SECOND-CLASS MEXICANS: STATE PENETRATION AND ITS IMPACT ON HEALTH STATUS AND HEALTH SERVICES IN A HIGHLAND CHINANTEC MUNICIPIO IN OAXACA

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ABSTRACT

Developing nations around the world are actively promoting programs which are explicitly intended to improve the lives of their disadvantaged rural populations. Such government efforts may affect the rural target population in a variety of ways. This dissertation examines a recent rural development program in Mexico which includes over 2,000 new rural health clinics designed to deliver "health" to millions of previously neglected Mexicans.

The conceptual orientation of this dissertation emphasizes the social impact which state penetration has on the lives of the people for whom government services are intended. Based on fifteen months (1980-1982) of participant-observation research in a highland Chinantec municipio in Oaxaca, this study reports on how villagers perceive a federal health clinic which recently opened in their community.

To judge from government reports, the penetration of state health services into the lives of rural inhabitants is laudable in intent and in practice. However, the delivery of rural health services as presented in this study is not merely a benevolent act on the part of the government. The provision of health services is also shown to be laden with hidden agendas and unexpected consequences both on the part of the political and economic elite who design and implement such programs, and also on the part of the recipients.

It is seen that while the villagers universally desire western medical services, they are deeply resentful of those provided in their new clinic. For a variety of reasons, the clinic is viewed as

providing "second-class" services. Accordingly, this recent form of state penetration served to reinforce villagers' self-perceptions of being "second-class" Mexicans. Despite this resentment, they are very eager to retain their clinic, albeit for reasons which have relatively little to do with health, and more to do with micro-level political factors involving a neighboring rival municipio. This paradox is analyzed in historical, sociocultural, and political terms. At a time when the federal government is proclaiming that rural Mexicans are finally enjoying their constitutionally guaranteed right to health, this study shows that critical health-sustaining factors such as poor environmental sanitation and undernutrition are not being addressed.

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CHAPTER I

INTRODUCTION, METHODOLOGY, AND ALTERNATIVE APPROACHES TO HEALTH SERVICES IN DEVELOPING COUNTRIES

Introduction

Developing nations around the world are actively promoting programs which are explicitly intended to improve the lives of their disadvantaged rural populations. Such government efforts may affect the rural target population in a variety of ways. This dissertation examines one recent rural development program in Mexico from an anthropological perspective. More precisely, this study focuses on the delivery of health services to millions of previously unserved rural Mexicans. To judge from government reports, this form of penetration by the state into the lives of rural inhabitants appears to be laudable in intent as well as in practice. However, as this dissertation reveals, even something so apparently unquestionably beneficial as the delivery of modern health services to the rural poor is, upon closer investigation, a highly complex undertaking, an undertaking which may be viewed by the recipients in quite a different light than that of the donors. The delivery of rural health services as presented in this study is not merely a benevolent act on the part of the government, eagerly accepted and appreciated by those in need. More than this, the provision of health services is shown to be laden with hidden agendas and unexpected consequences both on the part of the political and economic elite who design and implement such programs, and also on the part of the recipients.

The critical tone of this dissertation should not be misunderstood as personal criticism of officials within the various agencies of the federal and state governments in Mexico. To the contrary, I recognize that countless Mexicans have dedicated their lives to programs intended to improve the plight of the poor. This study intends no criticism on individuals. Rather, criticisms are aimed at government agencies, most specifically at the partial failure of agency programs to effectively realize their laudable stated objectives concerning helping the disadvantaged.

This study, then, is concerned primarily with policy outcome, and the effects of certain health policies on the lives of proposed beneficiaries. Evaluation of policy formation and policy implementation unfortunately lie beyond the scope of the present study. (They constitute a logical and important extension of the research presented here). Lacking first-hand information on high-level decision-making activities within the Mexican government agencies, this study utilizes the works of various political scientists who have investigated this highly complex aspect of the Mexican political system. Certain political scientists, (notably Kreisler (1981) and Musselwhite (1981)) have concluded that while the political and economic elites in Mexico formulate and implement health policies in response to a variety of interest groups (both rich and poor), the changes which do occur serve to maintain the non-egalitarian status quo. This dissertation makes no such claims. Instead, the intent of this dissertation is to demonstrate the impact which a recent federal health program has had upon the rural poor population for whom it is intended.

Bureaucracies in Mexico are urban-based, and are relatively unfamiliar with contemporary rural Mexico. Anthropologists are among the few who take it upon themselves to attempt to obtain a clear understanding of rural life. It is hoped that the criticisms of a newly created and highly ambitious health services program presented here are received in the spirit with which they are given, with the hope that they might help future program planners better realize their important stated goals related to improving the health status and health services for millions of rural poor Mexicans.

The conceptual orientation employed in this dissertation emphasizes the social impact which state penetration has on the lives of local-level people for whom government services are intended. Anthropological inquiry emphasizes the holistic nature of human existence. This study demonstrates this by showing how the lives of rural Mexicans are affected not only by social factors, but also by political, economic, geographic, and historical considerations as well. The delivery of government-sponsored health services to rural Mexicans involves not only the rural "beneficiaries" of such services, but also the urban-based government bureaucrats, or "donors." To consider only one or the other of these interrelated components is to be left with an incomplete understanding of the many factors which influence the formation, implementation, and utilization of rural health services. This dissertation accordingly considers the perspectives and priorities of both the "donors" and the "recipients."

Anthropological inquiry also recognizes the importance of history. The present-day social processes which are presented in this dissertation may only be understood by first learning about the historical

forces which have been instrumental in their formation. Accordingly, Chapters II and III of this study are devoted to an historical analysis of the region where this research was conducted. Therefore, this dissertation draws upon a broad range of historical and contemporary data in order to address the following questions. First, to what extent is the Mexican government health services program meeting its explicit, expressed goals? Second, what implicit, hidden agendas might the Mexican government be attempting to address through such health services? Third, how do the "beneficiaries" of the health services perceive them? And fourth, how is this form of state penetration impacting upon the villagers who are "covered" by these government-sponsored health services?

As will be seen in the following section on methodology, this study emphasizes one particular rural village in southern Mexico. However, the focus of this study goes beyond the limitations of traditional anthropological community studies by including extra-local political, economic, and historical factors. Anthropology's long-standing interest in community studies has in recent decades come to recognize that communities are affected by extra-community forces. In Latin America, Redfield's (1941, 1947, 1960) pioneering community studies were followed by the works of Wolf (1955, 1956, 1957) and Mintz (1953), who began to view rural communities not as isolated and independent units, but as entities intricately interconnected by numerous complex linkages with regional, national, and even international political and economic forces.

With this expanded perspective beginning in the 1950s, a series of questions began to be raised regarding how to understand and explain the social and economic conditions observed in rural communities.

Around this time, modernization theory was put forward as one way to explain differences which had long existed between urban and rural areas. Derived from neoclassical economics, modernization theory seeks to explain the poverty and "backwardness" of rural regions in terms of "adoption-diffusion" explanations, suggesting that it is only a matter of time before the "advantages" of "civilization" (as exemplified in urban and "modern" areas) will reach the rural regions. When this does eventually happen, modernization theory explains that only "superstitions" and "ignorance" would prevent the rural population from enjoying the advantages of "civilized" living. Modernization theory has provided justification for countless "development" projects throughout the world, all premised on the assumption that what exists in modern cities is best for the rural areas as well, and can be attained in due time by letting Western capitalism's "invisible hand" perform the transformations.

The persistence of poverty conditions in rural areas, even in nations such as Mexico which have experienced enormous economic growth over several decades, has led to skepticism about the explanatory value of modernization theory for understanding the nature of (and contributing causes of) rural poverty. Alternative analyses of rural living conditions have produced different theoretical orientations. This dissertation rejects modernization theory, and instead emphasizes the nature of the interactions between the state and its rural areas. The penetration by the state into rural areas often takes the form of organizational or institutional linkages, and may serve both control and developmental functions (Corbett & Whiteford 1983:10).

The related conceptual orientations of state penetration and center-periphery linkages (between the centralized state and the rural hinterlands) utilized by Corbett & Whiteford and others are an outgrowth of earlier explanatory efforts. Specifically, they are an extension of dependency theory, which itself is an outgrowth of the macro-perspective pioneered by Wolf (1955, 1956, 1957) in reaction to Redfield's (1941, 1947) community-focused studies. Frank (1967) was an early dependency theorist who attempted to explain the poverty and inequalities observed in Mesoamerica by stating that the underdevelopment of the traditional sector was a product of its linkages with the modern sector. Frank renamed these sectors "metropole" and "satellite," and claimed that the capitalist metropoles (first Spain and Europe, and later the United States and Mexico City) are directly responsible for Mesoamerica's underdevelopment (which Frank notes is <u>not</u> an original or necessary condition for development). Frank explains that metropoles expropriate surplus from satellites. This expropriation may take the form of a metropole such as Spain "underdeveloping" Mexico, or it may take the form of <u>internal colonialism</u>, wherein a metropole within the country (be it the national capital, or a provincial capital) dominates a satellite (or a smaller size and power position), extracting surplus which enables the metropole to develop while the satellite underdevelops.

Another scholar whose work reflects the influence of Wolf is Adams. His 1970 volume on the political and economic forces affecting Guatemala is an insightful work which, by incorporating Wolf's extralocal perspective, provides a comprehensive analysis of the social reality of Mexico's neighbor to the south. In order to understand the "life trajectories of peasants and poor peoples" in contemporary Mesoamerican society, writes

Adams (1970:3), it is essential to analyze and comprehend "the larger society within which they lived; and it is equally necessary to see how the larger society related to the world." Adams utilizes the concept of power and power structures to relate peasants to the larger society.

Influenced by Frank's dependency theory and Adams' emphasis on power relations, Mexican social scientists began examining how the penetration of capitalism and the role of the state impact upon local-level social systems. Stavenhagen (1975), for example, follows Frank's metropole-satellite perspective, but his emphasis on the nature of social classes differentiates him from Frank. "The establishment of colonial systems and the expansion of capitalism in underdeveloped countries led to certain processes of social change which accelerated the disintegration of traditional structures and gave birth to new social categories and social classes" (Stavenhagen 1975:53). Stavenhagen outlines the processes which have transformed class structures in Mesoamerica (1975:53-63). He minimizes the cultural differences between dominated (underdeveloped) people, and emphasizes their structural relationships to the larger society. In doing so, he notes that to the extent that the capitalist economy (and the national society) penetrated the Indian communities, the relations between the satellite and metropole (or colonized and colonizers) became transformed from colonial relationships to class relationships, resulting in the underdevelopment of the satellite.

The conceptual orientations of state penetration and center-periphery linkages which have evolved from several earlier explanatory models are employed in this dissertation because they afford the

greatest potential for understanding the forces impacting on contemporary rural Mexicans. As will be seen later in this dissertation, the state penetration model is not without its limitations. In the case of this dissertation, the lack of data regarding policy formation and policy implementation at the state and federal level prohibits evaluation of these important aspects of Mexican politics. Lacking this information, this dissertation concentrates on policy outcome. Specifically, this dissertation examines the impact which the penetration of federal health services has had on a rural population in southern Mexico. In this study it will be seen that such intrusions into the rural sector in Mexico are not without precedent, nor are they received in the same ways which the providers intended.

Among the many components of poverty in rural areas in developing countries, questions concerning health and illness are among the most urgent being investigated today. The delivery of health services and the improvement of health status for the underclasses in underdeveloped countries around the world are topics of great interest for government officials, health planners, scholars, and the disadvantaged peoples themselves. Much of this recent interest focuses on the provision of health services intended to reduce morbidity and mortality among the poor. Developing countries around the world are pursuing a variety of alternative approaches in their attempts to improve the health status and health services for the poorest segments of their populations. The kind of approach emphasized by any particular nation, and the seriousness with which such an approach is pursued, are heavily influenced by the political and economic orientations and priorities of the ruling sector of the nation. An implicit (and often explicit) assumption in

many government health programs is that improvements in health services (especially the provision of clinics and physicians) will best guarantee improved health status for the population covered by such services. However, as will be seen in this study, such an assumption is not necessarily valid.

This medical anthropology study, incorporating a broad range of historical and contemporary data, concerns itself with recent innovations in health care delivery in the developing country of Mexico. This study examines Mexico's recent attempts to provide health services to millions of rural citizens who, prior to 1979, had never had a physician's medical services locally available to them on a daily basis at no charge.

The Mexican government's innovative health services program has promised to improve the health status of millions of Mexico's most "isolated and marginal" people.[1] The findings presented in this study suggest that, based on observations made in one rural Mexican village, the Mexican government's health services program is attending to only a part of the health needs of the rural population. Moreover, this dissertation suggests that the government services are serving the vested interests of the urban-based political and economic elite by potentially preserving the status quo, which is to their advantage. The remainder of this dissertation is dedicated to conveying to the reader the validity of these findings, which have been presented here as a preview of what is to follow.

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[1]The government development program under study here (and presented in greater detail in Chapter VI) is referred to by its acronym, COPLAMAR (Coodinación General del Plan Nacional de Zonas Deprimidas y Grupos Marginados), the General Coordinating Board for the National Plan [to aid] Deprived and Marginal Groups.

The data on which this study is based were gathered by the standard anthropological techniques of long-term participant-observation, extensive interviews, and archival records (discussed below). While the research was conducted in a small village in southern Mexico, this study demonstrates that rural villages are not isolated, self-contained, independent entities, but rather are (and have been for centuries) significantly affected by external forces over which they have had little control. Health-related matters are no exception. As is shown in this study, external forces influence health services and health status by penetrating into places that are geographically, culturally, and economically very distant from Mexico's urban power centers.

Methodology

The data on which this dissertation is based were gathered using a variety of standard anthropological techniques. In addition to the fifteen months residence in the research site (a highland Chinantec village in Oaxaca), an additional two months were spent in Oaxaca City and Mexico City, where valuable contacts were established and important information was obtained. The overwhelming majority of the field data was collected in the village. This was done by participant-observation, open-ended informal interviews, and copying of official documents (when permitted).

Fieldwork in the particular highland Chinantec village where I resided was particularly challenging. The basis for the challenge lies in the long history of property disputes and inter-village feuding which has left the village in a precarious position in terms of its most valued resource, land (valued for its agricultural use and for its timber resources). So strong are the villagers' concerns about their

scarce resources that they regard any stranger in their midst with great suspicion. For example, when the federal census-takers arrived in the village in 1981 with the intention of gathering information regarding property boundaries (both individual and communal), animals owned, and crops planted, the village authorities managed to prevent them from gathering any information, while appearing to regret the "unfortunate obstacles" which were continually impeding the census team's work (including the absence of the appropriate village officials and the lack of any decent place for the visitors to reside during the period of their work). I was told by these census workers that of the thirty villages with which they were familiar in the Sierra Juárez, this one was the only village to offer any real resistance to their efforts.

My obtaining permission from the village authorities to live in their community was greatly aided by two factors. First, a letter of introduction from Mexico's National Institute of Anthropology somewhat legitimized my presence in their eyes. Second, and much more important, the fact that American missionary-linguists had lived there off and on over nearly three decades, occasionally making significant contributions to the well-being of the community, made them more familiar with (and receptive to) Americans.

However, my favorable entrée into the village took a most unfortunate turn early on. During my second month in residence, I was visited by an anthropologist who had been working for several months in the adjoining village, which is regionally (Luna 1980) and nationally (Angel Rivera 1977) famous for dominating the region (usually by intimidation, and occasionally by brutality). The villagers where I

was living did not feel threatened by the North American anthropologist coming to visit me. However, when they saw my guest get out of his vehicle in the company of the Chinantec man who is considered to be the number one cacique (regional power boss) in the most feared and despised village in the region (located immediately adjacent their village), the men in the village immediately armed themselves. I learned later that both visitors were "lucky to get out of town alive."

It was not long before I learned of the seriousness with which my visitors' presence was viewed. Late that same evening I learned that the day's events had prompted a village-wide assembly, as people tried to make sense out of what they had just seen. There was serious talk of removing me from the village permanently. Fortunately, I was advised of the meeting and the concern in the village. On the advice of a friend, early the next morning I explained to the village authorities that I was both innocent and ignorant of the legacy of their village's "public enemy number one," despite having hosted him to a meal in my residence. In fact, I learned later that this particular man (the cacique from the neighboring village) is so despised in the village where I lived that people there regularly show his photograph to those who have never seen him, so that all will be able to recognize him if needed.

The village authorities kindly and courageously consented to allow me to continue living in their midst (provisionally), under the condition that I never host any outsiders again without obtaining their consent. I held to my part of the agreement, and I was allowed to stay and complete my research. However, the incident was never forgotten. As a result, I was unable to administer formal questionnaires, and was denied access to most municipal archival documents.

In addition to the inter-village rivalry which affected my ability to obtain information in the village, another local-level factor severely constrained my ability to gain certain data, namely the existence of two factions within the village where I was living. While these factions are explained in detail in Chapter III, at this point it is necessary to report that because of the intense fears which the majority faction have of losing resources to the minority faction and its allies (which include the cacique mentioned above), I was almost completely unable to talk meaningfully with any members of the minority. I was advised repeatedly by the majority faction that it would not be acceptable for me to socialize with the minority members. While there is likely a wealth of information which I could not tap because of this, I decided to avoid all but the most superficial encounters with villagers alligned with the minority. Accordingly, virtually all of my data regarding the intra-village factions derives from conversations and interviews with representatives and sympathizers of the majority faction.

In spite of the villagers' legitimate and understandable concerns about what I was doing in their midst, I was generally treated with great kindness and warmth by nearly all informants. Despite the suspicion that almost certainly remained in many people's minds, I was generously welcomed into the homes and lives of countless people who freely shared their time, memories, and opinions with me.

Theoretical orientations in medical anthropology

The discipline of anthropology is concerned with the human condition. Certainly an important component of the human condition in any culture is the health status of the people. Medical anthropology focuses on this aspect of the human condition from a variety of

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theoretical perspectives. Theoretical orientations in medical anthropology have been evolving over the past several decades. Several different theoretical perspectives have emerged, including ethnomedical, bio-medical, historical, ecological, epidemiological, unified, and political economy. A brief review of each of these is presented here, followed by an explanation as to why the questions addressed in this study are best explained by utilizing a conceptual framework which emphasizes state penetration and its impact on the human condition at the local level.

Early anthropological interest in pathologies and associated behaviors was generally tangential and incidental to the research interests of the day. Any discussion of health and illness in early ethnographies was largely descriptive and atheoretical, usually under the heading of "primitive medicine" (a term which has largely given way to "folk," "traditional," "indigenous," or "non-Western"[2]). The scattered information contained in these early ethnographies and other sources (including reports by missionaries and travelers) was systematically classified in 1932 by Clements, who undertook the task of producing a geographical distribution of "primitive" disease concepts. Clements also speculated as to their relative antiquity, probable origin, and historical connections. Clements' work is widely recognized as a major contribution to the beginnings of medical anthropology, because of his important efforts of systematically compiling widely disparate data.

