributes to these problems of resource insufficiency. As Dr. Pedro, director of the UHC-SSA explained, every time the federal administration changes, new priorities are established on the national level and programs get cut. Explaining this problem, Dr. Pedro said:

> Every six years a president comes in with his plan, then another with his plans. But there are plans that were good that if they were continued, we would have extraordinary results. Now the program of Vicente Fox is "Opportunidades."[1] And we are doing this, but as soon as the PRI comes again, or the PRD, they will say, 'Now we are going to do this.' I think we need to strengthen, not get rid of programs.

In light of these many challenges and despite the effort on the part of the SSA to make at least basic health care available to the uninsured population, numerous obstacles prevent local health systems from achieving their goals of greater efficiency and health

[1] Opportunidades is a social program that was actually introduced in 1997, during Zedillo's presidency. The program involves subsidies for the poor towards nutrition, health and education. By 2000 (the beginning of President Fox's term), 2 million families were served by Opportunities and by December 2004, 5 million households were enrolled (IDBAmérica 2004).

care quality. The SSA has introduced an essential package of health services and decentralized the management of local health care to the municipality. Still, it appears that the problems of resource shortages, high user demand, and a lack of emergency services make this goal increasingly unattainable.

Public health sector challenges in perspective

As this discussion demonstrates, municipal health officials face a myriad of difficulties as they deliver health services to the population. In the SSA Urban Health Center, the demands of patients are outpacing the available resources. In the ISSSTE clinic, the user population is increasingly dependant on their social security benefits as the economy stagnates, straining available resources. The IMSS clinic director points to an inefficient system that hampers the ability of his clinic to meet the needs of the insured. These are only some of the problems that primary care health units face on a daily basis, while there are other more urgent problems, such as the complete absence of emergency services in the municipality.

Health sector reforms have been implemented by the Mexican government to increase the efficiency of health services. Efforts to privatize social security seek to achieve this goal by introducing greater competition into the health care market. However, some officials I spoke with expressed concern that privatizing IMSS will only increase the cost of health services and generate greater inequalities in health care. Decentralization strategies have been introduced by the government to achieve greater health system efficiency by granting more power to the municipality to distribute budgets and manage health resources. Yet, critics say increased municipal responsibility without

sufficient resources has contributed to underfunded programs, a lack of political will, and apathy from above. Under decentralization, state and federal governments can wash their hands of responsibility once they have distributed the municipal budget, raising questions of accountability in terms of the needs of the public.

These problems play out in local clinics where administrators and health practitioners must do more with less, while following the mandates of national health policies. The result is that patients are being asked to fill in the gaps of a declining system through user fees without improving their health facilities or increasing the stock of medicines available. One Ministry of Health official summarized the problem best when he said, "The population is growing and the problems are increasing. There are not sufficient economic, human, or material resources. There are always insufficiencies. And at times, the little that exists is not made use of in the best way."

My interviews with health officials suggest that prevention is being promoted as the panacea for many of the problems faced within the health sector. It appears that by placing greater focus on the individual, health officials avoid the systemic problems that need to be addressed. Moreover, the discourse of prevention often takes a blaming tone, explaining poor behaviors in terms of patient "culture" or lack of education. I found this discourse not only in the interviews I conducted but also in health reports I reviewed. For example, the Municipal Health Diagnosis (Miranda et al. 2002), which evaluates health and health care services in Yautepec, refers to education and culture numerous times to explain poor health outcomes. The following excerpt is taken from the diagnosis:

> The primary problem that conspires against the health of the people is a *lack of general education and more than anything, education related to a culture of hygiene.* If we take into account that 14 percent of the population older than 15 years is illiterate and that 38 percent have not received secondary education, we

> confront the sad reality of a population where *51.7* percent *do not possess the necessary knowledge that will permit them to have habits and norms of a healthy lifestyle* (italics added).

While education clearly contributes to health outcomes, a lack of education alone does not explain why people suffer from malnutrition, respiratory infections, and chronic illnesses. Other factors that may contribute to these problems include poverty, substandard housing, insufficient trash collection and uncontrolled demographic growth. Furthermore, substandard health care, limited emergency services, and the lack of well-trained public health professionals may aggravate the health problems present in a municipality. Rather than addressing these structural issues, the municipal diagnosis concludes that "it is necessary that individuals, families, and the community achieve a change of attitude in modifying the risk factors, with priority on vulnerable groups" (p. 91-92). In this case, prevention discourse advocates attitudinal change rather than promoting change on individual and structural levels. Indeed, as Carolina and Gustavo (2003) argue, health officials hide behind the discourse of prevention to veil their failure in achieving sufficient medical coverage for their population. Yet by carrying out discourses of blame, these authorities may contribute to the perpetration rather than the resolution of the conditions that sustain inefficient and inequitable health service delivery.

Conclusions

This chapter has considered a range of perceptions of municipal and state officials on health service delivery, the local impact of health reforms, and solutions to current health system problems. I have considered what officials within the social security

(IMSS, ISSSTE) and social assistance (SSA) branches of the national health system perceive to be central challenges within their institutions. In addition to looking at the day-to-day challenges that clinical directors and municipal government officials face in managing local health institutions and systems, I have drawn attention to the implications of health sector reform policies that emphasize privatization and decentralization strategies. In the next chapter, I explore the health seeking behaviors of a sample of Yautepec residents and examine their perspectives regarding the quality of government-sponsored health care.

CHAPTER FIVE: PUBLIC HEALTH SEEKING: A VIEW FROM "BELOW"

In this chapter, I outline the public and private health care options that are available to Yautepec residents. Using survey and interview data, I explore how women in this study make decisions when choosing health care service providers, and I outline their concerns regarding the quality and quantity of public health services, specifically IMSS and SSA. This chapter reports on perceived gaps in government sponsored health care and considers why municipal residents may be turning to private health care options instead, including alternative health services like those provided by the community health groups that are the focus of the later chapters.

Health care options in Yautepec

As I mentioned in the previous chapter, the social assistance (SSA) and social security (IMSS, ISSSTE) branches of the public health system provide health care coverage meant to meet the basic health needs of all municipal residents. Individuals who are "insured" through IMSS or ISSSTE receive their services for free, although a monthly premium is withdrawn from their paycheck by the institution to which they belong. SSA services cover the "uninsured," although anyone can use any SSA primary care clinics and general hospitals. SSA services require a user fee which averages about $2 USD for a general consultation and $6.50 USD for hospitalization.

In addition to public health services, Yautepec residents also have access to various private health care options. Private clinics are in abundance in urban areas in Yautepec although they are far less numerous in rural areas. Private clinics offer a range of services including family medicine, gynecology, dentistry, optometry, and a myriad of

alternative health services like chiropractics and homeopathy. Consultations with private medical physicians and established alternative medicine practitioners usually range from $10 - $40 USD. Some doctors however, charge on a sliding scale or allow their patients to pay when they can. For example, one medical doctor mentioned by numerous interviewees allows her patients to pay their bills when they have the money. As a result, this doctor is extremely popular in the neighborhood in which she works. In general, Yautepec residents with whom I spoke consider private medical services to be expensive, but usually worth the cost.

One health care option that is inexpensive and very popular among Yautepec residents is the *Similares* Pharmacy. *Similares* contracts resident physicians to work in a small clinic that adjoins the pharmacy. A brief consultation at *Similares* costs $2 USD. Residents with whom I spoke often describe *Similaries* as providing "good, quick" consultations. Because prescriptions are not necessary for many pharmaceutical purchases in Mexico, people often bypass the consultation and purchase their medicines without prescriptions. Since *Similares* sells generic drugs, their prices are typically the lowest in town. However, some residents I spoke with believe that generic drugs are less effective than brand name drugs and thus they may choose to buy medicines from another pharmacy.

There also are a plethora of non-biomedical options in Yautepec. The most popular is the natural health store (*Botiquín*) located in the town center. A naturopathic practitioner conducts clinical consultations in a section of the store partitioned off by curtains. Patients are not charged for the consultation, only for the products that they purchase. *Botiquín* sells a diverse array of natural remedies in the form of teas, tinctures,

creams, and lotions as well as natural food products (soy, grains, legumes, etc.). Additionally, there is a smaller natural medicine store (*Farmacia Natural*) where patients can receive a chiropractic consultation or massage for $6 USD and purchase natural remedies. Natural remedies and herbal products are also sold in the municipal market and by roving vendors in town.

Many alternative health practitioners operate out of clinics or their homes and offer a range of therapies including herbalism, homeopathy, massage, acupuncture, and naturopathy (for a description of these practices see Appendix A). These practices are becoming increasingly popular since there are three schools in Yautepec that train health promoters in traditional and alternative medicine, which will be described in the latter half of the dissertation. Alternative health providers typically charge between $6-$15 USD for a consultation and treatment. Medically trained physicians also incorporate some of these therapies in their private practices. For example, one physician in Yautepec practices nine different alternative medicine modalities including acupuncture, chiropractics, and homeopathy, in addition to providing biomedical consultations.

Although traditional healers are most commonly utilized in rural communities (i.e., see Nigenda et al. 2001a), urban Yautepec residents also draw upon a wide range of traditional practices and practitioners. Some of these practices include herbalism, massage, symbolic cleansings, and purification baths (*temazcal*). The practitioners who deliver these services include herbalists (*herbalistas*), bonesetters (*hueseros*), healers (*curanderos*), massagers (*sobadores*), and midwifes (*parteras*). It is difficult to gauge how many of these healers live in the municipality, but I spoke with at least one person who had used each of the services listed above. Traditional healers may charge a set fee

for their services (typically under $5 USD), or they may provide their services in exchange for goods such as food. Herbalists are the most visible of traditional practitioners. They often set up posts in the municipal market to sell an array of fresh plants, roots, and barks which they typically purchase from larger markets in the cities. Residents will explain their symptom to an herbalist who will then prescribe a specific remedy and provide instructions for preparation.

An additional category of non-biomedical treatment involves faith healing. Although I never observed any ceremonies, I learned from interviewees that Pentecostal and Catholic groups in Yautepec conduct healing ceremonies in individuals' homes. Other interviewees mentioned a Spiritualist temple that offers healing ceremonies. My interviews suggest that information about these healing options is spread through word of mouth.

Health seeking behavior

In the following sections, I will draw from the results of a survey that I administered to 100 women in two neighborhoods in Zarragoza and from in-depth interviews that I conducted with 30 of these women (see Chapter 2 for data collection methods). The survey explores the health care actions that women took outside of the household for family illnesses during the six months prior to their interview. While I acknowledge that the majority of health actions take place in the household (see Kleinman 1980), my intention is to shed light on the health services that women and their families use outside of the home. See Table 5 below for demographic information on these two samples.

Table 5. Demographic information for survey and interview participants (female heads of households)

	Survey (N=100)		In-depth interviews (N=30)	
Indicator	**No.**	**%**	**No.**	**%**
Age				
0-24	4	4	1	3.3
25-44	59	59	18	60.0
45-64	31	31	10	33.3
65 +	6	6	1	3.3
Marital status				
Single	19	19	11	36.6
Married/free union	68	68	17	56.6
Widowed	13	13	2	6.6
Years of education				
None	3	3	0	0.0
1-4	42	42	7	23.3
4-8	47	47	21	70.0
9-12	7	7	1	3.3
College/graduate school	1	1	1	3.3
Profession				
Home	55	55	12	40.0
Informal sales	33	33	15	50.0
Domestic work	3	3	0	0.0
Factory employee	2	2	1	3.3
Professional	7	7	2	6.6
Access to health insurance				
IMSS	42	42	12	40.0
ISSSTE	12	12	1	3.3
Uninsured	46	46	17	56.6

The women who I surveyed have a higher level of social security access than the municipal average. Fifty four percent of the respondents have insurance with either IMSS (42%) or ISSSTE (12%). This high rate of insurance, which is more than twice the municipal rate of 22%, can be explained in part because I intentionally drew half of the sample from a working class neighborhood that houses many individuals who are formally employed.

The majority of women sampled (55%) work in the home. An additional 33% conduct informal sales to generate income. These activities typically include selling food in the town center, selling produce or goods at the market, or selling items like cakes, candy, clothes, purses, or school supplies on an irregular basis. The professional activities in which seven women are involved include teaching, dentistry, secretarial work, administration, and accounting. These women who have steady jobs are in the minority in this sample. The large majority (89%) have no more than secondary school education.

Because I drew the sample from two neighborhoods in Zarragoza (a working-class and a farming neighborhood) the perspectives of these women do not reflect the experiences of all women living in the municipality. This discussion provides context for what some residents are doing regarding their health care, how they feel about government-sponsored services, and why they might choose to pay for private services.

Health care usage patterns

To learn about the health seeking patterns of the women sampled, I asked each survey respondent to list the specific illnesses from which members of her family suffered in the six months prior to the interview. I provided them with a list of 12 health care options that I had derived from preliminary interviews and asked them which services they used during each of the illness episodes. I collected a total of 282 reported health care visits among the 100 households (an average of 2.82 visits per household). Table 6 below shows the health services used by those insured by IMSS or ISSSTE and by the uninsured during these illness episodes.

Table 6. Health seeking decisions based on insurance status (N=282 illness actions)

Service provider	Insured % of actions (N=144)	Uninsured % of actions (N=138)	Total % of actions (N=282)
Private health care	**48.7**	**62.3**	**55.3**
Private biomedical clinics	27.1	26.1	26.5
Similares Pharmacy	9.0	24.6	16.7
Botiquín natural health store	5.6	5.1	5.3
Alternative health care provider	5.6	4.3	5.0
Traditional healer	1.4	2.2	1.8
Social assistance (SSA)	**14.6**	**30.4**	**22.3**
Social security	**34.7**	**4.3**	**19.9**
IMSS	27.8	3.6	16.0
ISSSTE	6.9	0.7	3.9
Miscellaneous *	**2.0**	**2.9**	**2.5**

* This category includes medical visits that are free of charge because a relative works for the institution, is a municipal employee, or is in the military and receives health service benefits.

Over half (55.3%) of the total reported medical visits in this sample involved a private health care provider – either a physician in a private office (26.5%), a resident physician at the *Similares* Pharmacy (16.7%), or a range of alternative practitioners (10.3%) or traditional healers (1.8%). Less than a quarter (22.3%) of all health actions reported were brought to an SSA clinic, even though all of the respondents have access to SSA services. Less than 20% of the illness episodes were brought to an IMSS or ISSSTE clinic or hospital even though 54% of this sample has access to these facilities.

IMSS/ISSSTE beneficiaries. Respondents who have access to IMSS or ISSSTE services used these facilities for only 34.7% of the 144 illness episodes they reported. This group relied on private health services for almost half of their health actions (48.7%). While 36.1% of these services involved biomedical consultations, 12.6%

involved alternative or traditional health care. The group utilized SSA clinics for 14.6% of their reported episodes. Considering that this group has access to free health care at their IMSS or ISSSTE clinics and hospitals, it is surprising that they relied so heavily on private providers and SSA services. These data suggest that cost is not always the primary priority for this group when seeking out health care. In many cases, patients are choosing to pay for private health care services, within the biomedical and non-biomedical arenas. Having access to public services through IMSS or ISSSTE does not necessarily mean that patient will utilize these services when seeking treatment.

The uninsured. This group also presented the majority of their health concerns (62.3%) to private doctors. Over a quarter of their illness episodes (26.1%) were brought to private biomedical practitioners and over a quarter of the episodes (26.5%) were presented to doctors at *Similares* Pharmacy. As I mentioned above, private practitioners charge their patients upwards of $40 USD while consultations at *Similares* cost around $2 USD, which is roughly equivalent to the user fee for a consultation at an SSA clinic. It is surprising that a little over a quarter of these illness episodes were presented to private biomedical practitioners, considering that the uninsured are usually among the lower socioeconomic classes. Moreover, 11.6% utilized to non-biomedical practitioners to resolve their health problems, an issue I will address in the latter half of the dissertation. These data suggest that many uninsured residents are willing to pay the cost of private health care rather than using the public services to which they have access.

Table 7 below lists the types of complaints most commonly brought to public and private health service providers.

Table 7. Complaints presented to health sectors in order of frequency

Service provider	Symptoms	%
Private (biomedical)	1. Respiratory infection /cold-flu symptoms	34.4
	2. Chronic illness symptoms*	18.0
	3. Intestinal problems / infections	17.2
Private (non-biomedical)	1. Chronic illness symptoms	26.5
	2. Emotional problems / stress	14.7
	3. Muscular problems	11.8
Social assistance (SSA)	1. Respiratory infection/cold-flu symptoms	23.8
	2 Intestinal problems / infections	17.5
	3. Reproductive health	12.7
Social security (IMSS/ISSSTE)	1. Respiratory infection/cold-flu symptoms	25.0
	2. Acute infections/illness**	23.2
	3. Chronic illness symptoms	15.9

*These chronic illness symptoms most often related to diabetes, asthma, hypertension, heart disease, and cancer

** This category includes a variety of acute health problems such as hepatitis, typhoid, anemia, gallbladder infections, bladder inflammations, and kidney infections.

Although this chart is limited to the three most prevalent complaints presented to each health sector (with the private sector divided into biomedical and non-biomedical services), it is clear that the majority of illnesses reported involved respiratory infections, cold/flu symptoms, and chronic illnesses. A few important points need to be made here. The most common complaints presented to non-biomedical health care providers included those related to chronic illnesses, emotional problems, and muscular problems. This is not surprising since these types of symptoms cannot be "cured" by biomedicine. This point will be addressed in later chapters. The women in the sample most often brought acute infections and symptoms like hepatitis; typhoid; anemia; and gallbladder, bladder, and kidney infections to an IMSS/ISSSTE clinic. This may be either because these services and medications would be very expensive among private practitioners and/or because IMSS and ISSSTE have doctors who attend to emergencies, even if one is

uninsured. Women in this sample most often presented their reproductive health issues relating to menopause, cancer detections, and pre- and post-natal check-ups to SSA clinics. These services are offered free of charge to the population.

In sum, the basic trends suggested by Table 7 indicate that, among those sampled, 1) chronic illness is a primary reason for health seeking along with symptoms relating to respiratory and intestinal infections and 2) different health sectors may be called upon for different symptoms. In the following sections, I unravel some of these differences between the two public health sectors (IMSS and SSA). Moreover, to better understand why insured and uninsured residents are turning to the private sector, I will consider the perspectives of the women I interviewed regarding public health services in Yautepec.

Patient perspectives on public health services

The survey that I administered to 100 women included the following question: Do you think sufficient medical services are available and accessible to you and your family in the municipality of Yautepec? Twenty six women (26%) answered "yes" and 74 women (74%) answered "no." If the respondent answered "yes," I asked why she felt that there were sufficient resources. Typical responses were:

-They are sufficient because we have insurance
-The doctors provide good service and attention

However, 10 of the 26 "yes" respondents added a complaint about the health system when they were asked to elaborate their answer. Most often, these complaints centered around either a specific institution or the public health sector and focused on a perceived lack of medicines, negligence of doctors, poor quality of health care, and a lack of emergency services and equipment. Only 16 out of the 100 women surveyed

expressed unequivocally that public health services in their municipality are sufficient and accessible.

The 74 women who said "no," there are not sufficient and accessible medical services in the municipality were asked to elaborate what they felt was lacking. These women echoed many of the complaints listed above when elaborating. They either spoke specifically about IMSS, ISSSTE, or SSA or they spoke generally about public health care in their municipality.

Almost 81% of the 26 respondents who answered "yes" to the question have insurance with either IMSS or ISSSTE. Almost 45% of the 74 respondents who answered "no" have IMSS or ISSSTE insurance. While the majority of residents who are most satisfied with public health services are insured, almost half of the insured residents sampled are not satisfied with their services. In the following sections, I explore respondents' perceptions of public health care system inadequacies. I specifically examine perspectives regarding IMSS and SSA since the majority of comments were directed at these two institutions.

Social security branch: IMSS

As I mentioned above, IMSS and ISSSTE members are eligible for free health care services and medicines from their institution's clinics and hospitals. However, 24% of the 54 insurance beneficiaries surveyed chose not to use their insurance benefits at all during the six months prior to the interview. They instead relied on private services and SSA clinics. When asked about the quality of health resources in their municipality, the respondents who referred to IMSS most often discussed problems relating to 1)

medicines; 2) quality of medical attention; and 3) treatment of non-insurance holders, in that order of frequency.

When discussing IMSS medicines, the most prevalent concerns respondents mentioned were that IMSS does not give out sufficient medicines, doctors prescribe the wrong medications, and medicines are of poor quality. For example, describing the lack of IMSS medicines, one respondent said, "When you are looking for a medication, it is not there. When you don't need it, it is there." Another woman explained that "there are *never* any medicines." One interviewee alluded to her sense of mistrust of IMSS doctors when she said, "They recommend medicines but there aren't any. I don't know if they are hiding it or stealing it or what." A few respondents also shared the perspective that IMSS medicines are of poorer quality than pharmacy-bought medicines. Many women criticized doctors for prescribing the wrong medicines for their symptoms. For example:

> You have to wait forever and then they give you the same medicine for your cold as they give to you for your diarrhea.
>
> They will give you penicillin no matter what you have.
>
> The IMSS has three types of medicines that they give out and they give out the same medicines for all problems.

When I probed one interviewee why she thought there was a shortage of medicines, she explained that more and more people are going to IMSS and asking for medicines. She said that the population is growing in Yautepec while the amount of medicines is not being increased. The result is that people must buy their medicines out of pocket from a pharmacy when the IMSS does not have the medicines in stock. This can be costly considering that antibiotics, for example, may range from $100-$300 pesos ($10-$30 USD). One woman, who is a diabetic, said that the medicines IMSS gives her

make her worse, so she buys them from a private doctor and pays $300 pesos every other week for them.

While some women suggested that the medicines they need are not available at the IMSS clinic, others explained that doctors give them medicines that they don't need to placate their symptoms. For example, three of the women I surveyed mentioned that all doctors do is give out tranquilizers. As one respondent explained, "With any symptom, they will give you a tranquilizer. Only when an illness is really bad will they do a real exam." This accusation that doctors placate the patient rather than treat them has been noted by other anthropologists (see for example, Scheper-Hughes 1992).

Another common complaint voiced by women who have IMSS benefits relates to the quality of attention provided to patients. A range of quality issues were mentioned during the interviews – from poor service, incompetence and irresponsibility of doctors, to outright neglect. Some of the comments include:

> I don't use IMSS because they don't give good medicines and the doctor never arrives on time. There is a lot of irresponsibility there.
>
> I don't know if it is egoism, but they only do a quick exam and then give prescriptions and nothing more. For this reason, I go to private doctors.
>
> They only receive 20 patients a day and if you arrive late, they may not see you. If you come with an emergency, there is usually no doctor.

The woman who made this last statement told me that when she brought her six year-old son to the IMSS clinic because of an emergency, she noticed a sign that said "the doctor has gone to Cuautla." On another occasion, she brought her husband to the IMSS hospital in Cuautla because of kidney problems, and they were told that no doctor was present at the facility. "But we saw him sleeping" she said.

The more serious complaints that I heard related to misdiagnoses and negligence on the part of doctors. For example, one woman I spoke with was diagnosed at the IMSS with benign ovarian cysts but continuous bleeding prompted her to get a second opinion from a private doctor. This doctor concluded that that she had uterine cancer and needed a hysterectomy. She reflected:

> Why didn't they detect it in the IMSS? When I got my diagnosis I was sitting there speechless. I felt my knees would buckle. I took my results to the IMSS and the gynecologist there told me that he was surprised and immediately they sent me to bed confinement and to surgery and they removed everything before the cancer spread and I stayed healthy thanks to God. But a private pathologist detected it, not the IMSS. Many patients die for this reason, because the tests are misleading.

This was not the only interviewee who suggested that negligence at the IMSS leads to unnecessary suffering and death. In fact, three other respondents had similarly harsh criticisms and used the phrases "you could die if you go to IMSS;" "they wouldn't attend you if you are going to die," and "IMSS kills their patients." One woman I spoke with whose family belongs to the IMSS, offered reasons why IMSS beneficiaries might use SSA services, such as the Urban Health Center (UHC).

> Here there is an institution called the Urban Health Center. Almost everyone goes there. We go there because it doesn't cost us, or it costs us minimally. And also, we don't have any faith in the IMSS. They are of absolutely no use. The IMSS has privatized and as soon as they privatized they lost their purpose. Here, if you go to the IMSS, you will die. They don't attend to you. It is better to go to the Urban Health Center.

Another concern regarding IMSS expressed by this sample of women has to do with the treatment of the uninsured. Respondents who have IMSS, as well as those who do not, asserted similar complaints about how the IMSS staff neglects those without social security even in the case of an emergency. By law, IMSS is supposed to provide emergency care to the uninsured. As one woman said, IMSS will not "waste their

material on a person who doesn't have *Seguro* (IMSS insurance). If they tell you that they give access to anyone in an emergency, they are lying to you." She said that she knows because her sister works for IMSS.

Another woman shared the story about her godfather being turned away from IMSS after he was referred there by the SSA-UHC after an accident. As a result, she had to take her grandfather to the general hospital in Cuautla to get treatment. I heard of numerous stories where patients would get referred from the SSA-UHC to the IMSS clinic and then to a hospital in Cuautla or Cuernvaca during an emergency. The lack of emergency services and lack of coordination between the institutions appears to be a dangerous combination based on the comments of interviewees.

While IMSS received the harshest critiques by those I interviewed, compared to the other two institutions, women consistently chose to deliver their babies in IMSS general hospitals, saying they did so because the services were free. Moreover, the insured and uninsured unequivocally agree that IMSS hospitals offer the best secondary-level care of all three institutions. This may explain why emergencies and surgeries were the fourth most common reasons women cited for IMSS/ISSSTE visits.

Despite all of the criticism leveled at IMSS by insurance holders in this sample, some respondents acknowledged that they are fortunate to have a resource that others do not have, even if they are not thrilled with the services. For example, after listing a litany of complaints about the poor quality of IMSS services, I asked one interviewee, "What health worries do you have?" She responded:

> We don't have any worries in this sense because we have *Seguro*. Many people do not have this opportunity and well, it is more secure to have *Seguro*. You can count on more trained personnel and an operating room.

One of the 16 women I spoke with who did not have any complaints about IMSS acknowledged that many people are unhappy with IMSS services but that she was happy with her benefits. She said:

> The truth is that they have attended to me well. They give medicines, although I have heard cases in which they don't take care of people and don't give out medicines. But I have always taken my kids to the IMSS. The IMSS takes good care of us.

Social assistance branch: SSA

Almost half (N=46) of the women in this sample do not have access to social security benefits. SSA facilities are the only public health option available to them. A handful of these women (5) feel that SSA services are sufficient to meet their families' needs. The complaints of the other 41 women who directed their comments at SSA services most commonly fell into five categories: 1) poor service and medical attention; 2) lack of emergency services; 3) lack of medicines; 4) lack of supplies and equipment; and 5) cost of services.

Their most common concern relates to the perception that SSA health centers offer low quality services. They cite numerous factors, including inadequate physician training, insufficient number of physicians, and "negligence" and "laziness" of doctors. In other words, women's criticism of SSA service "quality" often targets the physicians rather than the institution. For example:

> The doctors have too much authority but they don't do anything!

> The doctors are educated people because, well, they have studied. But many times they are arrogant and haughty. I don't know if they are this way because they see that those are people of the pueblo. But pueblo or city, we are human. We should be equal with everyone. Supposedly doctors study to be able to attend to the people.

> They don't have the professional ethics to attend to those who are sick. Many times one goes to a doctor, to *Salubridad* (SSA), and leaves disappointed because the doctor doesn't do a checkup nor do they even touch you. They look at you and they give you a prescription for medicine. I say that is a lack of professional ethics.

These comments reflect women's frustration with the power dynamics between the patient and physician. They are concerned that, while doctors have the ability to help the patient, they either choose not to help, or they treat people poorly out of arrogance. These comments reflect the expectation that doctors in the SSA system should fulfill a more humanistic role.

Another prevalent complaint expressed by this sample concerns the lack of emergency services at the Urban Health Center (UHC). Many women described how the emergency room at the SSA clinic is often overcrowded with people waiting to be seen by the doctor. As one women said,

> They are more and more crowded because so many people arrive and there aren't enough doctors or nurses to attend to the patients. We saw this recently because my mom became very sick and my sister brought her to *Salubridad.* She said that they were all seated for an hour because there were no beds for the patients where they hospitalize people.

Patients with emergencies usually are referred from the UHC to a general hospital in Cuautla or Cuernavaca. There are two municipal ambulances that belong to the county. The UHC must request one from the municipal president during emergencies. Numerous women complained about the lack of ambulance availability for transporting patients to the hospital. When an ambulance is not available, the patient must pay for a taxi to get to the hospital most rapidly. This may cost up to $15 USD, a sum that poor residents may not have available. Night-time emergencies put the most strain on

residents because public transportation is not an option and taxis are scarce and expensive.

Respondents' complaints about the municipality's lack of emergency services were most often raised in relation to scorpion bites. As I mentioned in Chapter 2, Yautepec has the highest rate of scorpion bites in the nation. People often are bitten at night, since scorpions reside under sheets or blankets and in warm, dry areas of the house. A scorpion bite is potentially deadly if it is not rapidly treated with an antidote. Thus, getting to a clinic quickly is imperative. Most often, Yautepec residents will go to the Urban Health Center where they expect to be provided with the anti-venom medicines. However, I heard of several occasions in which the clinic was out of the medicine, and the family had to gather up enough money (and lose time) buying the antidote at the pharmacy at a cost anywhere from $7-$15 USD. When these bites occur in the middle of the night, however, the three pharmacies in town are of no help since they are not open past 10pm.

The women I surveyed reported six cases of scorpion bites in the last six months. Three of the patients received their antidote from the SSA clinic for free. The clinic did not provide two of these patients with the antidote. As a result, they spent an average of $11 USD to buy the medicine. The sixth patient was provided with the medicine at the UHC but was charged for it. As she explained, "They admitted me (to the clinic) for the scorpion bite, and they charged me for everything, even the injections. To inject me cost $20 pesos ($2 USD), and I had to replace the medicines they gave me and buy the needles." In another case in which a woman's daughter was bitten, the SSA staff didn't

handle the situation as an emergency, and so she had to "fight with the staff to be let in to see a doctor."

Scorpion bites are not the only cause for complaints about medicines at the UHC. In fact, seventeen of the 100 women surveyed mentioned problems relating to the lack of medicines at SSA clinics. They complained about doctors prescribing two or three medications but only providing one at the SSA pharmacy. As one women explained, "You go and they tell you that there are none or there is no more than one (of the medications), and you have to buy the other two in the pharmacy. There are people who really don't have money to buy them." I asked this woman what the solution was. She responded "Well, we can't offer the solution; the government has to have one. What can we do?" I got the sense from many of the women with whom I spoke that there is an expectation that the SSA should provide them with medicines free of charge.

While some women criticized the UHC's pharmaceutical limitations, others focused on the lack of equipment, supplies, and ability to perform tests at the clinic. Most often these issues were discussed in the context of gynecological procedures and women's health. For example, one woman was angry about being sent to the Federal District because she needed a hormone test to find out if her cysts were benign or malignant. On numerous occasions, women complained that they could not get a mammography in Yautepec but instead had to go to Cuautla or Cuernvaca. One woman who was sent to Cuautla to get an ultrasound expressed frustration that the hospital was not able to do the test there either, and she then had to go to Cuernavaca. I heard of complaints that hospitals in the cities didn't have the machines to help premature babies and that women who need cesareans must be sent to Cuernavaca. As one woman said,

"Imagine the problems we face to go and stay there," referring to the cost of transportation, food, and lodging for the woman and her family.[1]

Cost was the next most prominent complaint for women discussing the SSA. Most often, these women mentioned the fees that were required for patients to be seen by a doctor at SSA facilities. These fees were a point of contention with six of the women who made statements like, "before, *Salubridad* offered free services but now they charge everyone" and "before health services were better. Now they charge in *Salubridad.*" As one woman said, "To pay $20 pesos ($2 USD) for a consultation is taking away $20 pesos that can cover food for the kids." Statements such as these suggest that not all health users have accepted that the government is now charging them for services that once were free. Although the fees have been in place for years, the issue seems to remain a point of contention.

An additional point of contention regarding SSA fees involves the miscellaneous charges for supplies. I heard numerous stories about how doctors would ask patients to pay for supplies before conducting a procedure or operation. For example, one woman explained:

> When my son had the accident I had to buy the thread to stitch him up because if not, they wouldn't stitch him up. When they gave me a cesarean also, they wouldn't do it (without the thread), and there was no one in my family who could buy it. They wouldn't operate and my son could have been dead because it was more than 11 hours from the time my water broke until my uncle arrived with the thread.

[1] To address some of these reproductive health problems, the municipal government was in the early stages of building a woman's hospital when I arrived in Yautepec. However, little progress had been made by the time I left. The women I interviewed were mostly reserved in their optimism about the completion of the project.

In addition to supplies, this woman was charged a fee of $40 USD for each of the two blood donations that she had needed and $180 USD for the operation. I asked her what happens if one cannot pay for the supplies or procedures. She responded:

> They won't bring you the child. Yes you will find some exceptions but either way, while it is very little, one has to pay. And there are people who simply don't have the money. At that moment, I had the money saved because I knew that I would be giving birth, but I never thought that it would be a cesarean. I already had 2 normal births and this was a cesarean. Thanks to my uncle, he loaned me money.