In the five decades since Clements' undertaking, a variety of medically-related anthropological studies have been conducted. These

[2]See Press (1979) for a discussion of definitions of medical systems.

studies reflect two broad theoretical orientations, namely ethnomedical studies (which view health problems from the perspective of the individuals or groups being considered), and Western bio-medical studies (wherein the categories of Western scientific medicine are dominant) (Fabrega 1971:167). (Of course there is much more overlapping of these two perspectives in Western societies where scientific medicine is prevalent than there is in non-Western societies.) More recently, a political economy perspective has emerged as an alternative theoretical orientation.

The ethnomedical approach addresses how a culture defines illness, how groups organize themselves for treatment, and the social organization of the treatment (Armelagos et al. 1978). Put another way, ethnomedicine refers to "those beliefs and practices relating to disease which are the products of indigenous cultural development and are not explicitly derived from the conceptual framework of modern medicine" (Hughes 1978:151).

Ethnomedical studies contribute important information regarding the cultural conceptualizations of, and responses to, illness. However, ethnomedical studies involving non-Western societies are not without their weaknesses. First, they are likely to minimize or overlook possible influences that biological components might have on illnesses. Second, ethnomedical data are not easily (or often) comparable (in biological terms) to illnesses in other cultures, because the ethnomedical data are typically only reported information, not observable manifestations of disease (Fabrega 1974:44, 89). For these reasons (and others discussed below), the ethnomedical approach has been found to be inadequate by many scholars who have chosen to utilize a Western bio-medical framework in their research.

The Western bio-medical approach in medical anthropology employs Western scientific medical concepts. In examining the Western bio-medical approach in medical anthropology it is useful to subdivide these studies into medical epidemiology studies and medical ecology studies, although the ecological approach is basically an inherent subcategory of epidemiology, and the distinction between the two is "somewhat arbitrary" (Fabrega 1971:191).

Epidemiology is generally defined as the study of the distribution and determinants of illness frequency in humans. As Rubel (1964:268-269) has noted, epidemiological studies can reveal which members of a population get ill, under what circumstances they do so, and what course an illness takes once it manifests itself. Medical epidemiological studies typically examine the distribution of (Western-defined) diseases in relation to physical, biological, or sociocultural factors in the environment. Epidemiological studies, while useful in demonstrating the inter-relations between diseases and environmental factors, have been criticized for neglecting the social and cultural aspects as well as the behavioral components of the diseases (Fabrega 1974:56). Rubel's (1964) work on the epidemiology of a folk illness (susto) represents an important exception to Fabrega's critique.

The ecological approach, like the epidemiological approach, differs from the ethnomedical approach, due to its Western scientific view of disease. Medical ecological studies are frequently involved with adaptation and evolution, and include population genetics, environmental biology, and human evolution (Fabrega 1974).

The ecological approach is perhaps the most holistic theoretical perspective used in medical anthropological studies. This approach has

made a significant contribution to medical anthropology not only because of its primary emphasis on the biological dimensions of disease (Wellin 1977:54, 58), but also because of its secondary incorporation of social and cultural aspects of disease as well. Utilizing evidence from human communities and their environments, the ecological approach was formulated in the late 1950s, beginning with Livingstone's (1958) classic study of malaria in West Africa. "The ecological perspective provides an integrative approach to understanding the interaction of the individual, the environment and the population in the disease process" (Armelagos et al. 1978:83). Others who have viewed one's health status as a reflection of one's degree of success in adapting to one's environment include Dubos (1959, 1965), Landy (1977:2), and Lieban (1973:1031).

The ecological approach to health and disease, despite its advantages over either the pure bio-medical perspective or the ethnomedical model, is not without its limitations. Studies of both medical epidemiology and medical ecology often overemphasize biological data, while downplaying important ethomedical data. Such studies "tend to disregard the perspective of the actor, the rules and values of the people, the meanings that illness has, and the ways subjects orient and respond to illness or disease occurrences" (Fabrega 1974:46-47). A meaningful ecological perspective must include an ethnomedical component. "Studying the influence of cultural practices of a population group on the effects of disease requires a careful delimitation of native categories of meaning in the domain of illness using biologically significant components of disease as referents" (Fabrega 1974:67).

An example of this shortcoming in an ecological perspective is provided by Young's (1976) article on the ideological component of disease. Young suggests that medical beliefs and practices can and do persist without necessarily being "effective" in Western scientific terms, and without producing hoped for results. His explanation is that such beliefs and practices serve to answer instrumental moral imperatives, and they are empirically effective in the eyes of the users and other interested people, and they do produce expected outcomes. This distinction between what people hope for, and what they expect, is central to Young's analysis of why medical beliefs and practices persist.

Young further states that "the empirical effectiveness of these practices has important ontological consequences, since it enables sickness episodes to communicate and confirm ideas about the real world" (1976:5). In this article, Young contrasts sickness episodes as perceived and treated in Western medicine versus non-Western medicine. Despite their differences, in both cases it is found that, when faced with actual or threatened anxiety, discomfort, or disaster, doing something (anything) is psychologically much more satisfying than passively waiting for something to happen (Young 1976:19). Even when a cure is not produced, the associated "medical beliefs and practices organize the event into an episode that gives it form and meaning" (Young 1976: 19, emphasis in original).

Another limitation of an ecological perspective as generally used in medical anthropology is that it fails to incorporate the notion of illness or disease as a mechanism for social control of "deviant" behavior or conditions. The belief that illness is a sanction for some deviation from the moral order (and that health depends on virtue) is

widespread throughout human societies. However, illness may also be viewed as a type of deviance on its own (indeed a special type of deviance in which the victim is not blamed). This view has been popularized by Parsons (1951:428-479), whose concept of the "sick role" is characterized as follows: (1) an individual is temporarily incapable of fulfilling normal role obligations, (2) this incapacity is seen as involuntary--the patient is not held responsible for his or her condition, and (3) the patient is obligated to seek and accept treatment.

In response to the difficulties inherent in the above-mentioned approaches to the study of health and illness/disease as used in medical anthropology, yet another approach has been suggested, namely the unified (or systems) approach. According to Fabrega, the unified view of disease "...is perhaps the most widely held view of disease among contemporary medical educators and theoreticians" (1974:138). In general terms, the unified theory attempts to incorporate as many dimensions of the problem as possible. For instance, Kleinman (1973, 1980) says that cultural, ecological, epidemiological, social, economic, and political considerations should be studied together as critical determinants of medical care.

> It is important to emphasize that in a unified or systems view of disease, not only are the manifestations or expressions of what we term disease seen as interconnected and hierarchically organized (that is, as segments of a whole), but in addition, the determinants of disease are also conceptualized holistically. Disease is seen as a natural consequence of man's open relationship with his physical and social environment (Fabrega 1974:140, emphasis in original).

While the unified (or systems) approach appears to be the most comprehensive and promising of the approaches discussed above, there is yet another important theoretical orientation which must be discussed

for its unique contribution to the understanding of pathological problems, namely a political economy perspective. This perspective, the explanatory value of which is only recently becoming recognized among medical anthropologists, takes issue with the preceding (unified/systems) approach's suggestion that disease is a "natural consequence of man's open relationship with his physical environment" (Faberga 1974:140). Instead, a political economy perspective focuses on forces and relations of production, and social (class) conflict. By doing so, a political economy perspective looks less to the individual for an explanation of his or her sickness, and looks more to the causal roles played by the larger economic and social systems which impact upon the individual. Recognizing that the individual is embedded in larger social, political and economic spheres of influence, Navarro (1975b:361) has written that "the greatest potential for improving the health of our citizens is not primarily through changes in the behavior of individuals, but primarily through changes in the patterns of control, structures, and behaviors of our economic and political system."

Elsewhere, Navarro has employed a political economy perspective to analyze the enormous maldistribution of human health resources in Latin America. In this study he associates the inequitable distribution of health resources with the same causal factors involved with the conditions of underdevelopment, namely (1) the dependence situation of developing countries, and (2) the economic and political resource control by certain special interest groups (Navarro 1974:5). Navarro's views, as will be seen throughout this study, have great relevance to the health status and health services observed in southern Mexico during the early 1980s.

Different theoretical approaches to health-related problems may lead to different interpretations and conclusions about the same question. For example, a biomedical orientation to a "rural development" project addressing undernutrition in a developing country (e.g. Arroyave 1975; Chavez et al. 1974; Lechtig et al. 1975, 1976; Mata & Behar 1975; Mata et al. 1975; Urrutia et al. 1975) might lead to recommendations of increased food production in the region (which may never reach the mouths of the undernourished population).

In contrast, a political economy perspective on the same question would likely inquire as to the undernourished population's access to productive means by which to maintain themselves (Gross & Underwood 1971, Hernandez et al. 1974, Laurell et al. 1977, Ledogar 1975; Marchione 1977, NACLA 1978, Taussig 1978). In this example, such an orientation might suggest that worsened nutrition and health status in rural Latin America are closely related to changes in productive relations between producer and product, a finding which may lend support to a land redistribution program in a developing country. In contrast, the studies employing a bio-medical approach to the same problem generally do not consider why inadequate food intake exists for some members of the population.

In this medical anthropology study of health and illness in a rural Mexican village, a political economy perspective goes farther toward answering the kinds of questions asked in this study than does any of the other theoretical perspectives presented above. The ethnomedical view, while important, is insufficient in and of itself. Similarly, the Western bio-medical approach is useful, but incomplete. Both epidemiological and ecological studies are also inadequate because they lack the ethnomedical dimension and lack political and economic

dimensions as well. The unified (or systems) approach, while more all-encompassing than the ecological approach, is also unsatisfactory because of its failure to consider political factors. In contrast, the political economy orientation, while utilizing ethnomedical and biological data to some extent, emphasizes the political, economic, and social dimensions of health and illness.

However, while the political economy perspective is superior to the alternatives discussed above, an even more useful conceptual framework exists for interpreting the issues of concern here, namely that of state penetration. Since the time of the Mexican Revolution (which "ended" in 1917, although many question how many revolutionary changes actually have transpired (cf. Ross 1975)), the revolutionary Mexican constitution has promised significant improvements in the lives of the urban and rural masses. These changes have come slowly. In recent years, however, the Mexican government has become much more actively involved in providing services for its rural citizens. This heightened interest in the rural sector marks a new phase in Mexican history.

The federal government in Mexico has long been a highly centralized bureaucracy, and conflicts between those within the centralized power structure and those in the periphery have persisted. In recent years conditions in Mexico have evolved to the point where "the state is expected not only to defend its citizens and protect them from harm, but to secure their welfare through the promotion of broad-gauge socio-economic development" (Corbett & Whiteford 1983:9). This dissertation examines this issue of state penetration by considering the health services delivery component of a larger rural development project designed to cover millions of rural Mexicans. The concept of state penetration

has been usefully divided into three categories: ideological penetration, institutional transformation, and structural penetration (Corbett & Whiteford 1983). This study examines the recent introduction of state-provided health services into rural Mexican villages and hamlets, and pays particular attention to the impact of such a development program on the lives of the rural inhabitants for whom it is intended. The concluding chapter of this dissertation will consider each of these components of state penetration in light of the information presented in the intervening chapters.

Alternative approaches to health services in developing countries

Health statistics for the poor majority in most underdeveloped or developing countries reflect a situation of chronic disease, discomfort and disability, especially in the form of upper respiratory ailments, gastro-intestinal diseases, and undernutrition (Bossert 1979, Chossudovsky 1983, Gish 1973, Grosse & Harkavy 1980, Navarro 1974). It is generally agreed (cf. Akhtar 1975) that the health status of rural inhabitants in developing countries is generally worse than that of urban residents. Differences of opinion exist, however, as to what should be done about the unhealthy conditions among the rural poor.

The provision of health services in rural regions of developing countries has taken many forms. Variations exist not only from country to country, but also from region to region within countries. While a variety of approaches have been utilized by health planners who are concerned with ameliorating rural health conditions and improving rural health services, the prevailing orientations fall into two basic types.

The less commonly encountered approach to rural health services is that typified by China's "barefoot doctors," involving the brief training of indigenous personnel in "simplified" medicine which is oriented toward the treatment and prevention of the most commonly encountered health problems in the rural area concerned. In this approach, inexpensive locally-known personnel treat the most prevalent ailments, and refer other health problems to more highly trained practitioners.

This professional (or "health by the people") approach to health care treatment has advantages and disadvantages. One advantage of this orientation is the low costs of training primary health care workers, emphasizing the (usually easily recognized) illnesses/diseases which comprise the majority of health problems in most rural areas (Ferguson 1975). Another advantage is that the paraprofessionals are generally recruited from the rural regions where they will be working. After brief intensive training, the recruits return to their homelands where they are familiar with the social, cultural, and physical environments, and where they are likely to remain for a long time.

The "barefoot doctors" of China are probably the best known example of a paraprofessional approach to health care delivery (Sidel & Sidel 1973). There are numerous others, however, including examples in northern Mexico (Werner 1976, 1977, 1979) and Guatemala (Behrhorst 1975, Heggenhougen 1977) which operate rather independently of their respective national governments.[3] One obvious disadvantage of this paraprofessional approach is that the health personnel lack the lengthy training and expertise necessary to treat sophisticated and complex

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[3]Because of the recent unrest in Guatemala (which has especially affected the department of Chimaltenango, where the Behrhorst clinic has been operating), it is difficult to know the present situation there.

health problems. However, it has been demonstrated that such simply trained and inexpensive personnel are able to satisfactorily treat the great majority of patients they face, provided they are sufficiently supervised (Habicht 1979).

The more commonly encountered approach to the delivery of rural health services, in contrast, involves an attempt to replicate the highly technical, physician-oriented health care delivery systems found in developed nations. This approach relies heavily on highly trained (and expensively trained) healers whose orientation is primarily curative rather than preventive.

This approach (often called "health for the people"), is premised on the assumption that in order to solve the health care delivery problems in sparsely populated rural regions, the highest priority must be given to placing sufficient physicians in these areas. There are obvious potential advantages to this approach. For example, highly trained medical students have the technical skills necessary to recognize and treat not only mundane illnesses, but also extraordinary and complex health-related problems. Such an approach also has the advantage of demonstrating that the national government is deeply concerned about the well-being of its rural population and is willing to provide "top quality" health care to even the most "marginal and deprived" regions located great distances from the centers of power.

In addition to these potential advantages, there are also obvious potential disadvantages to this orientation. For example, training sufficient numbers of physicians to adequately treat widely dispersed rural populations in an expensive venture. Encouraging urban-oriented physicians to work in remote regions is equally troublesome. Medical

schools in Mexico typically place very little emphasis on preparing their medical students for rural posts where they must spend a required year of social service. Accordingly, few doctors remain in their rural posts beyond their compulsory term. Their brief time in the rural setting is often personally frustrating inasmuch as their training in highly technical clinical medicine is generally inappropriate in rural clinics, where sophisticated equipment and technology (and even electricity) are often not available.

Western-oriented medical training is much more appropriate for the treatment of the "diseases of industrialization" which are found in urban settings, rather than for the treatment of the "diseases of poverty" which predominate in rural regions. Similarly, medical schools stress the biological component of disease, while almost entirely ignoring the social component. The Mexican program of health services delivery which is examined in this study is modeled after the physician-based, biologically-oriented, curative medicine approach. The implications of such an orientation, for both the "target population" and the "providers" comprise a major focus of this study.

These two contrasting approaches to rural health services have been characterized as (in the case of "simplified" medicine) what is "good for the many" and (in the case of physician-based medicine) what is "best for the few" (Ferguson 1975:11). Not surprisingly, the "simplified" approach to health care, which basically provides some benefits for most people, is most commonly associated with nations with socialist economies, such as China, Cuba, Tanzania, and Nicaragua.

Health planners and government officials in these socialist countries tend to view health-related expenditures as investments in

productive resources (i.e. the people).[4] This is because in these countries the benefits of production are much more equitably distributed within the entire population than is the case in dependent capitalist economies such as Mexico's (Felix 1977). The long-term benefits which accrue to the general population as a result of a transformation from a dependent capitalist economy to a socialist economy have been shown to be dramatic in the case of Cuba, which began such a transition in 1959. Nearly 25 years later (and in many cases after much less time), significant improvements have been reported for such indicators of health status as mortality, morbidity, natality, disability, and physical development (Aldereguia Valdes-Brito & Aldereguia Henriquez 1983).

In contrast, the technically-oriented approach to health care delivery is most commonly found in developed capitalist economies and dependent capitalist economies such as Mexico's. In these countries, health program officials and government leaders tend to view health services as costly and undesirable consumption expenditures, rather than profitable investments in production. The health services provided by the Mexican development program under study here, by emphasizing physician-oriented curative treatment, is much more in keeping with the centralized form of bureaucratic control which has long characterized Mexican politics. As will be seen later in this dissertation, this physician-based curative orientation recently bestowed upon millions of rural Mexicans does not appear to be addressing important causal

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[4]This is in sharp contrast to such programs as the Rockefeller Foundation's anti-malarial efforts in Latin America, because the Foundation's motives were to increase their profit margin (which did not benefit working class Latin Americans). By making a relatively small investment in such health programs, the Rockefeller Foundation reaped substantial returns on their investment (Franco-Agudelo 1983).

factors which are contributing to many of the most common health ailments affecting the target population.

The literature on the advantages and disadvantages of each of these approaches to delivering health services to rural areas of developing countries is enormous (Akhtar 1975, Newell 1975). While the majority of the reports in the literature favor a paraprofessional approach, the majority of the existing programs are physician-intensive. This circumstance is usually explained in terms of the medical establishment's reluctance to relinquish its dominant position in the provision of "official" health care. Another explanation is that "national pride" often dictates that the more prestigious and "modern" services be pursued, involving highly technical and expensive facilities and equipment (Joseph 1979).

While the debate about the kind of health care is certainly an important one, this dissertation suggests that any meaningful consideration and analysis of health and illness in rural regions of developing countries must look beyond the provision of health <u>care</u>, to include measures to prevent the <u>need</u> for health care when possible. No one is arguing that effective health care delivery is not needed throughout the developing world. However, the conditions of health and illness observed in southern Mexico (and replicated throughout other developing nations) suggests that <u>curative</u> treatment of ailments is only part of the problem, and perhaps not the most important part, in the long run. Of at least equal importance when considering health and illness in developing countries is the <u>prevention</u> of undesirable environmental and nutritional conditions which contribute to the onset or worsening of much of the illness and disease experienced by the rural poor.

Unsanitary environmental conditions, such as contaminated water sources, disposal of garbage and human and animal body wastes, and poor hygienic habits, are part and parcel of rural living in much of the underdeveloped world. Frequently compounding these environmental problems are the problems of insufficient food intake and overcrowded housing. The environmental conditions found in the Mexican village where this study was done are presented in Chapters III and V. It will be seen that the living conditions of the people in question are quite unhygienic. For example, there is no sewage disposal, unsanitary garbage disposal, crowded housing conditions, and considerable undernutrition.

The synergistic relationship between such conditions and the onset and persistence of illness is well known. This study suggests that until these conditions of an unsanitary environment and inadequate nutrition and shelter are improved, diseases which have been virtually eliminated in modern urban areas will continue to dominate the morbidity statistics in rural areas. One of the key arguments which this study supports is that for governments to pour scarce resources into the treatment of diseases, while ignoring the structural conditions contributing to their existence, is not likely to significantly improve the health status of the population over the long run as much as would placing greater emphasis on these ignored conditions (Akhtar 1975, Behrhorst 1975, Heggenhougen 1977, Laurell 1977, Newell 1975, Werner 1979).

While the literature on the various approaches to the delivery of health services in developing countries is vast, and while there is general consensus as to which is the better system of health care

delivery for the rural poor in developing countries, there is no agreement as to how to encourage national governments to implement it. If mention is made of this essential aspect of health services delivery, it is usually presented in terms of the need for a complete social transformation (i.e. revolution), or at least a significant redistribution of resources from the "haves" to the "have nots." Examples which are often cited of where this has occurred in recent times include Cuba, Tanzania, Chile, and Nicaragua.

Medical anthropologists who have examined health care delivery in developing countries have generally ignored the question of policy-making. Their emphasis has been, and continues to be, with the recipients of policies rather than with the makers of policies. To compensate for this lack of anthropological literature concerning policy-making, this dissertation utilizes political science literature. Four recent works which address health-related policies and issues in Mexico are especially useful (Kreisler 1981, Musselwhite 1981, Spaulding 1979, Wilson 1981). While each of these works investigates a different aspect of health and illness in Mexico, all share the opinion that there are vast inequalities in the quality and distribution of health services. This dissertation examines these inequalities and analyzes the impact which a recent rural health program is having on its "beneficiaries."

The form which state-created development programs takes is strongly influenced by the goals and the structure of the political elite. Similarly, how the target population is affected by state programs is also influenced by the political elite. Many developing countries, including Mexico, are spending millions of dollars annually on the provision of health care services for its rural poor. For a variety of

reasons (discussed in this chapter and in the concluding chapter), the Mexican government has chosen to emphasize the physician-oriented model of health care delivery. At the same time that Mexico is pursuing this course, analysts of alternative approaches to rural health care and health personnel training in developing countries in Africa, Asia, and Latin America have concluded that the health and well-being of the rural population in these continents can best be improved by a "marked increase in public health programmes, and not more doctors practicing acute, after-the-fact, curative medicine" (Ferguson 1975:12). This same investigator also concluded that it is less expensive in the long run in most cases to prevent disease than it is to treat it (Ferguson 1975: 13).

Of course government officials, especially in dependent capitalist economies, are often much more concerned with the short run than the long run, and in such cases expedience often calls for, and results in, actions which provide minimal long-term benefits to the poor. These actions often take the form of responding to more powerful interest groups (such as the medical establishment) and often leave the needs of the less demanding groups (such as unorganized rural peasants) ignored, postponed, or slighted.[5] Viewed from the vantage point of elite government officials, it may be less costly (in political as well as economic terms) in the short run to "treat" disease (however ineffectively) than to attempt to prevent it.

"Second-class" health services for "second-class" Mexicans

This study examines and critically evaluates a recent rural health program formulated by the Mexican government and implemented in 1979.

[5]This is not to say that all of Mexico's rural peasants are powerless. To the contrary, Mexico's peasant unions carry considerable clout.

Within three years this program included over 2,000 new rural health clinics, each staffed by a fifth-year medical student serving a required year of social service. Each clinic was designed and located with the expectation that it would "cover" a population of roughly 5,000 "marginal people" living in rural Mexico's most "deprived zones." Thus, over ten million rural Mexicans were said to have recently become "covered" by these new health clinics. This enormous and ambitious health services delivery program was but a part of a larger development agency (COPLAMAR), whose primary stated goal was to allow Mexico's most disadvantaged people to share more fairly in the nation's wealth.

Employing an anthropological perspective, this study examines health status and the delivery of health services in a rural agricultrually-based village in southern Mexico. Emphasizing the holism central to anthropological tradition, this study in medical anthropology examines a broad range of factors which impact upon health status and the provision of health services in rural Mexico. As will be seen later, there is considerable emphasis placed on the importance of macro-level political and economic forces which influence the well-being of the Mexican peasants who shared their village and their lives with me for over fifteen months between 1980 and 1982.

Political scientists have recently been noting the inseparable nature of politics and health in Mexico (cf. Kreisler, Musselwhite, Spaulding, Wilson) as have physicians (Lopez Acuña) and others. Unfortunately, anthropologists generally have been less attentive to the influence which political and economic forces play on the health status of the rural sector in developing countries. (Important exceptions include Dewey 1979, 1980; Laurell 1977; Marchione 1977; Navarro 1974,

1975a, 1975b; and Taussig 1978). In fact, in a recent statement in one of medical anthropology's most influential journals entitled "What is medical anthropology?" there is no mention whatsoever of the role played by macro-level or micro-level political or economic factors.[6] This oversight has been lamented by Morsy (1981) who accurately states that anthropologists who ignore the political and economic dimensions of health status and health services are overlooking an essential component of medical anthropological inquiry.

Health status and the provision of health services are embedded in larger social, cultural, political, and economic systems. Health phenomena cannot be isolated from these other factors. This dissertation focuses on the impact which state penetration has had on the lives of villagers in a highland Chinantec community in southern Mexico. The impact which externalities have had on the lives of peasants (both historically and presently) is emphasized in this study because the impoverished conditions experienced by most rural Mexicans (especially regarding unhygienic environmental conditions and undernutrition) significantly affect their health status. These conditions of poverty are in part the result of the particular ways in which the Mexican state has penetrated into its rural regions. The COPLAMAR clinic is emphasized in this study because it represents the latest illustration of state penetration in the village of interest, and because the state

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[6]Medical Anthropology Newsletter 12(4):7-8, August 1981. Similarily, nowhere in any of four major contributions to the recent emergence of the field of medical anthropology does there appear any mention whatsoever of political or economic factors influencing health status or health services (Foster & Anderson 1978, Landy 1977, Logan & Hunt 1978, and McElroy & Townsend 1979). However, the November 1982 issue of the Medical Anthropology Newsletter does include an article on the political economy of health (Baer 1982).

frequently points to it (and their other COPLAMAR clinics) as proof that the inequalities suffered by "marginal" Mexicans are being dramatically improved.

A central theme of this dissertation is the powerlessness of "marginal" groups such as the highland Chinantec of Oaxaca, Mexico. To attribute poor people's unfavorable health status to their own inability to get beneficial medical care (such as that purported to be offered by the COPLAMAR clinics) ignores the influence of such factors as environmental sanitation and nutrition and access to life-sustaining resources. Without hygienic living conditions and adequate nutritional intake, even the best health services would be hard pressed to restore health to patients. For a COPLAMAR clinic to be able to do so is all the more unlikely.

Mexico's new health services program which I examine here recognizes the great importance of such public health and preventive measures as those mentioned above, but COPLAMAR nevertheless emphasizes curative medicine, making little effort to implement public health and preventive medical measures. (This is discussed in Chapter VI). Curative medical measures may alleviate pain and suffering for a time, but they often ignore critically important factors which contribute to the onset, persistence, and recurrance of illness and disease. Especially important factors which are too often ignored are environmental sanitation and nutrition, things which preventive health measures and public health campaigns would improve.

This study will suggest that COPLAMAR's curative medical interventions, by ignoring these factors, leave intact the very conditions which contribute so heavily to the onset of many of the illnesses and

diseases they are treating. By treating symptoms rather than causes, the overall long-run health status of the population is not significantly improved. People in the village where I conducted fieldwork frequently complained to me about how the treatment that they received at the village clinic only helped them for a short while, and they wanted to be free of their recurring ailments on a more permanent basis. As will be seen later in this study, the villagers do not mind being treated (in fact they want to be treated), but they deeply resent not being cured of their ailments.

I also analyze in this study why most developing countries implement curative health services for the poor sectors of their populations, even while admitting the importance of public health and preventive medical measures. The theoretical orientation which I find most useful for analyzing the questions addressed in this dissertation is that of state penetration, because it places health systems in their broader political and economic contexts. From this more macro-perspective, it is seen that the scarcity of preventive or public health measures in rural areas relates to the dominance of curative medicine within the medical establishment (Akhtar 1975), and to the social, political, and economic formations of those countries (Navarro 1974).

In dependent capitalist economies such as Mexico's, many political scientists have suggested that the nation's political and economic elite act primarily to preserve their own privileged position vis-à-vis the lower classes. To more effectively do this, the elite utilize relatively inexpensive and highly visible programs (such as health clinics) and powerful rhetoric to attempt to placate and control the rural masses (Kreisler 1981). This point is addressed throughout this

study, and is returned to in the final chapter. It will be seen that in the case of the villagers about which this study is concerned, the government clinic has done little to placate their dissatisfaction with being impoverished.

As will be seen throughout this dissertation, the villagers under consideration in this study have been affected by forces originating outside their village for several centuries, and continue to the present day to be impacted upon by forces over which they have little or no control. Because the majority of the villagers in this study have traveled throughout Mexico, they are well aware that many urban Mexicans enjoy a standard of living vastly different from their own. As a result, they have come to think of themselves as "second-class" Mexicans.

These feelings of being in a lower class than many urban Mexicans have been reinforced in recent years, in part because of the arrival in their village of several new government-provided services, the most recent of which is the government (COPLAMAR) health clinic on which this study focuses. While one might expect Mexico's "marginal" and "deprived" rural population to be appreciative of such government-subsidized services, this study reports frustration and ambivalence to be the villagers' dominant feelings. While they universally desire physician-provided western-medical services in their village (not to the exclusion of traditional healers, however), they were deeply resentful of the services provided at their new clinic. In fact, they consider the health clinic (as well as other government services) to be unsatisfactory "second-class" approximations of what they have seen in cities.

This study examines and explains these feelings of "second-class" services for "second-class" Mexicans. Two key points will be made

throughout the disseration. First, as will be seen later, the health problems existing in the village under consideration here are largely the result of environmental and nutritional circumstances about which the health clinic is doing almost nothing (despite COPLAMAR's official recognition of the importance of these factors). Thus, the villagers' health problems recur and persist despite having been promised that their constitutional guarantee of health had finally been met, thanks to the new clinic. Second, the clinic is culturally and ethnically inappropriate for the Chinantec population for whom its services are provided (without their consultation). In fact, the COPLAMAR clinic does almost nothing to recognize and encourage Chinantec Indian identity. (The sole exception is a bilingual sign in the clinic on which is printed (in Spanish and Chinantec) a message from the Mexican president.) The government's lack of commitment to Chinantec identity is reflected not only in the clinic (discussed later) but also in the federal schools, where Chinantec is not taught and is further expressly forbidden to be spoken. Just as the Catholic church did nearly 400 years earlier (discussed in Chapter II), and as the federal schools have done in recent decades, the clinic acts as a foreign institution, operating in an alienating manner, denying the persistence of Chinantec identity which prevails among the villagers.

The health clinic under study here (one of 2,105 such new clinics in rural Mexico) is the latest in a long series of efforts on the part of the Mexican government to assimilate (or "Mexicanize") the ethnic populations throughout the republic. In the case of the health clinic, the goal of assimilation is quite subtle and almost coincidental to the stated goals of the health program. However, the clinic reflects the

national culture, the national worldview and Western scientific understandings of health and disease, and shows virtually no knowledge of, interest in, or sensitivity to, the Chinantec culture and worldview.

Thus, the COPLAMAR clinic represents the most recent example of state penetration into the village where I lived. As noted by Corbett & Whiteford (1983:10), such penetration may be viewed as a linkage between the state and the periphery. Such center-periphery linkages penetrate Mexico's "marginal" regions both structurally and ideologically. Furthermore, as in the case of the COPLAMAR health clinics, institutional transformation is being encouraged as the Western medical establishment seeks to control and dominate health care delivery by discouraging (implicitly and explicitly) existing traditional healing practices.

Structural penetration refers to the creation of new structures which function in such a way as to support the integration of traditional culture into the dominant national culture (Corbett & Whiteford 1983:13-16). This form of state penetration is often assisted by subordinate groups because such state participation (as in the case of a government health clinic) is often seen as desirable. Ideological penetration involves changing the values and behaviors of the target population to conform more with those of the dominant culture (Corbett & Whiteford 1983:12-13). In numerous ways, over several centuries, Mexico's indigenous groups have been ideologically penetrated by dominant outsiders. Despite the relatively isolated location of the highland Chinantec, the region has long been actively penetrated by various outside interests. The penetration by Spanish missionaries in the sixteenth century (discussed in Chapter II) continues to the present

day. And yet, despite centuries of being impacted upon by outsiders, the highland Chinantec have retained an ethnic identity which is uniquely Chinantec.

The highland Chinantec with whom I lived are intensely proud of their Chinantec heritage, their Chinantec language, and their Chinantec culture (albeit much more so in their village than in non-Chinantec areas, where they tend to speak Spanish among themselves when in public). Chinantec identity has survived both ideologically and materially (what Royce (1982) has termed "style"). As will be seen in Chapter II, the Chinantec were forced into congregated communities nearly 400 years ago. This forced resettlement into nucleated villages and hamlets greatly facilitated state penetration and religious, economic, and political incorporation into the dominant national culture. And while the Chinantec people continue to persist, the future of their ethnic identity is far from resolved, as the pressures of state penetration continue to affect their lives.

The Mexican federal government has been accurately accused of glorifying the Indian's past cultural heritage while at the same time obstructing their opportunities to continue to be Indians (Friedlander 1975). Mexico's National Indian Institute (INI) has actively pursued a philosophy of indigenismo--seeking to integrate the socially and culturally segregated ethnic groups (i.e. Indians) into the national society. This effort is consistent with the primary concern of the national leadership in Mexico, namely the modernization and industrialization of Mexico. The acculturation of the Indians has been viewed as a necessary means to the fullest realization of this goal, and the INI has been the vehicle through which the Mexican government has pursued it.

An important critique of INI's indigenismo philosophy, representing a new generation of Mexican anthropologists, appeared in 1970. The five contributors to a single volume generally hold that Mexican anthropology has been used to control the status quo in Mexico. Warman, tracing the historical development of Mexican anthropology, notes that it presently has three foci: (1) the Indians of the past, (2) the exotic Indians of the present day, and (3) the problematic Indians of the present day. This last focus is seen by Warman(1970:2) as the reason why the indigenismo philosophy was created. In this philosophy, the Mexican Indian is seen as impoverished, economically marginal, conservative, and devoid of culture. According to indigenismo, the only solution to this "Indian problem" is to force the Indians to stop being Indians (Warman 1970:24, 27). Toward this end, Mexico's first certified anthropologist, Gamio, when working for the revolutionary government in the 1920s, called for the integration of the Mexican Indians into the national culture. This goal was to be met by means of a cultural exchange of the "positive values" of the non-Indians and the Indians. Unfortunately, but perhaps not surprisingly, these "positive values" were defined entirely by the non-Indians.

This philosophy of indigenismo, and how it was reflected in matters concerning health and health services, is reflected in Gamio's later writings. In an article about social security in Mexico, Gamio notes that to improve the health status of Mexico's indigenous population would require "establishing medical services in the thousands of villages where none presently exists, and improving the diet which is presently very incomplete and unvaried" (1944:128). Gamio goes on to say that it is difficult to place physicians in Mexico's indigenous

communities because it is economically unfeasible and because "the cultural environment is distinct and incomparably inferior to that which [physicians] are accustomed" (1944:129, emphasis added). Gamio laments that the "sad reality" is that the indigenous population in Mexico is "more foreign than those [people] who, coming from whatever country, arrive at our beaches and borders [as tourists]" (1944:129).

Gamio's orientation is reflected in President Cárdenas' statement of 1940, wherein he summarized the national perspective on Mexico's Indian population. "Our indigenous problem is not to preserve each indian, nor to indianize Mexico, but to Mexicanize indians" (cited in Warman 1970:32). This orientation has not appreciably changed in the intervening decades.

Another of the new breed of Mexican anthropologists criticizing traditional Mexican anthropology and its indigenismo orientation is Bonfil. In addition to echoing Warman's sentiments about the ethnocentrism of an indigenismo policy, Bonfil notes the hidden objectives of the national society, including increasing internal consumption and surplus labor, and maintaining the established power structure. Indigenismo, writes Bonfil, is directly tied to the national power system, which aims to "reform" the Indians while not attacking the social and economic structures which impact upon them (Bonfil 1970). Unlike Aguirre Beltrán (1967), Bonfil recognizes that the indigenous communities (many of which constitute "regions of refuge") do have relationships with the national society. Bonfil further notes the asymmetrical form that these relationships characteristically take, to the disadvantage of the indigenous population (Bonfil 1970:52).

As discussed earlier, these relationships between government interests and the outlying population may be thought of as center-periphery linkages. Government programs (originating from the centers of power) such as the health clinics in this study which reach into Indian communities (at the periphery) provide linkages between local-level and national-level interests. Mexico's federal education system performs in a similar manner. The schools in rural Mexico provide educational opportunities for Mexico's Indians to learn to read and write, but they also convey to the pupils and their parents the dominance of the national culture (Stebbins 1977). Similarly, health clinics which offer Western medicine to Indians (while scorning herbal medicines) provide important health services, but they often do so in a way which reflects the national culture's beliefs, practices, and dominance regarding illness and wellness.

The health care provider in these clinics is a representative of the national culture, and the services provided reflect his or her background and training. Similarly, the government health posters which show blonde-haired, blue-eyed children using white porcelain toilets and hand basins with chrome fixtures also reflect national understandings of things which are alien to daily life in much of rural Mexico. As a final example, large posters prepared in the clinic which I studied told anyone who could read that "folk" beliefs about "witches" (brujos) and other "non-scientific" or "primitive" things should be discarded and forgotten, because they are only "ignorant superstitions."

And yet, despite the repeated negations (both subtle and blatant) of their Chinantec identity, the Indians with whom I lived definitely wanted locally available modern/Western medicine in their village.

However, they wanted it delivered on their own terms. As of May 1982, when I left the village, they had not been consulted on this matter. Conversations with government health planners in the COPLAMAR system in the state offices strongly suggest that such negotiations are unlikely to occur in the near future. Until such time as the villagers' desires are realized, they will continue to be frustrated and reluctant users of the "second-class" health services which their government has provided for them.