As this situation suggests, women often rely upon family members and relatives to help them cover the costs of health care in times of serious illness or emergency. For example, one woman I interviewed had a sister who was suffering from uterine tumors and had to have a hysterectomy. The family had saved up money for a year to be able to afford the operation at an SSA hospital. However, there were unanticipated complications from the surgery that necessitated a second operation which required that the family sell off most of its meager belongings. The interviewee explained that her sister is still very sick and that she is getting worse "because of her lack of money to be able to afford treatment." She associated her family's poverty with the worsening of her sister's condition. Such illustrations of unequal treatment due to the socioeconomic position of the patients were common among the women I interviewed. As one women said, "If you have money, you get treated better by a doctor. They will spend more time with you. The medicines that the doctor gives to you also depend on the amount of money you have."

Reflections on public health care critiques

The majority of women in this sample feel that the health services in their municipality are not sufficient for addressing their family's and their own health needs. Both the insured and the uninsured expressed concerns regarding the quality of public health services, although their comments differed regarding the social assistance and social security sectors. For example, complaints directed at IMSS focused largely on problems with the distribution of medicines and medical service quality. Some women perceive that doctors placate rather than cure patients by providing them with the wrong medicines while others feel that doctors arbitrarily withhold medicines even if they are in stock. While some respondents directed mild complaints at doctors for conducting rapid exams, others pointed more critically to cases of negligence, careless misdiagnoses, and cases where the medical staff ignored patients in crisis. Some women directed scathing remarks at the institution suggesting that health services may be harmful to the patient ("IMSS kills their patients"). In light of these harsh criticisms, it is important to mention again that the Yautepec IMSS clinic was recognized by the Ministry of Health in 2003 as one of the top clinics in the nation in its delivery of high quality services (Secretaria de Salud 2004). If this sample reflects concerns present within the larger community, then a significant discrepancy exists between patients' perspectives and the national standards used to judge the quality of IMSS facilities.

The complaints targeted at the SSA facilities were markedly different from those listed above. They included poor service ethics, conditions of overcrowding and long wait times, a lack of medicines, limited emergency services, a lack of essential reproductive health care, and fees for services along with physician-patient power dynamics and class inequalities. Since the lower-socioeconomic strata of Yautepec must

depend on SSA services if they do not have social security benefits or the funds for private health care, it is not surprising that more women in this group commented on social inequalities than those among the insured group. Inequalities between the social security and social assistance systems are surely a factor in the women's complaints. For example, the discrepancy that exists between staff at the Urban Health Center and the two social security facilities in Yautepec is striking. While the UHC employs four permanent and five contracted doctors to serve the uninsured municipal population which makes up 78% of Yautepec residents, the IMSS and ISSSTE clinics employ nine permanent doctors to meet the needs of 22% of the municipal population that is insured.

However, without sufficient resources (medicines, supplies, emergency equipment), all primary care units in Yautepec are struggling to meet the basic needs of their patients. While some residents understand the economic strain and pressures within medical institutions, others view doctors as individually culpable for the negligence of their patients. Insurance holders more commonly blame the social security institution as a whole for the problems while the uninsured more often blame doctors for their mistreatment. The uninsured most often view their low socioeconomic standing as a hindrance to quality medical care.

IMSS/ISSSTE beneficiaries expect that they will be provided with the medicines they need, that doctors will deliver quality services, and that emergencies will be attended to professionally. SSA users expect that they too will receive quality care, medicines, and the appropriate tests and procedures in a dignified manner. These expectations reflect promises made by the Mexican government during the primary health care (PHC) movement of the 1970s that emphasized the expansion of quality health service delivery

to the most geographically and economically marginal populations. Even though the PHC era is long over, interviewees still depend on their government to provide them with health care. In fact, when I asked each of the respondents who they feel is responsible for addressing insufficiencies in their health care system, they unequivocally pointed to the government. As one woman said, "We can't offer the solution; the government has to have one. What can we do?"

Neoliberal health reforms of the 1980s and 1990s have since shifted the orientation of the national health system towards state withdrawal from public services through privatization and decentralization strategies that aim to increase health system efficiency. Although community residents are now expected to participate in the public health solutions proposed by the government (see Chapter 3), it appears that many women in this sample have yet to accept their new role under neoliberal globalization. Despite the changes that have occurred in health policy over the last two decades, many residents still view it as their right to receive free basic health care services from their government.

Women in this sample seem to be expressing a lack of control in the health care process. For example, they describe experiencing long wait times in clinics, poor treatment by doctors, medical negligence, placation through tranquilizers, unequal treatment based on class, and limited recognition of basic women's health care needs. Instead of protesting or trying to change a system over which they feel they have little control, women are doing the only thing they can – turning to private health care. Indeed, their utilization of private health care – within biomedical and non-biomedical domains – may serve as an implicit critique of a health system that is failing them. After all, it is

likely that if residents believed that their public services were of a sufficiently high quality, they would be willing to pay the required fees that they instead place in the private sector.

Conclusions

In this chapter, I have described the health care seeking patterns of a sample of women in Zarragoza and detailed an array of perspectives regarding public health care. The perspectives I have highlighted shed light on the many problems that women face in the public health sector. They also illuminate perceived gaps between available health services and local expectations for quality health care. The chapter suggests that rather than accepting marginal public health services, many families are turning to the private sector for health care. As the public health sector declines and becomes increasingly dependent on patients' ability to pay and as barriers emerge in patients' ability to access public health care, user support is eroding and the system has become ripe for various new actors in the private sector (Fisk 2000; Fleury 2000; Laurell 2001). Included among these new actors is an emerging cadre of alternative and traditional medicine practitioners who address many of the quality of care issues mentioned above through their health care approach. It is to these actors that I now turn for the remainder of the dissertation as I consider alternative health care practices and the community groups that provide them.

CHAPTER SIX: THE ARCHAEOLOGY OF A HEALTH MOVEMENT IN MORELOS

As patient dissatisfaction with public health care grows and Mexicans increasingly recognize the limitations of biomedicine, many are turning to non-biomedical health care options. Responding to the growing critiques of biomedicine, a social movement is underway that seeks to offer new ways of "doing" health care. Local community groups are organizing around the study, application, and diffusion of traditional Mexican medicine and alternative medical practices. These groups embrace a variety of health practices that they seek to make available to all socioeconomic sectors of society. They offer health education through classes and training programs, clinical consultations and medical treatment out of community clinics, and natural remedies through their efforts to generate cooperatives and natural medicine pharmacies. The participants of these groups seek to promote greater awareness of illness prevention and natural healing options and to decrease dependence on formal biomedical health services.

In this chapter, I examine the emergence of this health movement, taking into account the many international and national trends that have spurred growing interest in and attention to medical alternatives. I conduct an "archaeology" of health organizing to explore the origins of the discourses and practices that appear to have influenced this movement. First, I will define what I mean by "traditional Mexican medicine" and "alternative medicine" and consider the practices and demographics specific to the two spheres. I will then explore how these non-biomedical alternatives have become widespread in Mexico and examine cultural revitalization efforts that have helped to establish a national movement towards "preserving" traditional Mexican medicine.

Finally, I explore how the Mexican government and other public institutions have participated and influenced the spread of non-biomedical alternatives. This chapter provides a historical and contextual backdrop for subsequent chapters that explore the efforts of health groups in Zarragoza.

Defining "traditional" and "alternative" medicine

The health groups that I studied label their work "traditional and alternative medicine." They view traditional medicine as encompassing health knowledge and practices utilized in Mexico over centuries. There is a long history of European influence in Mexico. Therefore, Mexican traditional medicine has emerged from a syncretic union of pre-Hispanic concepts and practices and Spanish European medicine (Nigenda et al. 2001a). According to Nigenda et al. (2001a), many Mexicans consider both traditional medicine and biomedicine to be mainstream medical systems. This is because much of the population is familiar with the logic inherent to both of these systems and thus may draw upon them for understanding and treating health and illness.

In the State of Morelos, traditional medical practices have had and continue to have an important presence, particularly in rural areas (Baytelman 1986 in Nigenda et al. 2001a). Traditional practitioners there utilize a range of practices that include herbalism, massage, symbolic cleansings (*limipias*), and therapeutic steam baths (*temaxcal*). Many "traditional illnesses" such as *susto*, *aire*, and *empacho* also have local significance. Individuals may call upon local healers, called *curandero/as*, who help patients resolve these symptoms. In addition to *curandero/as*, there is a range of "traditional healers" that include midwives, bonesetters, herbalists, etc. Traditional healers usually receive their

training empirically, meaning that they learn their practice through apprenticeship rather than formal schooling (Jordan 1993). They often charge a nominal fee for their services or accept in-kind payments making their services accessible to the low- and middle-income members of society who most often utilize traditional healers (Nigenda et al. 2001a). A significant body of traditional knowledge, practices, and beliefs has been documented in many rural communities where traditional medicine is most widely practiced (Baytelman 1993; Loya et al. 1991).

The term "alternative medicine," as it is used in this dissertation, refers to practices that are not indigenous to Mexico. For example, acupuncture and Chinese herbalism are practices within the Traditional Chinese Medicine system which originated in China. Other healing systems like homeopathy and naturopathy were not passed down from indigenous populations but were discovered in the late 1700s and late 1800s in Austria and Germany respectively. Current trends in Western consumption lump these practices together and refer to them as alternative medicine, natural medicine, or holistic medicine, among a host of other labels.

This brand of alternative medicine is relatively new to Mexico, having arrived during the 20th century. The exception is homeopathy which was brought to Mexico by Spanish physicians in the 19th century (Barnes 1998). Today, homeopathy is well established in the country as is evidenced by its two national homeopathic hospitals and two national education institutions (Barnes 1998). Among non-biomedical practitioners, only homoeopathists are recognized as professional practitioners in Mexico. They are trained in allopathic medical schools and study homeopathy as a postgraduate specialization (Whiteford 1999).

According to Nigenda et al. (2001a), there has been an influx in the variety and availability of foreign non-biomedical health care options in recent years, particularly in urban areas. These researchers suggest that this expansion is due to the population's increased participation in major political issues including debates over health care, the increasing number of private options for health care users, and the challenges that biomedical institutions face in light of continued economic decline. As they write:

> The perception that biomedicine is based on the utilization of drugs which can produce side-effects, the use of surgery as an intrusive practice, the excessive tendency of biomedicine to focus on symptoms and not on patients has also created a level of significant distrust by the population. As well as matters related to the costs of care, the lack of courtesy and ethical principles amongst personnel, and excessive waiting times in public units (Rubel 1990) may also be considered as factors contributing to the rise of alternative practices (p. 8).

These researchers suggest that while interest in alternative health care grows in urban areas, the demand for biomedicine remains high in rural areas since populations have been denied access for decades. This may be changing however, due to the spread of both formal and informal alternative medicine training programs throughout the country. These programs are creating a steady stream of practitioners who provide alternative health services at a relatively low cost and sometimes on a sliding scale to rural and low income urban communities. In Morelos, practices such as Chinese medicine, reflexology, polarity therapy, Bach flowers, Reiki therapy, and naturopathy are increasingly offered in clinics run by non-profit organizations, in natural health stores, and by religious institutions that charge a sliding scale or only for the cost of remedies (see Appendix A for a description of these and other health practices).

Nigenda et al. (2001a, 2004) report that alternative medicine practitioners in Morelos most often choose to work in the field because they perceive that health needs

are not being met by official health institutions. Universities increasingly offer diplomas in alternative and traditional medicine or through specialized courses offered through civil association groups. Practitioners may also learn their skills through apprenticeships and supervision. Since their presence in the health care field is fairly recent (compared with traditional healers), there are a fair number of alternative practitioners who combine and experiment with traditional Mexican healing techniques, thus furthering the process of medical syncretism in Mexico (Nigenda et al. 2001a).

Although the availability of non-biomedical practices is increasing, there exists no legislative framework from which to regulate traditional and alternative medicine in Mexico (Nigenda et al. 2001b). The General Health Act (Article 79) recognizes the healing practices only of medical professionals. However, some steps have been made to regulate traditional practitioners. For example, midwives were given formal status in 1976 with the condition that they receive training by doctors and be referred to as "trained traditional midwives" (Kay 1999). In 1998, the process was underway to license traditional therapists. One outcome of this process is that the Autonomous University of Morelos State (UAEM) began granting diplomas in 1999 to healers with 20 or more years of practice (Nigenda et al. 2001a).

Various government institutions like the National Indigenous Institute (INI), the Ministry of Health (SSA), and the Mexican Social Security Institute (IMSS) have included traditional healers and/or herbal medicines in their projects. These institutions have organized and provided training for traditional healers as well as have issued them identification cards. Nigenda et al. (2001b) note that traditional therapists mostly work "informally" – both economically and legally. For example, most informal therapeutic

work is conducted in the home or in locations where it would be nearly impossible for the state to regulate activities. Moreover, they argue, the wide variety of practices and lack of formal education of non-biomedical health care practitioners creates further obstacles to regulation. As a result, control as opposed to regulation, marks the asymmetrical relationship between government officials and traditional therapists. The state of Morelos has organized public forums to discuss legislation for non-biomedical practices although no formal changes have been made. As Nigenda et al. (2001b) conclude, "obligatory tolerance" best describes the attitude of governmental officials towards informal health practitioners.

The diffusion of traditional and alternative medicine

While traditional Mexican medicine has been an important health care resource for centuries, these "new" alternative medicine practices have gained popularity only in the last few decades. Their diffusion has been facilitated largely by processes of globalization – communication, travel, migration, and international trade for example. The holistic health movement in the United States, which began in the 1970s, impacted Mexicans beyond their neighbors' growing advocacy for natural therapies. As has been well documented in the media, U.S. citizens have increasingly demanded alternative health services in Mexico since the 1970s (for example, see Underwood 2006). This is because health practices across the border are out of the jurisdiction of U.S. federal and state medical regulations and authorities. Increased demand coupled with greater contact with alternative medical practices and practitioners on account of globalization have stimulated much expansion of alternative medicine in Mexico.

The popularity of alternative medicine in Mexico has been influenced by other global trends. In the 1970s, rural health care providers in China called "barefoot doctors" were achieving success in providing primary health care throughout rural communities and promoting public health campaigns. Barefoot doctors who combined both Western and Chinese medicine received much international attention for the diversity of their practices and their success in health care distribution. Influenced by this model, Cuba expanded its alternative health system that had existed alongside formal medicine since the 1960s. Thus, formerly marginalized alternative medicine became increasingly important, especially after the U.S. trade embargo was implemented in the early 1960s. Now, almost every medical facility in that country has an adjunct alternative clinic including natural medicine pharmacies (Jamison 2004). Cuba's success in the field has inspired Mexicans to search for alternatives to its increasingly inefficient national medical system. Furthermore, there seems to be growing collaboration between Cuba and Mexico regarding alternative medicine. For example, during my field research, I heard of numerous occasions in which Cuban doctors visiting Mexico were offering trainings on various alternative medicine modalities.

International organizations have also played a significant role in generating national interest in non-biomedical health care practices in Mexico (Nigenda et al. 2004). The 1978 International Conference on Primary Health Care (PHC) in Alma Ata was a watershed event for the revitalization of traditional medicine throughout the developing world. At this event, the WHO emphasized the importance of traditional medicine in achieving the goals of primary health care, since the majority of the world's population had little access to biomedical health care and relied primarily on traditional medicine.

The WHO declaration called for mobilization of traditional medicine systems and the integration of traditional medicine with primary health care. This declaration resulted from earlier resolutions by the World Health Assembly regarding the promotion and development of training and research programs in traditional medicine. By 1979, the WHO had established a Traditional Medicine Program that emphasized:

> ...the need for the governments of the countries interested in the use of traditional medical practice to give adequate support to engaging traditional medical practitioners in primary health care teams as and when appropriate and to the utilization of appropriate technology in these traditional medical practices, and to undertake adequate measures for effective regulation and control of traditional medical practices (WHO 1979).

The WHO urged low-income countries to search for substitutions to medicines that were expensive to import. It emphasized the training of traditional healers, encouraged studies of medicinal plants and traditional medicine, and supported the development of national pharmaceutical industries.[1] The WHO recognized the important contributions of traditional medicine to the provision of health care and provided funding and support only for government programs which it deemed "scientifically based." Such funding opportunities opened up new spaces for professionals to gain legitimacy but often privileged "scientific" medicinal plant studies to the detriment of traditional healers and their healing practices.

The institutionalization of traditional medicine

The WHO's recommendations came at a time when Mexico was focusing on the promotion of its regional cultures as a strategy to increase the country's status in the

[1] The Traditional Medicine Program was later merged with the Essential Drugs Program (EDP) in the 1990s, reflecting a priority shift within the World Health Organization (Seneviratne 2000).

developing world. The growing interest in regional culture, intellectual projects, and the celebration of indigenous values helped to bolster national interest in traditional medicine. Moreover, traditional medicine was viewed as an important part of the heritage and personality of the country (Lozoya 1987). The global focus on Traditional Chinese Medicine in the West also helped to legitimate Mexican traditional medicine (Lozoya 1987). The focus on revitalizing traditional medicine in Mexico culminated in the first Congress of Traditional Medicine which was held in Chiapas in 1974. At this gathering, participants criticized modern medicine on various fronts. They suggested that it was expensive, that physicians were ignorant of indigenous languages and culture, that public health centers treated the poor and indigenous badly, and that doctors ignored herbal medicine and healing practices that were important to local populations (Mesa-Lago 1992). The Mexican government responded to these critiques and international pressures by developing programs to incorporate traditional medicine (i.e., herbal medicine) into an integrative health care model.

To facilitate this integration, a range of new national institutions were founded to support the scientific study of traditional medicine. One of the most influential institutions was the Mexican Institute for the Study of Medicinal Plants (IMEPLAM) which was founded in 1975. Taking a multidisciplinary approach, IMEPLAM incorporated historians, anthropologists, doctors, botanists, chemists, and pharmacologists in the study of the use of medicinal plants. However, by 1980, researchers had concluded that studies of medicinal plants did not take into account the medical culture of Mexico and that there was little application of the results of these studies, particularly in the health sector and primary health care (Lozoya 1987).

Thus, in 1981 IMEPLAM modified its initial structure and was integrated with the Mexican Social Security Institute (IMSS) and renamed the Unit of Biomedical Investigation in Traditional Medicine and Herbalism. This new unit was to provide IMSS doctors with systematized information on traditional medicine and facilitate the distribution of a list of herbal remedies (once they were scientifically validated) through IMSS clinics (Lozoya 1987). By 1982, IMSS Solidaridad (today IMSS Opportunidades) was incorporating traditional medicine in its health program for low-income rural and urban residents. In 1986, IMSS opened a Research Center in Xochitepec, Morelos, to increase knowledge of herbalism and traditional medicine and extend its practice within the general population (Subsecretaría de Cultura 1988).

The humanistic counterpart to the scientific study of medicinal plants is the National Institute of Anthropology and History (INAH), a Federal institution that is responsible for the preservation of Mexican culture. In Morelos, INAH has played an active role in education and diffusion efforts relating to traditional medicine. In 1977, INAH developed the Program of Medicinal Ethnobotany and the Museum of Traditional Medicine in Cuernavaca and opened the Traditional Medicine Program of the Museum of Popular Culture in 1978. The Ethnobotanic Garden in Cuernavaca contains more than 800 distinct medicinal plant species and INAH researchers have registered more than 850 plants used as curative remedies in the state. INAH researchers have also developed relationships with more than 300 healers in the state to learn about traditional medicine resources and for the purposes of conservation and diffusion. INAH currently collaborates with IMSS-Xochitepec research center to further these goals (Palacios

2003). As a result of this institutional focus on traditional medicine, Morelos is at the center of the national effort to revitalize traditional medicine.

The National Indigenous Institute (INI) has also played a significant role in the trajectory of traditional medicine in the state of Morelos. INI, a Federal institution, was established in 1948 to help integrate indigenous people through coordinating centers. As part of its role in supporting the development of indigenous peoples, INI has been actively promoting the incorporation of traditional medicine in the National Health System since the WHO's 1978 recommendation. INI has organized traditional healers associations and has encouraged greater dialogue between health sectors. INI organized the first traditional healer's organization in 1988 (Menendez 1997) and in 1992, the institute organized the first Continental Congress of Traditional Medicine in Mexico (Bonfil Sánchez 1998). By 2000, 102 organizations in Mexico were registered with INI, including 4,465 practicing indigenous doctors working in the 23 states who participate in the Traditional Medicine Project. However, budget cuts accompanying health reforms in the 1990s have forced INI to significantly reduce its indigenous traditional medicine health programs (CDI 2005).

Cultural revitalization and traditional medicine groups

The Mexican government has not only attempted to incorporate indigenous healers, researchers, scientists, and medical institutions into its effort to revitalize traditional medicine, but has also focused on "civil society" (i.e., the general population) for participation in the movement. For example, in 1988 the National Council for Culture and the Arts established a program for the formation of cultural centers and cultural

committees throughout the country. In this program, cultural centers are expected to become spaces for the exposition and transmission of knowledge where cultural activities are planned and where communities gather to discuss affairs concerning their culture. Cultural committees are designated for the purpose of incorporating the community in cultural activities that are to be identified through a "cultural diagnosis." According to the Subsecretaría de Cultura (1988), the committees are to organize the participation of diverse groups within the population, and the cultural centers are to facilitate the "creation of voluntary and conscious raising movements that democratically give place to group decisions around what to rescue and how" (p. 127).

Cultural centers ("*casas de cultura*") were subsequently opened throughout the country, some with the support of the government and others funded through local initiatives. Efforts to "rescue" traditional medicine have been incorporated into many of these cultural centers. They offer herbalism classes, serve as meeting centers for women's groups working in the area of traditional medicine, and function as community clinics. In my travels throughout Morelos, I was introduced to a diverse array of cultural centers that were offering programs in traditional and alternative medicine. For example, a center in Oaxtepec houses a small civil association that is creating a database of medicinal plants native to the region and their uses. This group also runs a clinic out of its "*casa de cultura*" where the participants offer traditional and alternative health care treatments and distribute the herbal remedies they package. Similarly, a center in Tejalpa houses an association that offers clinical services in acupuncture, homeopathy, herbalism, Bach flowers, and massage. It also offers workshops in community and reproductive health, nutrition, and sexuality. In fact, five of the eight health groups that I visited run

health clinics, classes, and meetings out of a community center space modeled after the *casa de cultura* concept. The other three operate their programs from office and church spaces.

Because the government has made the revitalization of "traditional culture" a priority, funding is available for groups who work in the area of traditional medicine. For example, the National Council for Culture and the Arts runs a granting agency for the support of municipal and community cultures (PACMYC). PACMYC provides funding for project development in the area of popular and indigenous culture which includes traditional medicine projects. Private agencies also provide grants for groups that work to preserve traditional culture. For example, Comunidad A.C. supports a range of local associations in Morelos that organize workshops in traditional medicine, herbalism, and nutrition; train health promoters; and run microenterprises for selling local products, including herbal remedies. One explicit goal of both public and private agencies is to fund training for women to learn skills for income generation. Traditional medicine is one area in which these goals can be fulfilled since the domains of household health care and traditional medicine are typically associated with women.

In sum, the government's efforts to involve communities in revitalizing cultural spaces and to encourage local efforts in rescuing traditional medicine has helped to propel the formation of small community groups that work in the area of traditional medicine. Yet, none of the groups that I visited focus solely on traditional medicine. They also incorporate a strong focus on alternative medicine. Moreover, many groups not only train women as health promoters in traditional and alternative medicine, but they also organize community clinics to provide health services to local residents. These

clinics are largely unregulated by the government. Members are supposed to register any herbal product that they use or sell with the Ministry of Health and appoint a "responsible physician" to their clinic in the case of emergency. Despite their lack of regulation, the community clinics in Zarragoza do not raise the concern of health officials with whom I spoke. Rather, they regard the groups as merely gatherings of women doing what they have always done – resolving illness with traditional medicine. As I will detail in the following chapters, this an erroneous assumption that highlights how stereotypes are embedded in official health discourse which turns a blind eye to the relevance of global health care alternatives.

The communitarian model of health promotion: The case of Tlahuilli

The civil associations that I visited in Morelos are small with relatively few active participants (usually between 4-10 active members). These groups come and go since funding is often precarious and time and resources are limited among participants who largely belong to the lower socioeconomic classes. Despite limited resources, the groups all participate in a community service model seeking to make their services available to all sectors of society. This model was popularized in Morelos in the 1980s by a civil association called the Mexican Institute of Traditional Medicine "Tlahuilli." A brief description of Tlahuilli's contributions to the current health movement will help to contextualize the possibilities and challenges inherent in this model of health service delivery.

Tlahuilli was established in 1984 by a group of physicians, traditional healers, anthropologists, nurses, and other professionals who were interested in preserving

traditional medicine. The participants hoped that Tlahuilli would increase the acceptance of traditional medicine among individuals in poor communities that lack access to sufficient modern medical services. Based on communitarian and health promoter models encouraged by the Ministry of Health, the group organized a health committee. With community support, they later organized clinics, established herb gardens, and began to produce herbal medicines (Mesa-Lago 1992).

By 1987, with the support of international funding from a Dutch foundation, Tlahuilli had trained 100 health promoters (mostly traditional healers and midwives) in 12 communities in first-aid, natural therapies, and general health promotion. Health promoters collected and processed medicinal plants and established natural medicine pharmacies. They also gathered information on the socioeconomic conditions of the communities in which they were working. After the health promoters were sufficiently trained, they operated health centers which were supervised by medically trained doctors who also treated patients and organized local campaigns in coordination with public health agencies. The services offered by Tlahuilli concentrated on the ten most common diseases that residents faced, such as gastrointestinal infections, respiratory diseases, skin conditions, and high blood pressure (Mesa-Lago 1992). Patients were charged a nominal fee for consultations ($1.88 USD). If patients could not afford the cost, health promoters accepted in-kind contributions.

By 1989, with the support of the Inter-American Foundation to expand its activities, Tlahuilli had trained over 200 community health promoters, mostly women, many of whom were illiterate. At that time, Tlahuilli had opened about 20 outpatient consultation posts and four clinics and was serving approximately 100,000 people in 12

low-income communities that had few to no health services (which represented about one-tenth of the state's population). Tlahuilli also offered alternative and traditional medicine courses at its headquarters in Cuernavaca that were taught by an expert assisted by health promoters. By 1989, about 50 people were attending monthly, two-day courses. However, by 1989 the group's funding ended, its top leadership changed, and Tlahuilli entered a period of transition (Mesa-Lago 1992).

In an evaluation of Tlahuilli commissioned by the Inter-American Foundation in 1989, Mesa-Lago (1992) found that the organization faced a series of challenges beyond its funding problems, citing design of the program and a lack of acceptance by health promoters of the communitarian approach. For example, health promoters were expected to work on a volunteer basis in the clinics and in other Tlahuilli activities. Yet, most of the trained health promoters spent little time at the facilities. Instead they worked largely out of their homes and did so for a profit. The health committees were found to be largely inactive. Some campaigns organized by Tlahuilli had little success. For example, the cultivation of herb gardens often failed. Evaluators also found that in some communities, Tlahuilli clinics were underutilized, possibly, they suggested, as a result of health promoters diverting clients to their homes. Moreover, the evaluation described the initial leadership as "strongly centralized" and argued that it failed to facilitate full participation of the communities it served (Mesa-Lago 1992).

Once its international funding was withdrawn, Tlahuilli began to transform focus on generating in-house funds. It formed production cooperatives and other commercial and productive initiatives. It also started Tlahui, a web-based initiative that generates income through courses offered on the internet. Examples include Traditional Medicine

of Mexico and its Medicinal Plants, The Temazcalli of Mexico, and Acupuncture and Traditional Chinese Medicine. These courses cost between $520 and $729 USD. Tlahuilli now operates two clinics in Morelos (in Cuernavaca and Xochitepec) and the cost of a general consultation is $25 USD while a session of reflexology or acupuncture costs $15 USD. Thus, while it once promoted a communitarian model, Tlahuilli now largely markets its services to foreigners and economically solvent Mexicans. Still, in a statement issued in 1996, the director of Tlahuilli suggests that the association views itself as an institutional bridge "between popular and academic knowledge; between science and empiricism; between theory and practice; between official and marginal medicine" (Rojas Alba 1996).

Although Tlahuilli's service delivery model has been transformed from a communitarian approach to one that embraces a market orientation, the organization still plays a crucial role in the popular health movement in Morelos described in this study. In 1985, Tlahuilli organized the first annual National Medicinal Plant Festival. This festival, which is hosted in different locations each year, has grown exponentially over the last 20 years. It brings together traditional, alternative, and biomedical practitioners throughout the country and beyond to exchange knowledge and practices through a range of workshops. In 1998, Tlahuilli began coordinating monthly health festivals in association with the Autonomous University of Morelos State (UAEM). These events bring together local individuals and groups with an interest in traditional and alternative medicine. The fiestas are intended to raise awareness of health problems of local communities in Morelos, to help diffuse information regarding the diversity of health

care alternatives, and to establish support for the community work from the public sector and universities (Chao Barona and Delgado Rojas 1998).

Tlahuilli has been successful in involving the UAEM in the diffusion of traditional and alternative medicine. In 1998, UAEM developed a program in its Social Development Studies Unit (UNICEDES) called the Popular Council for Community Health (CPSC). This program helps to link civil associations that are training health promoters in traditional and alternative medicine through a state network. UNICEDES trains community promoters and strives to "promote spaces for reflection that will help us in constructing a social project where communities have the possibility to be their own creators and managers of the destinies that they choose" (Cruz Solano 1998). CPSC specifically encourages community health promoters to "elaborate, evaluate and execute projects" that provide solutions for community problems. It organizes individuals, institutions, and civil organizations around health promotion, health care, and the diffusion of knowledge.

In the same year that UNICEDES was developed, the university began providing diplomas to health promoters through civil associations that train them in herbalism, acupuncture, massage, and other traditional and alternative medicine modalities. Such efforts have been important for legitimizing civil association groups and their health promoters who provide clinical services in traditional and alternative medicine. Yet the university's participation in training and certifying health promoters may also contribute to the subordination of traditional and alternative medicine practitioners without formal training, particularly as traditional medicine becomes a body of knowledge that is to be acquired through coursework rather than through apprenticeship. As traditional and

alternative medicine is legitimized by the university and the state and traditional medicine becomes more closely linked with alternative medicine, both bodies of knowledge and practice are transformed and increasingly commodified.

Discussion

Since the late 1970s, a culmination of international and national pressures have facilitated the emergence of a national health movement focused on "rescuing" traditional Mexican medicine and incorporating imported healing alternatives into a health service model delivered by trained community health promoters. The WHO-driven global movement promoting traditional medicine stimulated the Mexican government's efforts focusing on traditional medicine. At the same time, the search in the West for alternatives to biomedicine was guided by a growing interest in "returning to nature," dissatisfaction with mainstream medicine, and an increased use of diverse natural therapies (Baer 2001). Both of these trends helped to legitimize traditional healing practices in developing societies like Mexico. By the 1980s, traditional medicine stood as a symbol of defiance and renewal for Mexicans who were tired of waiting for their government to fulfill its promise of "health for all" through a primary health care movement that ultimately failed to achieve a more equitable distribution of health resources. An excerpt taken from Tlahuilli's website best describes the moment in which the seeds of this health movement were planted:

> The country entered the final stage of what was initiated in the middle of the 1970s when the government had unsuccessfully claimed that it had distributed health services to all corners of the country by constructing rural clinics. Many communities were demanding government health services, with doctors in white coats. It was a moment in which our project was labeled as backwards – they pejoratively called us witches, herbalists, crazy...But it had already begun as well

> as the lack of confidence towards institutional and private health care that has resulted in the search for alternatives to medical attention that are less harmful and more in accordance with the sociocultural condition of the country. In this context, to recover the confidence in traditional and popular knowledge, in *curanderos*, in medical herbalists, required a set of strategies implemented through the development of the community model proposed by Tlahuilli (IMMTTAC 2005).

While community groups were organizing around traditional medicine, government institutions like the Ministry of Health, IMSS, INAH, and INI developed agencies and programs for the study of herbal medicines, to provide funding for community groups working with traditional medicine, and to organize local healers associations – all with the goal of generating cost-effective alternatives to formal health care. These efforts have had both positive and negative consequences for community groups. On one hand, they have stimulated individuals to organize autonomous groups around traditional and alternative medicine. On the other hand, they have co-opted local residents into government-sponsored cultural revitalization groups. Furthermore, much of the official government effort around traditional medicine concentrated on indigenous medicine. The government's efforts to integrate indigenous medicine with official medicine and to organize healers associations have been viewed by scholars as a means of controlling indigenous peoples and their practices (Ayora Diaz 1998; also see Pigg 1995 for the case of Nepal).

A consequence that has emerged from the government's interest in traditional medicine has been to further subordinate this realm of knowledge to that of biomedicine. Since the official health system takes biomedical knowledge as the standard against which the validity of other medical systems are measured, traditional medicine is viewed as marginal local knowledge in need of changing or a stop-gap resource to temporarily

address the lack of formal health care (Ayora Diaz 1998). As Pigg (1995) argues for the case of Nepal, at the same time that traditional healers have been encouraged that their skills are valued, their knowledge has been translated into a language compatible to biomedicine. In the case of health groups in Zarragoza, the work of health promoters is considered largely irrelevant by municipal officials, even though their goals appear to be directly in line with national health reform efforts, as we will see in later chapters.