This dissertation presents the findings of how villagers in a highland Chinantec village feel about their federal government's new health clinic which operates in their village. Further, this dissertation analyzes these findings and critically evaluates the social impact which this recent form of state penetration has had on the lives of the "marginal" people who are "covered" by these services.

The dissertation is organized as follows. Following this introductory chapter, Chapter II introduces the research region by examining the historical and geographical features of the area in and around the research site. Chapter III discusses the history and present-day conditions of the highland Chinantec village where the research was conducted during fifteen months fieldwork between June 1980 and May 1982. Chapter IV discusses the historical development of several forms of official health services in Mexico, and notes the relatively neglected status of Mexico's rural population throughout the twentieth century, despite revolutionary promises inscribed in the 1917 Constitution guaranteeing health for all Mexicans. Chapter V concerns itself with health conditions and curing options available to the highland Chinantec villagers who are covered by the new government

health clinic's services. Chapter VI examines the COPLAMAR development program which has as part of its concerns the 2,105 rural health clinics which are designed to deliver health and health services to millions of rural Mexicans, including those with whom I lived. Chapter VII presents these villagers' perspectives about the services which the COPLAMAR clinic delivers in their village, and Chapter VIII examines the same clinic (and its associated organization) from an outsider's view. Chapter IX concludes the dissertation by critically evaluating the role of state penetration as it impacts upon the peasantry. Development projects such as COPLAMAR's rural heatlh clinics are considered in terms of how they serve as linkages between the center and periphery in Mexico, as well as in terms of how they affect the well-being of the rural sector.

CHAPTER II

A HISTORY OF THE REGION

This chapter examines Mexico's highland Chinantec population from a broad historical perspective. The intent of this chapter is to demonstrate the extent to which historical events and geographical features have impacted upon the lives of the highland Chinantec population over the past several centuries. Their relative geographical remoteness from Mexico's (and earlier, Spain's) centers of political and economic power did not leave them unaffected by external forces. To the contrary, the highland Chinantec have been, and continue to be, heavily influenced by events and policies which originate outside of their social and political environment. Thus, this chapter serves to provide important historical information for the central focus of the dissertation, namely the critical evaluation of factors contributing to health status and health services in one highland Chinantec village, which I call Amotepec.

Mexico is divided into 32 states. The southern state of Oaxaca, where this research was done, has 2,015,424 inhabitants (1970 census), of whom more than 75 percent live in settlements of fewer than 2,500 people (Cook & Diskin 1976:13). While the state of Oaxaca comprises 4.8 percent of the total land area of Mexico, most of it is mountainous, with low agricultural productivity. A United Nations study (cited in Cook & Diskin 1976:13) reports that in 1960 only one-fifth of Oaxaca's land area was under cultivation, and that 92 percent of that land depended solely on rainfall for its seasonal harvest. The study further

reports that of Oaxaca's extensive non-irrigated lands, only 40 percent are being cultivated in any one year, with the remainder lying fallow. Over 45 percent (or 953,011) of Oaxaca's population speaks an indigenous language, and 43 percent of these Indians are monolingual (1970 census).[1]

Indians in Mexico have been defined according to several different criteria. In this study the term "Indian" refers to those people who are native speakers of an indigenous language. Using this criterion there are perhaps fifty distinct Indian groups in Mexico (Modiano 1973:1, Whetten 1948:56). The 1970 federal census reported approximately 3.7 million Indians in Mexico, comprising roughly 7.5 percent of the nation's population. Of the 57,847 speakers of Chinantec age five or older, 74 percent were considered bilingual, according to the 1970 census.[2] Chinantec speakers are located in the southern state of Oaxaca, and constitute the fifth most populous indigenous group in this relatively "Indian" state.[3]

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[1]There are at least fifteen different indigenous groups in Oaxaca, including (in order of size) Zapotec, Mixtec, Mazatec, Mixe, Chinantec, Chatino, Chontal, Huave, Cuicatec, Zoque, Trique, Nahuatl, Chocho-Popoloca, Amuzgo, and Ixcateco.

[2]While "the Mexican census is reputed to be one of the most reliable in Latin America" (Young 1976:69), my observations of census-takers where I worked leave me skeptical. For example, non-Chinantec-speaking census-takers working in Amotepec evaluated and recorded bilingualism in rather whimsical and erratic ways. These census-takers, working only during daylight hours, often found themselves at homes where no adult males (who are more likely to be bilingual) were present. In such instances, they would address any convenient adult female, usually beginning by asking her (in Spanish) if she spoke Spanish. Very often this question was met with a blank stare. At this point the census-taker's bilingual local assistant would repeat the question in Chinantec. Occasionally the woman would then answer in the affirmative (saying "yes" in either Chinantec or Spanish), and she would then be officially recorded as being bilingual! This scene was observed several times.

[3]Oaxaca has more speakers of Indian languages, and more monolingual Indians, than any other Mexican state (Whitecotton 1977:8). Of Oaxaca's fifteen linguistic groups, only the Zapotec, Mixtec, Mazatec, and Mixe are larger than the Chinantec.

While Chinantec speakers also reside either permanently or temporarily in metropolitan Mexico City, Veracruz, and elsewhere in the Republic (as well as in the United States), Chinantec is spoken as a dominant primary language only in the northern portion of the state of Oaxaca (see Figure 1, page 48). This region where Chinantec is habitually spoken is commonly referred to as the Chinantla (Weitlaner & Cline 1969:523), a word believed to be derived from an Aztec word meaning "an enclosed space" (Bevan 1938:9), of which there is no lack, owing to the rugged topography of the region.

Anthropologists and historians who have worked among the Chinantec consider the boundaries of the Chinantla to be defined by the existence of habitual speakers of Chinantec. However, Schultes (1941), a botanist who worked in the area in the 1940s, believes that this definition is too broad. Employing botanical criteria, Schultes defines the limits of the Chinantla as a much more restricted area than that used by anthropologists and historians. In this study, however, "the Chinantla" is used to refer to that region where Chinantec is habitually spoken.

The Chinantla encompasses great geographical and climatic variation. The majority of the Chinantec people live in lowland areas (scarcely above sea level) in the northern-most extremes of the "luxuriant Central America rain forest" (Schultes 1941:101). However, the highland Chinantec, who are the focus of this study, live and grow crops on the precipitous slopes of pine- and oak-forested mountain peaks which rise to nearly 10,000 feet in elevation.[4] Despite the tropical latitude

[4]As will be seen later, many highland Chinantec do not live in the highlands permanently. Many Chinantec have lowland ranches where they reside for varying periods each year, and many frequently work elsewhere in the Republic (and the United States), returning to their highland native lands sporadically or seasonally.

Figure 1

THE CHINANTEC SPEAKING REGION OF OAXACA, MEXICO

State of Oaxaca, showing the region inhabited by Chinantec speakers (shaded portion). Adapted from Weitlaner and Cline (1969:524).

(between 17° and 18° North), the highland Chinantec population refer to their homelands as tierra fria (cold country) because of the cool temperatures where they live (at around 7,000 feet above sea level).

While I observed no frosts during my 15 months of fieldwork, informants said that they do occur. One highland Chinantec hamlet, Santa Maria de las Nieves (Saint Mary amid the snows) is apparently named for its occasional frosts. During the winter months of my fieldwork, nighttime temperatures in the 30s (Fahrenheit) were not uncommon, and overnight lows in the 40s were frequent. The reader is reminded that highland Chinantec people often do not reside permanently in their highland village, even though they consider it to be their home. Many highland Chinantec (either men alone, or with their families) spend significant portions of most years elsewhere, either in lowland agricultural activities, or working in a variety of employment strategies throughout southern and central Mexico.

The mountains where the highland Chinantec people live are known as the Sierra Juárez, and are a small part of a larger mountain range known variously as the Sierra de Oaxaca (Cline 1946:162), the Sierra Madre Oriental (Gwaltney 1970:9), and the Sierra Madre del Sur (Luna 1980:7). The Sierra Juárez, lying entirely within the ex-district of Ixtlan, is populated not only by highland Chinantec, but also by highland Zapotec (see Figure 1). In fact, the Sierra Juárez (like the ex-district of Ixtlan de Juárez and the state capital Oaxaca de Juárez) is named in honor of Benito Juárez, the Zapotec Indian who was born in this Sierra and later became president of Mexico (in the 1850s). The highland Chinantec live on the northern slopes of the Sierra Juárez in an area which comprises much of the upper drainage basin of the Rio Grande, which is a primary tributary of the Papaloapan River (Gerhard 1972:258).

The Papaloapan River Commission was created in 1947 as a regional development project modeled after the Tennessee Valley Authority (McMahon 1973, Poleman 1964, Villa Rojas 1948). Central to the project was the construction of two large dams designed to provide hydro-electric power and irrigation for agricultural lands. This project has resulted in the displacing and relocation of tens of thousands of lowland Chinantec and Mazatec Indians. This program has been both lauded and condemned. It has provided vast quantities of electrical energy and water for agricultural activities, and has helped provide vast numbers of communities with public services (including electricity and piped water in Amotepec).

However, for the lowland Indians who were displaced, they have been called the victims of a "program of ethnocide" (Barabas & Bartolomé 1973: 13). In their analysis of the Mexican economy, these authors conclude that "the justification of regional development programs is based on the purported need to incorporate areas of comparative backwardness into the national economic development" (1973:4). They continue, saying:

> The only social objective under consideration is the great leap forward for change and progress. Within this scheme, the intent is to relieve the Chinantec, once and for all, after four hundred years of conquest and domination, of the burden of maintaining their own language, a coherent system of social and kinship organization, and an integrated relationship with a cosmos of their own conception. That is to say, it is to eliminate their culture and incorporate them into a single capitalist mode of development (1973:13-14).

Analysis of this example of state penetration into the lives of thousands of Chinantec Indians is beyond the scope of this dissertation. However, there are striking parallels between it and the much more recent rural "development" program which began bringing "modern" health services to a "remote and deprived" highland Chinantec village in 1979. These

parallels are presented at various points thorughout this study, and are considered in greater detail in Chapter IX.

The Handbook of Middle American Indians has one chapter on the Chinantec Indians, co-authored by the anthropologist (Weitlaner) and the historian (Cline) who have worked most extensively in the Chinantla. They reported (1969:523) that "the scientific literature on the Chinantec is neither extensive nor fully adequate." Three factors help explain this: 1) the region's physical difficulty of access; 2) the paucity of easily extractable and transportable valued resources; and 3) the relatively small and scattered population. Few substantial additions have appeared in the literature in recent years, and they are reviewed below. Far more has been written on the neighboring highland Zapotec (e.g. Cline 1946; Cook & Diskin 1976; de la Fuente 1949; Kearney 1972; Luna 1977, 1980; Nader 1964, 1969; Spores 1976; Whitecotton 1977).

Despite the close proximity of the highland Chinantec people to the highland Zapotec, the two ethnic groups are linguistically distinct. Their language differences notwithstanding, these highland neighbors share a common history, including being relatively powerless recipients of circumstances forced upon them by more powerful extra-local groups.

> For nearly all the colonial period [the highland Chinantec people] were in the same encomienda[5] and under similar administrative direction as [the] Zapotec [village of] Macuiltianguis and its dependencies...hence they share numerous traditions and memories (Weitlaner & Cline 1969: 545-546).

The human condition in the New World prior to the arrival of the Spaniards has been the subject of great speculation, investigation, and

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[5]Encomienda refers to "the colonial institution of labor exploitation in which a Spaniard was granted the use of the labor of a number of Indians as well as the obligation for their Christianization and education" (Cook & Diskin 1976:296).

debate. Unfortunately, information about Chinantec speakers prior to Cortes' 1519 arrival in what soon became known as "New Spain" is exceedingly scant. The historian Cline could find only one published article regarding archaeological investigation in the Chinantla, "reporting on a 1912 excavation of a small temple at the extreme eastern extremity of the Chinantla, only dubiously affiliated with it" (Cline 1959:158).

Archaeological reports concerned with Mesoamerica invariably include discussion of the Zapotec, who have inhabited much more expansive territories than the more localized Chinantec. In these reports, mention of the Chinantec, if made at all, is generally in reference to them marking the northern limit of the highland Zapotec who live north of the much more intensively studied Valley of Oaxaca (Barlow 1949; Flannery 1976; Flannery & Marcus 1983; Spores 1965). Flannery and Marcus have excluded the Chinantec from their report on archaeological investigations in Oaxaca "because so little was known of their prehistory" at the time of their study (1983:xix).

A two-volume work on the pre-history and history of the Sierra Juárez (Pérez Garcia 1956a, 1956b) provides interesting information about the Chinantla prior to the Spanish invasion. It is by far the most detailed account of life in the Sierra Juárez prior to the arrival of the Spaniards. Unfortunately, its accuracy is difficult to verify.[6] Pérez Garcia states that his work is "the result of several years of systematic investigation, begun in 1917, and concluded in 1949" (1956a:9).

Pérez Garcia attended primary school in the district capital of Ixtlan, and learned to speak Zapotec there. He states that he gathered

[6]No review of these volumes has appeared in the Hispanic American Historical Review, the most likely place such a work would be critiqued.

information from several villages, both from illiterate people and from municipal authorities who provided him with numerous interesting documents. He provides the reader with 42 bibliographic sources (1956b:345-346), but does not cite them in the text. Thus, Pérez Garcia's contributions are included here with a cautionary note to the reader. Pérez Garcia presents rather precise data (of uncertain reliability) regarding the Chinantla prior to the Spanish conquest (1956a:95-96). Pérez Garcia states that the Chinantec people existed at least as early as 1100 A.D., because the date marks the end of a period of 130 years of a single ruler governing over the entire Chinantla. Unfortunately, Pérez Garcia's interesting remarks cannot be substantiated. However, linguists, using lexico-statistics have concluded that the Chinantec language dates back at least twelve "minimum centuries" (Fernandez de Miranda et al. 1959: 55) and possibly as far back as 49 or 50 "minimum centuries," or roughly 5000 years (Swadesh 1967:95-96).

In the year 1100 it is believed that squabbles between descendants of the paramount ruler resulted in the Chinantecs dividing into two domains. There followed nearly 200 years of civil war (according to Pérez Garcia), until the year 1305, by which time the two groups had divided into two definite groups of Chinantecs. In the year 1435, as the result of new dissent among the Chinantecs, a third group was formed, comprised of the highland Chinantec population, with its headquarters near present-day San Pedro (a pseudonym).

One final piece of information prior to the Spanish conquest comes from a 1579 report on the Chinantla (cited in Bevan 1938:135-137) wherein a Spanish investigator reports to the Spanish Crown that prior to the arrival of the Spaniards, Moctezuma was extracting tribute in many

different forms, including crops, animals, and labor services from people who may have been Chinantecs. Bevan correctly notes that these reports of Moctezuma demanding tribute of the Chinantec contradict reports made by Bernal Diaz del Castillo to the effect that the Chinantec were not subject to Moctezuma's rule (Bevan 1938:49). Given the uncertainty of the 1579 report, it appears unlikely that the Chinantec people's subordination to outsiders predates the arrival of the Spaniards.

The history of the Chinantec after the arrival of the Spaniards is more adequately documented. Because the lowland Chinantec region extends close to where Cortes landed in 1519, it is plausible that the Spaniards contacted the Chinantec relatively soon upon arrival in what has been called the New World. In fact, it is reported that the lowland Chinantec (famous for their long spears (Bevan 1938:47-58; and Gwaltney 1967:198, both citing Bernal Diaz del Castillo)) were invited to join forces with the newly-arrived Spaniards to combat rival indigenous groups (Brinton 1892:23, Orozco y Berra 1864:187). Spanish penetration into the Chinantla highlands followed soon after. As early as May 1520, only a few months after Cortes landed, the Spaniards had already begun to exploit the minerals found in the Chinantla mountains (Gay 1950:358, Gerhard 1972:54). So pleased were they with what they found that they were tempted to stay on indefinitely (Bevan 1938:48).

Much of the early impact that the Spaniards had on the indigenous population of the highland Chinantla either went undocumented or has yet to be published. However, insights can be gained from available sources. For example, it is known that scarcely six years after arriving in New Spain, a Spaniard and his descendants who had been given rights to

collect tribute from one highland Chinantec community (as well as from a nearby Zapotec community) "complained that they profited little from these two places, whose population was not great and whose economy was not much above the subsistence level" (Cline 1955:118).

The Spanish institution of encomienda, for example, awarded certain Spaniards the right to extract tribute from Indian towns (Taylor 1972, Wolf 1959). While this was of little importance in the Oaxaca Valley, the highlands were more affected. The highland Chinantec region, for example, was primarily encompassed by an encomienda known as Tecuicuilco, which was first held by a Spanish conquistidor (Martín de la Mezquita) from the early 1520s until about 1527, when it was assigned to another conquistidor (Juan Rodríquez de Salas), who passed it to his son in 1550, who in turn passed it to his son in 1599, who held it until sometime before 1647, when the encomienda was reassigned to "the Moctezuma heirs" (Gerhard 1972:258).

A smaller part of the highland Chinantec region, including Mani-naltepec and probably Amotepec, was originally in the encomienda of Atlatlauca. This encomienda was formed in 1521. With the 1599-1603 congregations, the locality of Amotepec (the primary focus of this study) was transferred to the encomienda of Tecuicuilco (Gerhard 1972: 54-55, 258-260).

Although the highland Chinantec apparently could not contribute much to their new rulers, they "paid" in other ways. The devastating impact of wars and diseases for which they had no defenses has been widely documented for Mexico (Gerhard 1972:55, Taylor 1972:18, Wolf 1959:196-197). Pérez Garcia writes of the impact of the Spaniards' arrival on one highland Chinantec community where valuable minerals

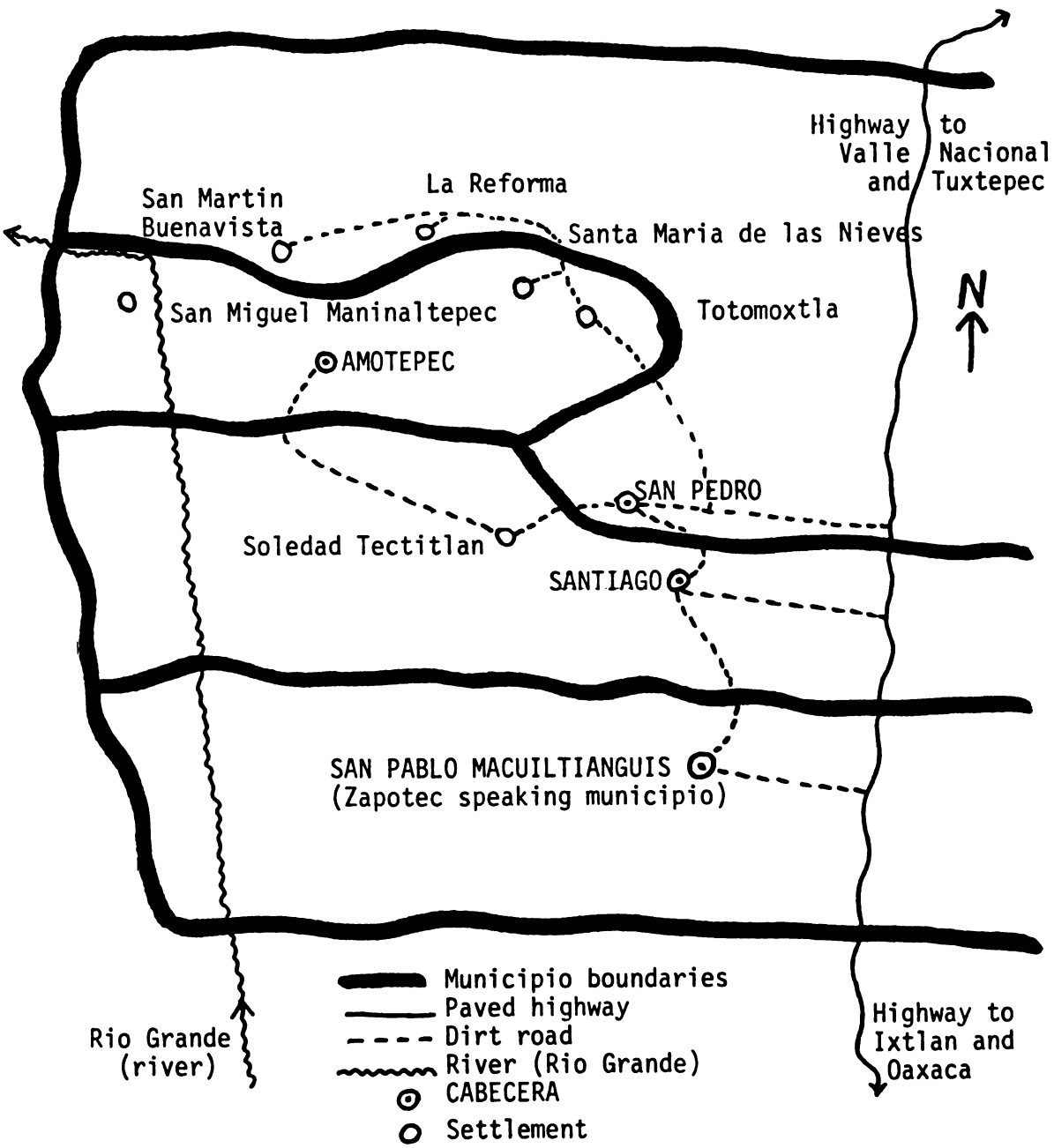
were found during the early 1520s. According to Pérez Garcia (1956a: 118), the population of San Miguel Malinaltepec (see Figure 2, page 57) was reduced by 80 percent of its original size, due to "unknown diseases" brought by the Spaniards. Even greater misfortune among the Chinantec has been recorded. Bevan (1938:52), writing about the lowland Chinantec, reports that "two great pestilences befell this region shortly after the Conquest," resulting in 95 percent of the population dying. Bevan concludes his chapter on the Chinantec in the 16th century by speculating: "Finally it appears that in their greed for gold, the Spaniards overworked the Chinantec and moved [some of] them from hot country to cold [where other Chinantec were already living], as a result of which change of climate and conditions, many of them died" (Bevan 1938:52).

The Spanish Crown wanted information about its new "discovery," and instructed its representatives in New Spain to investigate and respond to elaborate lists of specific questions. One report prepared in 1579 concerning one portion of the (primarily lowland) Chinantla (reprinted in Bevan 1938:129-134) reflects the ongoing extraction of wealth by the Crown's representatives. The response to the thirty-third question indicates that "these natives pay their taxes in Reales" (i.e. in cash). How the Chinantec obtained cash is unclear, but it is possible that cochineal (discussed below) was sold for cash. The 1579 report does not state what "benefits" these "natives" derived from their taxation, but the Spaniards' ethnocentric goals of civilizing and Christianizing the natives (Cline 1955:115) provided justification for a great variety of activities, many of them quite extreme (discussed below).

Figure 2

HIGHLAND CHINANTEC MUNICIPIOS AND SELECTED SETTLEMENTS
(crude sketch)

(The eastern portions of the municipios of San Pedro and Santiago are lowlands which produce valuable cash crops. Amotepec has no lowlands).



The innovation of requiring cash as a form of tribute from people who had no cash forced the Chinantec to work for wage labor under the Spaniards, and marked the beginnings of forced integration of indigenous communities into the Spanish-controlled market economy. While it may appear contradictory for people earning cash to be living at or below subsistence levels, it is entirely possible that the amount of cash earned did not surpass the amount of cash demanded by the Spaniards, thus leaving the Chinantec in effect unremunerated for their labor.

In addition to mineral wealth, the Spaniards found in Oaxaca (and elsewhere) a lucrative cash product in cochineal (Spanish: grana).[7] Hamnett (1971:1-2) notes that Oaxaca, because of its cochineal and cotton, was considered to be second only to the silver-mining regions of Guanajuato and Zacatecas in importance to the Spanish royalty and merchants who stood to profit from the wealth extracted from New Spain. Despite the fact that a dried pound of cochineal contains on average at least 50,000 insects, by the close of the 16th century more than 250,000 pounds (i.e. over twelve billion insects) were being exported through the port of Veracruz annually (Lee 1947-48). It is virtually certain that highland Chinantec communities were participating in this activity, because a Spanish reconnaissance team reported in 1599 that "the chief crop [sic] of all these [highland] Chinantec communities were maize and grana (cochineal)" (Cline 1955:121). Although the cochineal trade "died out" (so to speak) in the 1880s due to the introduction of analine dyes (Lee 1947-48:449), it is mentioned here to illustrate the rapidity

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[7] "Cochineal is a dye-stuff first discovered by Europeans in Mexico. It consists of the bodies of the females of a species of insect, Coccus cacti. The insect lives on the cochineal fig (Opuntia cochinillifera) and two other species of cactus" (Malinowski & de la Fuente 1982:52).

and extent to which the highland Chinantla has been penetrated and impacted upon by the larger world economy.

Not surprisingly, the indigenous population was often displeased with the dictates of the Spanish Crown and its local representatives (Taylor 1972, 1979). The forced resettlement programs (via congregations), the demanding of tribute (via encomiendas), and the diseases brought by the Spaniards were not appreciated by the highland Chinantec. This treatment of the Chinantec people can be seen as the inevitable result of the Spaniards' ethnocentric feelings of superiority, their eagerness to "christianize the heathen," and their drive to accumulate wealth. Interestingly, the earliest available report of the Spaniards' impressions of the Chinantec people were quite favorable. Bernal Diaz del Castillo, in his True History of the Conquest of New Spain, reported that the Chinantec were admirable people possessing great bravery and lances superior to those possessed by the Spaniards (cited in Bevan 1938:47).

However, less than fifty years later the Spanish missionaries, who came to the Chinantla for different reasons than did the soldiers, had quite a different view of the Chinantec. Commenting on (uncited) reports of missionaries, Bevan (1938:48) writes: "They were then pictured as a miserable band of savages, hiding themselves away in caves, scarcely capable of reason or of being rated as human beings--afraid of the world and of the Spaniards in particular..." Whether these two varying accounts reflect the biases of the observers, or whether the Chinantec people had suffered such a decline in the years after the arrival of the Spaniards is unknown. In any event, it is not difficult to find unflattering references about the Chinantec among

published reports regarding almost any aspect of their lives. For example, in the 1720s a Spanish priest living among the highland Chinantec wrote in a letter to the Oaxaca Bishop that the people with whom he was living were barely more than animals (Cline 1960:23).

In the late 19th century, Frederick Starr, the first ethnographer to visit the Chinantla, traveled through Mexico taking physical measurements and plaster busts of individuals among different Indian groups. Regarding the Chinantec he reported that their speech was very unclear, sounding more like the cries of animals than articulate human speech (Starr 1899:168). While Starr felt that "the Chinantla, in scenery, is one of the most beautiful parts of the mountainous Mexico," he blamed the "disagreeable climatic conditions...for the drunkenness which prevails" in the lowland Chinantec villages which he visited (Starr 1899:169). Highland Chinantec villages were similarly viewed some forty years later, where "chronic drunkenness is the order of the day irrespective of fiestas" (Lincoln 1939:58).

The Chinantec were not universally seen as undesirable sub-humans, however. Bevan, for example, reports that after three (albeit brief) expeditions, his team "had not satiated their desire to see more of a tribe which from the very outset had won their affection and had accorded them a friendly reception beyond all expectations" (1938:2). While remarking that the Chinantec seem to be very unenterprising people, he explains this as being due to "their honesty, their frankness and their kindliness" (1938:45). Ford, who lived among highland Chinantec people with the hope of converting them to Protestantism, writes that these people's "excessive belief in legends and superstitions...hinders their progress" (Ford 1947:295).

Civil congregations

With the preceding perspectives providing a frame of reference for how the indigenous inhabitants of the ethnographic Chinantla were viewed by early Spaniards and those who followed them, it is instructive to examine in some detail a specific example of the extremes to which the Spaniards attempted to restructure the lives of the people whom they encountered upon arriving in New Spain. This example, taken from the turn of the 17th century, serves to illustrate the relatively powerless position of indigenous groups in Mexico (specifically the highland Chinantec). By examining in some detail information from archival documents from 1599 to 1603, the reader is provided with an historical frame of reference from which to better understand the contemporary conditions observed during the early 1980s, the period with which this dissertation is most concerned.

The significant events which transpired in the Chinantla highlands between 1599 and 1603 have been painstakingly researched in the archives of Madrid, Mexico City, and the highland Chinantec village of San Pedro by Cline (1949, 1955), an historian who lived in San Pedro in the 1940s. The account which follows would have been impossible without his invaluable publications.

Near the end of the 1500s, less than eighty years after arriving in New Spain, the Spaniards embarked on an ambitious population relocation program which had an enormous impact on the lives of the highland Chinantec (among others) and which has continued to influence life in the highland Chinantla in terms of spatial location and religious predominance of the Catholic church. Perhaps equally important is the psychological impact which the affected population experienced,

contributing to feelings of inferiority and powerlessness which continue to pervade the world view of the highland population considered in this study.

The account which follows demonstrates one way in which outsiders forceably and powerfully impacted upon the lives of highland Chinantec people, and suggests that their current feelings of powerlessness can be traced back over centuries. What eventually transpired in 1603 was the direct result of orders from the Spanish Crown demanding that the relatively dispersed Indians of New Spain be resettled (with force, if necessary) into nucleated civil congregations for the dual purposes of facilitating religious indoctrination and political administration (i.e. control) (Cline 1949:350). As part of the Spaniards' ongoing efforts to dominate the indigenous groups of New Spain, about 30 special survey teams were created by Crown orders during 1598 and 1599 to penetrate the Oaxaca hinterlands (including the Chinantla highlands and lowlands) "to view the Indian communities which were deemed likely candidates for resettlement and at the same time to evaluate the potential sites on which they might be placed" (Cline 1949:351). The fact that these preliminary surveys were a "costly and extraordinary endeavor" (Cline 1949:351) demonstrates the importance which the Spanish Crown placed on controlling the indigenous population and the region's natural resources.

Documentation on the forced relocation and resettlement of the highland Chinantec Indians living in the region around present-day San Pedro and San Pablo Macuiltianguis (an area encompassing the research site of this study) is unique (Cline 1955:115). From a variety of archival sources, Cline has recovered the preliminary survey of the region undertaken in 1599, along with an appeal by the affected

Indians, and a journal kept by the officials who enacted the ultimate resettlement in 1603. What follows is a summary of Cline's (1955:124-137) findings.

Between September 10 and 12, 1599, the commissioners involved in the Crown's preliminary survey visited several highland Chinantec and Zapotec communities, and decided that San Pablo Macuiltianguis (the area's principal Zapotec village) was best suited as a site for congregating the surrounding population. On September 14 (as it was too rainy on the previous day), representatives of the eleven affected villages and hamlets met in San Pedro. After a religious Mass, the Crown's orders for these indigenous peoples to be congregated in San Pablo Macuiltianguis were communicated through interpreters. The assembled Indians were told that the reason for the forced resettlement was that it could enable more effective religious indoctrination (Cline 1955: 124).

Between 1599 and 1603 the officials in New Spain debated the feasibility of resettling the Indians as recommended by the reconnaissance teams. During this interlude the Indians were given an opportunity to appeal the selected location, but the Crown gave them no appeal as to the idea of the congregation. The archival documents uncovered by Cline show that the Chinantec-speaking representatives formally objected to being relocated in a Zapotec-speaking village. Their protest was effective, as the Crown ordered a separate congregation for the Chinantec, to be located a short distance from the Zapotec congregation, thus keeping the linguist groups separate while locating them in such close proximity as to allow easy administrative and religious control of both. This order was conveyed to the affected

parties on October 3, 1603, after which things began to move with great rapidity.

In early October the native populations were told what had to be done, and they were threatened with "punishment" for non-compliance. On October 15, the Indians began clearing the brush from the new site. Within the next fifteen days the new Chinantec-speaking congregated settlement was completed. The first structure to be located was the church, whose location was determined "with great solemnity" (Cline 1955:129). A large cross was placed on the spot, and a "flourish of trumpets" signaled the birth of the new congregation. Sites for other municipal buildings came next, and house lots were distributed to members of the affected Indian hamlets and villages one at a time. In all, approximately 297 men, women, and children were forcibly relocated into this new congregation from the surrounding area (Cline 1955:132).[8] When construction of the new dwellings was completed (in scarcely a week's time) the Indians were ordered to return to their old residences, collect their personal belongings, and destroy their former houses. Cline reports that the new village was completed by November 1, All Saints' Day, and the Indians were ordered to attend Mass, with a penalty of 24 lashes for absentees (1955:133).

After all the former dwellings and public buildings were destroyed, the overseeing Spanish officials informed the relocated Indians that "neither now nor in any future time should they return to rebuild [in

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[8]This congregation was comprised of 88 married couples, 27 unmarried adults, and 94 children who came from the following "communities": San Pedro (pseudonym), San Fransisco, San Juan, San Miguel, Santiago Chinantepec, San Juan Chichicazapa, Amotepec (psuedonym), San Martin, and San Mateo. Because San Pedro was much more populous than any other community, it did not lose its primacy or its name, despite being relocated (Cline 1955).

their former location], under the penalty of perpetual exile from it" (Cline 1955:134). That such an order was necessary to make suggests that the Indians were not necessarily pleased with the forced relocation.

Not content with telling people where they were to live (and where they could not live), the Spanish representatives also told the uprooted indigenous population where they were to sleep inside their hastily constructed dwellings. Cline reports that after the new town was established, the Spanish authorities "apparently...ordered that each house be furnished with cots made of cane on which the people should sleep, rather than on the floor, to prevent disease" (Cline 1955:136, emphasis added). This order was followed by an inspection trip, with "specific instructions" being given to those who had not yet complied with the order. This is perhaps the earliest documented externally-imposed "public health" campaign in the region of this study, the highland Chinantla.

With the new Chinantec town established, the Spanish officials on November 23, 1603 informed the now easily-assembled populace that "in addition to the houselots which had been given them, they were entitled to land on which to raise food" (Cline 1955:136). Cline's account closes with a report on another assembly held three days later, in which the Spaniards declared the new congregation completed, and congratulated the Indians "and expressed appreciation that no unfortunate occurrences had marred the congregation" (Cline 1955:136-137). In addition, the Indians were reminded that none of the displaced groups could return to their old sites to rebuild, and that even a visit to the old area would require permission of the priest and the government" (Cline 1955:

137).[9] The indigenous population was also urged to attend church weekly, and the commissioner "repeated the fact that the principal object of the congregation had been to permit them to live and die as better Christians" (Cline 1955:137).

This particular congregation experience has been examined in some detail not only because it involves the population under consideration in this study, but also because it vividly demonstrates the extent to which outside forces (in this case, emissaries of the Spanish Crown) have impacted upon Mexico's indigenous people. This case study from 1599-1603 also shows that the present-day ongoing intrusions on the part of the Mexican government (about which much more will be said later) have historical antecedents dating back nearly 400 years.

The impact of such an unsettling decree, and the geographical breadth of the congregations is suggested in the following quotation from Cline (1949:357).

> A considerable portion of the native population of early seventeenth-century New Spain had their lives drastically reoriented, and in some instances went through the almost equally disturbing experience of trying to re-create or revive an old pattern after it no longer existed. Some died in the process of congregation, or its allied consequences.

The "considerable portion" of the Indian population which was affected by these civil congregations has been estimated by Cline (1949:363) to be roughly 225,000, or around nine percent of the then-existing indigenous population of New Spain.

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[9] "Catholic priests were central to the penetration of Spanish authority into the Mexican countryside and to encouraging village life. Iberian Catholicism in the 16th century was a component of the government--not a separate compartment but an all-pervasive influence on the formation and implementation of state policy" (Taylor 1979:18-19).

It is no wonder, then, that the Indians often protested changes that were forced upon them by authorities whose objectives often strongly clashed with the preferences and priorities of the indigenous population. Cline reports that the recommendations of the delegates to the Crown "inevitably...brought forth protests from all sides, from vested interests, from the clergy, and from the Indians themselves"(1949: 353). The Indians' objections were generally ineffective, despite the fact that "from colonial times on [they] have always been present to object, to denounce injustice, and to defend their right to cultivate the land and retain its fruits" (Warman 1980:7).

It has been written of the indigenous population of Oaxaca (primarily in the Valley) that "excessive demands by the colonial authorities often forced Indians to choose between flight and active resistance, and many chose to abandon their homes" (Taylor 1972:28). So extreme were these externally-derived pressures that "several...mass exoduses from Indian communities are known" (Taylor 1972:28). While Taylor is not writing about the Chinantec, it is possible that these same pressures were felt by Chinantec people, including those who founded Amotepec, the focus of this study.

Chronologically, the next available known document regarding life in the highland Chinantla is the 1730 "Christian Doctrine in the Chinantec Language," prepared by a Catholic priest who resided in San Pedro between 1708 and 1728 (Cline 1960:17). De la Barreda's doctrine is believed to be the only early book printed in the Chinantec language (Cline 1960:9). In a lenghty introduction, Cline uses this document to describe aspects of life in the Sierra Juárez in the early 18th century. Three points are of special interest.