Yet, as international and national agencies pushed for the revitalization of traditional medicine in the 1980s, alternative medicine health groups began identifying with and renewing their interest in "their own medicine." This growing interest among Mexicans to participate in the movement to revitalize culture and tradition helped to propel popular health groups that trained "thousands of health promoters" (IMMTTAC 2005). The spaces that opened within diverse institutional sectors offered unique opportunities for partnerships between formal and informal healers, government and civil associations, and traditional and official medicine.

In Morelos in the 1980s, Tlahuilli took the lead to galvanize community groups around a community service model. The association's leadership was successful in politicizing the platform of the community groups promoting traditional and alternative medicine as a symbol for community participation in health care. They also were successful in bringing disparate civil association and university groups together to share their knowledge and practices. These efforts have been a boon to the movement on a state level. However, the competition for scarce resources and the involvement of UAEM in licensing traditional and alternative medicine practitioners have contributed to a situation in which legitimacy is increasingly being commodified as are health practices.

Tlahuilli's transformation from a communitarian to a capitalistic health service model signifies the slippery slope on which traditional and alternative medicine practices, practitioners, and advocates reside. As we will see in the next chapter, local groups in Zarragoza must confront these and other challenges as they seek out legitimacy and work to sustain their communitarian efforts.

Conclusions

The state of Morelos is at the center of a movement to revitalize traditional medicine in Mexico and incorporate community groups into an effort to "reclaim" its cultural heritage. While local groups are immersed in creating an identity for the future based upon the past, they also accept the benefits of globalization which has introduced a diverse range of healing practices from all over the world. As they combine local and global practices to address sickness and health, they contribute to the constantly evolving discourse about who controls the therapeutic process and how power and authority structure health care. In the next chapters, I will examine how health groups in the town of Zarragoza incorporate a myriad of discourses and practices into their communitarian model of health service delivery and health education, and will consider how health groups use these discourses and practices in their own struggle to participate in the health care process.

CHAPTER SEVEN: HEALTH ORGANIZING IN ZARRAGOZA

This chapter traces the trajectory of three community-based health associations in the town of Zarragoza – the Committee for Culture and Development (CCD), the Parochial Center for Health Promotion (PCHP), and the Center for Traditional and Alternative Medicine (TAM Center). These groups have organized coalitions around the study and diffusion of traditional and alternative medicine. They share similar interests and strategies. They express a critique of the dominance of biomedicine; they advocate a counterpoint to biomedicine's curative approach by embracing holistic health practices with roots in both Eastern and Western traditions; they run community clinics, natural pharmacies, and training programs in order to make the alternatives they propose accessible and affordable for all residents; and they advocate "community service" as a means to distribute their resources. The majority of the groups' participants are women who belong to the lower socioeconomic classes.

After outlining the histories of these groups, I will compare and contrast their approaches and the discourses that guide their work. I will explore their clinical and educational contributions to the community as well as examine the more constraining and conflictive aspects of group membership, particularly in relation to the economic strains, community hostilities, and inter and intra-group conflict that have marked their development. The high level of discord that this study documents challenges approaches to studying grassroots groups that presume women's empowerment and community solidarity. More salient here are the broader social tensions that frame the work of these health groups as they confront contradictions of social development, gender asymmetries,

and the competing ideals of Western capitalism and more "traditional" cultural values that they seek to preserve.

Health organizing in Zarragoza: Three case studies

The Committee for Culture and Development's (CCD) Health Committee

The Committee for Culture and Development (CCD) initiated its Health Committee in 1999. Funded with seed money from the Mexican government, the CCD was incorporated in 1999 as a civil association dedicated to the sustainable development of rural and urban communities in Morelos. The association runs programs for children, adolescents, and adults that focus on education, cultural preservation, and women's training. Its Health Committee trains women in health promotion and expects that they will apply this training in the household, within the larger community, as well as in the CCD clinic. The group targets low-income women living in and around Zarragoza for its health training.

The CCD operates out of a neighborhood community center which is located in the working class neighborhood of La Rosa. La Rosa is a government housing development for residents who have access to government credit through their work. This credit allows them to purchase their homes. Some of the 300 residents in this neighborhood also rent their apartments. The CCD was founded by a La Rosa resident named Anna in 1996. At the time, Anna was 39 years old and was a relative newcomer to the community. Anna had a young daughter when she moved to La Rosa and quickly became concerned that there was no designated space for young children to play in the neighborhood. She became determined to dedicate a community space for this purpose.

Prior to housing the community center, the building had been occupied by CONASUPO, a government subsidized agency that sold basic staple foods at a low cost for low-income citizens. Anna was the store manager of CONASUPO for a year. During this time, she was the victim of multiple attempted assaults and robberies. She proposed to CONASUPO management and to the municipal and state authorities that the building be turned into a community center. Her proposal came at a time when the government was encouraging local residents to organize activities and cultural centers that promoted Mexican regional culture (see Chapter 6). With the approval of the municipal government but without any funding, Anna began to run programs for children and the elderly out of the center.

Anna soon discovered that she could not apply for government funding unless the program was incorporated as a civil association. She began this process after she met her neighbor, Lety. Lety was 30 years old at the time and worked with a civil association based in Cuernavaca. She was involved in various women's projects such as cultivating medicinal plants, training women in nutrition and herbalism, and running community clinics in the states of Tlaxcala and Morelos. In 1999, Anna and Lety completed the paperwork and the CCD was officially incorporated as an association.

Lety encouraged Anna to apply for money to begin a training program in nutrition and herbalism at the community center. As she explained, "It is where I had been working and the area in which I had a little more experience, and it is also where I had seen that some funders wanted to give money to develop projects." At the time, federal government agencies like the Secretary of Social Development (SEDESOL) were funding local civil associations to train women in nutrition and herbalism and to develop

cooperatives for the purpose of selling herbal products so that women could become more self-sufficient. Health training was only one of many areas of interest to the government, which was also funding women's weaving, nursery, artesian, and bread making cooperatives.

In addition to seizing upon the funding opportunity to begin the CCD Health Committee, Anna and Lety both had personal reasons for organizing this effort. Anna's daughter and Lety's son both suffered from asthma, and they were interested in learning how to better attend to their children's health. As Anna explained:

> We started to work in the area of traditional medicine more than anything because of my anxiety relating to my daughter's health. I started to bring her to doctors who were very expensive. Then I became interested in learning about this, and I saw that there were many people who were interested in learning it as well. Lety and I involved ourselves in a SEDESOL project and we received funding.

In 2000, Anna and Lety received approximately $46,600 pesos ($4,660 USD)[1] from SEDESOL to run a 36-week course on nutrition and herbalism for women in La Rosa. They recruited teachers from other civil associations around the state and paid them a small sum to teach modules of the courses. Attendance forms from the classes show that 30 women signed up for both the nutrition and herbalism courses. During the 16-week nutrition portion, participants learned about food groups and the importance of good food combination. They were instructed where to buy foods like soy and wheat and how to make various healthy dishes. At the end of the session, the women produced a recipe book of nutritious meals.

After the nutrition course was completed, the CCD offered a 20-week health and herbalism course. These general health classes aimed at educating women about the most common illnesses in the region, how to diagnose and treat basic illnesses, prevention

[1] The exchange rate was approximately 10 pesos to the dollar during the time of my research.

measures they could take in the household, and how to use and prepare basic home remedies. In the herbalism classes, women were taught how to recognize various local medicinal plants, apply them to specific ailments, combine plants, and prepare herbal remedies. During the program, the group was taught how to assemble a "first aid kit" of herbal remedies that they could use in their home. They were encouraged to experiment with their remedies on family members and neighbors.

Although the same number of women signed up for the herbalism course as for the nutrition course, attendance began to drop off by the middle of the herbalism course. Anna felt that there were two reasons for this decline in attendance. First, she said the women may have found herbalism to be less practical than nutrition and thus less worthy of their time. Second, because the SEDESOL money had been used up before the course ended, the participants were asked to contribute $2-3 USD per class. Anna explained that women were willing to come to the center when classes were free but once they were expected to contribute their own resources, "they lost interest."

I interviewed six La Rosa women who did not complete the herbalism course, and I asked them why they withdrew from the program. All of these women cited time and financial constraints as the primary reasons for their withdrawal. However, when I pressed the issue, I learned that three of the women felt dissatisfied with the way in which the program was being run. These women said they felt frustrated because they perceived that the group became "cliquish" to the exclusion of others, and they felt that the core group was unfairly siphoning off the herbal products that were made in the center for their own use and for the purpose of generating income for the center.

While discontentment grew among some La Rosa participants, women from outside of the neighborhood heard about and began attending the course, some of whom had previous health training at the Center for Health Promotion, a local group that will be discussed later. The women with the most training ultimately banded together and became the most vocal about the direction of the group. The fact that some of the most active participants were "outsiders" to La Rosa (and were presumably sharing in the benefits of the herbal products produced in the center), was a point of contention for some of the neighborhood participants. In fact, this complaint was raised when neighbors fought to have the CCD evicted from the neighborhood community center in 2003, which I discuss below.

An additional explanation for the decline in membership relates to the pressures placed on participants to form a cooperative beginning in the summer of 2001. Since funding for the program was running out, Anna and Lety decided that the best way to increase the group's self-sufficiency was to sell the herbal products that the women were producing. Since a civil association is by law a not-for-profit entity, registering the group as a cooperative would allow the women to generate income. Anna and Lety told the participants that they would have to contribute time and money for their training and supplies in order to get the cooperative off of the ground. When I first arrived in Zarragoza in the summer of 2001, Anna and Lety were holding weekly meetings to discuss this proposal with the women in the group. Only about 12 women were still actively participating in the course at that time. By the time I returned to Zarragoza in 2003, only six women remained with the group. In the next chapter, I will explore the motivations of these six women for remaining with the Health Committee.

This smaller group organized many activities following my initial visit in 2001. They offered a series of workshops on Mayan massage which was supported by a grant from PACMYC (a government program run by the National Council for Culture and the Arts that funds municipal and community cultural and arts efforts). In 2001-2002, the CCD offered workshops on auricular acupuncture (i.e., acupuncture zones located on the ear) and polarity therapy (a form of energy healing), funded by another small grant from a government program called the Work Training Center. In July of 2001, the group opened a community clinic ("alternative medicine dispensary") where the most advanced health promoters of the CCD provided basic health services like therapeutic massage, nutrition, herbalism, auricular acupuncture, and polarity therapy (see Appendix A). Residents from the neighborhood as well as some individuals living in different parts of the municipality began using the CCD's clinic, which they learned about through word of mouth. However, the clinic was only open intermittently – for six months in 2001, three months in 2002, and six months in 2003 – because it had limited success in generating sufficient clients to justify the time that CCD members spent working at the facility.

During my field research in Zarragoza, the CCD was actively working towards developing a natural remedy pharmacy. They purchased a large amount of fresh herbal plants, roots, and bark from a market in the neighboring State of Mexico and were producing large containers of tinctures that they intended to sell. While the group primarily intended to sell their products locally, they discussed the possibility of expanding their efforts nationally and internationally. The members were motivated by a network of community groups in the states of Tlaxcala and Puebla with whom Lety had connections. This network was having success in selling their remedies through the

internet. Their model of production and commercialization contributed to the vision of the CCD's medicinal plant cooperative.

The CCD also ran several courses, for which they charged tuition, including an eight-month massage course and an eight-month herbalism course. The courses were attended by a mix of women from the neighborhood and outside of the neighborhood, some of whom traveled from nearby towns and cities to participate. The group also offered two workshops on the production of tinctures and medicinal soaps, two early cancer detection campaigns, and two week-long meditation courses. Only the massage and herbalism courses were taught by CCD members. The other programs were offered in collaboration with a state agency, the National Institute of Anthropology and Archaeology in Cuernavaca, a local NGO, and an international organization (The Art of Living) that provided trainers free of charge.

The CCD was no longer receiving government funding, and it charged participants a 30 peso ($3 USD) registration fee and a 160 peso ($16 USD) monthly fee to participate in each of the eight-month courses. The massage course enrolled 12 women and the herbalism course enrolled four participants. Ultimately, the CCD had more success in generating students for their courses and workshops than they did in generating income from their herbal sales. Although they registered a list of medicinal plants and products with the Ministry of Health and began to produce remedies, the cooperative never succeeded in generating much income from these sources.

Anna's long-term vision was that the group would eventually train a sufficient number of health promoters to expand the program to the three poorest rural communities within the municipality. She and Lety developed a proposal for a federal funding

program to train 20 health promoters at La Rosa who would then train other women in those three communities to work in small health posts (*casas de salud*). These clinics were to be opened in community spaces in order to offer basic therapeutic treatments and herbal first aid to local residents. The proposal included offering five training workshops in first aid and nutrition, herbal medicine, auricular acupuncture, and massage for women who lived in these three communities. The proposal never received funding and thus the project was not established.

While the CCD was able to build some momentum between 2001 and 2003, the group faced significant problems that ultimately led to its decline. I learned from public comments and interviews that some La Rosa residents were angry about the CCD's use of the community center. The residents who were not involved in the center felt that the space was being used for the benefit of CCD members rather than for the good of the community. Some residents argued that it was inappropriate for the CCD to charge money for their courses and services since they operated out of a communal space. From the CCD's perspective, the health programs and clinic could not operate without payment for services since they no longer received government funding for their programs and had no other source of income.

By June 2003, the neighborhood committee in charge of running the affairs of La Rosa was pressing the community to attend an assembly and vote to close down the center and evict the group. About 40 out of the 300 neighborhood residents attended this assembly where the participants divided themselves into pro- and anti- CCD coalitions. Those in opposition to the CCD stated that they did not want "culture" in their neighborhood if it only benefited a select few. Those in support of the CCD accused the

neighborhood committee of planning to evict the group so they could rent out the center for fiestas and ultimately generate income for themselves. This created concerns among neighbors who feared an increase in the already rampant problem of alcoholism in the neighborhood. After two bitter assemblies, the majority vote fell against the CCD. The group had kept no accounting books and had little financial documentation and was powerless to defend itself against the accusations of mishandling funds. The CCD was given 20 days to move out of the community center.

Anna called upon her contacts in the Yautepec municipal council to seek financial support for the transition. The municipal president agreed to loan the group a building in the center of town for three months while they reorganized. After that point, they would have to pay a rent of $200 USD a month. After the group moved in August, the participants seemed to slowly lose their motivation. For example, I saw little visible recruitment of new participants and clients, even though many had been lost in the course of the conflict. The inevitable rent payments loomed large in front of the CCD. The large vats of herbal product that the group had made remained largely unsold. Four of the core women spoke to me separately about their struggles in staying motivated after the community conflict. They each talked about focusing on other things in their lives. Doña Juana, the oldest member of the group, best put into words what many women felt – "I have waited and waited for things to work out, and I am just getting too old for this." By the time I left Zarragoza at the end of November, the group was all but defunct.

The Parochial Center for Health Promotion (PCHP)

The Parochial Center for Health Promotion (PCHP) is a civil association that operates out of the Catholic Parish in Zarragoza. Like the CCD, the PCHP offers training courses in traditional and alternative medicine and clinical consultations. The effort began in 1990 when a women's group within the parochial parish decided to offer health classes in the church. This group was part of an "ecclesiastical base community" within the parish that advocates liberation theology[2] which organizes its members to improve the living standards of the poor. According to Miguel, the vice president of the PCHP in 2003, this group initially visited sick members of their church to distribute the Holy Communion. However, in seeing the impoverished conditions in which people lived, the women eventually decided that it was not enough to distribute communion. They felt that they could help address the suffering of the poor by teaching them about nutrition, in hopes that this could help prevent illness and allow the sick to have some control over restoring their health.

According to Miguel, a nun at the parish named Sra. Maria was trained in natural healing methods. She demonstrated to this group how to incorporate various natural therapies in their visits, such as using water or the sun to detoxify the body or stimulate blood circulation. The group eventually began teaching the people they visited how to apply these basic therapies in their homes. Sra. Maria was later joined by Sra. Adela, who had recovered from a serious thyroid illness, which the doctors told her was incurable, by incorporating natural treatments into her lifestyle. After her recovery, Sra.

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[2] Liberation theology is practiced among some Latin American Catholics who encourage the church to concentrate its efforts on liberating people from poverty and oppression. Based upon Biblical interpretations of the wide income disparities in developing countries, poverty is viewed as a prouct of the organization of society. Participants of this movement work actively to improve their living standards, typically through cooperatives and civic-improvement projects (Berryman 1987).

Adela pursued training in natural healing and, according to Miguel, became an expert in the field. In 1990 Sra. Chayo, Sra. Maria, and the Holy Communion group began offering natural healing classes for free at the church with the support of two of the parish priests.

The following year, this group invited an acupuncturist named Raul to help the group expand the program. Raul subsequently established classes on herbalism, acupuncture, Chinese philosophy, and diagnostic techniques that were open to and free of charge for the community. In 1993, the group recruited a medical physician named Antonio to join the program. Antonio brought significant experience to the PCHP since he was previously the president of Tlahuilli, a well-known civil association based in Cuernavaca that promotes traditional and alternative medicine (see Chapter 6). Six months later Miguel, a polarity therapist and homoeopathist was also invited to join the group. Finally, Alicia, a massage therapist, was integrated into the PCHP staff.

According to Miguel, Antonio, the physician, took on an immediate leadership role in the PCHP. Antonio organized the group to open a clinic in one wing of the church, and he restructured the training program, adding courses including first aid, massage, dental hygiene, iridology, psychology, homeopathy, and energetic healing. To raise funds for the program, Antonio instituted a payment system for consultations and classes, which had previously been free to students. He also began an apprenticeship program so that students who were receiving training at the dispensary could work in the clinic on a voluntary basis to gain experience. Therapists were also now required to donate a large part of their earnings from the clinic to support the program. While the

parochial church was donating the use of its space, these fees and voluntary labor were to help cover the cost of supplies and to help further expand the program.

In 2000, Antonio proposed that the group become a civil association. He invited Miguel to be the co-founder of this association. Antonio invited a medical internist, Dr. Beltran, to be the president of the association. Dr. Beltran was also politically powerful since he had been a mayoral candidate in Cuernavaca. Antonio was well networked with other civil associations in the state that were working in a similar capacity as the PCHP. Moreover, he had contacts within the UNICEDES program at the Autonomous University of Morelos State (UAEM) which assists community organizations in training health promoters and collaborating in traditional and alternative medicine efforts (see Chapter 6).

According to Miguel, Antonio also developed a similar project in Cuernavaca with the support of the University, without consulting the rest of the PCHP staff. He also made an agreement with the University that students who studied at PCHP would receive a diploma. There was a tuition charge of $3,000 pesos ($300 USD) for this. If they did not pay the University charges, then students would receive only a certificate from the parochial parish. Thus, students of the PCHP not only saw the cost of their classes increase but also faced selective certification based on their ability to pay. Since some of these students hoped to open informal private practices, these diplomas were important to them as public validation of their training.

According to the therapists and students with whom I spoke, Antonio had great success in expanding the training program and the clinical operations between 1993 and 2002. While his contributions helped the association increase the number of services it

provided, they also created much friction among staff and students. Some disagreed with the direction in which the association was going on account of Antonio's effort to professionalize and expand the program. These participants viewed that his changes (specifically the institution of, and later increases in, fees) were contrary to the PCHP's original mission of promoting community service and making health training accessible to the entire community regardless of income. Moreover, those who disagreed with Antonio's strategy describe his control over the program as overwhelmingly authoritarian.

I repeatedly heard therapists and students tell a similar story about the events that led to the final separation of the PCHP into two groups. According to these reports, because of Antonio's authoritarian approach, his only supporters were a handful of women who were studying to be health promoters. Outside of these "loyalists," his practices stirred animosity among group members (both women and men) who felt that the association was transforming into a "business." Antonio had a significant amount of power because he was the only physician in the group, had the most ambitious plans, and was well-connected politically. Therefore, no one among the staff was willing to confront him. Eventually, Miguel took the first step and called a meeting to discuss the problems with hopes of clearing the air. Antonio did not attend this meeting, nor did he attend a second meeting called for the same purpose. According to Miguel, he sent his "loyalists" in his place and nothing was ever resolved.

Antonio had been planning for some time to open a separate health school and clinic less than a mile away from the PCHP, although the staff did not know about this. Miguel felt these meetings may have provided Antonio's group the excuse they needed to

announce their intentions to move. During the second meeting, Antonio's "loyalists" announced that they were moving the civil association to their new facility. According to three of the therapists who were at this meeting, these women abruptly gathered together all of the dispensary's materials, supplies, beds, chairs, etc. and left with them. Students of the PCHP with whom I spoke expressed a shared sense of disbelief that the classroom and clinic were emptied out overnight by this group. Ultimately, Antonio moved the civil association to a building nearby and renamed it the Center for Traditional and Alternative Medicine (TAM Center).

Antonio had convinced the majority of students and many patients to follow him to his new facility. Thus, the therapists, Miguel, Raul, Alicia, and some senior students were left to pick up the pieces of their school/clinic. These therapists immediately organized themselves into a new leadership structure. Raul became the president and Miguel became the vice president of the PCHP, while three female therapists filled the other leadership positions. The group quickly set a date to begin a new three-year training program similar to the one previously offered. The group solicited church donations to help replace the classroom and clinical items that were needed.

During my visits to the PCHP in 2001 and 2003, the space was physically transformed due to the split up of the original group. For example, during my first visit in the summer of 2001, I had noticed barely legible gray letters painted on the wing of the church where the dispensary was housed that announced the types of therapies offered at the dispensary clinic. Walking up the winding staircase that leads to the clinic, I saw the small consultation room with its gray and white tile and faded white walls. Above an old desk was shelving that had various bottles and glass jars with herbal medicines. Hanging

on the wall was a reflexology poster, indicating pressure points on areas of the foot that coordinate with organs in the body. During this first visit, the two beds in the clinic were occupied by patients and curtains were drawn around the beds. One man was receiving acupuncture treatment and had a number of small, thin needles placed in his body. On the other bed, a woman was receiving a type of Japanese energy healing called Reiki therapy. Alicia, the therapist I had come to visit, had her hands placed above this woman's chest and was standing quietly over her. Two patients waited on a purple bench outside of the clinic room for their appointment. I heard a teacher's voice coming from the adjacent room where a class was being held.

I returned to Zarragoza two years later in January 2003, about two months after the split-up. The PCHP had received a facelift. Through church donations, the group that remained had purchased three new massage tables. Alicia had made new curtains to surround each of the tables and the clinic and classroom had been given a fresh coat of white paint. A new dry erase board hung at the head of the classroom and 30 new desks sat in perfect rows. A few months into my research, the façade of the center's wing also received a new coat of white paint and the lettering was repainted in bold, maroon letters which now clearly read: "Parochial Center for Health Promotion Clinic-School. Services offered: Ryodoraku Acupuncture, Homeopathy, Polarity Therapy, Massage, Yoga, Chiropractics, Naturism, Herbalism, Speech Therapy." When I visited the PCHP that January, I noticed an announcement hanging on the door that invited students to enroll in a 3-year, 135 hour course on Natural and Alternative Medicine. I enrolled in the course and became part of the first cohort of this new health school at the PCHP.

The program announcement explained that the course would consist of three modules: nutrition (the combination of foods, knowledge of nutrients, and preparing nutritive dishes), natural therapies, and herbalism (familiarization with medicinal plants, their uses, how to prepare them and elaborate soaps, tinctures, and ointments). Ultimately, the program incorporated more topics than the announcement initially suggested. For example, during the first year the students were trained in Traditional Chinese Medicine philosophy; diagnostic techniques including bioenergy tests, iridology, and pulses; and nutrition, natural therapies, and herbalism. When I left Zarragoza, the herbalism section was ending and the class was preparing to spend the entire second year studying acupuncture. The classes were taught by the senior therapists and a few recent graduates of the program who remained at the PCHP.

Of the 26 students who enrolled in this first cohort, 24 remained by the middle of the first year. Vicenta, the PCHP Treasurer and therapist, predicted that 20-22 students would remain by the end of the first year and that only about eight would actually finish the three- year program. She had attended the PCHP program from 1999-2002 (when Antonio was still in charge). At that time, 35 students began the program but only 15 students completed it. She said that only four or five of those students consistently attended the school and all of them pursued additional training. In describing the barriers that students face in completing the program, she said, "I think that it depends on people's economic situation, because while this medicine is very respectable, like everything else it requires an expenditure of money. So to be able to stay with it, well, it is very difficult."

When I enrolled in the school, the PCHP charged a $100 peso ($10 USD) registration fee and $150 peso ($15 USD) monthly fee for classes. Thus, the cost for the 3-year program was approximately $640 USD at that time. This is a significant amount for many Zarragoza residents considering that the minimum wage in Morelos is about $4 USD a day. When I left Zarragoza, the group was working on registering as a civil association so that it could be affiliated with the University and its students could also have the option to receive university diplomas in natural and alternative medicine.

Although Antonio had taken many of his clients with him to his new clinic, the PCHP appeared well on its way to recovery by the time I left the field. There were days in which four or five people would be waiting to see a therapist at any given time. The therapists volunteer to cover one four-hour shift once a week, and they are assisted by a senior student apprentice. Many of the therapists have their own clientele or "regulars" as well as receiving drop-ins. Patients typically choose to visit the dispensary on a specific day because they like the therapist who is working. Sometimes, they are seeking out a specific type of treatment. For example, Raul is well known for his acupuncture; Miguel is well known for his work with polarity therapy and homeopathy; and people come to see Alicia for her skills in therapeutic massage or for spiritual cleansings (*limpios*).

Patients are charged between $5-6 USD for a consultation, which usually lasts approximately an hour. However, patients are treated regardless of whether or not they can afford to pay. If they do not have the money, their fees are waived or they are asked to pay when they have the money. By implementing a sliding scale policy and keeping

the costs low, the PCHP has regained its original function – to provide health services for those in need.

Patients come from diverse geographic locations – some travel from far reaching villages in Morelos or Mexico City. Others come from different *colonias* in Zarragoza or from larger cities within the state. In a sample of 100 patient records that I randomly selected from the set of available records, I found that 59% of the patients in the sample live in the municipality of Yautepec while 40% commute from other cities, towns, or villages throughout Morelos State. Ten percent of these patients reside in an urban setting while the rest reside in smaller towns or villages. Women represented 66% of the clinic users in this sample while men represented 34%. The majority of patients come from the lower- and working-classes, although professionals occasionally visit the clinic. Patients are involved in a diverse array of professions that include farmers, laborers, vendors, teachers, domestic workers, and students among others. Middle-aged housewives accounted for 28% of the patients in this sample. Fifty-eight percent of the patients who utilize the clinic do not have access to public health insurance (IMSS/ISSSTE) while 42% do have insurance.

In this sample, the most common symptoms reported were back, waist, leg, and knee pains (25%); abdominal pains, digestive problems, intestinal problems, and diarrhea (14%); problems of the eyes, nose, and throat (12%); irritability, anger, nerves, or fatigue (11%); diabetes and high blood sugar (6%); and rheumatoid arthritis (5%). Patients also presented symptoms relating to asthma, leukemia, epilepsy, Parkinson's disease, and ovarian cysts. A few patients were also seeking "psychic treatment" or were suffering from memory problems, "sensitivity," or vertigo.

For the most part, patients' symptoms are not acute in nature, although many suffer from chronic ailments. Based on my review of PCHP records, patients seek out services at the clinic for roughly four categories of symptoms: 1) those that do not respond well to biomedical treatment, are expensive to treat, or do not have a "cure" (e.g., chronic illnesses); 2) those for which natural therapies and herbal remedies have been known to be efficacious (e.g., digestive, respiratory problems); 3) chronic pains that are only temporarily abated by biomedical medication; and 4) psychological or emotional problems, that are usually afforded little attention in biomedical facilities (e.g., irritability, anger, nerves).

In large part because the PCHP services were affordable and accessible to local residents, the clinic seemed to be gaining popularity, and the group was attaining momentum by the time I left Zarragoza. Based upon my informants and observations, the therapists had positive reputations in the community, and the students enrolled in the school were enthusiastic and committed to their training. Two events during my research period helped to bolster the reputation and clinic base of the PCHP – a flood and a health festival.

A major flood washed through Zarragoza on July 4, 2003, seriously damaging the communities located nearest to the ravines. In response to the flood, the PCHP organized an emergency health brigade and opened a makeshift clinic in El Bosque, the neighborhood hardest hit by the flood. Over the course of a week, students and therapists volunteered their time to survey the houses that were damaged, talk with the residents about health complaints they experienced, and provide an array of health services to flood victims. These services included consultations, massages, auriculotherapy (treating

acupuncture points exclusively on the ear), homeopathic treatment, and herbal remedies for symptoms that were expected to occur as a result of the flood (i.e., respiratory intestinal problems, skin rashes, and nervousness). The group also distributed donated foodstuffs and clothing. Over the course of the week, the group provided consultations for 107 flood victims, and they invited each of them to the PCHP for a free follow up visit. Thus, many El Bosque residents were introduced to the dispensary through this tragic event. When I returned two months later to conduct questionnaires with a sample of El Bosque residents, I heard many stories about the PCHP health brigade and the hope it brought to neighborhood residents.

The second event that introduced many people to the dispensary was a "Health Festival" the PCHP held that August after a Sunday mass in the parochial parish courtyard. The priest announced the festival during the church service and at least 100 people attended. There was music and food during the event. Therapists and students provided free back massages and auricurotherapy and sold herbal remedies for specific ailments and herbal plants at a very low cost. The group also talked with attendees about nutrition and natural therapies. This event successfully introduced many church members to the PCHP services and proved to be a successful strategy to recruit new clients and students.

The Center for Traditional and Alternative Medicine (TAM Center)

In early 2003, Antonio opened the Center for Traditional and Alternative Medicine (TAM Center) after the dramatic split with the PCHP. Because of the stormy break up of the two groups, I learned about the TAM Center through my interviews with

affiliates of the PCHP. Due to my close relationship with therapists and students at the PCHP, I decided not to pursue interviews and observations at the TAM Center. While I never formally interviewed the TAM staff, I did speak with three students who maintained their studies with Antonio at the TAM Center while also joining the new cohort at the PCHP. These students were generally pleased with their training at the TAM Center. On two occasions, I visited the TAM Center. During the first visit, I spoke at length with a female health promoter there about the specific services offered at the center. She also gave me a tour of the facilities. During the second visit I spoke briefly with Antonio about his work and his vision for the school and clinic. We did not discuss the split up of the two groups, however.

When I visited the Center, I was immediately struck by how it contrasted in appearance with the PCHP. The TAM Center facility is much larger than the PCHP clinic and school. It has a large reception room, a kitchen, two separate consultation rooms, two classrooms upstairs, a natural therapy room with steam machines, and a patio for sun and water therapies. In contrast, the PCHP has one small room that serves as a dual reception area and consultation space, a classroom, and an upstairs patio. The TAM Center also had a more institutional feeling than any of the other community clinics I had visited. The building is vast with thick white walls, a long white hallway, and little color or sound. The rooms are sparsely furnished except for beds and desks. The institutional feeling is also conveyed through the white jackets that are worn by health promoters. This feeling contrasted with the more soothing and comforting feelings of the PCHP and the other community clinics that I had visited throughout the state.

The center's building facade conveys a mixed and somewhat contradictory message. A large Aztec-looking figure (part human, part animal) is painted in bright colors on the outside wall, symbolizing the pre-Hispanic elements of some of the healing traditions offered at this clinic. Under this figure, the name of the two responsible physicians and their Ministry of Health registration numbers are painted prominently in blue, as is common practice of biomedical practitioners throughout Mexico. To the right of the Aztec figure is a list of the four diplomas offered at the school – Traditional Medicine and Herbalism; Natural and Alternative Medicine; Natural and Alternative Community Medicine; and Acupuncture and Chinese Moxibustion. A list of courses offered at the center is also painted on the facade including massage, chiropractics, nutrition, iridology, homeopathy, herbalism, and home remedies. Below the course list is the statement, "All of the courses are in accordance with the Autonomous University of Morelos State (UAEM) through the Central Unit for the Studies in Social Development (UNICEDES) and the School of Nursing." In other words, the status of the two responsible physicians and school's university accreditation is communicated prominently to offer legitimacy for the promotion of traditional and alternative medicine.

The health promoter who showed me the facility, Adriana, explained that classes were held at the Center three days a week for each of three cohorts. Two of the cohorts were the students who transferred from the PCHP to the TAM Center. The third cohort had just begun their training with the opening of the Center. Diploma courses cost $3000 pesos ($300 USD). A course such as natural foods, nutrition, and cooking lasts almost eight months with four-hour classes one day a week. The center also holds shorter workshops. For example, a 16-hour course on treating women's illnesses with natural

medicine, acupuncture, and moxibustion costs $275 pesos ($27.50 USD). The clinical services at the center cost patients $100 pesos per visit ($10 USD). Adriana explained that the association had been around for 10 years, but they had only been in their new place for three months. She referred to the PCHP as the "little place" and explained that they were adding on to their new facility little by little.

I returned to the TAM Center three months later. When I arrived, Antonio was wearing a white physician's coat with the association's emblem sewed on the front. He was sitting on the purple bench that I had once seen in the PCHP, chatting with two of the female health promoters. From our conversation, I learned that 25 years ago he had started a program in the state of Mexico where he had trained a group of health promoters to go to poor communities to provide dental services. Antonio said that he had also opened up a community clinic where people could receive traditional and alternative medicine services at a low cost. Although he moved on when he was invited to join the PCHP after 10 years of this work, he said that he believes the clinic is still running. He explained that during his first year at the PCHP, there were 72 students who enrolled in the classes and that 26 students graduated after three years. Now, he said, his school has about 85 students, the majority of whom are housewives. For these women, he added, there is a dimension of self-sufficiency that comes with graduating from the school and becoming a health promoter. He compared health promotion work to the typical work that woman do – housework, sewing, and vending goods –suggesting that health promotion is more honorable than women's typical work.