First, de la Barreda reported that priests trying to learn Chinantec were having great difficulties trying to master the indigenous language, much more so than the priests trying to learn other indigenous languages in Oaxaca[10] (Cline 1960:17). An indication of how troubled priests sometimes met with difficulties can be seen in de la Barreda's request to the Royal Audience in Spain that he be allowed to wipe out (extinguir) the Chinantec language and replace it with an entirely different indigenous language. Despite the Crown's subsequent approval of his request, this endeavor only served to add to the priest's difficulties, and his efforts at banning Chinantec were unsuccessful (Cline 1960:20).

Second, in addition to de la Barreda's frustration with the Chinantec language, he was not above referring to his "flock" in disparaging terms (a characteristic shared by the present priest in the region). In response to a written order from the Bishop that the priests in the Sierra "increase their zeal and offer the Sacraments to the Indians," de la Barreda wrote on March 10, 1728 that based on his experiences of the last twenty years, it was wiser to withhold the communion, inasmuch as the Indians would continue to be "drunk, superstitious, and stupid" (brutos). In a second letter (dated April 6, 1728), de la Barreda attempted to defend his comments, saying that they were not his "personal opinions but rather that they represented the official church position" (Cline 1960:26-27). Attempting to reinforce his point, he added that in the region where he was working, "the Indians were little

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[10]Linguist-missionaries at the Summer Institute of Linguistics headquarters in Mitla, Oaxaca who had studied Chinantec for several years also felt that Chinantec was among the most difficult to learn of all of Mexico's indigenous languages.

more than animals" and thus the priests were justified in denying the Sacrament (Cline 1960:23).[11]

The third point of interest in Cline's introduction to de la Barreda's work of 1730 is the priest's references to land disputes in 1720 among highland Chinantec communities (including Amotepec) (Cline 1960:18). Cline's reference, and records of other property disputes preserved at the National Historical Archives in Mexico City, provide an interesting historical perspective to the persistent land disputes which dominate everyday life in the highland Chinantla to the present day (as well as elsewhere in Oaxaca (Dennis 1976b)). As will be seen below, the competition for scarce productive land has serious implications for health status and for the provisioning of health services in the research site.

The Chinantla in the twentieth century

Until the twentieth century, very little had been published on the human condition among the highland Chinantec. "The available sources are few, ambiguous, and not wholly reliable" (Cline 1956:646), and the bulk of what has been written about the Chinantla has concerned the Chinantec language.

In 1910, Espinosa published some general historical notes about the Chinantec and two of their neighboring ethnic groups, the Mazatecs and the Popolucas. Cline, in his introduction to the republication of this work (1961:40) states that Espinosa's work was one of the first to call to "the world's attention" the Chinantla and the Chinantec people,

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[11]The priest who was officially affiliated with the village of Amotepec (and who visited the village roughly every other month) also refused to offer communion to the villagers. His reasoning was that they were too ignorant to understand its significance.

who up to that point were "almost unknown" except by a few travellers (e.g. Starr 1899) and linguists (e.g. Brinton 1892, Melching 1912). Although it is unclear just how much of "the world's attention" was drawn to the Chinantec after Espinosa's work, it does represent the first work to emphasize (albeit not exclusively) the Chinantec people (primarily in the lowlands).

The Mexican Revolution was fought during 1910-1917. While people throughout Mexico (especially in Morelos and the north) were actively engaged in the struggle to improve their situation, peasant response to the revolution was not uniform. Conditions in Oaxaca differed from those existing elsewhere in the republic (Taylor 1972:194, Waterbury 1975).

> While the peasants of Morelos fought and died for change, albeit a change back to a traditional community-oriented agrarian life, the Oaxaca peasants, for the most part, remained passive or joined the fight to defend the status quo, a status quo similar in many ways to what Morelos peasants were striving to regain (Waterbury 1975:411).

It should be emphasized that it is difficult to generalize about peasant participation during the time of the Revolution (Katz 1976). In Oaxaca, for example, there were not only passive peasants and peasants defending the status quo. There were also long-standing local-level political disputes between villages which resulted in casualties, plunder, and wholesale eviction of peasants from their homes (Cline 1946, Kearney 1972:3).

More campaigns were waged and more battles were fought in Oaxaca's highlands and the Isthmus of Tehuantepec than in the Oaxaca Valley (Whitecotton 1977:226). The Sierra Juárez provided three generals, one of whom came from the Chinantec village where this study was done. These generals, rather than fighting for the revolutionary goals of

"bread and land and liberty," fought on the side of the conservative Carranza forces (Fransisco Rameriz 1970, Pérez Garcia 1956b:248). "In Oaxaca, and in particular the Sierra, the dominant political figures were not in sympathy with the aims of the Revolution" (Young 1976:247).

This is largely explained by two circumstances. First, the people of the Sierra had some land of their own, and were not subjected to the pressures exerted by hacienda owners in places such as Morelos, where haciendas had displaced vast numbers of peasants from their lands, while exploiting their labor power (Warman 1980). Second, Mexico's ruling dictator up until the revolution, Porfirio Díaz, started his political career in the Sierra Juárez, and retained the support of the Sierra politicos throughout his dictatorship (Waterbury 1975).

Many Chinantec-speaking people lost their lives before the revolution ended. General Pedro Castillo, whose picture adorns the municipal building in his hometown of Amotepec, fell victim to typhus after only a few campaigns, and died shortly thereafter, in December of 1916 (Ibarra Diaz 1975:178). Nearby Santiago lost fifteen men, and neighboring Zapotec-speaking Macuiltianguis lost sixteen men (Pérez Garcia 1956b: 176, 234).

One outcome of the Mexican revolution was the writing of what was then the world's most progressive national constitution. Among the numerous social reforms which are inscribed in the 1917 document (which includes promises of land, liberty, and education) is the guaranteed right to health for all Mexicans (Musselwhite 1981:120-121,146). It goes without saying that not all governments deliver on all of their constitutional promises. With that in mind, this dissertation examines the extent to which the Mexican government has addressed the promise of

guaranteed health by considering health status and health services in a highland Chinantec community in Oaxaca's Sierra Juárez.

While it is believed that Chinantec-speaking people were living in highland elevations at least as early as 1435 (Cline 1952-3:284, Pérez Garcia 1956a:96), it was not until Bevan's 1938 publication that the cultural and linguistic differences between highland and lowland Chinantec were reported. Bevan's published survey for the Panamerican Institute of Geography and History was based on five expeditions ranging from four days to one month, all between 1934-1936. These explorations were done on horseback, as there were no roads into the highland Chinantla until 1955 (Luna 1980:51).

Bevan's report on these expeditions contains minimal information on the highland Chinantec, partly because only two of the five expeditions spent any time there, and partly because Bevan intended to write a separate account of the highland group (Cline 1956:641), an account which unfortunately has never been published. Bevan did report that the highland Chinantla was "most difficult to access" owing to great mountain barriers and "very difficult mountain trails" (1938:9). Bevan also reported that the highland Chinantec villages "differ profoundly from the remainder of the Chinantla and must be considered absolutely apart" from the lowland Chinantec (Bevan 1938:9), a distinction supported by Weitlaner and Cline (1969). The distinctions between the highland and lowland Chinantec which these authors emphasized included differences in climate, vegetation, agricultural cycle and crops, and house materials. This study concerns itself with a highland Chinantec population.

Oaxaca and the highland Chinantec of the Sierra Juárez

Most analyses of post-Revolutionary Mexico agree that despite the rhetorical promises of the 1917 Constitution, rural Mexico generally received little governmental attention until the late 1930s, during the Presidency of Lázaro Cárdenas (1934-1940). Before examining the events which transpired in the research region since the late 1930s, it will be useful to briefly describe some relevant political and geographical considerations in the area.

By numerous statistical measures, the state of Oaxaca ranks among the poorest of all the Mexican states. For example, the 1960 census shows Oaxaca to be next to the last in the nation in terms of literacy, last in terms of families with radios, television, and other electrical apparatus, and 27th (of 32 states) in terms of number of persons per room. Of special significance for this study, Oaxaca's general mortality and morbidity rates are the highest in the nation (COPLAMAR 1978a:129, Cook & Diskin 1976:24). Oaxaca ranks 28th in terms of inhabitants per doctor (4,105:1) and 30th in hospital beds per 1,000 inhabitants (0.4:1,000) (Lopez Acuña 1980b:115). Oaxaca's disproportionate sharing in the national wealth is reflected in the fact that (in 1968) Oaxaca contained 4.5 percent of Mexico's population, but the state's gross national product was only 1.4 percent of the gross national product (Cook & Diskin 1976: 23).

Below the state level, the next political unit is the municipio,[12] of which Mexico has 2,090. The state of Oaxaca is unique in its

[12]A municipio is the most important unit of local government, usually consisting of a cabecera (administrative head town) and agencias (smaller outlying hamlets).

disproportionate number of municipios (with 570, it has more than 25 percent of the national total), a situation that has been termed an "administrative nightmare" by one health official in the state capital (Arevalo Vargas, personal communication, 1982). In the latter half of the 19th century Oaxaca was divided into thirty districts (each one responsible for roughly twenty municipios). However, this structure was formally abolished in the 1917 Constitution in response to charges by the municipios that the district intermediaries were not adequately representing their interests at the state and national levels (Greenberg 1978:80-82). Despite their official eradication, the districts in Oaxaca continue to retain certain administrative powers and functions, and for practical reasons communites throughout the state continue to be identified by the ex-districts in which they are located.

According to the 1970 census, there were 57,847 Chinantec Indians in Oaxaca (2.7% of the state population). Nearly half (49.22%) were considered monolingual. The highland Chinantec live wholly within the district of Ixtlan de Juárez, in three municipios: Amotepec, San Pedro, and Santiago (see Figure 2, page 56). Located among pine and oak forests with mountain peaks reaching nearly 10,000 feet in elevation, the highland Chinantec have cleared fields for the cultivation of primarily corn and beans, which comprise basic food staples for the population. Each municipio contains a cabecera (administrative head town), at an average elevation of around 7,000 feet, and politically incorporated outlying hamlets (agencias) of relatively smaller populations (some of whom live at lower elevations). These three municipios, then, comprise the highland Chinanta.

While the census figures (see Table 1, page 76) suggest that Amotepec (the focus of this study) compares favorably with its neighboring highland Chinantec municipios in terms of land ownership, local reports and other sources suggest that Amotepec is seriously disadvantaged vis-à-vis highland neighbors in terms of both land quality and quantity. The disparity between census figures (of questionable accuracy) and local reports is explained primarily by numerous land invasions and parcels of disputed ownership,[13] and secondarily by the unproductive nature of much of the Amotepec land.

Totally dependent upon rainfall for moisture, the highland fields produce only one crop per year, on lands that informants (and archival census data in Oaxaca City) describe as third or fourth class.[14] The peasants of Amotepec are familiar with commercial fertilizer. However, it is not available to them through any government program, and it is prohibitively expensive to purchase commercially. Thus, no one in Amotepec uses it. The variable nature of the seasonal rains in Amotepec produces variable harvests. In bountiful years (when the rains are neither too hard, too infrequent, nor too early or late) many Amotepecans can pass the entire year without buying any corn or beans. In poor years, no one enjoys such a position.

However, property in the highlands is valued not only for its ability (however limited) to produce subsistence crops. Land is also

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[13]Conflicts over land in Oaxaca have a long and fascinating history (Dennis 1976b). The next chapter addresses this issue as it concerns Amotepec.

[14]Agricultural lands in Mexico are both officially and informally classified as first, second, third, or fourth class, depending on soil quality, water availability, and productivity.

TABLE 1

HIGHLAND CHINANTEC POPULATIONS AND LANDHOLDINGS

Municipio Name	Municipio Population	Cabecera Population	Municipio Land Area (square kilometers)
Amotepec	2,179	1,570	325.34
San Pedro	2,012	967	127.58
Santiago	1,836	1,083	65.07

Source: IX Censo General de Poblacion, 1970, Estado de Oaxaca. Volumen II. Datos por municipo.

valued for timber resources (primarily pine and oak) which can provide significant income for the municipios. In addition, the people of Amotepec know that valuable minerals have been extracted from the region in the past,[15] and they believe that the day may come when some mining company would pay Amotepec for the right to extract minerals from their lands.[16] For these reasons, disputes over land titles and property boundaries date back centuries, and continue to influence life in these highlands, occasionally to the point of death (Luna 1980:150-160).

In addition to the highland parcels of land, the municipios of San Pedro and Santiago control extensive parcels of land at lower elevations (to the north of their cabeceras) which provide two crops of corn and beans annually, and also produce important cash crops such as coffee. Informants in Amotepec explain their community's lack of lowland property by saying that Amotepec is a relatively "new" town (compared with its neighbors), founded by eight or nine families who moved into the region long after the neighboring villages had been established. This interpretation is supported by Pérez Garcia (1956a:121), who estimates that Amotepec was founded either shortly before or shortly after the arrival of the Spaniards in New Spain. Accordingly, the original founders of Amotepec were able to purchase (and possibly receive as gifts as well) only relatively small amounts of land, primarily from neighboring San Miguel Maninaltepec and Totomoxtla. These two once-thriving communities have since seen their populations decline to such

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[15]Mining in the Sierra Juárez at La Nativad (near the ex-district capital of Ixtlan) has gone on for decades.

[16]In fact, some people in Amotepec suspected that my real reason for living in their village was to investigate for mineral resources there.

an extent that they are now officially classified as agencias, under the political control of Amotepec.

With the literature on the Chinantla generally so limited, it is not surprising that research on the highlands is even more limited. The geographical remoteness of the highland Chinantla has likely contributed to the paucity of research undertaken to date in the region. Until the relatively recent penetration of vehicular roads, the highland Chinantec cabeceras were generally a two or three days walk from the state capital (to the south) or to Valle Nacional and Tuxtepec (to the north). Rains and other problems often left the trails in extremely hazardous condition. For example, Ford (a Wycliffe bible translator who lived in San Pedro during most of the 1940s) reported that the paths to the lowlands were very rough and that there were places where animals were "scarcely able to pass" (Ford 1947:293). Virtually all male informants in Amotepec over the age of thirty can vividly recall the suffering involved in walking these trails, often with heavy loads.

Yet, amazingly, despite the "isolation" of the highland Chinantla, as early as 1912 the highland cabecera of San Pedro had telephone service, scarcely six years after the telephone reached the state capital (1906) and only three years after it reached the district capital of Ixtlan de Juárez in 1909 (Pérez Garcia 1956a:275ff). I was unable to confirm <u>why</u> San Pedro obtained telephone service so rapidly. Speculation suggests that perhaps General Pedro Castillo (of Amotepec) might have been influential in ordering the telephone, only to have it fall short of his town, due to some clever manipulation on the part of the rival village of San Pedro. Amotepec, in contrast, did not get telephone

service until the early 1970s. After functioning for a brief time it went out of service and was inoperable for several years before being repaired in 1982.

The earliest "specialist" in cultural aspects of the Chinantec people is undoubtedly Roberto Weitlaner, "an Austrian-born investigator" (Cline 1956:639). In addition to the five expeditions led or organized by Weitlaner between 1934-1936 (see Bevan 1938), Weitlaner and his daughter, Irmgard, published extensively on the lowland Chincantec language, calendar, and mythology (I. Weitlaner 1936; R. Weitlaner 1939, 1946, 1961; Weitlaner & Castro G. 1954; Weitlaner & Cline 1969).

In 1956 an event occurred which has, perhaps as much as any other outside event since the arrival of the Spaniards, transformed the lives of the highland Chinantec residents. In response to international balance of payment problems in the mid-1950s, the Mexican government decided to begin to exploit local timber resources in order to reduce paper imports into Mexico. The extensive timber forests of the Sierra Juárez were targeted by the state government, and yet another intrusion into the Chinantla was soon underway.[17]

To haul out the timber resources, the state constructed an "all-weather" road through the Sierra Juárez in 1956, connecting Ixtlan de Juárez (and of course Oaxaca and the rest of the Republic) with Tuxtepec and the state of Veracruz. This infrastructural change suddenly brought

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[17]Jaime Luna's 1980 study of the penetration of capitalist timber companies into the Sierra Juárez reports that the 1970 census shows the district of Ixtlan as having 143,502 hectares of territory, divided as follows: 33,503 hectares of mature timber; 20,697 hectares of immature timber; 15,063 hectares of workable farm land; 12,591 hectares of pasture land; 5,421 hectares of level plains (llanuras). The remaining lands were classified as follows: 45,875 hectares of uncultivable or grazing land; 10,363 hectares of "uncultivated products" and 9,767 hectares of land which could be cultivated (Luna 1980:12-13).

people who had lived two or three days walk from the cities to a situation of being a relatively easy few hours walk from the highway, where trucks and buses were going to the urban centers. By the early 1970s, the three highland cabeceras were all accessible by vehicles all year round, except for washouts and roadslides caused by heavy rains.[18] In addition to these recent roads into the cabeceras, roads have also penetrated into those agencias where extractable timber resources were found. Timber continues to be the single most valued natural resource in highland Chinantla.

In the 1940s, linguist-missionaries from the Summer Institute of Linguistics began studying the highland Chinantec language (which varies from village to village) with the ultimate goal of translating the Bible into Chinantec and converting the indigenous population to their own particular understanding of Christianity. (See Stoll 1982 for a recent analysis of the Summer Institute of Linguistics.) While these linguist-missionaries lived among the highland Chinantec over extended periods of time (often decades) and became extremely knowledgeable in both the Chinantec language and certain aspects of their culture, their sporadic publications have emphasized the linguistic aspects of their observations, with very little having been published regarding ethnographic or historical information.

Four anthropologists have recently written about three rather disparate aspects of the human condition in the Sierra Juárez. Rubel (1955, 1983, and 1976 with Gettelfinger-Krejci), whose association with

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[18]During July 1983 the road connecting Amotepec with the outside world washed away due to heavy rains. As of January 1984 it has not been reopened, and the road was not expected to be repaired until at least March 1984.

the Chinantec spans nearly three decades, has concentrated primarily on issues of health and illness, with special emphasis on the folk illness susto, as experienced in the municipio of Santiago. Gwaltney (1967, 1981) conducted field research on cultural adaptations to blindness in the municipio of San Pedro.[19]

In addition, a Mexican anthropologist (Luna 1980) has written on the impact of capitalist penetration into the Sierra Juárez, especially emphasizing the significant timber exploitation which began in earnest with the opening of the trans-Sierra highway in 1956. While Luna's study focuses on the Sierra Juárez as a whole (which includes more Zapotec speakers than Chinantec speakers), he did visit several highland Chinantec villages, and includes them in his analysis. Most recently, Browner (1982, 1983, 1984) has investigated beliefs and practices of both male and female Chinantecs regarding their knowledge and understanding of medicinal plants, and has also reported on various aspects of social organization and social division in a highland Chinantec locality, especially concentrating on how women attempt to organize themselves to their benefit.

This chapter has examined in some detail certain historical factors which have influenced the formation of the daily lives of the highland Chinantec in Oaxaca's Sierra Juárez. Despite their relatively "remote" geographical location, the Spanish colonization which began

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[19]While both Santiago and San Pedro enjoy definite benefits from their productive lowland ranches, they do so at the risk of contracting onchocerciasis. Despite considerable gains resulting from widespread eradication efforts, blindness is not unknown among these highland Chinantec who work for several months out of the year in the tropical lowland onchocerciasis zone. See Strong (1934:50-51) for one early discussion of onchocerciasis in the San Pedro lowlands.

early in the sixteenth century has profoundly and lastingly affected life among the highland Chinantec. Having presented this historical overview of the highland Chinantla, it is now possible to consider the research site within its larger context. The next chapter examines the highland Chinantec village of Amotepec. Its own particular historical circumstances are presented, and its present-day social, political, and economic conditions are examined.

CHAPTER III

THE HISTORY AND PRESENT-DAY CONDITIONS OF AMOTEPEC

The previous chapter discussed various historical and geographical considerations intended to help the reader better understand the highland Chinantla, where Chinantec Indians have lived for centuries. This chapter is devoted to the history and present-day conditions of one particular highland Chinantec municipio, which I call Amotepec, where I conducted research for fifteen months between June 1980 and May 1982. The purpose of this chapter is to relate the general theoretical issues presented in Chapter I to the particular circumstances in Amotepec. The nature of state penetration in Amotepec in recent years will be presented in some detail. It will be seen that inter-village land disputes and intra-village factions play an important role in influencing how state programs and services (including health) are obtained, perceived, and utilized in the village.

The research site

The municipio of Amotepec, according to the 1970 census (which is fraught with possible errors), contains 2,179 people on 325.34 square kilometers of land. Nearly all of the land is steeply-sloped hillsides at altitudes ranging from roughly 5,000 feet to 8,000 feet above sea level. Most of the land is uncultivated, and is covered with scrub oaks and pines. The remainder is used primarily for the cultivation of corn and beans and squash, and is entirely dependent upon rainfall for water. The impact of the Spaniards' congregation campaign in 1603 can

be seen in that the municipio's population is almost entirely made up of the four nucleated settlements within the municipio. The largest settlement is the cabecera (administrative head town), also called Amotepec[1] (population 1,570). The remaining three agencias (outlying hamlets administratively controlled by the cabecera) are located within one to three hours walking distance from the cabecera, and are relatively small (with a combined population of 611. See Table 7, page 173 for details).

It is unclear whether Amotepec existed at the time when the Spaniards arrived in the New World (1519). To the extent that Pérez Garcia's work can be trusted, it appears that Maninaltepec (also spelled Malinaltepec), a present-day agencia of Amotepec, was flourishing when the Spaniards arrived. An official report from the mid-sixteenth century states that Maninaltepec had "good lands, good fish in the river [Rio Grande], honey, and cacaó, with a population of roughly 960" (Perez Garcia 1956a:114).

Ethnohistorical accounts of the founding of Amotepec report that, around the time of the Spanish conquest, a group of seven to ten families moved into the region from the cañada to the northwest.[2] Having no land and a few resources, these "newcomers" managed to obtain

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[1]It is not uncommon in Mexico to find the municipio and its cabecera with identical names. Throughout this dissertation an effort is made to use the terms municipio and cabecera when confusion might arise.

[2]It is unknown why these families migrated into the area. During the 16th century, according to Taylor (1972:28), "pressures within a community or excessive demands by the colonial authorities often forced Indians to choose between flight and active resistance, and many chose to abandon their homes...[and] several...mass exoduses from Indian communities are known." These ethnohistorical accounts may be influenced by the existence of a pre-conquest archeological site of the same name, which is located in the cañada region to the northwest of present-day Amotepec.

a relatively small quantity of land from their already established and comparatively "land-wealthy" neighbors (Maninaltepec, Totomoxtla, and Soledad Tectitlan). These early Amotepecans are believed to have moved within their new boundaries two or three times before settling in their present location.

These ethnohistorical accounts are supported by Pérez Garcia (1956a: 58), who writes that "many pueblos have disappeared or changed site, including Loma de los [Amotes] in the jurisdiction of Maninaltepec." People in Amotepec today agree that the contemporary site of Loma de los Amotes (about five kilometers south of Amotepec) was the place from which the founders of Amotepec moved for the last time.

Amotepec's history prior to the forced congregation of 1603 is unclear. However, it is quite likely that the 1603 congregation resulted in Amotepec being shifted from the Crown's Atlatlauca jurisdiction to the Tecuicuilco jurisdiction, along with Maninaltepec (Gerhard 1972:54, 258, 295). Thus, for the people of Amotepec, the forced congregation of 1603 meant not only being physically relocated, but also being administratively reassigned. As will be seen in the discussion on the new health clinic in Amotepec, extra-local authorities continue to make decisions concerning Amotepec to the present day, even though they are often uninformed about political and geographical features of great local significance.

The National Archives in Mexico City contain vast volumes of historical accounts of many aspects of life in Mexico following the Spanish conquest. Archival research into the early history of Amotepec is complicated by the long-standing existence of another place of the same name, also in the state of Oaxaca. The earliest archival reference to what is

definitely Amotepec is found in the archival section regarding lands (tierras). The entry documents a prolonged (1719-1733) dispute between Amotepec and neighboring Totomostla (or Totomoxtla) and Tetitlan (or Soledad Tectitlan) over a small piece of property. Land disputes continue to be a very significant concern in the daily lives of the highland Chinantec villagers.

Inter-village land disputes

Conflicts over land ownership have been an ongoing fact of life in Oaxaca for several hundred years (Dennis 1976b). The highland Chinantec villages around which this study focuses are no exception. Disputes over property boundaries have been endemic among highland Chinantec villages for centuries, according to the historian Cline (1957:282), who found numerous references of litigation during the period 1700-1820 in the National archives in Mexico City. Even prior to the arrival of the Spaniards, it is quite likely that there were numerous disputes involving the highland Chinantec (Espinosa 1910:159-160, Pérez Garcia 1956a:114, Pérez Garcia 1956b:46, 175-178).

While today's land disputes involving Amotepec are concerned with the land's agricultural potential and timber resources, in earlier times it was minerals, along with cochineal, that were the most valued resources in the highland Chinantla. As stated above, Spanish gold-seekers overcame the rugged terrain to penetrate the highland Chinantla in their very first year in New Spain. In early 1520 Maninaltepec (a present-day agencia of Amotepec located two hours' walk downslope from the cabecera) was visited because of its gold. Writing in 1803, Alexander von Humboldt reported that among several gold and silver mines in the Sierra Juárez, one at Santa Maria Totomoxtla (an agencia of

Amotepec located a relatively easy hour's walk from the cabecera) was especially good (Pérez Garcia 1956a:263).

However, Mexico's War of Independence from Spain in the 1820s resulted in many mines being abandoned. This may account for the fact the "good lead mines" of Amotepec were reported as abandoned by then-governor Benito Juarez in his annual address to the State legislature in 1849 (Pérez Garcia 1956a:263-266). However, in 1968 a Frechman named Farret (a 57-year old Protestant) purchased the lead mine in Amotepec for 400 pesos, an investment which apparently returned some wealth before being sold by Farret's offspring some years later (Pérez Garcia 1956a:267). To this day the tomb of Jose Fransisco Farret ("born in Beziers, France, died in Amotepec December 1, 1891 at age 67") is the largest and most elaborate in Amotepec's cemetery. The mines near Amotepec have reportedly not been worked since the time of the Revolution.

Information on the history of Amotepec in the late 19th century and early 20th century is scanty. It is clear that Amotepec's limited landbase has long affected the economic strategies of its residents (this is discussed later in this chapter). Amotepec's limited landholdings are on precipitous terrain, and of poor soil quality. Chemical fertilizers are prohibitively expensive, and lack of irrigation leaves the peasants highly vulnerable to drought. Lacking sufficient quality and quantity agricultural lands, the harvest of most Amotepec families do not meet their families' subsistence needs.

Amotepec's only current serious land disputes concern the adjacent municipio of San Pedro, with whom they have fought "since time immemorial" (Pérez Garcia 1956b:247). Archival documentation of these disputes can

be found dating back to at least 1720 (Cline 1969:18). Life in the highland Chinantla cannot be fully understood without an appreciation for the seriousness of land feuds, which not infrequently have resulted in small wars being fought and numerous casualties inflicted. Even such seemingly unrelated things as petitioning for and providing medical care are affected by the competition for land (as will be seen later in this dissertation). Preoccupation with neighboring San Pedro explains this. For example, Amotepecans occasionally expressed fear that their clinic's pro-San Pedro auxiliary was in the position of being able to distribute medicines which could harm them. Also, for reasons which will be clarified below, one of the reasons why Amotepec wanted a clinic in the first place was because of the potential regional-level political ramifications of not having a clinic, especially their concern that Amotepec might be consolidated with (and dominated by) the San Pedro municipio. An anthropologist working in San Pedro in the 1960s reported that "the overwhelming public preoccupation centers upon the land issue" and that "the losers in these land feuds have quite literally been forced to the mountain wall" (Gwaltney 1970:21, 23).

Of the highland Chinantec municipios, only San Pedro is believed to have large amounts of land,[3] a matter of intense concern for the people of Amotepec, who feel that their legitimate landholdings have been stolen from them by the caciques (power bosses) of San Pedro.[4] Amotepec natives have numerous accounts of brutality perpetrated by

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[3]The census statistics in Table 1 (page 75) indicate otherwise, for reasons explained on page 74.

[4]This interpretation is denied by the San Pedro men accused of being caciques (D. Bauer, personal communication, 1982).

San Pedro caciques, including the cold-blooded murder of the Amotepec municipal president in 1965. In addition to killings, countless examples of physical, verbal, and psychological injuries were also reported to me by various Amotepec informants. I also witnessed several examples of Amotepec men being intimidated and threatened with death while we were riding through San Pedro on the federal roadway, including the pre-dawn kidnapping of a high-level Amotepec municipal official. The kidnapping was accomplished with high-powered automatic rifles. While Amotepec authorities feared for the life of the victim, he was released unharmed after fourteen hours in the San Pedro jail.

A Mexican anthropologist who has worked among the mountain Zapotec and the adjacent mountain Chinantec has also commented on San Pedro's caciquismo, stating that it began in the 1930s, when San Pedro manipulated a land title from Maninaltepec (an agencia of Amotepec) for a minimal sum of money (Luna 1980:98). Natives of Amotepec feel that San Pedro's domination of the area dates even earlier, and includes misdeeds perpetrated against not only Amotepecans, but each of Amotepec's agencias as well.[5]

Doing research under these conditions was frequently taxing. In addition to the methodological challenges presented in Chapter I, I soon learned that Amotepec's preoccupation with land disputes affects even

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[5]Luna cites six examples of assassinations of no fewer than thirteen opposition voices (1980:98-99). Luna's tally does not include an account from around 1966 when San Pedro caciques reportedly assassinated thirteen men from neighboring Santiago while they were working in their fields. Informants also told of repeated bullying on the part of San Pedro residents, who often beat up or charged fees of Amotepec people who must travel the federal roadway through San Pedro to Amotepec. There are numerous people in Amotepec who prefer to walk three hours in predawn (avoiding San Pedro) to catch a different bus rather than pass through San Pedro on a bus or truck which departs from Amotepec.

some seemingly innocuous behaviors. For example, an activity so innocent as walking out of the village a few kilometers along the road toward San Pedro could be viewed with suspicion. I was told by trusted informants that an occasional afternoon stroll along the road out of town (which I liked to do for exercise and a temporary respite from the responsibilities of fieldwork) could easily be seen as a way for me to secretly rendezvous with conspirators from rival San Pedro.

Because of this inter-village feuding all kinds of social relationships are affected. For example, there are virtually no marriages between residents of these two villages, and social and economic transactions are almost non-existent. Only the non-native schoolteachers and the clinic pasantes attend fiestas in San Pedro, and this behavior adds to the distrust which Amotepecans have for them.

The two most recent allegations regrading San Pedro's involvement in regional events illustrate the Amotepec perspective on life in the Sierra Juárez. In 1979 five unarmed Amotepec natives (including one woman and two children) were killed while farming in disputed territory. The understanding in Amotepec (and elsewhere in the region) is that San Pedro caciques are responsible for the killings, which were carried out to illustrate the vehemence with which San Pedro feels it is the rightful owner of the disputed property.

The second recent incident occurred on June 24, 1979, when between 60 to 100 state soldiers unexpectedly invaded and terrorized Amotepec, killing two men, looting houses, intimidating and injuring several others, and hauling nine men to the state capital for imprisonment on the charges of being "guerrilla sympathizers." The local understanding of these events in Amotepec is that caciques in San Pedro hired these

soldiers (at a cost of perhaps 2,000,000 pesos) to harass Amotepec, with the intent of showing Amotepec what can happen to its citizens if it dares to challenge the dominance of San Pedro. It is believed that among the soldiers invading Amotepec were a few natives of San Pedro who came along to identify those Amotepec men which San Pedro wanted to jail. While most of the Amotepec municipal authorities were able to avoid the harassment of the soldiers by fleeing into the hills, their absences allowed their offices in the city hall to be filled by Amotepec men sympathetic with San Pedro. The Amotepec majority needed forty days and considerable bribes to state and federal officials in order to regain their duly elected municipal offices.

The end results of these events for most people in Amotepec are a further intensification of the hatred of the San Pedro caciques, and a further depletion of valued scarce resources. Access to farm and timber lands are threatened by San Pedro, rifles were confiscated during the soldiers' invasion, and hundreds of thousands of pesos were needed to buy the freedom of the imprisoned Amotepec men and to regain control of the municipal government. An indication of the power of the rivalry between Amotepec and San Pedro can be seen in the fact that an Amotepec woman's death in the spring of 1983 was explained as being the result of physical and psychological injuries (susto)[6] which had befallen her at the hands of the San Pedro-ordered soldiers during their invasion in June of 1979.

The intense rivalry between Amotepec and San Pedro affects the delivery of health services for Amotepecans, both at the inter-village

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[6]Susto is a culture bound syndrome found in many regions of Latin America. Symptoms include restless sleep, listlessness, diminished appetite and strength, and depression (see Rubel 1964).

level and at the intra-village level. At the inter-village level, Amotepec does not want to be, or even appear to be, inferior to San Pedro in any way. For example, San Pedro's new municipal office building is a source of great irritation and concern for Amotepecans. They are irritated because they feel that San Pedro would not have been able to build such an expensive "palace" without the wealth they unfairly gained as a result of invading Amotepec lands and exploiting Amotepec timber resources. Amotepecans' concerns go well beyond a matter of pride. The Oaxaca state government frequently raises the possibility of consolidating many of the state's smaller municipios into larger municipios. The people of Amotepec clearly do not want to become part of any larger municipio (especially not one including San Pedro) unless they could remain politically dominant within their municipio. Rubel (1983) and Browner (1982) report similar concerns in the highland Chinantec cabecera of Santiago.

However, as we have seen in the preceding discussion of the history of the region, the people of Amotepec cannot always be certain of controlling their destiny. Amotepecans have no expectations of dominating San Pedro, but they do fear being dominated by them. Accordingly, Amotepec is concerned about being every bit as impressive and "developed" as San Pedro in every possible way, even if only in appearance. To the extent that they are able to do so, they reduce the chances of becoming incorporated into a municipio dominated by San Pedro. It is Amotepec's hope that if municipio consolidation ever were to occur in the region, their population and available public amenities would be so impressive as to allow them to continue to be the administrative center of their municipio.

Because of these perceptions and priorities, Amotepec was very interested in obtaining a clinic for their village for two rather disparate reasons. On the one hand they desired quality medical services not only to treat their physiological ailments, but also to keep their population as large as possible by preventing medically avoidable deaths. On the other hand, Amotepecans wanted a clinic for political reasons, on the hope that such an amenity would reduce the possibility of ever becoming subordinated to any other village (especially San Pedro) in the event of municipio consolidation. This logic affected Amotepecs' efforts to get a clinic located in their village, and continues to influence their desires to keep the clinic from being removed.

The importance of inter-village relations between Amotepec and San Pedro has been presented in some detail because an accurate understanding of life in the Chinantec highlands requires familiarity with inter-village feuding. It is important to note that it is difficult, if not impossible, to determine the "true facts" of the disputes between the highland municipios of Amotepec and San Pedro. However, it is equally important to note that it is much easier to learn what people <u>believe</u> to be true. Whether peoples' feelings about the neighboring municipio are based on "true facts" or on erroneous information is largely irrelevant. What is relevant is how they <u>perceive</u> the truth, and the intensity with which they hold to their perceptions.

To this point this chapter has attempted to convey to the reader a sense of the general powerlessness vis-à-vis outsiders that rural highland Chinantec Indians living in Amotepec have historically experienced. Also, the preceding pages have tried to show that the particular municipio where this research was done has been especially affected

by its proximity to a regionally dominant municipio (San Pedro), to the extent that Amotepec men, women, and children have lost life and limb, and that the municipio in general has lost valuable material resources, most notably land parcels valued for their agricultural potential and/or timber value.

The rivalry with San Pedro also affects the delivery of health services in Amotepec at intra-village level. As is discussed below, there are two competing factions in Amotepec. The primary auxiliary at the clinic is the daughter of one of the leaders of the minority faction, and she is identified as being in sympathy with this minority. Because of this, there is suspicion among some of the majority faction that she is distributing medicines to patients differentially, depending on their factional affiliation. A more detailed discussion of how this situation impacts on the delivery of health services in Amotepec is deferred until Chapter VII.

Intra-village factions

Before describing the physical layout and characteristics of Amotepec, mention must be made of the fact that Amotepec is not a unified community. Its citizens do not speak with one voice. There are two factions in the cabecera. The majority (comprising roughly 90 percent) have been at odds with a minority faction for several decades. The majority view themselves as the true representatives of Amotepec, and consider the opposition minority to be the puppets of San Pedro, and this minority is suspected of being paid by San Pedro to create problems in Amotepec.

These intra-village factions made socializing and interviewing very difficult until I learned how people aligned themselves vis-à-vis

the factions. I quickly realized that whom I was seen with could have serious repercussions. Villagers who aligned themselves with the majority faction cautioned me against socializing with villagers from the rival faction, saying that they were "bad people" and "liars." The majority faction made it clear that I would not benefit by talking very often with the minority faction. I reluctantly heeded their suggestions. As a result, my movements were restricted not only in and around the village. Even in the distant city of Oaxaca I had to be careful about even talking with members of the minority faction, because members of the majority faction might see me and mistakenly assume I was aiding the minority in some way.