Antonio explained that his group recently moved into the new facility because there were problems with the other group at the PCHP. Now, he works at the TAM

Center in Zarragoza one day a week. Margarita, a trained female health promoter, runs the TAM Center in his absence. He operates a similar health center in the city of Cuernavaca and also has a private practice in the nearby town of San Lucas. Antonio sees his association as contributing to the "social development" of the community. He explained that the philosophy behind the association was to "help others help themselves." He contrasted this philosophy with that of the PCHP which he described as "helping poor people."

Antonio explained that the work of the TAM Center is part of a "social movement" (*movimiento popular*) that is building momentum throughout the nation. He feels that biomedicine has reached its peak, and now people are complaining about allopathic medicines and services. He said that people often choose to use alternative medicine because allopathic medicine has not worked for them. When they try alternative medicine, they find that it works. Antonio thinks that it is only a matter of time before the country turns its full attention to alternative and traditional medicine. He explained that so far, the social movement has been successful in pressuring the Ministry of Health to develop a department of traditional and alternative medicine. Although the department doesn't do much, Antonio suggested that it is a sign that things are changing.

Reflections on health organizing in Zarragoza

The three Zarragoza health groups described here share a similar mission of educating the public and providing non-biomedical health services for the community. As we will see in detail in Chapter 8, the groups draw from a diverse potpourri of therapies from China (Traditional Chinese Medicine), Europe (Homeopathy), North

America (Polarity Therapy), and Mesoamerica (Mexican Herbalism). To make their services accessible, the groups have historically adhered to a communitarian model of service that encourages health promoters and students to serve low-income populations and to volunteer their time in the clinics. This approach has helped them to maintain the relatively low cost of services. The majority of students who are enrolled in the schools are women; however, men occupy the most prominent leadership roles in both the PCHP and the TAM Center. The CCD is the only group of the three that is led by and comprised only of women.

While the groups share similar health promotion strategies, they are nonetheless driven by different interests and incentives. For example, the CCD's Health Committee was initiated when it received government funding to organize a women's training program in nutrition and traditional herbalism. The group's organizers, Anna and Lety, applied for and received government funding available for "social development" programs that target women's training and support community efforts for the preservation of regional culture. As Anna explained, the primary objective of the Health Committee is to "educate women because they are the foundation of the family. They are the nurses at any given moment and they need to know what to do."

This statement illustrates how the CCD leadership has adopted discourses pertaining to gender development. The CCD also attempted to organize an herbal medicine production cooperative as a means of increasing the economic self-sufficiency of the group and its female participants. However, as government funding was withdrawn, not enough women contributed their own money to maintain the cooperative and the training program. The neighborhood committee's protest of their use of

community space and the CCD's subsequent expulsion from the community center further contributed to their demise.

Unlike the CCD, which was influenced by government discourses on gender and development, the PCHP was initiated by a group of women influenced by Catholic liberation theology with its focus on improving the living standards of the most impoverished segments of society. These women sought to promote greater nutrition and health awareness among poor residents of Zarragoza. Eventually, they opened a small school in the parochial parish where they taught classes on nutrition and natural healing. They invited alternative medicine specialists to the group who transformed the effort into a more formal training program and clinic, which was supported by the parochial church. However, Antonio's vision for expanding the association and initiating a fee structure clashed with the vision of some of the PCHP staff members who wanted to retain the more communitarian approach inherent to the group's original mission. This ideological rift was not to be mended. As a result, Antonio opened the TAM Center, separate from the PCHP.

The TAM Center now offers similar services as those offered by the PCHP. Its fees are higher and its facilities are more extensive. The TAM Center boasts strong institutional contacts maintained by the two medical physicians who lead the effort. For example, the training program is registered with the Ministry of Health and the Secretary of Public Education as well as with the University of Morelos (UAEM). Such institutional ties provide a level of legitimacy to the TAM Center that the other two groups do not have. Furthermore, because the TAM Center is well integrated in a network of civil associations linked together through UAEM's Popular Community

Health division of UNICEDES, it is able to provide university diplomas and receive promotion for its programs in a way that the CCD and the PCHP cannot. Students who can afford to train at the TAM Center may be drawn to the association because of its institutional ties and the formal legitimacy that a diploma brings, particularly as competition in the field of health promotion increases. The director of the TAM Center sees his program as contributing to Zarragoza's social development. In his words, the effort is "helping others help themselves" rather than merely "helping the poor," as he characterizes the mission of the PCHP.

None of the three groups rely on international funding and only the CCD relied on government funding. The groups have chosen to remain independent of the political parties that distribute resources to local groups and instead attempt to fund their programs through service fees and the volunteer efforts of their staff. Yet the cost differences between the services at the TAM Center and the PCHP and CCD suggest that the organizations may be moving in different directions financially. For example, the PCHP and CCD charge around $15 USD per month for students to participate in weekly classes while the TAM Center charges about $37.50 USD per month. The PCHP and CCD charge between $5 and $6 USD for a clinical consultation while the TAM Center charges about twice that ($10 USD) for a basic consultation. It remains to be seen if the PCHP remains sustainable as it attempts to keep its fees low, and to what extent the community accepts the higher fees at the TAM Center.

Culture, community, and conflict

The theme of conflict is striking in the historical narratives described above. Conflict seems to loom large, particularly around the groups' income generation strategies. For example, in the case of the CCD, La Rosa neighbors explicitly claimed that the group was out to "rob the community" through their income generating activities. This argument was ultimately used to evict the group from the community center. I observed similar community conflict in a neighboring municipality. A women's health group became the target of hostility because the participants were having success in running a clinic and a *temazcal* (pre-Hispanic steam bath used for therapeutic purposes) which drew wealthy foreigners to the town. However, such accusations were not only targeted at groups by community residents. On numerous occasions, I encountered similar accusations directed at individual group members by other participants, especially at those who had success in operating their own private practices. The accusations directed at Antonio by some PCHP students and staff members regarding his presumed intention to "create a business for himself" are a further example of how group members maintain a watchful eye when it comes to the threat of successful capitalist endeavors.

The tension between community service and income generation (or communitarian and individualistic endeavors) is a recurrent theme that emerges from my observations with health groups. For example, Anna describes the struggle that she faced in running the CCD on account of this tension:

> We charge $120 pesos ($12 USD) or $160 pesos ($16 USD) per month (for classes), and it is more like community service. It is not like a business. It is not lucrative but rather it is for the benefit of all. This is our ideal, and we are working towards this. However, we have problems since we are not making money. The fewer people that we train, the fewer people that will be assisted. And we know that when [the services] are less expensive, more people will be able to access them. But this is a problem because we can't sustain it.

One way in which the CCD had hoped to resolve this dilemma was through organizing a cooperative with the explicit objective of generating money for the association and its participants. As Lety, the co-director of the CCD explained, the cooperative was formed so female health promoters could not only give their services, but they could receive remuneration as well. She suggested that all too often, women are expected by civil associations to provide their services for nothing since they are "closer to traditional knowledge than men." As she explained:

> What has happened is that for example, if I have traditional knowledge or know how to heal with herbal medicines, they use me, they teach me, but they (the association members) don't pay me. Culturally, I have the obligation to share my knowledge because I have it and I want it to be reproduced, but they don't pay me. So how am I going to live if they don't pay me, if I don't have another means to live off of? I am not going to get rich; getting rich is very different than doing something that will allow me to survive as an individual.

Lety argued that the effort to maintain traditional medicine should not be a "titanic struggle in which women die of hunger fighting for it. That is not worth it. Women have to give something culturally, but they also have to receive something."

Miguel, the vice president of the PCHP, echoed the idea that compensation is important in the work of health promoters. He does not see a conflict in individual or collective efforts to generate money by selling traditional and alternative medicine. This is because he views the services offered by health promoters as significantly less expensive than other private health services. Furthermore, he argues that students have a responsibility to "lead the people to a healthier way of life" as well as to practice and teach the principals they learn at the PCHP. At the same time, he said, "They certainly have the right to charge for their services." He suggests that charging for services is like a "reward for the effort that we are making."

In addition to his work at the PCHP clinic, Miguel runs a private clinic in his house and he visits his patients in their homes. He charges $150 pesos ($15 USD) for a private consultation, but if people tell him they don't have money, then he will provide the services for free. As he explained:

> I was educated to serve the people. I know some people really don't have any money. So I feel bad. I don't charge anything. Or, I ask them to pay me later. In the clinic, we only charge $50 pesos ($5 USD). If people don't have any money, we don't charge anything. They just pay for the medicine. If people can't afford a consultation in my office, then I send them to the clinic. Many people think $150 pesos ($15 USD) for a service is expensive. But, they are charged $400 or $450 pesos ($40 or $50 USD) for the same services I provide if they go somewhere else.

Many health group participants who I interviewed are interested in generating money from their health training by running their own private practices or selling their remedies. Although women do not often join the groups or begin their training because they have professional interests in mind, they usually see that there are opportunities in the informal health sector that can help them improve their economic situation (see Chapter 9 for consideration of this issue). Experienced therapists who see patients in their home often charge more than what is charged in the community clinics (usually between $8 - $15 USD), although they too adhere to the sliding-scale rule if patients are unable to pay. However, students who are training usually do not charge over $6 USD for a consultation.

I heard in numerous interviews about a type of criteria used by health group participants to judge whether or not a health promoter is conducting business ethically. This criteria is based on whether or not the health promoter is perceived to be "open" or "closed" in sharing his/her health knowledge and providing services to those in need. According to this perspective, an "open" health promoter is viewed as willing to teach

others and to offer services with little expectation for compensation if necessary. In contrast, a "closed" health promoter is perceived as only having economic gain in mind. Miguel, who was constantly offering free workshops and trainings at the PCHP and delivering his services to poor individuals free of charge in the community, was often described as the ideal "open" health promoter by interviewees. In contrast, Antonio was often viewed as the opposite – the "closed" practitioner who was capitalizing on the clinical and educational services offered at the PCHP. Arguably such judgments help to maintain the relatively low cost of services offered by health promoters as well as a community service ethic. This is particularly important since the informal health care sector is a largely unregulated domain in terms of service quality and cost.

Conclusions

This chapter has outlined the histories of three health groups in Zarragoza, comparing and contrasting their approaches and the discourses that guide their work. It has demonstrated how health groups are influenced by government funding, community politics, local dynamics, gender inequalities, and development discourses among other social forces. The organizational strategies of the groups reflect the many tensions inherent to Mexican society, including those pertaining to capitalism vs. community service and the influence of Western values vs. notions of tradition. I suggest that through the lens of health organizing in Zarragoza, we can gain a snapshot of many transformations that are occurring in Mexican society today.

CHAPTER EIGHT: HEALTH GROUP DISCOURSE AND PRACTICE

In this chapter I explore some of the health care philosophies and practices included in the health promoter training programs and community clinics run by the Parochial Center for Health Promotion (PCHP) and the Committee for Culture and Development (CCD) in Zarragoza. Nigenda et al. (2001a) suggest that in the context of globalization "where health care practices trespass across frontiers to become adapted to new environments, the mixture of local and foreign forms of non-biomedical practices in Mexico deserves to be understood" (p. 5). This chapter seeks to further this understanding by considering the range of health practices and philosophies that have been adopted by local groups for the purpose of addressing physical, emotional, and social aspects of suffering. In addition to examining how health groups define and attempt to resolve ill-health in Zarragoza, I explore how participants advocate a set of values that emphasize the relationship between health, society, and the environment.

Background

The range of practices utilized by health groups in Zarragoza is extensive and diverse. In fact, the large cornucopia of therapies employed by health groups is one defining characteristic of this alternative health care movement in Mexico. The practices include Mexican herbalism, Chinese acupuncture, homeopathy, auriculotherapy, therapeutic massage, reflexology, and polarity therapy among many other therapies (see Appendix A for a description of these therapeutic practices). The PCHP and CCD incorporate these disparate practices into a package that they label as "traditional and alternative medicine" (TAM).

In chapter 6, I defined "traditional Mexican medicine" and "alternative medicine" as categories that are locally differentiated based upon the origins of the practices. For example, health group participants with whom I spoke define "traditional" medical practices as those having roots native to Mexico.[1] They define "alternative" medical practices as those originating in countries outside of Mexico. However, in practice, health group participants do not spend much time making distinctions between traditional and alternative medicine.

Nigenda et al. (2004) suggest that in the state of Morelos, the populations that use traditional healers are principally people of low to middle socioeconomic status while those that use alternative medicine are principally from middle to high socioeconomic classes (Nigenda et al. 2001a). In my survey of 100 Zarragoza residents (see Chapter 6), I also found that traditional healers were most often used by the lower classes and expensive alternative medicine treatments were used by more economically solvent households. However, my study suggests that the practices and services offered by local health groups blur the boundaries of user demographics since they make alternative medicine affordable for all socioeconomic levels. Specifically, the lower classes who primarily utilize the PCHP clinic (see Chapter 7) are receiving alternative health care services that would be largely unaffordable through private providers. Moreover, the few middle-class professionals who use the clinic may be seeking herbal remedies or *limpias*, otherwise considered to be "traditional" medicine.

[1] Traditional medicine may also be defined as the "outcome of the syncretic union" between pre-Hispanic concepts and health care practices that were incorporated with the arrival of the Spaniards (Nigenda et al. 2001a). However, local discussion of traditional medicine does not refer to this syncretism, only to practices that are presumed to be "native" to Mexico.

The groups also blur boundaries between which practices are conceived of as local or global in origin (i.e., "traditional" and "alternative" in practice). This is demonstrated by the diverse patchwork of health practices that is taught to students and applied in community clinics. As I mentioned above, these health group participants do not make a distinction between "traditional" and "alternative" medicine practices (unless they are asked by a researcher to explain the difference between the two categories). Instead, they learn the practices as a package of illness prevention and health care options.

The practices that I describe below are linked by a philosophy that emphasizes a holistic view of health. This means that health is viewed as the outcome of the physical, emotional, psychological, and spiritual domains of the individual as well as the interaction between the body and its social and physical environments. In addition to addressing these multiple health domains, I suggest that the health practices advocated by the Zarragoza health groups are a response to numerous social factors. These include the availability of diverse health care options through processes of globalization, growing awareness of the limitations of biomedicine, and alarm at the decline of traditional social values and the destruction of the environment. By examining the practices and philosophies employed by the PCHP and CCD, I seek to understand how health groups respond to social changes that are affecting the health and well being of the population.

I became familiar with the discourses and practices employed by these health groups as a participant-observer and as a student of their schools. I was enrolled in courses from February-November 2003 (see Chapter 2 for an outline of the methodology used to gather data for this chapter). Below I draw from class and workshop notes;

observations at the community clinics; meetings and events; and the relationships that I developed with students and health promoters to paint a picture of the health discourses and health care practices that these groups are advocating and employing in Zarragoza.

Health promoter training

The PCHP and the CCD both run health promoter training programs that educate students on illness prevention, diagnosis, and treatment using a range of non-biomedical healing practices. The PCHP runs a three-year, 135 hour course in "Natural and Alternative Medicine" that focuses on various healing modalities including nutrition, herbalism, natural therapies, acupuncture, massage, and psychology. After completing the course, students receive a certificate from the Parochial Parish.[2] The CCD runs eight-month courses and short workshops on nutrition, herbalism, natural therapies, and massage. Students who complete the long courses receive a certificate through the Secretary of Public Education. These certificates are largely symbolic since there is no official license or permit for practicing these modalities.

In the following sections, I examine the discourses, values, and ethics that students are exposed to through their participation in these health groups. I contend that the philosophies and practices taught in the classroom go beyond instructing students how to prevent and heal illnesses. They offer a holistic view of health that emphasizes the relationship between mind, body, and society, as well as impart moral discourses about protecting the environment, adhering to cultural values, and maintaining family connections as important elements of corporeal "balance."

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[2] Students will eventually receive a certificate from the Secretary of Public Education (SEP). Before I left the field, the PCHP was in the process of registering as a civil association which is a prerequisite for becoming accredited through SEP.

The elements of health promotion

Here I describe four modules– nutrition, natural therapies, herbalism, and Chinese medical theory – that were covered in detail during the first year of the health promoter training program at the PCHP and in courses offered by the CCD during my research period. I explore how the discourses that are embedded within each training module contribute to the overall therapeutic approach of the health groups. Although these modules represent only a few of the many different therapies taught in the health promoter programs, I describe them here as examples of a larger set of discourses applied by the members of both groups.

Nutrition: "Let food be thy medicine and medicine thy food"

Health promoters studying at the PCHP and CCD are taught that the base and most fundamental strategy in illness prevention and health promotion relates to balanced nutrition. This idea that "nutrition is the basis of all health actions," was mentioned in many of my interviews with health group participants, as well as in the nutrition classes that I attended. Students are taught that a healthy diet is a tangible remedy for the many health problems that have accompanied rapid industrialization, changes in cultivation patterns, and the influence of Western consumerism in Mexico. For example, a nutrition handbook produced by the CCD Health Committee outlines the pressing problems that Mexicans face in relation to declining nutrition habits.

> Nutrition and health problems are accentuated in marginal communities in Morelos State and throughout the country in general, given the poverty in which these communities live and ignorance about how to nourish oneself and combine the foods that families have. Additionally, contact with propaganda on television

> generates great confusion and desperation for not having economic resources to acquire canned fruits with vitamins, foods prepared with milk, boxed cereals, among other things. This problem is lived out daily in our communities when schools give out snacks like Sabritas (chips) and a soft drink or instant soup. This situation prevents us from understanding that we can generate healthy diets with the resources that we possess.

The social changes occurring in Mexico are a frequent topic of discussion in the classroom. Students are taught about the transformation of consumer patterns in their country. The example of diabetes is often drawn upon to demonstrate one detrimental and widespread effect of the recent changes in the Mexican diet where more traditional staples are being replaced with processed, refined Western food and drink. As a result of these changes, nutrition instructors advocate a return to and reliance on local and natural foods. They suggest that nutrition is one of many important aspects of healthy living. As Vicenta, a PCHP instructor explained:

> Why do we get sick? Because we are out of balance, because of our poor eating habits, lack of exercise, not drinking sufficient water, smoking, a lack of hygiene, our many vices, stress, and rushing around. How do you prevent illness? Through good nutrition, exercise, sufficient water, and a positive attitude.

To educate students on the theory and practice of nutritional healing, the PCHP offered a three month nutrition course as part of their health promoter training program. The class examined the functions and operations of the digestive system, nutrition theory, food combinations, properties of vitamins and minerals, and characteristics of a healthy diet. They put these lessons into practice in cooking sessions which took place at the home of an instructor. These sessions offered students hands-on experience with cooking a range of healthy meals. While cooking (and eating), the class practiced cooking techniques and discussed healthy eating habits to ensure optimal digestion and positive eating environments, and how emotions affect digestion, among other topics.

In addition to driving home the relationship between poor nutrition and illness, instructors also advocate that healthy eating patterns are the gateway to other positive life changes. In fact, nutrition is identified as the most fundamental starting point for other health changes. As Belinda from the CCD explained, "When you try to eat more nutritiously, you begin to change your emotions, your lifestyle, your way of thinking and this is a very good change." I heard similar comments in many of my interviews with health promoters.

Nutrition therapy, as it is taught in the PCHP and CCD, is viewed as a preventative as well as curative strategy. For example diabetes, which is the primary cause of death in Mexico (Secretaría de Salud 2004a), is a disease that requires that sufferers be extremely vigilant about the foods that they eat. Because diabetes affects so many people in Mexico (in fact, almost every woman I surveyed in Zarragoza listed at least one friend, relative, or neighbor who suffers from diabetes), the PCHP provided a special workshop on the causes and management of diabetes with a focus on nutrition. Students were taught to be more aware of the signs and symptoms of diabetes and how to use nutrition to manage this disease. They were also instructed on how a well-balanced, natural diet can prevent Type II diabetes.

Thus, while students learn about nutrition as an individual strategy for illness prevention and healing, they also learn about the cultural consumer shifts taking place in Mexican society that are leading to unhealthy eating patterns. As a result of these shifts, nutrition instructors suggested that cultural changes as well as individual changes are required to improve the overall health of Mexicans. In other words, health groups emphasize nutrition as a gateway to other positive changes, greater health awareness,

illness prevention and healing, and an antidote to the negative effects of Western dietary influences.

Naturism: "You find life in all things that come from nature"

Naturism is another module that is taught in the PCHP and CCD health promoter programs. The philosophy of naturism, as it is taught in these settings, is based on the idea that the body is a microcosm of the larger environment in which it exists, and this larger environment contains the best resources possible to support the body's natural healing processes. Adhering to this philosophy, both groups teach students how to use natural therapies based on water (hydrotherapy), sun (heliotherapy), land (geotherapy), and air (respiration). Hydrotherapy is emphasized for its detoxifying and purifying effects. Students learn about and practice the many different forms of hydrotherapy – steam baths, cold towel baths, sitz baths, etc. Hydrotherapy is recommended for treatment of scorpion bites, typhoid fever, bronchitis, and pneumonia because of its detoxifying and blood purification effects.

Instructors teaching natural therapies also emphasized sun baths; exposing certain parts of the body to the sun for periods of time to stimulate nerve endings, assist in expelling toxins, and help to eliminate microbes to prevent skin infections. Alicia, a PCHP instructor, recommended sun baths to help with circulation, kidney and liver problems, tuberculosis, obesity and rheumatoid arthritis among other ailments. Clay and mud therapies (i.e., placing clay or mud on certain parts of the body for periods of time) were taught as a means to help detoxify and purify the body, as well as serving as anti-inflammatory agents. Clay can either be placed directly on the body as a compress, or

ingested in small amounts. Clay was recommended for intestinal infections and other infections like TB, dysentery, asthma, arthritis, and eye problems. Students were taught that because clay has important salts and minerals, such therapies are useful for menopausal women and women with osteoporosis. During the "practice" classes, students experimented with sun baths targeting certain organs and with clay therapies to experience the effects.

These natural therapies fit in well with the idea of health promotion as community service, as advocated by the two groups. First, natural therapies cost nothing to administer since all residents, regardless of income, have access to sun and water. Clay is relatively inexpensive to purchase at natural food stores or can also be dug from the earth. Second, like nutrition, natural therapies depend on the patient's willingness to participate in the therapy. Thus, health promoters teach residents how to utilize natural therapies and the patient can administer them as needed. Finally, health group participants say the use of natural therapies contributes to greater environmental awareness and a better understanding of the relationship between health and the environment. For example, Anna explained that the reason that the CCD was offering a course on natural medicine was to:

> ...increase people's awareness that nature is the best remedy. And also it is a form of raising awareness about how to care for our environment because our life, our health comes from there. There are repercussions for everything that we do to the environment. We believe that in order to be healthy, we have to live well in our surroundings.

The classes that I attended on natural therapies encouraged students to think about the quality of the air they breathe, the water they drink, and the nutrients in their land. Students were led into discussions concerning the ways in which humans control and

exploit the same environment that provides them with life and health. In essence, the classes on natural therapies drove home a moral lesson – taking care of our natural surroundings is essential if we are serious about health promotion. Conversely, if we choose to ignore our environment, then we can only blame ourselves for the sicknesses we endure. As Alicia, a PCHP instructor explained:

> If we have a good environment, we have good health. But because of all of the scientific advances, men believe that everything they do is beneficial. We are losing water because of scientific advances. We don't know how to breathe. We have contaminated our air. We have problems with the land, too. Because of chemicals, our land doesn't produce healthy foods. Thus, we do not have good digestion, or good blood running through our bodies. The reality is that we are making ourselves sick.

While students are presented with a moral imperative to act daily to preserve their environment, they are also taught a particular model of the historical roots of loss of their natural resources and traditional health practices. As Alicia explained:

> In the early days, few people became sick. When they were, people cured themselves with plants, the sun, earth, and water. But with the invasion of the Spaniards, different illnesses arrived in the country. This is where medicine was first introduced. We were healthy before foreigners and their science entered. That is where the problem started.

Thus, while the lessons in nutrition focus on the current "invasion" of Western consumer values, natural therapy classes emphasize the losses associated with science and modern medicine which have replaced more natural healing approaches. Such discourses encourage health promoters to be stewards of the environment, advocates for the use of natural healing traditions, and participants in cultural resuscitation, as the case of herbalism below suggests. Thus health promoter training not only imparts health knowledge and practice but also a moral ethic and ideals of social responsibility.

Herbalism: Resuscitating the past

Herbalism (*herbolaria*) is an important area of study and practice within the PCHP and CCD groups. My observations suggest that most students come to herbalism training with little more than basic knowledge of a few commonly used medicinal plants (e.g., chamomile, spearmint, aloe) and the ailments that they help to resolve. In fact, only a few of the 100 women I surveyed in Zarragoza could list more than five herbal remedies and their uses. Even though many Zarragoza residents may know little about traditional herbalism, this does not mean that they do not use herbal remedies. Many people I spoke with seek out herbal cures at the local markets where generations of herbalists sell fresh plants, roots, and barks, or at the natural health stores that sell pre-packaged and bottled remedies.

Participants of health groups often speak of the importance of herbalism relating to its position as the most ancient form of healing in Mesoamerica. As I discussed in Chapter 6, the practice of herbalism is viewed by government agencies and community organizations as an important aspect of Mexico's national heritage. As a result, a diverse cadre of groups is working to research and "rescue" herbalism as both a cultural project and a health care endeavor. Health groups are contributing to this work through their education efforts. At the same time, they are aware that private researchers, pharmaceutical companies, and bioprospectors are eagerly pursuing and extracting medicinal plant knowledge and resources from the country. As result, herbalism is by no means a neutral area of discourse or practice.

Groups like the PCHP, the CCD, and similar health collectives are working towards diffusing the knowledge so that all Mexicans can utilize this ancient practice. In

fact, I was surprised during my first visit with a health group in the town of Coatetelco with the openness by which its members were sharing their knowledge. One of the members with whom I visited shared with me the ingredients of some of the remedies that she sells to patients who consult with her. She expressed the hope that all Mexican women will learn how to use medicinal plants and that individuals will bring this knowledge to the United States so that people outside of Mexico can have access to this resource.

This position, that herbalism is a domain of knowledge to be shared rather than guarded, is similarly advocated by the PCHP and CCD. In order to spread herbal knowledge, the two groups offer courses that provide students with extensive background and practical information on identifying and using medicinal plants for illness prevention and treatment. In the two courses that I attended, students learned how to identify different parts of plants, their component chemicals, and the curative effects of the plants. They learned how the body absorbs, distributes, metabolizes, and eliminates medicinal properties and how to prepare and administer herbal medicines (amounts, dosages, combinations, etc.). Although there are hundreds of medicinal plants in the region, the courses focused on any 15-20 plants that serve a diverse array of elements. Some of these plants include marigold (*pericon*), chamomile (*manzanilla*), prickly pear cactus (*nopal*), tejocote tree fruit and root (*tejocote*), orange tree leaves (*hojas de naranjo*), borrage (*borraja*), toronjil (*balm*), and worm wood (*estafiate*), among others. As Marcela, an herbalism instructor at the CCD explained:

> It is not true that you have to learn about all of the plants that exist. In Mexico, there are more than 5000 plants. It is impossible to learn how to use all of them. It is better to learn 20 plants very well. Every plant can cure 10-15 illnesses. So

it is better to know a handful of plants very well. You can never finish learning *herbolaria.*

Students are taught that plants receive their curative properties from the elements of air, water, soil, sun, and metal that nourish their growth. Instructors encourage students to ask permission from the land before taking a plant, to give thanks to the earth for providing the plants, and to take only the plants that they need.[3] Both schools organized plant collection outings where students gathered in fields and forests to identify and collect plants to produce remedies. Using the fresh plants, students are to develop their own personal "first aid kit" with the plants that they collect so they can experiment with the remedies and have them on hand in the case that a family member or neighbor gets sick. The herbalism instructors recommend that this first aid kit include remedies for fevers, vomiting, diarrhea, cough, burns, wounds, and insect bites.

While the health groups say they are trying to "rescue" the knowledge of their ancestors that has been lost, in fact I observed that much of their information is retrieved from the many books that are being published on the topic. Some of these books draw from local research being conducted with traditional healers and in rural communities throughout Mexico, while others belong to popular culture, many of which are published outside of the country and translated into Spanish. Thus, the "ancient" tradition is undergoing new interpretations and influences while health groups advocate that they are resuscitating and revitalizing traditional herbalism before it disappears from Mexican culture. Explaining this position, Monica, a CCD instructor said:

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[3] The rule of taking only what you need became a focus of discussion in a CCD class after the instructor had learned from her students that a PCHP instructor who led a plant collection outing supposedly hoarded plants that he intended to make into remedies to sell for his own profit. This situation was used to emphasize the point that students must respect the earth and take from it only what is needed.

> Herbalism is one of the most ancient forms of healing with our natural resources. God has given us medicinal plants. Through divine wisdom, in every corner of the planet where illnesses exist, there are plants specifically to cure them. From the beginning of time, our ancestors used plants as medicine and food. They knew about plants, their qualities, their properties, and the illnesses that they cured. Unfortunately, at the time of the Spanish conquest, we lost much valuable information about our medicinal plants. Today we are rescuing this valuable treasure that belongs to us.

In order to rescue this "treasure," health promoter students are encouraged to learn about plants, their qualities, properties, and the illnesses that they cure. They are told to seek out plants that exist in their own backyards rather than depending on doctors, herbalists in the market, or natural health store attendants. Students learn that natural remedies are safer than many pharmaceuticals, although they are informed about the potential toxicity of some plants.[4] Students were eager to explain to me why natural remedies are less harmful than synthetic medicines. For example, as Alma, a CCD student said:

> It should be an option that all of the people here are well informed about these [herbal] medicines because a natural medicine like this causes less harm to your organism than a [synthetic] medicine. The [synthetic] medicine completely attacks your body but natural medicines, like those from plants, don't hurt your body. They have a slower effect but they alleviate [your symptoms] and your system is better. You can cure yourself with what is natural rather than putting so much (synthetic) medicine into your stomach.

Using the example of birth control pills and penicillin, Evangelina, a PCHP student, explained why medicines may be harmful:

> By taking birth control, you are killing your good and bad hormones. The medicine doesn't know how to distinguish if they are good or bad, they grab both. It is the same in many organs, many parts of your body. They start to hurt because of all of the medicine that you are taking. When you go to a doctor and you ask how you are going to get better, what they give you is penicillin. And

[4] Neither the Parochqial Dispensary nor the CCD advocates that natural remedies should be used in place of pharmaceuticals in the case of serious illness or infection. They view their approach as complementary to biomedicine. However, they take the position that Mexicans overuse pharmaceutical drugs and that in many cases natural remedies are more cost effective and efficacious if used properly.

> penicillin is supposed to make all of your problems better. Now that I study, I know that you have to look for other ways.

In sum, students are motivated through their instructors to learn more about these "other ways" of improving health. Instructors recall Mexican history and point to the current exploitation of natural resources to argue that Mexicans have an obligation to protect cultural resources that "are being taken away by the ton by foreigners who are selling our lives by extracting a huge amount of plants to make medicines." Students are encouraged to help protect natural resources by learning how to respect and use them wisely.

Chinese medicine theory: Balance and imbalance

First-year students at the PCHP are taught Chinese medicine theory based on the five elements. These elements are used to understand the relationship between the physiology and pathology of the human body and the natural environment. Students learn that all matter is composed of five elements – wood, fire, earth, metal and water – which are in a constant state of fluctuating energy based on states of yin and yang (excess and deficiency). Each vital organ is associated with one of these five elements and exists in a relationship that can affect the other elements, either generating or subjugating energy. As Miguel, an instructor at the PCHP explained, "When one element is weak, it must borrow the energy from the next, then that energy takes energy from the next. It is a constant movement. When an element is in bad shape, it will affect all of the rest of the elements."

In this theory, imbalance (i.e., illness) occurs when there is an excess or deficiency of energy in an organ/element in the body. More broadly, disequilibrium is

viewed as a product of an imbalanced system. As Miguel explained, "Alternative medicine doesn't talk about health and illness but of equilibrium and disequilibrium." To illustrate this concept, he explained that the perfect organization of the organs "resembles a family," each contributing to the whole. Conversely, when there is an imbalance in the family system, then there is a breakdown of the whole unit.

Miguel drew upon this familial metaphor to help students understand the principal behind the cycles of creation and destruction (or energy generation and subjugation). He explained that the cycle of creation resembles a mother-daughter relationship, and the cycle of destruction resembles a grandmother- granddaughter relationship. For example, in the cycle of creation, mother (wood element associated with the liver) creates a child (fire element associated with the heart) who in turn creates a child (earth element associated with the spleen and pancreas). Energy that is created in one organ is passed on to the next. Conversely, in the cycle of destruction, grandmother (wood/liver) overrides the authority of mother (fire/heart) destroying grandchild (earth/spleen and pancreas). Thus, the familial relationship is drawn on to illustrate the concept of health (balance) and illness (imbalance). While the concepts of Chinese medicine may be foreign to the PCHP students, by using such familiar metaphors, the instructors try to make the concepts relevant to students.

A further example of how PCHP instructors made the philosophy of Chinese medicine accessible to students was through the emphasis on hot and cold characteristics of foods, illnesses, and remedies. In Chinese medicine, as taught in the PCHP, the characteristics of cold and heat contribute to states of yin and yang respectively. These characteristics do not relate to temperature but rather describe the effect that is produced

in the body. An imbalance in the body results when an excess or deficiency of heat or cold occurs.[5] As Raul, the acupuncture instructor explained during one class:

> The body reacts to climate as well as to bad eating and a lack of rest. An illness that is yang starts out of heat and continues to grow. An illness that is yin grows out of cold. Almost all illnesses start from the outside. When you have a situation of yang (heat), you have the capacity to change it. But it if is yin (cold), it is more difficult to do so. This is where we get chronic illnesses. Climates are a constant threat because they provide heat and cold. They affect our body the most.

To alter these states and to bring the body back into balance, foods and medicinal plants that have the opposite property (heat or cold) can counteract the yin or yang state. Although the terms yin and yang are specific to Chinese medicine, hot and cold characteristics are well known characteristics of Greek humoral medicine. Anthropologists who have studied Mexican health beliefs have found similar classifications to be part of the Mexican lexicon to describe food and sometimes illnesses and healing properties (Foster 1978, 1987; Messer 1987). Some researchers even argue that a hot/cold classification system has indigenous roots in Mesoamerica rather than being imported to Mexico (see Ortiz de Montellano 1990; Lopez Austin 1988).

Some of the women I interviewed used characteristics of hot and cold to describe foods as well as illnesses. Often, I heard students studying at the PCHP and CCD use these characteristics to describe plants and their healing properties. Students easily learned to categorize foods and plants as hot or cold and quickly picked up the concept that the opposite property should be used to balance a deficiency or an excess in the body. These students also began incorporating the concepts of yin and yang into their

[5] Hot/cold classifications are one characteristic of Greek humoral medicine which is arguably the most broadly influential belief system in the world. The humoral system asserts that four properties exist -- hot and cold, wet and dry -- and that four humors are produced by the combinations of these properties. The humoral coding of hot and cold properties influenced Chinese medicine around 500 A.D. (Anderson 1987; Good 1994).

health lexicon. Thus, the Chinese system has become well integrated in health promoter training.

PCHP instructors integrate concepts from Chinese medicine into many of their courses, including those on nutrition, natural therapies, and herbalism (described above). For example, Vicenta, who taught the nutrition classes, grouped foods into the five elements system to illustrate how food can help bring the body back to a state of balance. She demonstrated how to determine which foods restore yin or yang to a specific organ based on color, hot/cold classification, and Ph level. Placing foods within a hot/cold/neutral classification system, Vicenta also demonstrated how to determine good and bad food combinations. Alicia, who taught the natural therapies classes at the PCHP, grounded her teachings in Chinese medicine theory as well. She taught students how to view natural therapies in the context of the "generative relationship" or energy generating cycle. She explained, "If there exists good nutrition, natural therapies, herbal medicine, good respiration, good digestion, routine sun baths, then we are going to begin to generate health."

Although this discussion simplifies some very complicated course materials, my intention is to demonstrate how students are introduced to a theoretical perspective that guides many of the practices they are taught. When instructors introduce therapeutic techniques such as massage and acupuncture for example, they begin by recalling Chinese medicine theory; reminding students how imbalance occurs in the body; how they can identify the source of the imbalance; and how they can redirect energy to that source of imbalance through different techniques like massage, auriculotherapy, reflexology, or acupuncture. Because learning acupuncture zones on the ears

(auriculotherapy) or feet (reflexology) is easier than learning the entire system of acupuncture, students can quickly gain access to simple techniques to redirect energy and stimulate the body's own healing mechanisms.

During the first year of the PCHP program, students learn diagnostic techniques fundamental to Chinese medicine – observation, listening and smelling, questioning, and palpitation. They learn basic massage skills as well as auriculotherapy and reflexology techniques. Their lessons in nutrition, herbalism, and natural therapies are also applied to Chinese medicine theory. The students spend their entire second year learning acupuncture as well as studying psychology. Thus, much of their training is based on foreign concepts and practices that they are incorporating into their "medicine bag" as their own.

The elements of "healing"

The mind-body connection: Emotions and illness

In the first classes of the health promoter training program at the PCHP, students are taught that "you can't separate the physical, emotional, mental, and spiritual domains," which are all interconnected in health and illness. According to Juanita, an instructor at the PCHP, the physical domain is the point at which the emotional, mental, and spiritual dimensions express themselves. This philosophy guides the work of both the Dispensary and CCD clinics.

I often heard patients talk about depression, anxiety, stress, and nervousness in conjunction with listing their physical symptoms. Health promoters are trained to view emotional problems as precursors to or symptoms of imbalances within the body.

Vicenta, a therapist at the PCHP, explained to me how their approach differs from psychology. She said, "Psychologists only attend to the emotions. They sit and listen to people talk. But they don't take it to the next level and look at the connections between the emotions and physical well being, or how emotions enter the body."

I noted that the relationship between the "mind and body" is often noted by the women I interviewed in Zarragoza. For example, in discussing her kidney problems, Alejandra explained that the buildup of calcium in her kidneys is because of the anger that she held for a long time, what she called "gnawing resentment" (*corajes entripados*). "And this causes kidney problems," she concluded. Similarly, Vicky described having recurring stomach pains and explained the relationship between her condition and the anger that she has experienced on account of her ex-husband's infidelity. She said, "Even though one resists, anger contributes to this. I have had vomiting because of the pains. I said, 'Why should I let this affect me but it does even though one doesn't want it to.'" Anger and stressful emotions are local common causes of illness in Mexico as anthropologists have noted (i.e., see Finkler 1994).

The therapists at the PCHP and CCD recognize this relationship between emotions and health. For example, Miguel, who practices homeopathy and polarity therapy at the PCHP, explained his view of the mind/body connection:

> I always look back in time. What was wrong before the person got sick? I usually find something that was not working well. This is something I learned with Polarity -- the human body is not wrong. It reflects what is inside, what is in our thoughts and feelings. If you feed your body right, if you have positive thoughts, and you let these thoughts guide you, if you exercise every day, your body is going to respond accordingly. On the contrary, if you hurt your body, if you threaten it, if you don't feed your body in a good way, then your body is going to complain – your liver, your heart, your bones, and your skin.

Similarly, Alicia, a Dispensary and CCD therapist, explained to me that "the body never lies." On several occasions, I observed that Alicia identified past injuries, emotional problems, and physical ailments that her patients had not previously discussed with her through her application of diagnostic massage techniques. Sofia, a student and apprentice at the Dispensary described a formula that she uses for diagnosing emotional problems. She said that emotional problems that become seated in the neck and upper back are related to anger or stress. Problems in the middle of the back relate to economic problems. Lower back problems are related to sexuality and the place where fear shows up is in the kidneys. I heard other health promoters refer to physical pain locations as a guide to the emotional issues that might be at the source of a patient's health problems.

In my interviews with a range of alternative health practitioners in Morelos, I found that the mind/body connection is a central element that links many disparate practices from homeopathy to acupuncture. For example, one homoeopathist I interviewed in Cuernavaca offered the following perspective on the relationship between the body and mind. He said that the body has "intelligence" and it speaks through its symptoms: "The body is telling you what to do every time. If you pick up on the symptoms that the body is giving you, then you are working with the yesterday of the mind. If you pick up on the symptoms that the mind is giving you, then you are working with the tomorrow of the body." Because health promoters who work at the PCHP and CCD clinics share this viewpoint, it is standard practice that they ask a series of questions about emotions when beginning a consultation with a patient. In fact, Monica from the PCHP explained that the role of the health promoter is not only to provide therapy for the patient but also to "provide direction for internal work." Thus, patients who present

symptoms such as depression, anger, or nerves are treated for these symptoms as well as provided with directions for "internal work" that may include expelling anger, getting out of the house, or even studying at the PCHP.

Social stressors, women's "limitations," and the isolation of the elderly

In addition to paying close attention to the relationship between emotions and physical symptoms, health promoters are also trained to identify the impacts of social stressors on health. When students are learning about diagnostic techniques, they are taught to ask their patients questions relating to occupation, household labor, relationships, life events, and so on. In fact, the PCHP offered a special workshop on stress-related illnesses and students learned that different kinds of stressors (i.e., social, emotional, nutritional) may result in symptoms such as hyperactivity, fatigue, anxiety, weight gain, depression, suicidal thoughts, panic, and excessive sleep. Students were taught that behavioral changes, nutrition, herbal remedies, and other therapies can be efficacious in these cases. While health promoters are not trained to believe that they can change the circumstances in which people live, they are encouraged to listen to their patients and to help them make positive changes in their lives.

The relationship between social stressors and health is commonly cited by PCHP patients. For example, I regularly heard statements from patients like the following:

> -I have headaches when there is no money.
> -My kidney problems are the worst when I am working a lot and stressed out.
> -One does not get ill when they are working. Without work, one gets ill from the stress of it.

While therapists at the PCHP and CCD acknowledge that some things are difficult to change, such as work responsibilities and economic hardships, they try to help patients

attend to what they can do to cope with their situation. For example, they recommend stretches for those with aches, cramps, and pains; breathing exercises to calm nervousness; and apply massage, acupuncture, and reflexology to stimulate or unblock energy. Yoga classes are offered at the PCHP on Friday nights to help bring about greater mind-body awareness and relaxation.

Both men and women struggle with occupational stress, economic strains, and physical ailments. However, a number of health promoters told me that men are more likely to visit the PCHP when they are extremely sick, while women come more often with less serious symptoms. Vicenta, a therapist at the PCHP explained, "Men have to deal with a lot of stress and pressure, they die of heart disease. When they come here, their condition is extremely grave and we often send them to the hospital." On the other hand, Vicenta explained that women more often suffer from symptoms caused by "frustrations." She said that these frustrations emerge because of the limitations that women experience in society.

> The woman here is very limited. The man is the woman's boss (*patrón*) and the woman always has to keep quiet. This is why women are more blocked. This is not like women in the United States who have more freedom. Here, women are limited, confined. They administer the houses, administer money, they have a lot of stress. The majority of patients here are women. What you see is that they are living in a way in which they do not want to live. They establish their lives in this way. They hold on to it like a custom, but they are not content. So the problems, more than anything, are psychosomatic. They fight a lot with this; they fight a lot to be able to cure their mind.

Sofia from the PCHP describes the problems that women face in similar terms:

> Women are living with feelings of angst and impotence; their marriages enclose them in the household and because of male chauvinism, they can not leave. They are preoccupied with the children, with their housework. They are worried economically, and they get sick.

These perspectives share similarities with what Kaja Finkler (1994) calls "life's lesions." She uses this term to describe the many chronic, non-life threatening ailments from which poor women in Mexico City suffer. Finkler argues that life's lesions "are fostered by and rise out of perceived adversity, hostile social relations, stressful life events, or unresolved contradictions that corrode one's existence, take hold of the body and carve impairments on it" (p. 16). She concludes that women are more predisposed to non life threatening illnesses than are men because they most often find themselves caught up in these nets of adversity.

Elderly women were also singled out in my observations at the clinics. In Vicenta's estimate, elderly women seek help largely because they suffer from isolation. As she explained:

> I see many people, elderly people, people who have become widows, or whose children are grown up, who come and say that this or that hurts. The only thing they want is to be taken care of. I think that we are all like this, no? Who doesn't like that we caress them, that we give them attention, that you give me a massage? So I have realized that this is one of the fundamental causes from which people become sick.

Women's health is often a topic of discussion in both of the clinics that I observed, in large part because women make up the majority of therapists and patients. The clinics both offer what I would describe as a very "woman friendly" space where patients can safely disclose their problems, be listened to, and be acknowledged by female health promoters who can empathize with them. Even if patients experience only temporary abatement of their symptoms, many return for a massage or acupuncture treatment or to pursue further advice about an ailment. Clinic staff believe the attention that women receive during their consultations may be as (or more) efficacious than the treatments provided, since they might not receive this attention elsewhere. As Sofia, a

PCHP health promoter explained, "People come in here who are not listened to, who are not shown affection. People in their own house are not listening to them. We listen to these people. We build trust with these people."

Patient participation: Healing as a shared endeavor

During one of the first classes I attended, Miguel explained to the students, "The goal of our work is to inculcate a different consciousness. It is important to leave some habits behind and to take on other ones. We are here to learn how to make personal changes, to learn new concepts and healthy practices." Students who train in health promotion are expected to be active participants in the learning process and are encouraged to apply the lessons that they learn to all domains of their lives.

In a similar vein, patients at the PCHP and CCD are expected to become active participants in the therapeutic process. While patients receive treatment in the clinic (i.e., massage, acupuncture), they are also provided with information on dietary changes, natural therapies, stretching and breathing exercises, and herbal remedies that they must administer themselves. Therapists say that treatment outcomes are dependent on patients' willingness to participate in the healing process.

A review of the medical records that Alicia keeps at the CCD clinic indicates that this expectation of a shared partnership between practitioner and patient is indeed prevalent. The records show that 80% of a random selection of 40 medical records includes specific recommendations that patients were to follow in the home. For example one patient with waist and back pains, significant menstrual pain, irregular periods, headaches and nausea was instructed to: "Drink herbal tea of marigold and arnica and

apply poultices with the same herbs." Another patient who suffered from digestive problems, circulatory problems, and possible colitis was instructed to: "Eat garlic, raisins, raw fruits, and vegetables prior to meals; take olive oil with lemon, and take sitz baths."

Although the medical records outline only the basic parameters of Alicia's recommendations, patients receive written as well as verbal instructions on how to implement the recommendations (i.e., nutrition instructions, the amount and length of time to take herbal teas, how to prepare and use microdoses, and how to prepare sitz baths, etc.). In addition to the expectation that patients apply these health actions in their homes, some patients are also invited to join the school as a means to facilitate further participation (see Chapter 9). The shared responsibility in the healing process is a value that is widely acknowledged by the health promoters with whom I spoke. For example, Sofia, with the PCHP explained, "When you are giving health, you share the work with the patient. This is different from wanting to alleviate the illness. If a patient is not willing to share the work, he will not get better."

Reflections on the PCHP and CCD health promotion model

In this chapter we have seen a range of concepts and practices used at the PCHP and CCD schools and clinics. We see that the health promoters advocate a set of ideals and practices that strive to generate greater health awareness among their students and patients, educate and involve individuals in illness prevention, and motivate patient participation in the healing process. Health group members believe that illness reflects energy, emotional, and social imbalances and not only biological pathologies. Their diverse range of therapeutic practices attends to these multiple aspects of ill-health.

Health group members consider environmental protection and social consciousness to be integral components of health and well-being, since many healing resources and processes are available through a healthy social and physical environment. Thus, the health groups advocate practices and philosophies that address the "social body" as well as the individual body (cf: Scheper-Hughes and Lock 1987).

Baer's (2003) recent consideration of complementary and alternative medicine (CAM) in the United States suggests that while the CAM movement stresses mind-body-spirit connections, it fails to adequately make mind-body-spirit-society connections. As this discussion suggests, Zarragoza health groups make the "society connections" by emphasizing cultural roots, familial relationships, and environmental awareness as essential to corporeal balance. Further realizing these "society connections," the groups encourage health promoters to volunteer their services in the clinic and in the community, critique the negative health affects of Western consumer influences, attend to the channels through which social stressors affect the individual body, and provide patients with recommendations for healing their "wounds," particularly when the sources of their suffering are social and emotional in nature.

In contrast to biomedicine which tends to make patients dependent on physicians, health promoters working in the community clinics involve their patients in illness prevention and management and attempt to empower them to learn more about health and participate in the healing process. Contrasting the two approaches, one CCD health promoter explained that with biomedicine "patients *receive* diagnoses, operations, and medicines while here they share in the work." Patient involvement is encouraged through

recommendations for lifestyle changes such as altering nutrition patterns, using natural therapies, and sometimes by recommending enrollment in a training program.

Despite their advocacy for natural therapeutic practices, the health promoters are aware of the limitations of their approach. They also recognize the value of biomedicine, particularly in addressing infections, grave and acute illnesses, and injuries. Rather than viewing their work in opposition to biomedicine, health promoters are taught to view it as a complement to formal health care. Health promoters will refer a patient to clinic or hospital if the symptom(s) appear to require biomedical care. Importantly, all civil associations that run community clinics are required by the Ministry of Health to select a "responsible physician" to oversee their work. While the CCD and PCHP were, on paper, operating in agreement with this requirement, I never observed the physician at either of the clinics. While this alternative mode of health care is not in competition with biomedicine, it is hardly regulated by any formal structures.

My observations and interviews suggest that the health promoters that work in the CCD and PCHP clinics share the belief that, if used correctly, their practices can be safe and efficacious. Such a strong belief raises questions regarding whether health promoters fully understand the limitations of their practices, the extent to which some might have blind faith in their therapies, and the circumstances under which they may fail to recognize a situation that requires biomedical care. A few of their practices raised concern in my evaluation of the health groups. At times, I would observe that the bottles used by the CCD for their herbal remedies were not disinfected and the remedies were not provided with an expiration date. I also noticed that acupuncture needles were typically soaked in a solution and then reused rather than disposed of. This raises

questions regarding safety in light of the transmission of diseases such as HIV/AIDS. Overall, practices of sanitation, hand washing, and the cleaning of medical instruments varied from practitioner to practitioner and are difficult to generalize. Clearly, there is room for error in many of the practices used – from massage to acupuncture. However, I never spoke with a patient who experienced negative effects from their treatments.

Since this study focused mainly on the social aspects of this health promotion approach, I can draw no conclusions regarding what types of medical benefits or risks may exist in the practices I observed. Regardless of the real or perceived risks, however, patients continue to be drawn to the clinics. When I asked health promoters why people might use these services, the most common response that I received was that the patients "have good results" from the therapies. Lourdes, a PCHP therapist best summarized the factors that may be motivating patients to the use their clinical services.

> People have good results from their treatment. Also it is cheap and the word passes by mouth or by recommendation. Many people say, 'It is economical, it is natural, they give good results, and it doesn't harm you.' Or people prefer to go where they can get nutritional advice. People feel better because someone is taking them into account; they feel good because someone is giving them attention. They say, 'How wonderful! No one has worried about my nutrition before.' So they make a change and with the treatment they feel good. And this is when they realize that they can make other changes and feel better.

Conclusions

In this chapter I have examined how health groups define health and attempt to resolve illness in Zarragoza. I have demonstrated how groups draw from local and global concepts of health and healing to formulate an approach that they label "traditional and alternative medicine." While advocating a package of practices and therapies designed to

address the multi-faceted nature of illness, the groups also promote a range of moral values that address current social and environmental conditions within Mexico. Although critical of lifestyle changes taking place on account of Westernization, the groups nonetheless are taking part in the global flows that have made alternative health ideas and practices available to them. As they emphasize "rescuing" medical traditions from the past, they are in fact assembling their own model of health promotion, largely built from global healing practices. Grounded in critiques of biomedicine, this model seeks to raise health consciousness and offer greater control over the health care process.

CHAPTER NINE: WOMEN'S PARTICIPATION IN HEALTH GROUPS

During my initial visit with the Committee for Culture and Development (CCD) in 2001, I asked the women who had gathered for a health class to explain why they chose to participate in the group. Their responses included: "I want to help my family;" "Some of my friends are sick and I want to help them;" and "It is a good opportunity to be with friends." Others spoke about how they enjoyed learning traditional and alternative health care practices, and one participant suggested that the work is "especially important for the poorest groups that do not have economic resources." The women all agreed that the health practices that they were learning are more cost effective and less "harmful" than allopathic medicine.

Prior to beginning my dissertation research, I had a limited understanding of these women's lives. After my initial visit with the CCD, I hypothesized that three primary issues propelled women's participation in health groups: 1) a strong critique of allopathic medicine and the institutions that deliver it; 2) a need for women to gain better control over their and their families' health; and 3) an interest in gaining new skills and developing social networks. After conducting in-depth interviews and collecting surveys with a sample of participants, I came to realize that while these explanations are not altogether incorrect, they only partially explain what has drawn women to groups like the CCD and the Parochial Center for Health Promotion (PCHP) (see Chapter 7 for background on the two groups). I now see that these women's participation is also driven by a variety of issues I had not anticipated, including a search for purpose in a society that limits their professional aspirations, a sense of isolation that they experience as their

children leave the house, a deep distrust of the doctors working in public medical clinics, a desire to contribute to those who are less fortunate than they, and a desire to generate income through informal health care practice.

In this chapter, I will explore participants' motivations for joining health groups. I draw from a questionnaire that I administered to 18 health group participants to provide an overview of who is participating and why. I then draw from in-depth interviews conducted with eight active participants to detail the circumstances that have led these women to become involved in health groups. In addition to exploring women's interests in health groups, I also illustrate some of the challenges that women face as a result of their participation and explore their perspectives as they take on new roles in community health promotion.

Background

The health groups observed for this study open their doors to anyone – men and women, rich and poor – who wants to learn traditional and alternative medicine. As was discussed in Chapter 7, the PCHP runs a 3-year health promoter program while the CCD runs 8-month and shorter courses that focus on massage, herbalism, polarity therapy, acupuncture and other healing modalities that are described in detail in Appendix A. Both groups charge approximately $15 USD for weekly classes. While the fee precludes the participation of many women from the most impoverished segments of society, it is not a burden for most lower-middle class women. The CCD offered scholarships to some

students who could not pay the fees.[1] Overall, the socioeconomic level of women who participated in the CCD was lower than those who participated in the PCHP.

Demographics

To obtain basic demographic information on the students who are studying in these health groups, I handed out a nine-question survey to students at the CCD and PCHP schools. I received back 18 surveys out of a total of 36 students enrolled in the two schools (see Chapter 2 for survey collection methodology). The surveys that I collected were all from women. They were designed to elicit demographic information, reasons for participation, and level of participation in the groups.

I also conducted in-depth interviews with eight active participants in the two groups. These women are no longer students at the schools, although they may be taking courses elsewhere to continue their training. They have taken on leadership roles in the CCD and PCHP in addition to serving as therapists and/or instructors. These interviews were designed to provide a detailed view of the reasons why some women may become active in these associations. The demographic information for both samples can be found in Table 8 below.

[1] These scholarships were provided at the discretion of the CCD group leaders. There was no formal application process.

Table 8. Demographic information for surveys and interviews conducted with health group participants

	Survey (N=18)		In-depth interviews (N=8)	
Indicator	**No.**	**%**	**No.**	**%**
Age				
0-24	0	0	0	0
25-44	7	38.9	3	37.5
45-64	11	61.1	5	62.5
65 +	0	0	0	
Marital status				
Single	6	33.0	0	0
Married/free union	11	61.0	8	100
Widowed	1	6.0	0	0
Residence				
Yautepec resident	6	33.0	6	75.0
Non-Yautepec resident	12	67.0	2	25.0
Years of education				
1-4	4	22.2	4	50.0
4-8	9	50.0	2	25.0
9-12	4	22.2	1	12.5
College/graduate school	1	5.6	1	12.5
Profession				
Home	3	17.0	2	25.0
Informal sales	2	11.0	1	12.5
Domestic work	1	6.0	0	0
Professional	2	11.0	2	25.0
Student/practitioner of alternative/traditional med.	10	55.0	3	37.5
Access to health insurance				
Insured (IMSS/ISSSTE)	7	38.9	6	75.0
Uninsured	11	61.1	2	25.0

The median age for the student sample is 45 years old while the median age for the active participants/therapists is 44 years old. More of the students (67%) travel from outside of Yautepec to participate in the health programs than do the active participants (25%). In both samples, the majority of women have received no more than secondary school education (72% of the student sample and 75% of the active participant sample).

The majority of the student sample (83%) either works in the household or generates income through informal sales or through lay health promotion. This is also the case with the active participant sample where 75% are involved in at least one of these activities. Interestingly, over half (55%) of the student sample listed their profession as either student or practitioner of traditional and alternative medicine, suggesting that many identify professionally with their health group participation, a point I will return to later.

Many of the students surveyed have a fair amount of experience with traditional and alternative medicine groups. For example, eleven of them (61%) have been taking classes for more than a year and five (28%) have been taking classes longer than three years. Moreover, the majority of students (67%) participates or has participated in multiple groups. In addition to the three groups discussed in Chapter 7, these women are participating in similar groups in Tepotzlan, Cuernavaca, and Mexico City. Half of the active participants (50%) are receiving additional training from or serving as therapists in additional groups as well.

Ten of the students (56%) reported that they provide health consultations inside or outside of their homes. It is interesting to note that of these 10 women, seven of them (70%) charge a fee for the services or remedies they provide. These fees are usually charged on a sliding scale and are minimal, between $20- 60 pesos ($2-6 USD). All 18 students (100%) indicated that they regularly give health advice to their family, friends, and/or neighbors. Thirteen (72%) said they give health advice daily or weekly while five (28%) offer advice less than two times a month. In other words, students appear to be actively applying their training outside of the classroom.

The women who are most active in the health groups fall into three categories: program coordinators (25%), therapists (50%), and therapist-instructors (25%). All of these women have been training in alternative medicine for at least three years. The majority received training at the PCHP, suggesting that there is a significant overlap between the two schools. Three of these women provide health services outside of the clinics to which they belong – either out of their homes or in the community. Additionally, three of them produce herbal remedies to sell.

Women's narratives

The in-depth interviews I conducted focused on the context within which women chose to become involved in health groups. Below, I summarize three of these women's narratives. I chose these narratives because they most clearly articulate many of the prevalent themes found in these interviews. Because each of the women's lives and perspectives is unique, these narratives are not meant to speak for other women's experiences. Instead, the case studies provide a picture of the context of women's health group participation, highlighting the challenges women face as they pursue their health interests and some perceived outcomes of their participation.

Alicia's story

Alicia is 45 years old and is married with three children. She was born in a small village in the state of Michoacan, on the border of Guerrero. She was raised by her grandparents until she was eight when she moved to Mexico City to live with her mother who was a domestic worker. Her family moved to Zarragoza a year later and Alicia has

lived there since. From a young age, Alicia had aspirations to become a nurse. After she graduated from secondary school, she studied nursing for two months. However, due to health problems marked by fainting spells, she had to terminate her nursing studies. She instead followed her mother's advice and attended secretarial school. She then worked in an administrative job and later became a teacher in a remote village in the state of Morelos. She met her husband in this village, and after four years, they married when Alicia was 20. Her husband was always supportive of her work, but she stopped teaching after she had her first child. As the years passed, she says she became discontented and began looking for something to fill the void. She briefly studied cardmaking, cosmetology, and haircutting, among other things. As she recalls, "I went out searching for things to do and I didn't find what I wanted until I found medicine."

At the time that Alicia learned about the PCHP, she was suffering from severe health problems. She had bled for 40 days after her last son was delivered by Cesarean section. She went to the IMSS clinic and the doctors told her that she had "cysts in the womb" and needed a hysterectomy. "They told me that if they don't operate I was going to die of cancer," she recalls. However, Alicia was adamant that she did not need a hysterectomy. She did not trust her doctor's diagnosis after a series of previous misdiagnoses.

After returning home, Alicia encountered a neighbor who noticed that she was very upset. This neighbor told her about the PCHP and recommended a therapist named Raul. She told Alicia, "He is special; he gives pure natural medicines, all herbs." Alicia went to the dispensary to see Raul who worked mainly with acupuncture and herbs. As Alicia recalls, "People would go and sleep there to get an appointment with him." Alicia

never got an appointment with Raul. Instead, she saw Antonio who, after evaluating her, told her that she was "one degree away from having diabetes." As Alicia recalls:

> I had irregularities of pressure, high blood pressure and then low blood pressure and then I fell into a depression. He told me that I also had an inflamed liver. Also during this time I was obese, weighing 100 kilograms. He told me the obesity was a serious problem. I had constant vaginal bleeding and he told me they were provoked by cysts, but more because of the obesity. The obesity was giving me all of these problems – blood pressure, depression, borderline diabetes, and I was having strong anemia.

Alicia was put on a papaya diet for 15 days. She lost 25 kilograms. Along with recommending natural therapies, Antonio told her to keep going to the IMSS for her examinations. When she went back to the IMSS, the ultrasound showed that she no longer had cysts and the doctor did not feel it was necessary to operate on her. As Alicia recalls:

> This was the last time I went to the IMSS. I never returned and this was when I began using only natural medicine. Antonio asked me, 'Do you want to learn how to cure yourself?' 'Yes,' I said. 'Good,' he replied, 'on Friday we are going to begin classes.' I had never been so happy.

Alicia is the most experienced of the female health promoters who I interviewed. She was a student in the first cohort of the PCHP school in 1993. She completed the three-year program and has been practicing at the PCHP clinic ever since. She pursued additional training through numerous courses and workshops in Mexico City, Cuernavaca, and Zarragoza.

Unlike the majority of women I interviewed, Alicia has a significant amount of power in her household. Alicia's husband provided her the financial support necessary to take health classes, and he has supported her work as a health provider. She says that because she was raised in poverty by a single mother, she has always had a strong work ethic "to be able to eat." This work ethic has stayed with her. Her work is no longer

driven by economic necessity but by the pride that she receives as a healer. Since the basic household necessities are taken care of through her husband's paycheck, Alicia enjoys the freedom that a little extra spending cash provides her and her children.

During the time of my research, Alicia split her time between the PCHP clinic, the CCD clinic, a clinic in Mexico City, and providing in-home visits for patients in Zarragoza. Alicia also teaches at each of the three settings. She works mostly with therapeutic massage, acupuncture, and herbalism, although she applies a range of other therapeutic techniques in her work. Alicia has hopes of someday opening a private clinic in an unfinished room that is attached to her house. In the meantime, she enjoys visiting clients in their homes and bringing her services to people in the community.

As this case illustrates, health group participants may become involved as a result of their own struggles to resolve their health problems. It is not uncommon that therapists invite their patients to train at the schools as a way to involve them in their healing process. In Alicia's case, like in the case of Vicenta below, many women are drawn to the health groups because they are searching for a purpose in a society that does not encourage women's educational or professional development.

Vicenta's story

Vicenta is 35 years old and is married with two children. She grew up in a village in Mexico State with her mother and six siblings. Vicenta's father died when she was seven years old, leaving her mother a widower at age 48. To feed the children, her mother moved to Mexico City, where she worked in a store selling ceramics. Because of their dire economic situation, Vicenta worked in her mother's ceramics store after

completing secondary school, rather than continuing her education. She married Juan at age 17 to "relieve some of the burden" for her mother. She and Juan had their first child when she was 18. Juan worked for a railroad company while she took care of their child and managed the household. Juan was laid off in 1997. Shortly thereafter the family had a second child and moved to Zarragoza with government credit to buy a house. After working at various temporary jobs, Juan ultimately decided that he must look for work in the United States, which is fairly common among men in Zarragoza. Juan left in 1999 and Vicenta stayed behind in Zarragoza to raise their two children. Juan continued to send back regular checks from the U.S., as he had promised.

Vicenta "found" the PCHP shortly after her husband's departure to the U.S. She recalled that after her husband left she felt alone since she knew few people in Zarragoza. She also felt deeply unfulfilled. Although she had studied for a year to learn dressmaking and first aid, she had never developed a profession. She noticed the PCHP on an afternoon walk and after seeking further information, became intrigued by what the group was doing. Two of the therapists working there, Raul and Miguel, encouraged her to join the program and study with them. As she recalls, she was very insecure about her abilities, but Raul said that "he would show us how to challenge ourselves." Miguel took her under his wing. "He taught me many, many things that today I am putting in practice, which I am thankful for. And he motivated me a lot."

Vicenta links her instant connection with the PCHP to her heritage. Her mother is from a small Zapotec village in the state of Oaxaca where her grandmother was a well-known *curandera*. Vicenta explained that her grandmother always healed people with herbs and ointments. People sought her out because there were no doctors. Vicenta's

mother inherited this knowledge and cared for her children with medicinal teas and natural remedies and she "spoke a lot about herbs." Yet Vicenta claims that when they moved to Mexico City, her mother forgot much of this knowledge. When Vicenta found the PCHP and began her training, she felt as if she was reconnecting with her past. As she mused, "For me to come to the state of Morelos, and to run into these same people was as if I had been given a jolt that told me – 'you also belong to this world of *curanderas*' – so I tried it and I liked it, I like it a lot."

Vicenta began an apprenticeship in the clinic with Miguel soon after she began studying in 1999. Three years later, she graduated from the program. After the dispensary group split in 2002 (see Chapter 7), Vicenta decided to stay with the original group and joined the PCHP staff. She became the clinic coordinator one day a week and the treasurer of the dispensary. In 2003, she opened her own private clinic with a colleague in an apartment space where she lives. She offers massage, acupuncture, and other types of energy therapies. She also makes and sells and her own herbal remedies.

In reflecting on her impetus to begin training with the group, Vicenta explained that when her husband left, she had the freedom to explore things that she was not able to explore previously, because he had never accepted the idea that she work outside of the home. She attributes this to a larger cultural problem, whereby men in Mexico feel that they should be the sole household providers and that women should to stay in the house. Thus, her husband's departure opened up the space that she needed to begin to explore the opportunities at the PCHP. She said this was only possible when the "tremendous responsibility" of being a couple had been eliminated. Fortunately, her husband continued to help support the family and Vicenta had enough money from remittances to

run the household and also afford classes. Even though she struggled to maintain her studies and her household responsibilities, she is thankful that her life has taken on new meaning. As she explained, "The PCHP has turned me around. It has resuscitated me and redefined me." Although she is now beginning to generate some income from her private practice, her primary goal remains to help others. As she explains:

> Something I have learned is that yes, money is important because it gives stability, but that is not everything. So my mission is to continue growing, to continue learning to be able to keep helping people because many people are very blocked; they come in very ill. I still have limits and I have to keep moving on, and I believe that this happens throughout life. But to excel within the terms of humility and awareness, to help people as they are, to love them, to appreciate them, so that they can grow as human beings, as they are, this is my intention.

As Vicenta's story suggests, women may be drawn to health groups as a means to "improve themselves," gain practical skills, and attain a professional identity. As I will discuss later, women often face many obstacles in achieving these goals if they choose to participate in a health group. However, as Belinda's case below suggests, the interest in self-improvement may be secondary to the need for a social network, which is what draws other women to the groups.

Belinda's story

Belinda is 51 years old and is married with 3 children. She was born and raised as one of 13 siblings in the city of Cuautla where she currently resides (approximately 30 minutes away from Zarragoza). Her father was a construction worker and always had steady work while the children helped out by selling milk. Belinda finished primary school. She then left her studies to work in a perfume store and then a clothing store. The last job she held was working at the counter of a pharmacy when she was 16 years

old. She stopped working altogether when she married Roberto a year later. Since then, she has dedicated her life to raising her children and maintaining the household. She discovered the PCHP in 1999 and took classes there for two years. When she learned about the CCD, she began training at the La Rosa community center as well. Since 2001, she has been a faithful member of the CCD, helping to run the clinic and collecting herbal recipes for the collective effort. Roberto's steady income as a teacher provided her with the economic ability to take classes. Additionally, he also has experimented with natural medicine which allowed him be more open to Belinda's interest in working with the health groups.

Belinda's participation with the PCHP offered her a chance to formally study what had been a long term interest in alternative medicine. This interest began when she and her husband "discovered" homeopathy 20 years prior. Roberto was taking Karate classes when someone referred him to a homeopathic doctor. At the time, one of their children had a kidney infection that was not responding to biomedicine. The homoeopathist helped their daughter recover from her infection, giving them a very positive impression of homeopathy. Over time, Belinda's interest in homeopathy grew to the point where she rejected allopathic medicine altogether. She shared some stories with me about how medical doctors have over-prescribed medicines and given her inaccurate diagnoses when her children were sick. Belinda said that she tried to look for something else, "something natural, but back then, we didn't have a lot of information about natural medicine."

Belinda's use of homeopathy opened the door to other health practices in her household. Their homeopathic doctor put her husband on a vegetarian diet to lose weight

and help manage the health problems from which he suffered. Belinda began to learn more about nutrition and started experimenting with soy and different vegetables. She learned about the PCHP through one of her daughter's friends who told her about nutrition classes that were being offered at the time. Belinda said she was instantly intrigued for two reasons – because of her interest in nutrition and natural health and because of her growing sense of isolation in her home. Two of her children had recently married and left the house. The third was busy in high school. Since Belinda had dedicated her life to raising her children, the changes occurring in the household had left her depressed. Her only social outlet had been a Gnostic group[2] in which she and her husband had participated. However, the group had disbanded and Belinda no longer had any social or intellectual outlets. As she explains:

> More then anything I started going to the dispensary because I wasn't going out at all. I didn't leave the house for anything; I didn't even go downtown. When I started to go there, it was like an escape, an outing. It was something that was important to me and it interested me a lot and I kept going for two years.

Belinda spoke with conviction about the importance of natural foods and medicines. She sees her role as somewhat of a messenger. As she explains, "I want people to change their way of eating. I have seen that this has worked for us. I would like it if everyone changed." Belinda assists the CCD by providing massages, nutritional advice, and herbal remedies to patients. However, she does not take on the role of a lead health care provider. Her main interest is in assisting at the clinic, learning about healing modalities, and experimenting with herbal remedies. She does not have any interest in opening her own private practice, but she does have hopes of selling herbal remedies

[2] Gnosticism is a loosely organized religious and philosophical movement centered around the idea that the salvation of the soul results from a special kind of knowledge of the universe. During my field research, I encountered an active Gnostic group in Cuernavaca and two centers in Zarragoza and Cuautla that were no longer open.

some day. Her interest in selling remedies is largely economic since she is deeply dissatisfied with her economic dependence on her husband. On various occasions, Belinda shared with the CCD group members some of her struggles with her husband. While Roberto supports her involvement with the health groups, he is demanding in the household and expects that she cook, clean the house, and wash the clothes. Moreover, because she has only primary school education, she says he likes to make her feel intellectually inadequate. Thus, for many reasons Belinda welcomes the opportunity to gain some independence from her husband as well as new skills.

Belinda is very dedicated to her own health education and to assisting others in this learning process. When I asked Belinda why she continues to participate with the CCD, she explained that she enjoys giving out remedies when people are sick, helping people find alternatives to allopathic medicine, and helping them change unhealthy eating habits. To some extent, this work has brought her a sense of purpose that she had previously been lacking. Beyond the intellectual outlet that the group offers her, Belinda is most satisfied with the community of women that she found through her work with the CCD. As she reflects on the contrast between her past and present, she explains:

> Before I didn't leave for anything; I married, I had my kids, I raised them and here I stayed. Now I have friendships that I didn't have before when I did nothing more than lived shut away in here. I found friends and I like being with them and getting together with them. Before, there was nothing else in my world except my husband and my kids. That was my world.

Why do women participate in health groups?

As these narratives suggest, women are motivated to become involved in health groups for numerous reasons in addition to their interest in alternative medicine. These

reasons include dissatisfaction with allopathic medicine, a search to resolve their health problems or the health problems of their children, a search for a purpose in a society that does not encourage women's educational or professional development, a sense of isolation once their children leave the home, a desire for social interaction outside of their homes, and a desire for greater economic independence. Each of the women I interviewed feels a connection with the therapeutic approaches applied by the PCHP and CCD. For example, Vicenta feels that connection through her family heritage of *curanderismo*. Belinda feels connected to natural medicine because of her positive experiences with homeopathy. Alicia's connection with health promotion is rooted in her unfulfilled dream of becoming a nurse.

The three cases also demonstrate the different circumstances that bring women to health groups. For example, Alicia found her way to the dispensary during a time in which she suffered from serious health problems and distrusted her doctor's diagnosis. Having experienced positive results from her treatments at the dispensary, she was thrilled to be invited to take classes and become part of the group. Vicenta discovered the dispensary when she was feeling depressed and was looking for something to do. She had spent the previous 14 years confined to her household and her husband's departure to the U.S. opened up the space that she needed to pursue training at the dispensary. Lastly, Belinda's involvement in the dispensary began as she was experiencing a deepening isolation and depression due to "empty nest" syndrome. The dispensary offered her a way to re-engage with the outside world and to find lasting friendships. In addition to finding these social connections, there was also a spiritual dimension to her search.

In these narratives, we see how multiple issues are interwoven through each woman's story of how she came to participate in a health group. In the following sections, I explore some of the themes that emerge from the interviews and consider some challenges that arise for women as they work with health groups. By singling out specific patterns or themes that run through the narratives, my intention is not to simplify women's lives, their reasoning processes, or the many factors that may simultaneously motivate their participation. The discussion below seeks to examine some of the many issues that play out in these women's lives and lead them to interact with health groups.

Health problems and the search for control

Women's concerns for resolving their own health problems and those of their families are central to their decisions to participate in health groups. Most of the questionnaire respondents (67%)[3] and all but one of the interviewees explicitly linked their involvement in a health group with health concerns. Half of the interviewees describe being drawn to a health group because of a personal health problem. Women reported health problems ranging from depression to migraine headaches to diabetes. For example, Juana began studying with the CCD when she was ill with what she describes as a "filthy nervous system" (*"tenía el sistema nervioso hecho un asco"*). She explained that when she began to study with the group, she couldn't walk without holding onto the walls. Her blood pressure was high and she experienced constant dizziness and diarrhea. Yet she says that this has changed since she has been working with the CCD. As she

[3] Only 16 questionnaire respondents answered this question.

explained, "When I went to study, one of my teachers started to give me herbal recipes and - look at me! Now I am making them myself."

Seventy five percent (6/8) of the women interviewed said their participation stemmed from an interest in helping their children. For example, Anna, Lety, and Monica (all participants in the CCD) felt drawn to natural medicine because their children suffered from acute asthma and the medical resources were not available at their public clinics to sufficiently address their needs. Anna described how the SSA Urban Health Center never had oxygen or an ambulance available when her daughter had asthma attacks. She began looking for ways to prevent the attacks and took her daughter to naturalist doctors but they were very expensive. Monica shared a similar story about her interactions with public health facilities when her son had asthma attacks and explained that "this is where my restlessness began to search for some other alternatives."

Almost all of the women's stories about their children's illnesses communicate a sense of powerlessness in public health institutions and a distrust of doctors. For example, Vicenta shared a story about how her youngest child suffered from chronic respiratory problems. When he was four, he came down with symptoms of pneumonia complicated by asthma. She brought him first to the IMSS and then to the SSA Urban Health Center. The doctors at both of these clinics told her that they didn't have any equipment that could help him, or an ambulance to transfer him out of town to a hospital. When she finally got him to a general hospital in Cuautla (after begging a neighbor for a ride) his breathing was short and he was very weak. She recalls how the clinic staff took her son away and didn't communicate with her about his condition for hours. When he was released the next day, they gave him a "very, very strong" antibiotic treatment. Not

believing that her son needed such a high dosage of medicine, she asked her mother, who was well versed in traditional herbalism, to help her decrease the dosage by incorporating medicinal plants into his regimen. She believes that her son was helped more by the herbs than the shots. Such stories about medical crises and women's search for greater control over their children's health often included descriptions of the efficacy of natural or alternative therapies in contrast to the inefficiency of government health services.

Unequivocally, women who join health groups are eager to learn more about how to use alternatives to care for their families. Their stories suggest that they are looking for a way to gain some control over the health care process. Often, their participation in a health group connects them with trained health promoters who they come to use as their family doctors and who teach them how to effectively use natural treatments. For example, when Vicenta began studying at the dispensary, Miguel examined her son's weak lungs. He made a homeopathic treatment for him and then taught Vicenta how to make the treatment. She said she soon saw a significant improvement in her son's condition. Later, when her son was sick with tonsillitis, she gave him medicinal plants to which he responded well. Vicenta then began to treat herself for migraines with homeopathic remedies. As she explains, "This medicine has given me very good results. I haven't returned to using (allopathic) medicine, except if I have a very strong infection, where plants work but a little more slowly."

The women who participate in the CCD and PCHP ultimately share a similar therapeutic network since there is much interaction between the groups' health promoters. Miguel, a therapist at the PCHP, has been an especially important resource for each of the eight women in this sample who, at one time or another have called upon

his services. For example, Juana said Miguel's remedies have helped her daughter improve in her struggle with cervical cancer, although she is receiving treatment at the IMSS hospital as well. The women I interviewed share a sense that the remedies promoted in the health groups can be highly efficacious if used correctly.

The interviews revealed that many of these women have experienced a lot of anxiety about their and their children's health problems. It is possible that the health provider network and information to which they gain access through their affiliation with the groups helps to decrease this anxiety. For example, I observed how the women in the CCD would use each other as their first point of contact during a non-acute illness episode. Not only would they provide each other with instructions on what to do or remedies to take during illness episodes, but they would also accompany each other to a clinic if necessary. This was most important for women like Monica, whose husband was in the United States and who had little other social support outside of CCD participants. In this sense, having a support network (akin to Janzen's [1978] kin therapy managing group) to call upon in the case of an illness appeared to be comforting particularly during times of distress.

Empty nest and the search for a purpose

Three (38%) of the women I interviewed explicitly linked their participation in a health group to their search for a purpose for themselves after their children left their home. These searches took on different forms. Belinda discussed her transition in terms of the isolation that she felt when her children grew up. Juana described the freedom she felt when she gained time to dedicate to herself. Juana's narrative emphasized her

feelings of resentment for having to spend her life taking care of her family and trying to make ends meet in front of a sewing machine. When she learned in 2001 that classes were being offered by the CCD in her neighborhood, she eagerly joined and has been working with the group ever since. Juana's economic situation was dire, but she was given a "scholarship" to study with the CCD and her fees were waived. She struggles with the fact that she is 54 and is just beginning to find her purpose. As she reflects:

> Sometimes I get desperate. I think it is too late. So I question God, 'Why hasn't this happened until now?' But, I also think that it was the best moment for this. God allowed me to rise and do this. I was not well prepared before, so I probably would have not done this in the right way. I think this is the right time, after I raised my grandchildren. Because I feel free now. I was born free. They tried to keep me tied up but I still have my freedom. At least, I have freedom of my mind.

Sofia also found the PCHP during a time in which her life was changing dramatically. She suffered from a severe bout of depression which came on slowly as her four children grew up and left the house. While her youngest daughter was still at home, Sofia started to feel very alone and she recalls "that this is when you start imagining and thinking things. You start to say, 'No one loves me anymore.' Because in the depression I began to feel that I was not useful, that life was not giving me anything. And you begin to believe this is true." Sofia was drinking at the time. Her physician recommended that she get involved in Alcoholics Anonymous as a way to get out of the house and have social interaction. Although she participated in women's embroidering and discussion groups through AA, she said that the women didn't accept her there because she was only a "social drinker."

As her depression got worse, Sofia eventually stopped doing anything; she stayed in bed and did not leave her house. During this time, one of her friends fell and hurt her

coccyx. This friend was not able to walk so she asked Sofia to drive her to the PCHP. After watching her friend recover from her injury, Sofia became intrigued with the dispensary and brought other people there for treatment. However, it took some time before she sought treatment for herself. When she finally did seek help, it was for allergies and asthma that she says was brought on by excessive allopathic medicine. Eventually, she enrolled in the school and then began recovering from her drinking. Things started to change for her. As she explains:

> At first you start doing it for yourself, changing your nutrition, and everything starts to change – your mentality, your lifestyle. For example, when I started to take homeopathic medicine – I told you that I liked to drink alcohol a lot, and between then and now I have quit much of that. I was studying here when I started to change everything. I started to become a little more aware and I started to understand more, because you see people who are sick and it is like you start to put yourself in their place, and to say – yes, I have a lot to give. More than anything, I can help others.

This comment suggests that one important aspect of women's participation relates to achieving awareness that they have something to contribute to society. This is often difficult for them to see when their children leave the home and they question their role. The interviews I conducted suggest that many members may gain a sense of purpose and professional identity through their training and participation in health groups. In fact, 56% (10/18) of the students sampled in the survey described their profession as student or practitioner of alternative medicine. It is noteworthy that none of these 10 women work outside of the home, except for occasional sales. Rather than reporting that they are housewives (*ama de casa*) as is typical among the women I sampled elsewhere in Zarragoza, these women label their work under the umbrella of an alternative medicine profession.

The opportunity for women to study at the CCD and PCHP is also important because few of these women had more than secondary school training and many ended their education after primary school. As Vicenta explained, "For women, this is an important place. Before, they were not permitted to learn; they didn't have the right to learn." Few opportunities exist for Zarragoza women with minimal education to join the work force unless they chose domestic work, office cleaning, or operating a stall in the market. Interviewees repeatedly told me how women over the age of 35 have little to no chance for formal employment since ageism exacerbates sexism in hiring practices. Although health groups do not ensure employment per se, some well-trained women have success in starting their own private practices or in generating income on a small scale as I will discuss below. While this is a desired outcome for some participants, failure to establish a private practice does not necessarily detract from the professional identity that participants gain through their association with the groups.

Sofia, for example, has no interest in generating income through her work as a health promoter. She views her work as a useful contribution to society and is dedicated to continuing her training and volunteering. This interest in serving her community as a health promoter emerged only after discovering the PCHP. While Sofia rarely left her house before this discovery, she has since built a new life around her studies and work as a health promoter. During the time of my research, Sofia volunteered in the clinic on Mondays and Wednesdays, came to the PCHP weekly staff meetings on Thursdays, and returned for yoga classes on Fridays. She also participated in the CCD's eight-month massage course on Tuesdays. Sofia made two-hour long commutes to come to the activities. Her husband drives a private school bus through Zarragoza on his daily route

and is able to make this possible. While transportation fees are not an issue for her, the extent of her commitment is nonetheless impressive, particularly since she is not paid for her volunteer work.

Such commitment is not unusual for the majority of students who study at the CCD and PCHP. As Table 8 shows, 67% of the students surveyed come from outside of Zarragoza to attend classes and to work in the clinics. The majority of these students live within the urban corridor outside of Zarragoza, specifically in the cities of Cuernavca, Cuaulta, and Juitepec, which are between 30 minutes to one hour away by public transportation. This high commute rate is a testament to the reputation and low-cost of the CCD and PCHP schools, relative to the more expensive training programs in the cities. It is also a testament to women's commitment and desire to be part of these programs.

Health participation as a social outlet

The CCD members, even more than PCHP members, view their group as an important social outlet. This is largely the case because the La Rosa community center, where the CCD holds its meetings, offers a unique space for social interaction to which many of the participants do not otherwise have access. For example, many of the classes in which I participated turned into discussion sessions or mini-fiestas. The women would bring food and spend half of the class chatting and eating. Sometimes, part of class time would be spent discussing one woman's health issue or addressing an emotional problem that someone was experiencing. Many times, women's personal problems would become the focus of class discussion. For example, when a student broke down crying during one

of the massage classes, the instructor led the class through a workshop on treating emotional problems through massage. I observed that the participants were open to shifting gears during classes and they appeared to view these specific instances as learning opportunities.

In another CCD class, the instructor Alicia had an emotional crisis that became the focus of the class. She had been experiencing significant anxiety about a patient who had come to see her at the PCHP clinic weeks before with an acute kidney infection. Alicia stayed up an entire night treating him with acupuncture and by morning he was out of crisis and could move again. He went home and Alicia did not see him for a few weeks during which time she began to worry about whether or not he was okay. One day, the patient finally showed up at the La Rosa community center during class to let her know he was okay. When he left the center, Alicia lay down to have a student practice a massage on her and this is when she began weeping.

Juana took the lead in managing this crisis. She went to her house across the street from the community center and pulled out a special herbal concoction for "reviving" people in these states. She massaged Alicia's body with the green liquid while the rest of the students stood around Alicia and held her hand. It took hours before Alicia recovered. When I spoke with her later about this crisis, she explained that she had let very intense emotions build up – not only about this patient, but also about family issues. She did not have an outlet to release these emotions until the patient presented himself. In Juana's analysis of the situation, Alicia's breakdown occurred at that time because she knew that she was in a safe environment.

During my observations, each of the CCD Health Committee members openly shared at least one personal crisis when the women were all together during clinical hours or classes. Regardless of the activity that was occurring, the other women would give their full attention to whoever had the problem. They would listen, provide a massage, and tell the woman that she was not alone. Massages seemed to serve an important purpose in that they provided a hands-on connection that seemed to be reassuring and soothing for the woman in crisis. In essence, the group's gatherings often served as a therapeutic outlet for participants. As Monica enthusiastically said, "Thank god I have found people that have supported me so much and that I can count on." Her sentiments were repeated by many of the CCD members.

The PCHP classes are more structured than those of the CCD and there is less opportunity to socialize during classes. However, the clinical space was often a gathering place for people involved in the group – students, patients, and health promoters (many filled all three of these roles). In addition to offering a space for congregating, the PCHP also seemed to be a uniquely nurturing place. Observing the clinic regularly on Tuesdays, I was struck by the way in which therapists would listen to their patients, spend as much time with them as was necessary, hug them, and invite them back. As a result of this nurturing approach and because many patients I spoke with said that the therapies had been helpful for them, it is not surprising that many people are drawn to the group. It offers individuals a place to go where they can safely speak and be listened to and where health promoters can find community and potentially, a spiritual home. The environments cultivated by these two health groups seem to offer an otherwise unavailable socially sanctioned space for women to socialize, learn, and heal together.

Community service

Regardless of education or income level, the women I interviewed all share an interest in helping others, particularly in helping people living in rural communities who have very limited access to formal medical services. In comparing the town of Zarragoza with the surrounding rural communities, Anna explained, "If we here in the county seat don't have the necessary medical services that we need, then they [people living in rural communities] have fewer. At times they die because of scorpion bites, from diarrhea or vomiting. They die from curable illnesses. Here we are training women, and we hope that they become trainers as well."

As I discussed in Chapter 7, a community service or communitarian approach is central to the work of health groups. Students are taught that one of their primary roles as health promoters is to help others who are in need. This discourse appears to be incorporated into women's own narratives about how they should serve the community. For example, Sofia explained that rather than opening her own clinic in her community, she would rather work in other communities. "Those which are far, those in which almost no information arrives, where there is almost none of this," she said. Similarly, Juana explained that she has dreams of moving to a rural community where she can work as a health promoter. She said:

> It is not important if it is a community far away from here – that is what I would most like, to go to an indigenous region where there are no doctors, where you can honestly serve. That is what I want, and I don't know where I will go, but as soon as I find it I know that it will fulfill me, not economically but as a human being.

It is interesting to note that these two women were solidly among the lower-classes. Ethnically, they are *mestizo*, or of mixed Spanish and Indian decent, as are the majority of residents in Zarragoza. Yet they, like other participants I spoke with have an interest in working in poor indigenous communities, despite their own economic struggles. Even if health group participants do not explicitly view their role as ambassadors to indigenous communities, some nonetheless use the language of "helping others" to describe why they began to study traditional and alternative medicine. For example, one survey respondent answered the question, "Why do you want to study natural and traditional medicine?" saying, "I want to help others because there are no economic resources to heal ourselves." Another woman responded that she wanted to study "because I like to help people with medicines and treatments that do not have any side effects and that can help them." Survey respondents referred to the benefits of natural medicine, problems with allopathic medicine, and the limited economic resources available to improve health to explain their reasons for wanting to help others through this medium.

Such responses point to a sense of altruism that many of the health group participants share. It is not clear from the interviews to what extent Catholicism plays a role in this altruism.[4] Interviewees do share, however, a strong belief in the healing potential of the therapeutic methods that they are taught. While the discourse of community service may not initially motivate women to participate in health groups, the shared spirit of altruism and the strong belief in the healing potential of natural medicine

[4] The women I interviewed were all born into the Catholic faith although their adherence to religious dogma and ritual varies significantly.

appear to be important factors that motivate women to continue their training and their participation.

Economic incentives

When I asked the student survey respondents to explain why they began studying traditional and alternative medicine, the majority (67%) described their personal health problems or their interest in improving their health and that of their families. This is consistent with many of the interviews with active health participants (88%). This group expressed a much more complicated set of factors that include depression, lack of intellectual and social stimulation, and search for a purpose. These data and my observations suggest that women typically do not have economic interests in mind when they first become involved in a health group. Their economic interests appear to develop as they gain awareness of the economic possibilities that exist for them when they see that others have success working as lay health promoters.

Rather than speaking about income generation as an ultimate goal of their health group work, the women I spoke with describe it as one of many benefits to their participation or as a secondary goal. For example, when I asked Maria why she is involved in the CCD Health Committee, she explained, "Because I like it, it is a way to help others, and it offers me a way to generate income." Maria runs a clinic out of her house and offers therapeutic massage and herbal remedies to her clients. She sees approximately 30 clients each month and charges on a sliding scale. As a health promoter who has a steady clientele, Maria is in the minority.

Monica, a CCD participant, has been unsuccessful in her efforts to garner an income from her health services over the past year. Her husband had been in the United States for three years, and although he sent back some money on a monthly basis, Monica was constantly worrying about being able to pay to keep her kids clothed and in school and to cover her rent. The only income that she was generating herself was by baking and selling cakes, occasionally cleaning a house, and even more occasionally, providing a therapeutic massage. She sought out clients for her massages in Zarragoza and also invested time in Mexico City where she believed that, with the help of her relatives who lived there, she could tap into a more economically solvent population. However, she always returned from her trips tired and disappointed from the lack of response that she received. She only occasionally succeeded in selling a massage or an herbal remedy or oil and never generated enough money to make her efforts worth the time. One reason why Monica's efforts failed is that similar to any therapeutic profession, the development of a client base takes time, referrals, and trust. Although many Zarragoza residents use the door-to-door strategy to sell goods, such strategy is not necessarily suitable for the therapeutic profession. Moreover, beginning a solid business requires time and money that Monica, and most women in Zarragoza, simply do not have.

For the most part, the women who train at the CCD and PCHP do not generate significant income from their work, although there are a few exceptions. This does not mean that health group participants are not trying to earn money from their therapies, as was the case for Monica. For example, 56% of the students sampled in the survey offer clinical consultations in their home, in a clinic, or in the homes of patients. The majority of these women charge at least a minimum fee for the services. Two have formal

employment using their massage skills – one woman is a masseuse at a spa and another works in a doctor's office. These women are the exception since they make a relatively steady income from selling their services. Most receive only intermittent income. Still for many women even the smallest amount of money is significant since they are otherwise completely economically dependent on their husbands. Moreover, as women develop their skills and therapeutic repertoires, they may have a greater opportunity for increasing the revenue of their practices.

Alicia's situation is unique in that she has been extremely successful in her work as a health promoter. This can be credited to the time that she has put in to her work as a health promoter and her unique (and arguably, natural) skills as a healer. She is proud of her work and of the income that she is able to generate through this work. She said that now that her children are almost grown up, she has the luxury of providing herself and her kids with some "pleasures." As she explained:

> Now I decide what to do with it (the money); I can give my kids something to spend, to buy things with. I decide to buy things for my kids. The money that I make is not to maintain us. The money that I make is so that they don't have to have live in deprivation. We can't give them everything, but they can have some pleasures. This is my work, this is why I work, and I work because I like to.

In this sense, it would be difficult to separate the economic incentives from the many other reasons why women participate. Alicia has more control in her household than the majority of other women I interviewed. The income she generates helps her feel like she is contributing to the well being of her kids, although this is not the central reason for her work. However, for those women who have little control in their households, even a small amount of extra income helps them to feel more independent from their husbands, as is the case for Belinda. In the case of Monica, whose husband is

in the United States, income generation is a necessity to keep her kids in school. Thus, she is trying, albeit unsuccessfully, to capitalize on her skills as a health promoter to make ends meet. These cases suggest that the extent to which women are motivated by the economic incentives of their work in health groups relates directly to their specific household situation.

Obstacles to health group participation

While this research suggests that women's participation in health groups offers them much in the way of social support, a sense of purpose, greater health knowledge, and control over the health process, participants also report that their involvement with health groups brings about certain challenges. It was not uncommon that women reported battling with their partners or suffering the gossip of their neighbors because they chose to leave the house and "improve" themselves. Many women are confronted with their husbands' insecurities about their involvement in activities outside of the house. As Sofia explains:

> For those of us who are here [at the PCHP], it is because we have had to fight very hard with our partner or with our husband because it is not easy for them to accept this situation. It is not easy for them to say, Yes my love, go and study.' No. They think that men will be here; they are going to be naked. This is the filth that fills their heads. They start to think that you are going there to see someone else. For example, I left [the house] to find a space for myself because I like to feel tranquil and I like it here. In the house I feel bad, I get sick. They see this and they ask, 'What do they give you there? What is going on there?' And you start to have these types of problems.

Juana shared perhaps the most intense frustrations of all of the women I interviewed because of her husband's disapproval of her participation. When she told him she was going to study herbalism with the CCD, he didn't speak to her for three

months. Juana explained that he wanted her to attend to him "day and night without leaving the house." She said that he has never accepted her interest in medicine, not even to this day. After studying herbalism, polarity therapy, and massage for a year at the center, Juana began to see some clients in her home. She said that no one in her family was supportive of this effort. Her husband claimed that it was "a waste of time" since it paid very little. She explained that she wanted to work with poor people who needed her help and getting rich off of the consultations was not her goal. Her husband described this as her own "mediocrity." In her analysis of the situation, Juana explained:

> Men can't stand that a woman is bright and successful. If a woman accomplishes achievements in her life, men will get jealous of that. That's something that bothers them. Men say that they need you or they love you. Yes, they want you there at home. They even want you to be covered and hidden, so nobody would see you. That is something that women can't accept, because that is not what women deserve as human beings.

For Vicenta, this conflict was abated when her husband left for the United States, freeing her to pursue her interests. As her case suggests, migration may open up spaces for women to more freely seize opportunities to develop their skills and interests. Importantly, when Vicenta's husband returned, she reported that he was gradually growing to appreciate what she was doing. Since she was beginning to have a steady clientele she was able to carry her family through the transition of her husband's unemployment. Although it was difficult for him to accept that she was the breadwinner at first, Vicenta explained that he had become more open to such alternatives from his experience in the U.S. In Sofia's case, although her husband initially resented her desire to leave the house and improve herself, he too came to appreciate the work she was doing. In fact, he eventually became a regular patient at the PCHP seeking treatment for his kidney and back problems.

While a husband's migration to the U.S. might theoretically free a woman to actively participate in a health group, there are still other obstacles that some women encounter as they pursue this work. For example, Monica's husband had also migrated to the U.S. while she stayed behind to take care of their two sons. Her in-laws live directly across the street from the house that she rents, and they were not in favor of her participation with the CCD, viewing this work as a waste of time. As a result, they were quick to offer harsh criticism about her participation, which had a significant impact on Monica's sense of freedom, even though her husband was abroad. Similarly, Sofia reported that her neighbors were judgmental of her leaving the house for long periods of time. She said this made her unable to view herself as really free and worthy of the opportunities presented to her.

As these examples suggest, women's entry into health groups requires that they confront some of the social and psychological barriers that have historically served to limit women's participation in the public domain in Mexico. As Anna explained, "There are social expectations and women are still sealed within these." Vicenta goes as far as to suggest that these barriers are at the source of some of women's illnesses. She explained:

> One of the causes of illness is a lack of awareness or knowledge – and it is not poverty, because one can be very poor and eat beans and handmade corn tortillas, and the people are very healthy – but the ignorance of not understanding to respect ourselves and love ourselves. This is what people don't understand and for this reason they get sick.

Vicenta views the training that women receive at the dispensary as therapeutic in and of itself. She sees it as an antidote to a lack of self-esteem that so many women feel because of the barriers that they face in society. Sofia provides a strong testament to this perspective. As she discussed her previous bouts of depression and the changes that had

occurred as a result of her participation in the PCHP, she explained, "You begin to know where you are, how you are...that you feel good. That is the only thing that you are interested in." She argues that women must be "selfish" and "think only about themselves" to maneuver through the resistance that they encounter as they pursue what they believe is good for them. She suggests that the key to being able to negotiate these conflicts lies in women's ability to learn to love and appreciate themselves. She explained that "this is something that the PCHP teaches."

Women's participation in context

This chapter describes how women in the CCD and PCHP are participating in a collective effort that is focused on health education and the provision of alternative health care. As I have demonstrated, health group efforts go beyond addressing practical problems relating to heath care. These groups also offer women a unique opportunity to gain knowledge and professional skills, build friendships and expand their social networks, achieve a new sense of identity, and develop self-esteem. Some of the additional benefits of their participation may include gaining a therapeutic community that they can rely on in times of need, developing confidence in their ability to treat their own and their family's health problems, and generating income. These opportunities are significant for some women who have limited social and professional opportunities.

Lack of time, resources, and or/perseverance are among the many factors that conspire to limit women's participation in health groups. Furthermore, women may face disapproval from their husbands, families, or neighbors for their participation. Those who persevere with the groups must directly confront their household challenges by

insisting on attending classes and meetings despite the objections and obstacles. In doing so, these women are confronting some of the gender inequalities that have historically limited their freedoms.

Although their primary motives for participating in health groups are based on practical and personal concerns, women's involvement is by no means limited to these realms. As "politics permeate everyday life," their participation illustrates how personal concerns are made into political ones (Gallin 2002: 61). By challenging the traditional dichotomies that have historically marginalized women within the private domain of society, their participation moves their concerns into the public realm. Women's collectivization of tasks such as health care provision helps to construct a new gender identity not only based on women's private responsibilities as mothers and wives, but based on their public rights as citizens (Safa 1995). This identity is constructed as women offer health care alternatives to the community and publicly take a critical position regarding biomedicine and the powerful actors and institutions that deliver it. As Escandon (1994) suggests, "By bringing personal concerns to the public arena and demanding them as rights, women have given a new dimension to what is considered political" (p. 208).

Scholars suggest that "feminist consciousness" is produced through women's interaction in grassroots organizations which begin as a response to "practical" gender issues (Ryan 2005). For example Jaquette (1994) writes, "Women in movements often speak of how their participation has changed their lives, expanded their awareness of the unjust structures of society, and given them new self-esteem – even when their involvement brings them into conflict with husbands, children, and other family

members" (p. 225). However, as Gallin (2002) points out, feminist consciousness raising does not only occur when women formally mobilize or address unjust structures of society. In her case study of working-class women's chanting groups in Taiwan, she suggests that talking itself constitutes a form of consciousness raising. She writes:

> ...when women came together in a group they talked. They aired their grievances and they offered each other solace and support. Perhaps more importantly, by letting their resentments be known, they enrolled other women in the project of curbing male behavior they found intolerable" (p. 70).

Gallin (2002) further argues that talking can politicize women and bring injustices to the social realm. She states:

> One woman's articulation of injustice brought to mind other injustices for the whole group. Individual problems became social problems. The shared knowledge created helped women develop critical perspectives on the world in which they lived. This shared knowledge politicized women, enabling them to resist power on the patriarchal terrain of daily life (p. 72).

Women in chanting groups never formally called their gathering a form of consciousness raising. It is likely that neither these women nor the ones that I studied thought of their meetings in this way. However, discussion of the "patriarchal terrain of daily life" was never too far away among women health group participants, as talk would often return to the control that physicians and medical institutions have over women's bodies and the power that husbands have over their daily activities. The environment created by the groups politicized these issues as much as it provided women the much needed space to talk about them. By simply remaining with the groups, continuing their training, and applying the lessons to their daily lives, women appeared to be participating in a form of consiciousness raising as well as in a collective health care effort.

Much of Third World women's writings on feminism has focused on "oppressions" stemming from gender, race, class relations, etc. as fundamental to the

experience of women's social and political marginality (Mohanty et al. 1991). Feminist scholars often point to the importance of income generation for improving the situation of women. For example, Gallin (2002) suggests that when poor women achieve a small cache of earnings, they may gain a minimum space for control over their lives and a measure of self-respect. With this economic boost, women may also gain greater bargaining power over "male prerogatives embedded in the conjugal relationship" (p. 69). Moser (1993) argues that a significant transformation of women's status can only occur if women have greater access to income as well as resources like health care, education, and self-esteem. She suggests that, "The critical issue of increasing women's self-perception of their status and personal power has led to a focus on the role that the collective action of women's solitary groups play. In the confrontation of the persistent reinforcement of inequalities, their activities are vital" (p. 27). This case has shown that women's participation in health groups has the potential to facilitate income generation, greater control over health care, education, and self-esteem – factors that all seem crucial to the work of chipping away at gender inequalities.

While health groups are organized around addressing practical aims, this process can be an entry point for meeting more strategic gender needs (Moser 1993). Whether it is achieved through "talking," gaining health education, offering "woman centered" care, or resisting dominant biomedical discourses, health groups appear to be contributing to a larger project of rearranging the social status quo. As Alvarez and Escobar point out (1992 in Gallin 2002), although minor forms of resistance may not lead to significant structural transformations, women can produce changes that "have revolutionary

implications for how people lead their daily lives and construct and reconfigure their worlds" (p. 61).

CHAPTER 10: CONCLUSIONS

This ethnographic study explores how local individuals and groups in Morelos, Mexico, negotiate the shifting terms of health care as a result of neoliberal health reforms that have contributed to public health care decline while opening up new spaces for private sector actors. It details how health reforms have reconfigured the ways in which the local government delivers health care and constructs "healthy municipalities." Lower class residents are most vulnerable to the impacts of neoliberal reforms as the government relies increasingly on market-based strategies, widening the access gap between wealthy and poor users. At the same time that public health care declines, processes of globalization are introducing new health practices and discourses, which are appropriated by local health groups that seek to make health care alternatives available to low income residents. The study considers how Zarragoza residents are impacted by and respond to international health policies, national health reforms, global health practices, and local health traditions.

My objective has been to highlight the interaction between structure and agency as residents navigate a myriad of political, economic, and cultural obstacles to secure health and welfare. By illuminating the case of health organizing in Zarragoza, I demonstrate how individuals, specifically women, are responding to these obstacles and devising new strategies to adapt to the pressures, constraints, and opportunities that arise in the context of neoliberal globalization. This case illustrates how health groups are challenging dominant discourses and practices to produce "counter-tendencies" that are at the center of change (Arce and Long 2000). Enmeshed in the contradictions of

modernity, this dissertation demonstrates how individuals can simultaneously be producers and products of social change.

Mismatches between international, national, and local agendas

This study reflects a growing concern among anthropologists regarding how international health policy is implemented by national governments in the absence of consideration for the realities and interests of local populations (i.e., see Castro and Singer 2004; Whiteford and Manderson 2000). To this end, I have examined a set of discourses and practices couched in the context of neoliberal frameworks, documenting the mismatch between international policy aims, national health programs, and the needs and realities of citizens. Using the example of Mexico, I demonstrate how national health programs may impose ideas about what constitutes healthiness, which health promotion actions are efficacious, and how much health care the government should provide. I have shown that by promoting discourses of "participation," the Mexican government has placed increased responsibility in the hands of local individuals to finance the health sector and manage health resources. Yet many residents with whom I spoke still expect their government to provide them with the health services they need. These residents feel that local health services are deficient on many levels and wonder where their contributions have gone since their public health care facilities have not improved.

I have also shown how, as neoliberal policies expand the responsibility of individuals and communities, civil associations like the Committee for Culture and Development (CCD) and the Parochial Center for Health Promotion (PCHP) may emerge to take on responsibility in providing health services to meet the needs of underserved

populations. From the perspective of international development analysts, such community-based organizations are viewed as a potential bridge between government and community residents as they take on the elements of primary health care that the state cannot cope with (Jareg and Kaseje 1998). Indeed, the model promoted by the Zarragoza health groups I studied are in accordance with the ideals of Mexican health reforms in that it emphasizes community participation, prevention, and education as key strategies for improving municipal health. Given that these groups are working towards similar goals as the government, it seems logical that they would be incorporated into government strategies towards reducing health system dependency.

Yet, rather than acknowledging the contributions of local health groups, the attitude shared by municipal and health officials with whom I spoke can be best described as passive acceptance regarding their work. They do not view health groups as relevant to helping resolve municipal health problems, despite the rhetoric of community participation that is so central to current health reform strategies. Community participation appears to be relevant to health officials only if it occurs within formal health structures and carries out government priorities. By overlooking the Zarragoza health groups, local officials reinforce the message that has been communicated through public health efforts for decades – that there is only one avenue to improve community health and that is through formal health care structures and the delivery of biomedical knowledge and practice.

As Chapter 3 suggests, municipal officials incorporate citizens into participatory structures but only those which are devised by national governments and managed by local authorities. This leaves little opportunity for community input or participation in

issues that matter to local residents. For example, I documented cases in which residents identified "pressing" problems that were different than those identified by the government. These locally-identified problems were only to be ignored and the government's agenda inserted in their place. Similarly, local health groups are identifying solutions to health care problems that are outside of the realm of biomedicine and these solutions were ignored as well. It seems that despite the rhetoric of participatory planning, a predetermined agenda guides public health programs. While citizens are not truly integrated into the problem solving process, they are nonetheless expected to participate in health committees and local projects, contributing to an agenda to which they ultimately have little input.

In addition to incorporating citizens into formal participatory structures, the government has taken up a neoliberal discourse of "self-empowerment" that emphasizes individual responsibility through illness prevention actions. By placing the emphasis on prevention and individual behaviors, government attention is shifted away from structural issues that contribute to community health problems, issues such as poverty, inadequate housing, and insufficient health care distribution. While expecting that behavioral and attitudinal changes will help resolve local problems, government officials overlook local knowledge and initiatives, ignoring their importance to community planning (Wayland 2001).

Researchers have noted how Mexican state reformers recognize decentralization as the panacea that will bring about a more efficient, comprehensive, and egalitarian health care system (Leyva Flores 2000). However, despite efforts to make the municipal government responsible for managing local resources, a centralized government

bureaucracy still maintains control over these resources (Rodríguez 1997). In the case of health care, the federal government determines the types of programs that are implemented on the local level and dispenses the total budget that state and municipal governments are to distribute. While decentralization strategies are designed to bring about increased community participation and intersectoral collaboration, such strategies are ultimately driven by a centralized definition of what needs to be done, who is equipped to do it, and how these parties should accomplished the stated goals.

Ultimately, municipal governments command limited power and resources to resolve community health problems. These limitations are in turn passed on to other sectors of civil society in the name of decentralization. Hackenberg and Hackenberg (2004) suggest that as government functions decline, the concept of civil society itself has become the "black box" that is representative of the "models and operations that will spell salvation" for the problems that the government can not resolve (p. 391). However, in the case of health groups in Zarragoza, the municipal government has overlooked their potential contributions to help bridge the health service gap.

As I suggest in Chapter 6, the health officials with whom I spoke most often stereotype the groups as "women practicing what they have always practiced – traditional medicine," to use the words of one health official I interviewed. Statements like these locate the work of health groups squarely within the domain of traditional Mexican medicine which is assumed by the health officials to be practiced primarily by women. This assumption overlooks the diversity of the groups and their global and complex alternative health care approaches. Perhaps health officials see traditional medicine as less threatening, economically and socially, than other alternative therapies which have

greater global prestige and are most often used by wealthier Mexicans. Alternative medicine might represent a threat to the dominance of biomedicine and the institutions that deliver it as it is commercialized and comfortably accommodated within the capitalist marketplace. As Buttel and Gillespie (1998 in Beus and Dunlap 1990) suggest, "Adherents of a dominant paradigm can defuse the threat posed by a competing paradigm – appropriating its positive imagery or, at most, accepting its least threatening components, while ignoring or even denying its radical implications – without appearing to be trying to defeat it directly" (p. 611).

In light of the ways in which community groups and local residents are rendered invisible in the context of neoliberal health reforms, this study seeks to make their perspectives, concerns, and efforts visible. I have employed an actor-oriented approach to demonstrate how health group participants are actors in a complicated process of health care delivery and health care reform. I have argued that they are constructing new visions of community health, attempting to decrease patient dependency on public health care, and attending to needs not being met by biomedicine. While offering alternative health resources for their communities, they challenge a hegemonic medical model that reinforces social inequalities by determining how health services are distributed and who has access to them.

The global and syncretic nature of medical pluralism

Another goal of this dissertation has been to further our understanding of the global and syncretic nature of medical pluralism. While earlier studies of medical pluralism recognize that overlap exists between different medical systems (Foley 2002), I

have demonstrated how global ideas and repertoires can be incorporated into local health practices to create a new panorama of health care options and health discourses. I suggest that the boundaries between "local" and "global" health practices are blurred by health groups, as their agendas reflect global trends and their practices re-shape local ideas of health and healing.

Many scholars who examine complementary, alternative, and traditional medicine describe the importance of these practices on account of the "blind spots" or limitations of biomedicine. For example, Micozzi (2003) suggests that Western medicine is not "practical or sustainable" for treating the majority of Third World patients since the cost of medicines are often out of reach, and the technology is of limited availability in much of the developing world. Biomedicine is ubiquitous and deeply institutionalized in Mexico, and formal government services provide at least basic primary health care for the majority of the population. While Mexicans clamor for medical technology, not all sectors of society have equal access to medical care because of income and geography (Finkler 2001). The failures of biomedicine to meet the expectations of many Mexicans contribute to a growing disillusionment with formal medicine, and have led many to seek out alternatives. As the availability of health care alternatives increases, the types of health care treatments advocated by health groups like the ones in Zarragoza may become of interest to more Mexicans.

Many anthropologists have criticized biomedicine for its bureaucratic approach to health care, the impersonal means through which health services are delivered, the invasive medical procedures that accompany its practice, and its tendency to reproduce social hierarchies (e.g., Baer 2001; Good 1994; Gordon 1998; Rhodes 1996; Waitzkin

1991; Whiteford 1996). The therapeutic approach advocated by the PCHP and CCD seems to address many of these critiques. For example, these groups work to eliminate the hierarchical relationship between practitioner and patient by providing counseling and emphasizing human touch, basic practices that are largely missing in formal medical interactions. The groups encourage health promoters to volunteer their time at community clinics and make their work communitarian in practice. By making their services available to all sectors of society, they aim to eliminate socioeconomic barriers to health care access.

Health promoters in the groups I studied are taught to ask questions, listen, observe, smell, and touch their patients in order to diagnose health problems. This is markedly different from the rapid consultations typical in Western biomedicine and the "detached concern" of the physician, who completes medicalized tasks that are not directed at the patient's life world but at constructing diagnostic evidence (Hahn and Kleinmann 1983). In contrast, the health promoters spend time with their patients, take on the role of therapist, and probe into the social circumstances and emotional states that may have brought on a particular illness episode. Similar to the Spiritualist healers that Finkler (1985, 2001) describes, the health promoters in this study view disease as emerging not only from the physiology of the human body but also from the anatomy and physiology of the "social body." They believe that acknowledging the difficult conditions that patients confront and providing them with attention are essential elements of the therapeutic process.

In contrast to biomedicine, which seeks to advance itself by perpetually incorporating new, expensive scientific technology, the approaches advocated by the

CCD and PCHP rely on the resources available in nature (and in the community) – such as plants, sun, air, water, and clay – which have sustained the health of Mexicans for centuries. The health promoters share a "vitalistic orientation" with other practitioners of alternative medicine worldwide who perceive that there is a life force or vital energy that is involved in healing (Collinge 1996). According to this perspective, yin/yang disorders cannot be diagnosed or treated with modern medical apparatuses because the source of imbalance is viewed as completely "energetic." Thus, the health promoters learn to diagnose and treat illness with manual therapies, herbs, and acupuncture which are less invasive than biomedicine procedures.

Anthropologists have argued that by emphasizing technology and the management of the human body, biomedicine contributes the false idea that humans can overcome nature (Gordon 1988). In contrast, the approaches advocated at the CCD and PCHP clinics rely primarily on patient participation and natural resources, arguing for greater environmental consciousness in protecting the resources that generate and maintain health. Instructors at the CCD and PCHP call upon lessons from Mexico's history to rouse social consciousness for preserving and "rescuing" natural resources. In essence, health groups are calling for a shift in cultural values that acknowledges the wisdom of the past in order to protect the future. They seek to reattach culture to "place," arguing for the efficacy of local resources in health promotion and healing.

While the health groups call for the "resuscitation" of traditional medicine, they are in fact creating new traditions; traditions that draw from local knowledge and the resources available to them through globalization. Adapting practices and ideas from traditional Chinese medicine, homeopathy, naturopathy, and Indian traditions, the groups

devise new approaches that merge global languages and concepts with local ideas about health and healing. For example, the health promoters conceive of illness as "imbalance" rather than the result of germs in a similar way that illness is understood in Chinese medicine theory. They do not view the notion of imbalance or the hot/cold characteristics of healing foods and herbs as strictly of Chinese origin but as part of the traditional Mexican view of health, illness, and healing.

The package of health care practices that has emerged from this local/global fusion incorporates more than ideas and treatments however; it includes a prescription for ethical, moral, and spiritual dimensions of living. This prescription involves respecting the environment; embracing cultural traditions; relying on natural healing methods and foods; contributing community service; and nurturing family, community, and self. These aspects of health promotion, which are largely missing from biomedical discourse, are intended to comprise a lifestyle rather than merely a healing modality.

In my evaluation, the philosophy advocated by these health groups has significant potential to bring about some of the changes envisioned by neoliberal health reforms. For example, if individuals take greater interest in their own health, understand the broader factors influencing their well-being, and gain access to health education, their health may improve and their dependence on public health care may decrease in the long run. However, these changes are not going to come about through "top-down" government discourse or the "blame the victim" approach of medical doctors. Health group members understand that lifestyle changes will only come about if individuals are empowered with knowledge and motivation to make transformations. This study suggests that these transformations can come about even among the poorest individuals in

society, who have the least access to resources. However, such lifestyle changes will not eliminate the need for quality biomedical care. Nor will alternative health care provided by community groups ultimately fill in the growing gap left by a declining public health care system. The state must also play its part in fulfilling its constitutional obligation to provide "health for all."

Divergent paradigms in conventional and alternative medicine

Undoubtedly, the concerns of the health groups I describe intersect with a range of social movements occurring worldwide. For example, the holistic health movement in the West emphasizes "getting back to nature," expresses disenchantment with mainstream medicine, and encourages members to attend to the spiritual and emotional aspects of health (Baer 2001). The environmental and alternative agriculture movements also promote a simpler existence, less reliance on mechanized and industrial processes that pollute and poison our land and air, and greater harmony with nature (Beus and Dunlap 1990). These movements offer critiques and alternatives to dominant, expensive, inequitable, and in many ways unhealthy practices associated with conventional medicine and conventional agriculture respectively.

In a publication titled "Conflicting Paradigms in Agriculture," Beus and Dunlap (1990) outline and contrast divergent themes that they find prevalent in the literature on conventional and alternative agriculture. The contrasting paradigms they identify include dependence vs. independence; competition vs. community; and domination vs. harmony with nature, among others. Their discussion is strikingly similar to the ways in which the health group members compare their own values and practices with those associated with

the general biomedical paradigm. To highlight these divergent paradigms as viewed by the health group participants, I present a sample of their views, in a table modeled after Beus and Dunlap's (1990) approach.

Table 9: Divergent elements of conventional and alternative medicine

Conventional medicine	Alternative medicine
Dependence	**Independence**
▪ Consumerism and dependence on the market	▪ More personal and community self-sufficiency
▪ Primary emphasis on science, specialists, and experts	▪ Primary emphasis on personal knowledge, skills, and local wisdom
▪ Great confidence in science and technology	▪ Limited confidence in science and technology
Competition	**Community**
▪ Lack of cooperation; self-interest	▪ Increased cooperation
▪ Traditional healing traditions are outdated	▪ Preservation of traditional healing traditions
▪ Health care is a business only	▪ Health care is a way of life as well as a business
▪ Scientific discovery	▪ Self-discovery; simpler lifestyles
Domination of nature	**Harmony with nature**
▪ Humans are separate from and superior to nature	▪ Humans are part of and subject to nature
▪ Human-made systems imposed on nature	▪ Nature is valued primarily for its own sake

As the right-hand column suggests, health group participants see themselves as promoting their patients' self-sufficiency and reducing their reliance on government health care. Their health education programs emphasize personal knowledge and skills and draw on local knowledge and the wisdom of past generations. Cooperation is an important component of the value system they espouse. Cooperation is also important for practical purposes, since they run their programs with limited budgets. The theme of cooperation contrasts with how health promoters view formal health care – as a "business" rather than a humanitarian service.

Nature is an important aspect of, and offers vital tools for the work of health groups. Rather than attempting to control or exploit nature through expensive technologies and synthetic medicines, the groups emphasize the preservation of natural

resources given their health-creating and sustaining elements. In addition to emphasizing a range of "natural" practices, health groups advocate a simple lifestyle.

While these generalized differences between conventional and alternative medicine hold true in the health group discourse, this study suggests that the boundaries separating the two domains may not be so rigid in practice. For example, alternative medicine like biomedicine has the potential to become highly commoditized. The differences between the two systems also diminish if we examine the tension between communitarian and individualistic values that play out in health group work.

Alternative health care as a commodity

It is easy to see how biomedical health practices and services have become commoditized, particularly as globalization has reduced barriers to foreign goods and opened avenues for foreign capital. Under neoliberal reforms, the state's direct role in the economy is reduced (Wise et al. 2003), and health care increasingly becomes a product to be bought and sold rather than a social right, as was envisioned by the authors of the Mexican constitution. This shift is visible in many ways – social security reforms are transitioning workers into the private insurance system while the public social insurance system is being phased out; fees are now being charged for health services in the public assistance sector that had historically been free; and private health care may now account for over 40% of all health investment by some estimates (Tamez and Molina 2000).

While the market favors the rich, health groups like the CCD and PCHP attend to the needs of the poor. The communitarian discourse they advocate and the low costs of

their services demonstrate their intention to promote greater health care equitability. Yet these health groups do not altogether reject discourses of individualism and privatization tied to neoliberal frameworks; they are also taking part in these discourses. While promoting community service, some health group members also charge a considerable fee for their services outside of clinics. Some hope to benefit from the market niche carved out by alternative medicine. Groups like the CCD were also involved in developing an herbal medicine cooperative with the goal of generating income. They modeled their work after a successful cooperative in a neighboring state that was selling their products internationally through the internet.

Indeed, the economic generation activities of health promoters affect the groups' communitarian efforts. This was demonstrated in Chapter 6 with the case of Tlahuilli, one of the first civil associations in Morelos to implement the communitarian model used by the CCD and PCHP. An evaluation of Tlahuilli conducted by the Inter-American Foundation (Mesa-Lago 1992) suggests that its community clinics were failing because many of the trained health promoters were working out of their homes for a profit, rather than in the clinics. In my observations of health groups in Zarragoza, I noted what I would describe as frenzied involvement of some students in multiple health groups, in an apparent effort to gain rapid training in multiple treatment modalities to offer these services for a fee. Thus, while the health groups critique the commodification of biomedical health care, it appears that they are participating in similar practices, despite the rhetoric of communitarian values.

Health groups occupy a contradictory position as they try to balance these conflicting forces. The community and intra-group conflict that I describe in Chapter 7

was a result of this contradictory position. These conflicts centered on the tension between capitalist and communitarian values. Claims by La Rosa neighbors that the CCD was out to "rob" the community were echoed by health group participants who suggested that other members were unjustly enriching themselves by charging for their services. In these cases, jealousy interacted with the limited income generation options available for Zarragoza residents, contributing to hostility towards those who were profiting from their entrepreneurial endeavors. "Robbing" accusations must also be situated in the context of Zarragoza's resource scarce environment, where public funding for health groups is extremely limited and great competition exists for the few resources that are available. Since three health groups were selling similar services and vying for the same clientele in Zarragoza, it is not surprising that such conflicts erupted.

As health groups and their participants navigate a multitude of social discourses, it appears that they have learned how to negotiate these contradictions. Although market-based approaches may be contrary to the mission of community service, capitalizing on the economic benefits of alternative medicine may provide the only option for the groups to remain viable, particularly in the increasingly competitive alternative medicine market. On the other hand, it seems the groups use the discourse of community service as a language to maintain their validity in the eyes of the community, even though more individualistic motivations may also drive their work.

As I demonstrate in Chapter 9, women have a variety of non-monetary motivations in joining groups. However, they may see others having success in selling their services or products and come to desire that same success. Practical interests and needs clearly play a role in keeping women motivated to work towards the goal of

becoming health promoters. While altruism is noble, it doesn't pay the bills. Particularly since women living in Zarragoza have so few opportunities for formal employment, informal health care may be one of the more accessible and possibly respectable professional options for them.

These tensions highlight the complex position in which health group participants find themselves. Like any other service or commodity, alternative medicine (and its providers) must adapt to the market in order to remain competitive and viable. In becoming too market-oriented however, health groups risk contributing to what Baer (2001) calls, a "marketed social movement" (Baer 2001). The holistic health movement in the United States exemplifies this potential pitfall, particularly since it receives much of its visibility through health food stores and the internet. As scholars argue, the holistic health movement as well as others like the organic agriculture movement, have in many ways come to represent a consumer lifestyle rather than a civic responsibility (Baer 2001; DeLind 2000).

The future direction of health groups in Zarragoza remains to be seen. Will they maintain their mission of community service and continue working to "rescue" ancient healing traditions? Will they move toward a more capitalist and entrepreneurial model of service that further embraces Western individualism? Is it possible that they can maintain the "essence" of their original mission while becoming more market-driven? How will their health practices be affected as they "accommodate" to the market? This study raises many questions that cannot be answered here. Instead, I pose them to illuminate the conflicts and struggles that many Mexicans face as they attempt to negotiate powerful forces that are rapidly changing the world in which they live.

Rethinking gender and development through the lens of health organizing

This "view from below" of health organizing in Zarragoza contributes to the women's social movements literature. While a voluminous literature theorizes about women's social movements in Latin America, few studies provide ethnographic detail of the inner workings of grassroots mobilizations or the reasons for women's participation in them within the context of their everyday struggles and realities. Furthermore, there are few case studies that focus explicitly on health movements or link women's health care strategies with gender and development concerns (for exceptions see Foley 2002; McCormick et al. 2003). This dissertation attempts to bridge these gaps.

While researchers discuss a myriad of approaches for incorporating women into development, improving women's lives in the developing world, and transforming gender hierarchies (e.g., welfare, equity, antipoverty, and efficiency approaches), these paradigms have all too often fallen short of effectively empowering women in the context of development. Some Third World women have articulated an approach that seeks to empower women through greater self reliance and the ability to reach strategic gender needs through their practical concerns (Moser 1993). This "empowerment" approach views gender mobilizations as a central means through which women's empowerment is possible.

This case study of health organizing in Zarragoza considers one way in which women are responding to development (i.e., international health) agendas by mobilizing around alternative health care. In order to participate in this movement however, women are forced to interact with gender hierarchies and constraining social structures in new ways. As they navigate these forces, they encounter both challenging and liberating

elements of health group participation. This study therefore identifies the capacity that local groups have to empower women while illustrating the many obstacles that limit women's participation.

The large majority of health group participants in this study are of low economic standing. Their participation may increase their economic dependency on their spouse because of the cost of training. These women may also confront significant household obstacles as they participate in health groups. They most often face disapproval from their husbands, families, or neighbors. Stephen (1997) has documented cases in which participation in women's groups has led to increased domestic violence. Although the women I spoke with did not mention any overtly abusive situations, spousal or familial disapproval was a common theme in their narratives. For some of the women, participating in health groups increased the conflict they faced in the household, which sometimes led to diminished confidence rather than self-empowerment. Instead of viewing health group participation as an opportunity, some may view it as an additional battle they do not wish to take on.

Even though women represent the majority of participants and contributors to health groups, men still hold the top leadership roles. This phenomenon has been reported in development initiatives where women have community managing roles while men are involved in positions of direct authority (Moser 1993). The problem has been described in holistic health groups as well. For example, Baer (2001) describes the case of the Agni Circle, a healing community in Washington State, where women functioned as the primary healers while the most famous healers were men. In the case of health organizing in Zarragoza, the CCD was the only group comprised of and run solely by

women, and it had all but disbanded by the time I left Zarragoza. While this is not necessarily related to the lack of male leadership in the group, it raises questions regarding the sustainability of women-centered efforts.

Despite the gendered, social, and household obstacles that women face in their participation, some do find ways to overcome external resistance and confront the barriers that otherwise block their professional and personal freedoms. By taking on everyday structures of oppression, these women appear to be doing more than gaining education and skills; they are chipping away at the social structures that limit their mobility. As I point out in Chapter 9, while participants do not necessarily identify with feminist struggles per se, they nonetheless seem to be involved in a consciousness raising process. As they share their everyday struggles, contribute to "woman centered" care, shape a feminine social space, and challenge dominant discourses inherent to biomedicine, they are creating a new collective identity based upon their contributions to society rather than their limitations.

This study therefore contributes new perspectives on how some women are reworking dominant social discourses from the "bottom-up." Beyond addressing gender limitations, women are taking back control of the domain of health care that has fallen largely into the hands of men. Through education and practice, participants may gain confidence and a new kind of authority that can help them manage challenges that may arise in public health settings and in the household when family members are sick. By proposing new ways of "doing" health care that embrace holistic and humanistic aspects of medicine, health group participants are helping to reshape the medical landscape in their communities.

These health groups are also reworking the ways in which participation and decentralization are conceived. Rather than participating in a top-down model of development, these health group members have input into how health is defined and how health care is delivered. Women have a voice in determining the direction of their associations. They take part in the groups' leadership structure, even if they are not in the top positions. Their viewpoints are included rather than ignored in organizational planning and health care delivery.

Participants of these health groups are taking advantage of the social space that has opened up for them to chip away at hegemonic discourses and practices. Both directly and indirectly, they are challenging everyday social structures and reconfiguring social values through their participation. Their efforts may not be unambiguously "feminist" or explicitly directed at "empowerment," but they have the potential to be liberating. Whether intentionally or not, and despite the obstacles they face, their efforts are opening new spaces for women to envision, if not participate in, a different reality.

Directions for future research

There are numerous important questions and issues raised by this study which could be illuminated by further ethnographic research. The first issue pertains to HIV/AIDS in the municipality of Yautepec. In presenting my research in diverse settings, the question that I am most often asked is, "To what extent are these health groups addressing the problem of HIV/AIDS?"

HIV/AIDS is a growing problem in the municipality of Yautepec. Many health officials explained to me that the municipality has the second highest HIV/AIDS rate in

the state because of its location between two major cities and in a corridor that is brimming with adult entertainment venues. With the unfortunate lack of industry in the municipality and the failing economy, many women are engaging in sex work. While the municipal government runs an HIV/AIDS/STD prevention program that is specifically targeted at prostitutes, not all are willing to participate.

HIV/AIDS is a much stigmatized disease that is not discussed in casual conversations. Because of this stigma, it appears that the general public has little access to information about prevention and treatment. I had to prod the women in health groups to discuss HIV/AIDS but gathered very little information on their perspectives. The disease was rarely mentioned in health promoter training classes. This is notable considering that their main focus is on illness prevention. Moreover, I noticed that acupuncture needles were typically soaked in a solution and then reused. The Centers for Disease Control and Prevention (1999) recommends that acupuncture needles be disposed after they are used while other sources like the Australian Health Department suggest that needles be thermally disinfected after they are sterilized (NSW Health Department 2003). It is not clear to what extent health group practices pose a risk to acupuncture patients,[1] but they do raise questions about sanitation, in light of the spread of HIV/AIDS. Additional information is needed to understand how health promoters view HIV/AIDS, the extent to which their practices are sensitive to the epidemic, whether they might play an active role in HIV/AIDS prevention, and the cultural obstacles that stand in the way of their taking on this role.

[1] According to the CDC, only one case of HIV transmission through acupuncture has been documented (1999).

A second issue that would be interesting to explore is the relationship between the different types of health organizations that exist in the state. For example, health tourism is prevalent in the large cities and in tourist towns. Health spas, *temazcales*, traditional medicine classes, massages, herbal remedies, etc., are offered by civil association groups that share some of the same practices with the Zarragoza groups but explicitly cater to the tourist market. What does this version of health organizing look like and how does it compare to the more communitarian version? What do the groups have in common and how do they differ in terms of organizational structure and health practices? Further questions can be asked regarding the differences between male-dominated associations and women-centered associations. To what extent are their discourses similar or different? Are male-dominated groups more often connected to for-profit enterprises? Are they more economically successful than women-centered groups? Conducting observations with a larger sample of health groups in Morelos can help to better illuminate the extent of and diversity within this movement and indicate the direction in which it might be heading.

A further set of research questions raised by this dissertation pertain to the patients who utilize community clinics. Here I have focused largely on the cultural, political, and economic reasons for the emergence of health groups as well as the social and symbolic aspects of women's participation and the practices they employ. However, I gathered little formal data on the circumstances that bring patients to the community clinics run by health groups. Nor did I conduct research on the perceived efficacy of their diverse therapeutic practices. It would be interesting to learn more about patient demographics, their health histories, what brings them to the clinics, the symptoms they

present, and their perspectives on the efficacy of alternative health practices. How do their perspectives on the successes or failures of their treatments compare with biomedicine users who suffer from similar symptoms? As chronic and degenerative diseases increase in prevalence and formal health services decline, consideration of the perceived efficacy of alternative treatments could help to determine the extent to which these clinics and others like them may be a viable health resource in the future.

Finally, this research prompts questions concerning whether Mexicans are exporting these health ideas and practices to the United States. Does a similar cottage industry of traditional and alternative medicine exist among Mexican migrants living in the U.S.? Are community health groups running similar clinics? If so, are their practices similar to those I observed in Morelos or do they reflect a different kind of syncretism, perhaps drawing from popular practices in the U.S.? Do the groups provide low-cost services for immigrants who do not have access to formal health care? How are they contributing to the shifting terms of health care in the U.S.?

Exploring these questions can help us better understand the ways in which Mexicans – in Mexico and beyond – are organizing themselves to resolve their most pressing health care problems in the context of political and economic change. This dissertation represents a first step towards increasing that understanding. By examining local health organizing efforts in Morelos, this study offers a snapshot of how some individuals and community groups are navigating, negotiating, and responding to the many pressures, forces, and challenges that emerge as the right to formal health care decreases in their country and throughout the world.

APPENDIX A

Therapeutic practices

Acupuncture	Acupuncture involves the insertion of thin, sterile, stainless steel needles just below the surface of the skin in the epidural layer. The point locations are determined by meridians and acupuncture points on the body described by Chinese medical therapy. Some therapists use electrical stimulation of the needles (electroacupuncture) in increase the effect.
Auriculotherapy (Auricular acupuncture)	Auricular acupuncture is a technique of treating acupuncture points exclusively on the ear. The practice can be traced as far back as 400 AD in China when medicine books described the ear as having a relationship with all human organ systems. In 1957, a French doctor made a detailed map of the ear that linked zones and points with the body's organs.
Bach Flower remedies*	Bach Flower Remedies were discovered in the 1930s by an English medical doctor and researcher, Dr. Bach, who identified 38 flower remedies that are in use today. The remedies are extremely dilute concentrations of preserved water that has been infused with energies from the petals of flowers. Remedies are selected for a person according to his/her emotions rather than physical symptoms.
Herbalism (Herbal medicine)	Herbalism is the use of medicinal plant substances which are easily assimilated and integrated into the body's chemistry. The traditional use of herbs is based on introducing certain qualities into the body to balance or harmonize the dynamics that may be involved in disease. Herbs are available as raw materials (for boiling and drinking as teas), as herbal extracts (tinctures), and in pill form.
Homeopathy	The roots of homeopathy can be traced to Hypocrites who taught about the law of similars 2400 years ago. The practice was rediscovered in the 1790s by a German physician who found that materials from plants, animals, and minerals could cure the same symptoms they would cause. Homeopathic remedies are administered through small pills that enter the bloodstream by dissolving under the tongue. They are prepared by a process that involves repeatedly diluting the material to infinitesimally small amounts. The goal of homeopathy is to subtly provoke the body to summon up its own healing resources to eliminate pathogens and symptoms.
Massage therapy	Hands-on manipulation is probably the oldest healing practice. The oldest written records go back 3000 years to China, but it is presumed to be much older than that. The most basic principal of massage is that improved blood circulation is beneficial for almost all health conditions. Massage is believed to move lymphatic fluid which plays a key role in removing wastes, toxins, and pathogens; reduce stress and tensions; enhance all bodily systems; and direct energy flow.
Naturopathy (Natural medicine, naturism)	Although naturopathy traces its roots back thousands of years to many ancient cultures, the version commonly practiced today was pioneered in the early 19th century in Europe. Naturopathy is based on using the natural healing abilities of the body. It emphasizes regulating diet, breathing, exercising, bathing, and the employment of natural forces to eliminate toxins from the system. Naturopaths use a variety of manipulative therapies, massage and bodywork as well as hydrotherapy, light and air baths, mud baths, mineral salts, and steam baths.
Polarity therapy	Polarity therapy is a form of energy work that was developed in the mid 1920s by an Austrian who emigrated to the United States. Polarity therapy is based on the idea that every cell has both negative and positive poles and energy flow is enhanced through gentle manipulation. Subtle touch and holding on to specific points harmonizes the flow of energy throughout the body and enhances the body's structural balance.
Reflexology	The manual stimulation of points on the hands and feet are thought to "reflex" through neurological pathways to distant parts on the body. Pressure applied to these

	points is used to relieve stress and tension, improve blood supply, promote unblocking of nerve impulses, and help restore balance in the body. Reflexology was introduced in the U.S. in the early 1900s as "zone therapy." Similar methods resembling shiatsu and acupressure have been practiced in China for thousands of years.
Reiki	Reiki is an ancient Japanese practice in which the healer serves as a conduit for healing energy that comes from the universe. The practitioner receives Reiki energy through the top of the head which exits through the hands and is directed to the patient's body. This practice is a subtle form of energy healing that is administered without any physical contact.
Temaxcal**	The Temaxcal, named by the Aztecs, is an ancient sweat bath that has been used in Mesoamerica for centuries. The Temaxcal brings about "healthful sweating" that has long been known to be beneficial for problems of the skin, liver, and circulation; rheumatism, arthritis, gout, and other chronic diseases; as well as acute problems like muscular pains, colds and congestions. Every bath is directed by a specially trained healer, most often a woman called the "Temazcalera." There has been renewed interest in Mexico in the ancient sweat bath over the last two decades.

Source: Collinge (1996)

*Source: www.bachcenter.com

** Source: www.tlahui.com/temaz1.html

BIBLIOGRAPHY

Alvarez, Sonia E., Evelina Dagnino, and Arturo Escobar, eds.
1998 Cultures of Politics, Politics of Cultures: Revisioning Latin American Social Movements. Boulder, CO: Westview Press.

Anderson, E. N.
1987 Why is Humoral Medicine So Popular? Social Science and Medicine 25: 331-337.

Arce, Alberto, and Norman Long
2000 Anthropology, Development and Modernities. London and New York: Routledge.

Arizpe, Lurdes
1993 Una Sociedad en Movimiento. *In* Antropología Breve de México. Lourdes Arizpe, ed. Pp. 373-397. México, D.F.: Academia de la Investigación Científica.

Ayora-Diaz, Steffan I.
1998 Globalization, Rationality and Medicine: Local Medicine's Struggle for Recognition in Highland Chiapas, Mexico. Urban Anthropology and Studies of Cultural Systems and World Economic Development 27:165-195.

Baer, Hans A., Merrill Singer, and Ida Susser
1997 Medical Anthropology and the World System: A Critical Perspective. Westport, C.T.: Bergin & Garvey.

Baer, Hans A.
2001 Biomedicine and Alternative Healing Systems in America: Issues of Class, Race, Ethnicity, and Gender. Madison, WI: The University of Wisconsin Press.

2003 The Growing Interest of Biomedicine in Complementary and Alternative Medicine: A Critical Perspective. Medical Anthropology Quarterly 16(4):403-405.

Bakkar, Isabella
1994 Introduction: Engendering Macro-economic Policy Reform in the Era of Global Restructuring and Adjustment. *In* The Strategic Silence. Isabella Bakkar, ed. Pp. 1-29. London: Zed Books.

Barnes, Nielan M.
1998 Seeking Health Care: The Social Construction of Medicine in Urban, Middle-Class Mexico. M.A. Thesis, University of California, San Diego.

Bastien, Joseph
1998 Adaptive Strategies of Bolivian Herbalists to Biomedicine. *In* Crossing Currents: Continuity and Change in Latin America. Michael B. Whiteford and Scott Whiteford, eds. Pp. 305-318. Upper Saddle River, NJ: Prentice Hall.

Baytelman, Bernardo
1993 Acerca de Plantas y de Curanderos: Etnobotánica y Antropología Médica en el Estado de Morelos. México: INAH.

Beccerril Straffon, Rodolfo
2001 Señales de Alerta: Una Mirada Crítica al Morelos del Siglo XXI. Mexico, D.F.: Miguel Ángel Porrua.

Berryman, Phillip
1987 Liberation Theology: Essential Facts about the Revolutionary Movement in Latin America and Beyond. Philadelphia: Temple University Press.

Beus, Curtis E., and Riley E. Dunlap
1990 A Note on Conflicting Paradigms in Agriculture. Rural Sociology 55(4):590-616.

Bonfil Sánchez, Paloma
1998 Las Manos y la Tierra: La Función de las Mujeres como Agentes de Salud de los Espacios de Poder Indígenas. *In* Mujeres Pobres: Salud y Trabajo. Paloma Bonfil Sánchez and Vania Salles, eds. Mexico: GIMTRAP.

Bose, Christine E., and Edna Acosta-Belen, eds.
1995 Women in the Latin American Development Process. Philadelphia: Temple University Press.

Brodie, Janine
1994 Shifting the Boundaries: Gender and the Politics of Restructuring. *In* The Strategic Silence. Isabella Bakkar, ed. Pp. 46-60. London: Zed Books.

Cardaci, Dora
1995 Pensando Como Mujeres...Propuestas Educativas en Salud de los "Colectivos" y "Redes" de Mujeres. *In* Las Mujeres y La Salud. Soledad Gonzáles Montes, ed. Pp. 129-165. México: El Colegio de México, Programa Interdisciplinario de Estudios de la Mujer.

Carolina, Martínez S., and Leal F. Gustavo
2003 Epidemiological Transition: Model or Illusion? A Look at the Problem of Health in Mexico. Social Science and Medicine 57:539-550.

Castro, Arachu, and Merrill Singer, eds.
2004 Unhealthy Health Policy: A Critical Anthropological Examination. Walnut Creek, CA: AltaMira Press.

Centers for Disease Control and Prevention (CDC)
1999 HIV and it's Transmission. Electronic document, http://www.cdc.gov/hiv/pubs/facts/transmission.pdf, accessed April 11, 2006.

Chao Barona, Alejandro, and Myriam Delgado Rojas
1998 Fiestas de la Salud. *In* Las Hojas de la Comunidad. Cuernavaca: UAEM: UNICEDES.

Collinge, William
1996 The American Holistic Health Association Complete Guide to Alternative Medicine.New York, NY: Warner Books, Inc.

Comisión Nacional Para el Desarrollo de los Pueblos Indígenas (CDI).
2005 Programas y Proyectos del Instituto Nacional Indigenista: Proyecto de Medicina Tradicional. Electronic document, http://www.cdi.gob.mx/ini/ini/progra05_3.html, accessed Novermber 1, 2005.

Concheiro Bórquez, Luciano
2001 Mercado de Tierras en el Ejido Santa Inés Oacalco, Municipio de Yautepec, Estado de Morelos. *In* Una Perspectiva Campesina del Mercado de Tierras Ejidales. Siete Estudios de Caso. Luciano Concheiro Bórquez and Roberto Diego Quintana, eds. Pp. 189-227. México: Casa Juan Pablos, Universidad Autónoma Metropolitana Xochimilco.

Conners, Margaret
1996 Sex, Drugs, and Structural Violence: Unraveling the Epidemic Among Poor Women in the United States. *In* Women, Poverty, and AIDS: Sex, Drugs, and Structural Violence. Paul Farmer, Margaret Conners, and Janie Simmons, eds. Pp. 91-123. Monroe, ME: Common Courage Press.

Contandriopoulos, Damien
2004 A Sociological Perspective on Public Participation in Health Care. Social Science and Medicine 58:321-330.

Cook, Maria L.
1997 Regional Integration and Transnational Politics: Popular Sector Strategies in the NAFTA Era. *In* The New Politics of Inequality in Latin America: Rethinking Participation and Representation. Douglas A. Chalmers, Carlos M. Vilas, Katherine Hite, Kerianne Piester, Scott B. Martin, Monique Segarra, eds. Pp. 469-488. New York: Oxford University Press.

Cooke, Bill, and Uma Kothari, eds.
2001 Participation: The New Tyranny? London; New York: Zed Books.

Crandon, Libbet
1983 Grass Roots, Herbs, Promoters and Preventions: A Re-Evaluation of Contemporary International Health Care Planning. The Bolivia Case. Social Science and Medicine 17(1):1281-1289.

Craske, Nikki
1993 Women's Political Participation in Colonias Populares in Guadalajara, Mexico. *In* "Viva:" Women and Popular Protest in Latin America. Pp. 112-135. London and New York: Routledge.

Cruz Solano, Alejandro
1998 Promotores de Salud Comunitaria. *In* Las Hojas de la Comunidad. Cuernavaca: UAEM: UNICEDES.

DeLind, Laura
2000 Transforming Organic Agriculture into Industrial Organic Products: Reconsidering National Organic Standards. Human Organization 59(2):198-208.

Doyal, Lesley
1995 What Makes Women Sick: Gender and the Political Economy of Health. New Brunswick, New Jersey: Rutgers University Press.

El Instituto Mexicano de Medicinas Tradicionales Tlahuilli A.C. (IMMITTAC)
2005 La Fiesta Nacional de la Planta Medicinal Y El Instituto Mexicano de Medicinas Tradicionales Tlahuilli A.C. Electronic document, http:// www.tlahui.com/fiesta/, accessed October 2, 2005.

Escandon, Carmen R.
1994 Women's Movements, Feminism, and Mexican Politics. *In* The Women's Movement in Latin America: Participation and Democracy. Jane Jaquette, ed. Pp. 199-221. Boulder: Westview Press.

Escobar, Arturo, and Sonia E. Alvarez, eds.
1992 The Making of Social Movements in Latin America: Identity, Strategy, and Democracy. Boulder, CO: Westview Press.

Escobar, Arturo
1995 Encountering Development: The Making and Unmaking of the Third World. Princeton: Princeton University Press.

Evers, Barbara and Mercedes Juárez
2003 Globalization, Health Sector Reform, Gender and Reproductive Health. Globalization Committee Reproductive Health Affinity Group, Ford Foundation.

Electronic document, http://www.fordfound.org/publications/recent-articles/globalization.cfm, accessed June 12, 2004.

Fajardo Ortiz, Guillermo
2002 La Atención de la Salud en México en el Siglo XX. *In* Primer Coloquio Interdisciplinario de Seguridad Social. Facultad de Derecho y Ciencias Sociales. Pp. 127-132. Temixco, Morelos: UAEM: UNICEDES.

Finkler, Kaja
1985 Spiritualist Healers in Mexico: Success and Failures of Alternative Therapeutics. Salem, Wisconsin: Sheffield Publishing Company.

1994 Women in Pain: Gender and Morbidity in Mexico. Philadelphia: University of Philadelphia Press.

2001 Physicians at Work, Patients in Pain: Biomedical Practice and Patient Response in Mexico. Second Edition. Durham, North Carolina: Carolina Academic Press.

Fisk, Milton
2000 Neoliberalism and the Slow Death of Public Healthcare in Mexico. Socialism and Democracy 14(1):63-76.

Fleury, Sonia
2000 Reforming Health Care in Latin America: Challenges and Options. *In* Reshaping Health Care in Latin America: A Comparative Analysis of Health Care Reform in Argentina, Brazil and Mexico. Sonia Fleury, Susana Belmartino, and Enis Baris, eds. Pp. 3-24. Ottowa: International Development Research Center.

Foley, Ellen E.
2001 No Money, No Care: Women and Health Sector Reform in Senegal. Urban Anthropology and Studies of Cultural Systems and World Economic Development 30(1):1-50.

2002 In Sickness and In Health: Responding to Disease and Promoting Health in Senegal. Ph.D. Dissertation. Michigan State University.

Foster, George
1978 Hippocrates' Latin American Legacy: "Hot" and "Cold" in Contemporary Folk Medicine. Colloquia in Anthropology 23-19.

1987 On the Origin of Humoral Medicine in Latin America. Medical Anthropology Quarterly N.S. 1355-393.

1999 Bureaucratic Aspects of Inernational Health Programs. *In* Anthropology in Public Health: Bridging Differences in Culture and Society. Robert A. Hahn, ed. Pp. 345-364. Oxford: Oxford University Press.

Frenk, Julio, Jaime Sepúlveda, Octavio Gómez-Dantés, and Felicia Knaul
2003 Evidence-Based Health Policy: Three Generations of Reform in Mexico. The Lancet 362:1667-1671.

Gallin, Rita S.
2002 The Politics of Resistance: Working-Class Women in Rural Taiwan. *In* Gender Politics in the Asia-Pacific Region. Brenda S. A. Yeoh, Peggy Teo, and Shirlena Huang, eds. Pp. 61-78. London and New York: Routledge.

Good, Byron J.
1994 Medicine, Rationality, and Experience: An Anthropological Perspective. Cambridge: Cambridge University Press.

Gordon, Deborah R.
1988 Tenacious Assumptions in Western Medicine. *In* Biomedicine Examined. Margaret M. Lock and Deborah R. Gordon, eds. Pp. 19-56. Boston: Kluwer Academic Publishers.

Gómez-Jauregui A., Jessica
2001 Costos y Calidad de la Prueba de Detección Oportuna del Cáncer Cervicouterino en una Clínica Publica y en una Organización no Gubernamental. Salud Pública de México 43(4):1-10.

H. Ayuntamiento Municipal.
2003 Informe de Actividades Correspondiente a la Problematica de Salud Priorizada en el Taller Intersectoral de Planeacion.

Hackenberg, Robert A., and Beverly H. Hackenberg
2004 Notes toward a New Future: Applied Anthropology in Century XXI. Human Organization 63(4):385-399.

Hahn, Robert A., and Arthur Kleinman
1983 Biomedical Practice and Anthropological Theory: Frameworks and Directions. Annual Review of Anthropology 12:305-333.

Hahn, Robert A.
1995 Sickness and Healing: An Anthropological Perspective. New Haven and London: Yale University Press.

Hersch Martínez, Paul
1992 Participación Social en Salud: Espacios y Actores Determinantes en su Impulso. Salud Pública de México 34(6):678-688.

1995 Participación Social en Salud. Algunos Comentarios Bibliográficos. *In* Primer Anuario de la Dirección de Etnología y Antropología Social. Isabel Lagarriga Attias, ed. Pp. 393-406. México, DF: INAH.

Hunt, Linda M.
1995 Inequalities in the Mexican Health Care System: Problems in Managing Cancer in Southern Mexico. *In* Society, Health, and Disease: Transcultural Perspectives. Janardan Subedi and Eugene Gallagher, eds. Pp. 130-147. Upper Saddle River, New Jersey: Prentice Hall.

Instituto Nacional de Estadística, Geografía e Informática (INEGI)
2001 XII Censo General de Población y Vivienda, 2000. Aguascalientes, Mexico, INEGI.

2005 Base de Datos 2003. Electronic document, http://www.sesa-mor.gob.mx/, accessed October 12, 2005.

Isaacs, Stephen and Giorgio Solimano
1999 Health Reform and Civil Society in Latin America. Development 42(4):70-72.

Instituto de Seguridad y Servicios Sociales de Trabajadores del Estado (ISSSTE)
2005 Informe Anual de Actividades. Electronic document, http://www.isssste.gob.mx/informes/IINF-ACTIVIDADES-2004.pdf, accessed October 12, 2005.

Jamison, Barbara.
2004 Alternative Health Care in Cuba. Global Exchange. Electronic Document, http://www.globalexchange.org/countries/americas/cuba/sustainable/natTradMedicine/mylifepath050801.html, accessed June 23, 2005.

Janzen, John
1978 The Comparative Study of Medical Systems as Changing Systems. Social Science and Medicine 12:121-129.

Jaquette, Jane S.
1994 The Women's Movement in Latin America: Participation and Democracy. Boulder: Westview Press.

Jareg, Pai, and Dan C.O. Kasege
1998 Growth of Civil Society in Developing Countries: Implications for Health. The Lancet 351:819-822.

Jordan, Brigitte
1993 Birth in Four Cultures: A Crosscultural Investigation of Childbirth in Yucatan, Holland, Sweden, and the United States, Fourth Edition. Prospect Heights, Illinois: Waveland Press, Inc.

Kay, Patricia
1999 Training Midwives in Rural Mexico. Presentation for the 23rd ICM International Congress of Midwifery.

Kim, Jim Y., Joyce V. Millen, Alec Irwin, and John Gershman, eds.
2000 Dying for Growth: Global Inequality and the Health of the Poor. Monroe, Maine: Common Courage Press.

Kleinman, Arthur
1980 Patients and Healers in the Context of Culture: An Exploration of the Borderland Between Anthropology, Medicine, and Psychiatry. Berkeley: University of California Press.

Kleinman, Arthur
1995 Writing at the Margin: Discourse Between Anthropology and Medicine. Berkeley: University of California Press.

Lane, Sandra, and Robert A. Rubinstein
1996 International Health: Problems and Programs in Anthropological Perspective. *In* Medical Anthropology: Contemporary Theory and Method. Thomas M. Johnson and Carolyn F. Sargent, eds. Pp. 396-423. Westport, Connecticut: Praeger.

Laurell, Asa C.
1991 Crisis, Neoliberal Health Policy, and Political Processes in Mexico. International Journal of Health Services 21:457-470.

2001 Health Reform in Mexico: The Promotion of Inequality. International Journal of Health Services 31(2):291-321.

Lewis, David
1999 Revealing, Widening, Deepening? A Review of the Existing and Potential Contributions of Anthropological Approaches to "Third Sector" Research. Human Organization 58(1):73-81.

Leyva Flores, René.
2000 Descentralización de los Servicios de Salud: ¿Una Política de la Crisis del Fin de Siglo? Paper presented at the People's Health Assembly, Bangladesh, December 2000.

Long, Norman, and Ann Long
1992 Battlefields of Knowledge: The Interlocking of Theory and Practice in Social Research and Development. London and New York: Routledge.

Lopez Austin, A.
1988 The Human Body and Ideology, Volume 1.Salt Lake City: University of Utah Press.

Low, Setha
1985 Culture, Politics, and Medicine in Costa Rica. New York: Redgrave Publishing Company.

Loya, Martha S., Roberto P. Castro, and Mario P. Bronfman
1991 Medicina Tradicional y Medicina Moderna en una Comunidad de Morelos: El Caso de Ocuituco. Medardo T. Uribe, ed. Cuernavaca, Morelos: UNAM: CRIM.

Lozoya, Xavier
1987 La Medicina Tradicional en México: Balance de una Década y Perspectivas. *In* El Futuro de la Medicina Tradicional en la Atención a la Salud de los Países Latinoamericanos. Jesus Reyes Heroles, ed. Pp. 137-150. México: CIESS.

Magdaleno Mora, Raquel and Miguel Angel Guillén Magdaleno
2002 La Farmacia del Campo. Morelia: Col. Sabiduría Popular.

Marchand, Marianne, and Jane Parpart, eds.
1995 Feminism/Postmodernism/Development. New York: Routledge.

McCormick, Sabrina, Phil Brown, and Steve Zavestoski
2003 The Personal Is Scientific, The Scientific Is Political: The Environmental Breast Cancer Movement. Sociological Forum 18(4): 545-576.

Menéndez, Eduardo L.
1997 Antropología Medica: Espacios Propios, Campos de Nadie. Nueva Antropología 15(51):83-103.

Mesa-Lago, Carmelo
1992 Health Care for the Poor in Latin America and the Caribbean. Washington D.C. and Arlington, VA: Pan American Health Organization and Inter-American Foundation.

Messer, Ellen
1987 The Hot and Cold in Mesoamerican Indigenous and Hispanicized Thought. Social Science and Medicine 25:339-346.

Micozzi, Marc S.
2003 Culture, Anthropology, and the Return of "Complementary Medicine". Medical Anthropology Quarterly 16(4):398-403.

Miranda, Miranda C. Leonor, Navarro Álvarez, C. Rafael, and Erika Beltrán Chirnos
2002 Diagnostico de Salud de Municipio de Yautepec, Morelos, México. Yautepec, Morelos, Ayuntamiento Constitucional del Municipio.

Moctezuma Navarro, David
2001 Las Finanzas Municipales en Morelos. Cuernavaca, Morelos: Centro Regional de Investigaciones Multidisciplinarias, UNAM.

Mohanty, Chandra T., Ann Russo, and Lourdes Torres, eds.
1991 Third World Women and the Politics of Feminism. Bloomington and Indianapolis: Indiana University Press.

Molyneux, Maxine
1985 Mobilization without Emancipation? Women's Interests, the State and Revolution in Nicaragua. Feminist Studies 11(2):227-254.

2000 Twentieth-Century State Formations in Latin America. *In* Hidden Histories of Gender and the State in Latin America. Elizabeth Dore and Maxine Molyneux, eds. Pp. 33-84. Durham: Duke University Press.

Morgan, Lynn
1991 The Importance of the State in Primary Health Care Initiatives. Medical Anthropology Quarterly 3(3)227-231.

2001 Community Participation in Health: Perpetual Allure, Persistent Challenge. Health Policy and Planning 16(3):221-230.

Morsy, Soheir A.
1996 Political Economy in Medical Anthropology. *In* Medical Anthropology: Contemporary Theory and Method. Thomas M. Johnson and Carolyn F. Sargent, eds. Pp. 21-40. New York: Praeger.

Moser, Caroline O. N.
1993 Gender, Planning and Development: Theory, Practice and Training. New York: Routledge.

Nash, June C.
2001 Mayan Visions: The Quest for Autonomy in an Age of Globalization. New York and London: Routledge.

Nigenda, Gustavo, Lejeunne Lockett, Christina Manca, and Gerardo Mora
2001a Non-biomedical Health Care Practices in the State of Morelos, Mexico: Analysis of an Emergent Phenomenon. Sociology of Health and Illness 23(1):3-23.

Nigenda, Gustavo, Gerardo Mora-Flores, Salvador Aldama-López, and Emanuel Orozco-Núñez
2001b La Práctica de la Medicina Tradicional en América Latina y el Caribe: El Dilema Entre Regulación y Tolerancia. Salud Pública México 43:41-51.

Nigenda, Gustavo, Enrique Cifuentes, and Warren Hill
2004 Knowledge and Practice of Traditional Medicine in Mexico: A Survey of Healthcare Practitioners. International Journal of Occupational and Environmental Health 10:416-420.

NSW Health Department
2003 Skin-penetration Fact Sheet: "Acupuncture." Electronic document, http://www.health.nsw.gov.au/public-health/ehb/general/skinpen/fs_acupuncture.pdf, accessed April 11, 2006.

Nuijten, Monique
1992 Local Organization as Organizing Practices: Rethinking Rural Institutions. *In* Battlefields of Knowledge: The Interlocking of Theory and Practice in Social Research and Development. Norman Long and Ann Long, eds. Pp. 189-207. London: Routledge.

2002 Organizing the Peasants: Participation, Organization and the Politics of Development in a Mexican Government Program. Anthropologica XLIV 223-235.

Ong, Aihwa
1996 Strategic Sisterhood. Indiana Journal of Global Legal Studies 4(1):109-135.

Ortiz de Montellano, Bernard R.
1989 Mesoamerican Religious Tradition and Medicine. *In* Healing and Restoring: Health and Medicine in the World's Religious Traditions. Lawrence E. Sullivan, ed. Pp. 359-394. New York: MacMillan Publishing Company.

1990 Aztec Medicine, Health, and Nutrition. New Brunswick: Rutgers University Press.

Oswald, Úrsula
1991 Desarrollo, Crisis y Alimentación en el Estado de Morelos. Primeras Jornadas de Investigación en el Estado de Morelos 223-242.

Palacios, Elizabeth
2003 Medicina Tradicional: Naturaleza e Historia del Pueblo Mexicano. La Jornada, January 3, 2003.

Petchesky, Rosalind P.
2003 Global Prescriptions: Gendering Health and Human Rights. London: Zed Books.

Pigg, Stacy L.
1995 Acronyms and Effacement: Traditional Medical Practitioners (TMP) in International Health Development. Social Science and Medicine 41(1):47-68.

Radcliffe, Sarah A., and Sallie Westwood, eds.
1993 'VIVA': Women and Popular Protest in Latin America. London and New York: Routledge.

Rhodes, Lorna A.
1996 Studying Biomedicine as a Cultural System. *In* Medical Anthropology: Contemporary Theory and Method, Revised Edition. Carolyn F. Sargent and Thomas M. Johnson, eds. Pp. 165-180. Westport Connecticut: Praeger.

Rist, Gilbert
1997 The History of Development: From Western Origins to Global Faith.New York, NY: Zed Books.

Rodríguez, Victoria E.
1997 Decentralization in Mexico: From Reforma Municipal to Solidaridad to Nuevo Federalismo. Boulder, CO: Westview Press.

Rojas Alba, Mario.
1996 Algunas Palabras Sobre el IMMTTAC Y TLAHUI. Electronic document, http:// www.tlahui.com/plante0.htm, accessed June 12, 2005.

Rounds, Christopher R.
1987 From Hacienda to Ejido. New York & London: Garland Publishing, Inc.

Ryan, Josephine C.
2005 Encountering the State: Cross-Cultural Perspectives on Women's Political Experience. *In* Gender in Cross-Cultural Perspective. Caroline B. Brettell and Carolyn F. Sargent, eds. Pp. 320-332. Upper Saddle River, New Jersey: Prentice Hall.

Safa, Helen I.
1995 Women's Social Movements in Latin America. *In* Women and the Latin American Development Process. Christine E. Bose and Acosta-Belen, eds. Pp. 227-241. Philadelphia: Temple University Press.

Salamon, Lester M.
2001 The Third Sector in Global Perspectives. IAF/OAS. Building Democracy from the Grassroots. Presentations from the Hall of Americas, Organization of American States. Washington D.C.

Sarmiento Silva, Sergio
1997 Morelos: Sociedad, Economía, Política y Cultura. México, D.F: CIICH-UNAM.

Schensul, Stephen L., Jean Schensul, and Margaret D. LeCompte
1999 Essential Ethnographic Methods: Observations, Interviews and Questionnaires. Walnut Creek and London: AltaMira Press.

Scheper-Hughes, Nancy, and Margaret M. Lock
1987 The Mindful Body: A Prolegomenon to Future Work. Medical Anthropology Quarterly 1(1):6-41.

Scheper-Hughes, Nancy
1992 Death Without Weeping: The Violence of Everyday Life in Brazil. Berkeley: University of California Press.

Schmal, John P.
2004 Morelos: The land of Zapata. Electronic document, http://www.houstonculture.org/mexico/morelos.html, accessed September 8, 2005.

Secretaría de Salud
2003 Anuario Estadístico. Secretaría de Salud, Servicios de Salud de Morelos. Electronic document, http://www.sesa-mor.gob.mx/pdf/an03_introduccion_demografia_cobertura.pdf, accessed October 4, 2005.

2004a Salud: México 2003. México, D.F.: Secretaría de Salud.

2004b Información Estrategia Salud: México 2003 por Entidad Federativa. México, D.F.: Secretaría de Salud.

Sen, Gita, and Caren Grown
1987 Development, Crises, and Alternative Visions: Third World Women's Perspectives. New York: Monthly Review Press.

Seneviratne, Kalinga.
2000 Traditional Medicine often Lauded but Neglected. Third World Network. Electronic document, http:// http://www.twnside.org.sg/title/lauded.htm, accessed July 15, 2005.

Simonelli, Jeanne M.
1987 Defective Modernization and Health in Mexico. Social Science and Medicine 24(1):23-36.

Singer, Merrill
1990 Reinventing Medical Anthropology: Toward a Critical Realignment. Social Science and Medicine 30(2):179-187.

Slater, David
1998 Rethinking the Spatialities of Social Movements: Questions of (B)orders, Culture, and Politics in Global Times. *In* Cultures of Politics, Politics of Cultures: Revisioning Latin American Social Movements. Sonia E. Alvarez, Evelina Dagnino, and Arturo Escobar, eds. Pp. 380-401. Boulder, CO: Westview Press.

Smith, Gavin
2002 Grass-Roots Participation and Bureaucratic Interfaces: The Case of Mexico-Introduction. Anthropologica XLIV 159-163.

Sotelo, Juan M., and Fernando Rocabado
1994 Salud Desde el Municipio: Una Estrategia para el Desarrollo. Salud Publica de México 36(4):439-446.

Sparr, Pamela
1994 What is Structural Adjustment? *In* Mortgaging Women's Lives. Pamela Sparr, ed. Pp. 1-10. London: Zed Books.

Standing, Hilary
2002 Frameworks for Understanding Health Sector Reform. *In* Engendering International Health: The Challenge of Equity. Gita Sen, Asha George, and Piroska Ostlin, eds. Pp. 347-371. Cambridge and London: The MIT Press.

Stebbins, Kenyon R.
1986 Curative Medicine, Preventive Medicine and Health Status: The Influence of Politics on Health Status in a Rural Mexican Village. *In* Health and Health Care in Developing Countries. Peter Conrad and Eugene B. Gallagher, eds. Pp. 139-148. Philadelphia: Temple University Press.

Stephen, Lynn
1996 The Creation and Re-creation of Ethnicity. Latin American Perspectives 23(89):17-37.

1997 Women and Social Movements in Latin America: Power From Below. Austin: University of Texas Press.

Subsecretaría de Cultura
1988 Diagnóstico Sociocultural del Estado de Morelos. Mexico, D.F.: Dirección General de Culturas Populares.

Tamez, Silva, and Nancy Molina
2000 The Context and Process of Health Care Reform in Mexico. *In* Reshaping Health Care in Latin America: A Comparative Analysis of Health Care Reform in Argentina, Brazil and Mexico. Sonia Fleury, Susana Belmartino, and Enis Baris, eds. Pp. 133-152. Ottowa: International Development Research Center.

Torres Martínez, Lizandra
1992 Feminismo Popular en el México Contemporáneo. Homines 16(1):283-288.

Udvardy, Monica L.
1998 Theorizing Past and Present Women's Organizations in Kenya. World Development 26(9):1749-1761.

Underwood, Jill.
2006 Mexico's Controversial Clinics. Time Online Edition Electronic document, http:// www.time.com/time/health/article/o,8599,115692,00.html, accessed March 3, 2006.

Waitzkin, Howard
1991 The Politics of Medical Encounters: How Patients and Doctors Deal with Social Problems. Yale University Press.

Wayland, Coral
2001 Gendering Local Knowledge: Medicinal Plant Use and Primary Health Care in the Amazon. Medical Anthropology Quarterly 15(2):171-188.

White, Sarah C.
1996 Depoliticising Development: The Uses and Abuses of Participation. Development in Practice 6(1):6-15.

Whiteford, Linda M.
1996 Political Economy, Gender, and the Social Production of Health and Illness. *In* Gender and Health: An International Perspective. Carolyn F. Sargent and Caroline B. Brettell, eds. Pp. 242-259. Upper Saddle River, New Jersey: Prentice-Hall, Inc.

Whiteford, Linda M., and Lenore Manderson, eds.
2000 Global Health Policy, Local Realities: The Fallacy of the Level Playing Field. Boulder, CO: Lynne Reinner Publishers, Inc.

Whiteford, Linda M.2000 Local Identity, Globalization, and Health in Cuba and the Dominican Republic. *In* Global Health Policy, Local Realities: The Fallacy of the Level Playing Field. Linda M. Whiteford and Lenore Manderson, eds. Pp. 57-78. Boulder, CO: Lynne Rienner Publishers, Inc.

Whiteford, Michael B. and Scott Whiteford
1998 Crossing Currents: Continuity and Change in Latin America.Upper Saddle River, New Jersey: Prentice Hall.

Whiteford, Michael B.
1999 Homeopathic Medicine in the City of Oaxaca, Mexico: Patients' Perspectives and Observations. Medical Anthropology Quarterly 13(1):69-78.

Wise, Timothy A., Hilda Salazar, and Laura Carlsen
2003 Confronting Globalization: Economic Integration and Popular Resistance in Mexico.Bloomfield, CT: Kumarian Press.

World Health Organization (WHO)
1979 Traditional Medicine Programme. Electronic document, http://www.who.int/medicines/areas/traditional/trm_assembly_doc/en/, accessed June 25, 2005.

Wolf, Eric
1959 Sons of the Shaking Earth. Chicago: University of Chicago Press.

Worsley, Peter
1982 Non-Western Medical Systems. Annual Review of Anthropology 11:315-348.

Yoder, P. Stanley
1997 Negotiating Relevance: Belief, Knowledge, and Practice in International Health Projects. Medical Anthropology Quarterly 11(2):131-146.

Young, James C.
1981 Medical Choice in a Mexican Village. New Brunswick, New Jersey: Rutgers University Press.

Zaidi, S. Akbar
1994 Planning in the Health Sector: For Whom, By Whom? Social Science and Medicine 39(9):1385-1393.

Zakus, J. David L.
1998 Resource Dependency and Community Participation in Primary Health Care. Social Science and Medicine 46(4-5):475-494.