An understanding of the history of Amotepec's factions is important for comprehending the contemporary situation. The origins of these two factions date to 1915, when a dozen natives of Amotepec signed a land purchase agreement with neighboring San Miguel Maninaltepec (with whom they have never had serious quarrels). The entire basis for the dispute rests on whether these dozen Amotepec men purchased the land as individuals in their own right, or as representatives of the cabecera as a whole.

The "facts" of the dispute presented here are remarkably consistently agreed upon by informants in Amotepec as well as informants (municipal authorities) in San Martin Buenavista. For several decades the question of ownership was not raised, and the land was used by many Amotepec families to graze their animals, paying rent to the cabecera treasury. However, in 1940 and 1941 the majority of the dozen signers of the 1915 document decided to claim ownership of the land and accordingly refused to pay rent to the cabecera for grazing rights.

This action was deeply resented by most of the citizens in Amotepec, who claimed that the grazing lands belonged to all "sons of the pueblo," not just the dozen original signers of the land title. The upshot of this disagreement was that most of the dozen "owners" fled Amotepec one evening in April of 1944 and established residence on a strategically defendable ridge in the middle of the disputed territory (known as San Martin Buenavista). The Amotepec majority could have easily asserted their will over these few men (and easily could have reclaimed the land) except for the fact that San Pedro came to the aid of the Amotepec rebels (now occupying San Martin Buenavista), and ensured their successful defense of the territory.

So complete was San Pedro's interest in protecting (and controlling) this disputed territory that San Pedro succeeded in having San Martin Buenavista (and its valuable grazing and forest lands) removed from the municipio of Amotepec and annexed into their own municipio (of San Pedro) in a matter of weeks (on June 30, 1944). This 1944 reassignment of the San Martin Buenavista territory is being appealed by Amotepec. I was told by officials at the Agrarian Reform office in Oaxaca, and by municipal authorities in Amotepec, that the matter had passed through the state courts to the Supreme Court in Mexico City, where a decision was not believed to be imminent.

This series of events not only resulted in Amotepec losing control of a very significant and valuable parcel of property, but also created an internal division in Amotepec, because those who fled Amotepec left behind relatives and friends, some of whom sympathized with those who fled. The existence of two factions in Amotepec has repeatedly affected tje social, political, and economic life of the village. The majority

of the Amotepec residents with whom I spoke during my stay with them felt strongly that San Pedro has "always" (to the present day) been disrupting Amotepec's municipio affairs by encouraging an active minority to obstruct "progress" in Amotepec.

There are widespread accounts of the "anti-pueblo" minority travelling to the district and state capitals to lodge formal statements of opposition to virtually every community development which has occurred in Amotepec in the recent past, including the construction of the new school, the potable water system, the road into the village, the electricity, and the government-subsidized food staples store, the CONASUPO.[7] The anti-pueblo minority is believed by the majority to be financially supported by the caciques of San Pedro, an allegation which I was unable to confirm or deny.

Regardless of whether there was financial backing from San Pedro, it is certain that the existence of opposing factions affected the many different forms of state penetration which have occurred in Amotepec in recent years. While all of these government-sponsored improvements were eventually obtained by Amotepec's municipio authorities, there is wide-spread resentment in Amotepec of the minority faction whose actions required the authorities to spend great amounts of time and money in order to convince the government officials that the majority of the Amotepec citizens did indeed want the improvements. (Despite wanting

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[7]CONASUPO is "a Mexican federal agency responsible for administering the government's agricultural price support program and for regulating the staple goods market at both the wholesale and retail levels" (Grindle 1977a:38). For a detailed analysis of the CONASUPO, see Grindle 1977b.

and obtaining several government-sponsored improvements, it will be seen later in this chapter that Amotepecans view them with mixed emotions).

These accounts of Amotepec's relations with the neighboring municipio of San Pedro have been presented here to provide the reader with an understanding of the research population's perspective on their near neighbors. How closely their allegations coincide with the "truth" is quite irrelevant as compared to the intensity with which they carry these feelings.

Up to this point, occasional mention has been made of how the people of Amotepec feel about their more distant countrymen, namely the state and federal government officials. It has been noted that the penetration of government policies and agencies into the highland Chinantec village of Amotepec has significantly impacted upon the villagers lives in numerous ways. The new government health clinic is the most recent example, and the one on which this dissertation focuses. We turn now to a more detailed analysis of these matters. In doing so, we begin with a description of the locality that received a new government health clinic in 1979, called Amotepec.

The cabecera of Amotepec

According to the 1970 census the Republic of Mexico has 97,580 localities, of which 97.8 percent had a population smaller than 2,500.[8] Amotepec is one of these. The Amotepec municipio population is

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[8]Of the 95,400 Mexican localities smaller than 2500 population, 11,700 are between 500 and 2500 people (accounting for 15.7 million Mexicans. There are also 83,710 communities with fewer than 500 people (accounting for 11.4 million Mexicans). These 27.1 million rural Mexicans live primarily in areas where agriculture is solely dependent upon rainfall, there being no irrigation (COPLAMAR 1978:xi, 1981:21).

officially listed (in the 1970 census) as 2,179, with the cabecera accounting for 1,570 and the three outlying agencies (hamlets) providing the balance. All of the dwellings in Amotepec are made of adobe block construction, except one. (The exception is a cement block residence owned by a wealthy store owner who is one of the leaders of the "anti-pueblo" minority faction. His daughter is the clinic's primary auxiliary).

A census conducted in 1980 by the local schoolteachers found there to be 267 occupied houses (and 86 unoccupied houses, explained below) with an average of 5.6 persons per dwelling. House roofs were traditionally all made of ceramic tiles. However, all newly constructed houses are roofed with corrugated sheet metal, and many older dwellings have had their tiles replaced by sheet metal if the owners can afford to do so. Nearly all floors are hardened earth.

Nearly all houses consist of two separate enclosed rooms and an open (roofed) porch area. The main room of each house is used for sleeping, storage, and a variety of other activities. In addition, it houses the family's "altar," a large table against a wall which is adorned with many religious objects. The kitchen room of the house is generally somewhat smaller than the main room, and is used primarily for cooking and eating. The open porch area is used during daylight hours for many activities, including socializing, sewing, shucking corn, and napping in hammocks.

Electricity reaches over two-thirds of the homes in Amotepec, and is used primarily to allow one bare lightbulb in each room, although record players, tape recorders, blenders, and even televisions are found. Glass windows are extremely rare in Amotepec. Instead, most

rooms have one or two small openings in the walls which let in some daylight while at the same time discouraging excessive amounts of cool air from entering the dwellings on cold days. A piped water system was installed in Amotepec in 1970, and public spigots are located within one hundred feet of most homes.

Despite some efforts on the part of the clinic doctor to encourage residents to construct bathrooms or outhouses for their families, bathrooms are almost non-existent in Amotepec, and outhouses are rare. Most people take care of their physiological necessities in their nearby fields or ravines. The only flush toilets in Amotepec are located in the school and the clinic (both federally provided) and adjacent to the residence of the federal schoolteachers. The municipal outhouse, despite its central location, was so undesirable that it was almost never used. There is almost no sanitray sewage piping in town, although the municipal authorities express great interest in obtaining it with government assistance.

In addition to residential structures, Amotepec has a large Catholic church, five one-story adobe municipal buildings, a basketball court, a school, a clinic, and a cemetery and chapel. There are three "large" one-room general stores in Amotepec, and about four or five much smaller concerns which sell an extremely limited supply of household consumables. There are no public places to eat or sleep, and the general stores which sell alcohol and other beverages have no tables or seats for their customers. The road stops in Amotepec, so there are never any accidental tourists "passing through" town.

Political organization

Amotepec's municipal affairs are carried out by adult (usually married) males, in some ways similar to the classic civil-religious hierarchy (cargo system) found elsewhere in Latin America (Carrasco 1961, Smith 1977). Adult males are selected for service by the town elders (ancianos) on the basis of their perceived ability to perform the required duties, and on their perceived obligation to the community. The town elders have themselves served at least four cargos, and know the system and the community well. Those men selected to serve the community are obligated to fill their unremunerated posts for the required twelve to eighteen months (depending on the office), although extenuating circumstances may excuse them (perhaps only temporarily) from their burden. The town elders and the municipal cargo holders are key participants in the decision-making processes in Amotepec. Elaboration of how decisions are made in the village is deferred until later in this chapter, when recent developments in Amotepec are discussed.

Both civil and religious positions exist in Amotepec, although the civil posts are far more numerous and generally much more demanding. The highest civil posts require extensive paperwork and repeated personal appearances before numerous government officials in their district, state, and federal offices. The village president, his secretary, and the sindico (a high constable, in charge of public affairs) have the most burdensome cargos, each lasting for eighteen months with little relief. All other cargos are relatively less demanding, generally involving one year terms that are shared on a rotating basis with one or two other men. For example, the three regidores (fiscal officers) in Amotepec each work only two weeks out of every

six. The two chiefs of police alternate duties every two weeks, as do their police teams of four men each. The alcalde (justice of the peace) and his secretary serve a year with little relief, as does the municipal treasurer. Each of the above officials has an officially designated alternate (suplente) who is expected to be able to serve the position in the absence of the regular officeholder.

In addition, there are six school-related cargo posts, including the president and treasurer of the association of parents of school-children, and there are four lesser officers who serve as general custodians and truant officers. Thus, the execution of the civil responsibilities in Amotepec involves either directly or indirectly nearly forty adult men. Inasmuch as there are fewer than 300 adult men permanently residing in Amotepec, of whom roughly sixty are free of cargo obligations by virtue of age or completed service, roughly one in six eligible males is tapped each year to serve a cargo post.

The religious cargo posts, in contrast, involve only three men (sacristans) who share their duties on a rotating basis during most of their year's obligations. While religion is an essential part of daily life in Amotepec, the Catholic church building holds masses sporadically. There is no resident priest in Amotepec, and the townspeople must pay large sums of money to entice the priest to visit. Accordingly, the priest is in Amotepec on only the most significant religious holidays, and is widely disliked for his pompousness and hypocrisy. (For example, he tells the villagers that they drink too much, and then he proceeds to get publicly drunk). A small minority of women attend daily morning and evening religious services which are led by an elderly male resident of Amotepec, who leads them through the rosary and other religious rituals.

Virtually no males attend these daily services, except on occasional Sundays.

Economic strategies for Amotepecans

The primary economic activity in Amotepec is self-employed plow agriculture. However, as was noted above, Amotepec's agricultural lands are inadequate both in quality and quantity to meet the subsistence needs of all but a very few of the families in the village. This lack of sufficient productive land has been a problem in Amotepec for several decades.

The most popular strategy for addressing their food shortage during the 1930s through the 1950s involved seasonal wage labor migration, generally to the nearby (three days walk) lowland tobacco plantations around Valle Nacional. Also during the 1950s and 1960s, between thirty and forty men from Amotepec also worked as braceros (agricultural laborers) in the United States.

During the 1930s an alternative economic strategy developed in the Chinantec highlands, namely the itinerant peddling of various regionally-obtained medicinal herbs and spices. The earliest travelling salesman (comerciante ambulante) was reported to be a blind man from Amotepec who began selling around 1930. Gradually his economic endeavors were copied by two or three other Amotepec men. Around the same time, those Amotepecans who were involved in hauling harvested coffee beans out of the Sierra by mules began taking items in to the Sierra to sell in these same coffee regions, thereby becoming part-time travelling salesmen. During the 1940s a few more men (perhaps three or four) began selling medicinal plants in places outside of Amotepec. With the arrival of the trans-Sierra highway in 1956, and even more importantly with the

penetration of a vehicular road into Amotepec in 1973, the travelling salesman economic strategy became an increasingly popular way to supplement one's economic resources in order to be able to buy sufficient food for the family. In fact, during the period of my field research in the early 1980s, slightly more than half of all adult Amotepecan males were self-employed as part-time travelling salesmen for varying periods of time each year.[9] No females are known to have worked as travelling saleswomen, although they often play an important role in packaging the herbs and spices in plastic bags at home in the village.

Many of the Amotepec travelling salesmen rented small rooms (often with other Amotepecans) in distant towns which they used both for living and for storing their merchandise. The frequency and duration of their sales journeys outside of Amotepec depended on their families' needs. A few Amotepec travelling salesmen (I knew of four) were actually out of the village more than they were in it. The majority, however, were outside of Amotepec for an average of two to four months per year, typically involving absences of one to three weeks every other month or so.

It is important to emphasize that these travelling salesmen, while perhaps renting a room with a fellow villager, never sold their wares

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[9]A reasonable estimate would be that about 55 percent of all adult Amotepec males engage in at least some itinerant peddling. However, a precise estimate is problematic for several reasons. First, I was unable to conduct a house-to-house census for methodological reasons explained in Chapter I. Second, the 1980 federal household census data classified almost all Amotepec males as small farmers, and did not inquire about other economic activities. Third, the itinerant peddling of some Amotepec males is so infrequent and so brief that they do not consider themselves to be travelling salesmen, despite the fact that they do occasionally engage in the activity. In spite of these caveats, I am confident that over half, and far fewer than two-thirds, of all Amotepec males work as travelling salesmen for at least some portion of the year.

together, because to do so would, in their eyes, be to be competing with one another for their client's cash. It is also important to note that there was little apparent "seasonality" involved among the Amotepec travelling salesmen. (The exception was in the weeks preceding the fiesta of Todos Santos, where there was widespread interest in accumulating sufficient cash in order to more lavishly celebrate these days in the village.) Rather than there being seasonality among Amotepec salesmen, it would be more appropriate to state there was a noticeable lull in sales activites during Amotepec's two largest fiestas, namely Todos Santos and Easter, because all Amotepecans make every effort to be in the village on these occasions. In general, however, the Amotepecan self-employed travelling salesmen come and go in a variety of schedules. The end result is that at any particular day of the year there are far more "travelling" salesmen who are <u>in</u> Amotepec (not travelling) than there are men <u>out</u> of the village. In other words, Amotepec should not be thought of as a village relatively underpopulated by males, because the absences of the travelling salesmen are overwhelmingly infrequent and short-lived.

While approximately two-thirds of these travelling salesmen engage in selling medicinal herbs and spices (obtained either near Amotepec in the wild or else purchased in bulk, primarily in Mexico City), a great variety of other things are sold, including sewing items, plastic products, clothing, games and toys, and jewelry, to name the most popular items. In addition, three or four Amotepec men sold locally grown walnuts and peaches in season. The Amotepec travelling salesmen sell their wares both door-to-door and in small stores in villages and towns throughout southeastern Mexico (predominantly in the state of Veracruz).

The self-employed "travelling salesman" economic strategy is a necessary adaptation to Amotepec's relative land shortage. This is reflected in the fact that the other highland Chinantec villagers do not engage in such activities, preferring instead to cultivate their productive lowland plots for several months each year. Amotepecans have responded to their relative land shortage not only by becoming travelling salesmen. In addition, beginning in the 1960s, scores of Amotepec men began migrating (both seasonally and permanently) to Mexico City and other urban areas to work for wages in a variety of primarily unskilled jobs, including washing cars and working as janitors. This accounts for Amotepec's 86 unoccupied houses noted above. In the early 1980s there were approximately 100 Amotepec men (many with families) living rather permanently in Mexico City, and another 45 men were living in other urban areas in Mexico, while about twenty Amotepec males were working in the United States. In other words, Amotepecans are quite accurate when they say that "nearly half of the pueblo lives outside" (of the village).

Because so many Amotepecans live and work in cosmopolitan and industrial urban centers for at least part of the year, it must be emphasized that Amotepec is <u>not</u> a community comprised of unsophisticated peasant farmers who are unaware of life outside of the village. Because of their exposure to urban amenities and lifestyles, Amotepecans are quite aware of the fact that many millions of Mexicans experience living conditions which contrast sharply with the village they call home. This familiarity with urban Mexican facilities has had a significant impact on how Amotepec and its inhabitants relate to their recent government clinic and its provisioning of health services. Those men

who have travelled and lived outside of Amotepec as itinerant salesmen have both seen and experienced alternative health treatment facilities. Furthermore, those salesmen who peddle medicinal herbs are constantly hearing about urban health providers from their customers as well as from radio and newspaper sources.

In addition to the travelling salesmen, those Amotepecans (both male and female) who have worked in urban Mexico are also exposed to urban facilities and to the government media campaigns promoting health improvements. As a result, the villagers of Amotepec, whether first-hand or through a close friend or relative, feel that they have a great awareness of urban facilities, including health treatment facilities. Because of this, Amotepecans critically evaluate their own new clinic in terms of what they perceive to be available in urban Mexico. In addition, they view their rural clinic in terms of government information and proclamations which they are exposed to in urban areas. As will be seen in detail in subsequent chapters, Amotepecans are in many respects keenly disappointed with the services they receive at their clinic, and are frustrated with what they feel are unfulfilled government promises.

Amotepecans who work in urban areas necessarily become reasonably competent in the national language, Spanish. This fact places them in a category quite distinct from that of unsophisticated country farmers. Instead, these Amotepecans acquire an essentail linguistic tool for dealing with the national system in which they are unavoidably embedded.

Very little Spanish is learned in Amotepec's schools, despite the fact that all instruction is done in Spanish, and attendance through sixth grade is required. This requirement is not enforced, and very

few children in Amotepec complete the sixth grade. Of those who do, only about 10 to 15 percent continue their formal schooling (by going to secondary school in the Zapotec-speaking community of San Pablo Macuiltianguis).

The Amotepecans living in Mexico City have formed an association, and they play an active and essential part in the political, economic, and social life of their village. They attend major festivals in Amotepec if they can get vacation time. They also make financial contributions to the community for a variety of public works. Great numbers of these Mexico City Amotepecans will attend court hearings and other official meetings whenever a strong showing of community support is needed. Most importantly, perhaps, these relatively more sophisticated Amotepecans contribute extremely important skills for their village in legal matters, including their efforts to obtain and/or retain such desired government services as the health clinic, new school buildings, and more school teachers, to name a few.

During my time in Amotepec no major decisions were made by the village authorities without consulting with the Mexico City contingent (especially one particular individual who was working on a law degree). Because of this "urbanized" aspect of village life in Amotepec, the village has been able to defend itself with some success in recent years from harrassment purportedly perpetrated by San Pedro's caciques. Similarly, the fact that many Amotepecans have been exposed to urban-centered bureaucracies has prepared them to somewhat better deal with them. Nevertheless, as is pointed out later in this dissertation, Amotepecans are generally frustrated with the government bureaucracy for the numerous second-class services they receive, and for the numerous times when their petitions for other matters are ignored.

There are no communal agricultural lands (and no ejido lands[10]) in Amotepec. (Amotepec does hold communal forested lands). The agricultural efforts that are undertaken in and around Amotepec are thus undertaken on privately owned land, and the crops planted are principally corn, beans, and squash. All production of these three food staples is for household consumption. As noted previously, almost all Amotepec households are unable to produce sufficient crops to feed their families. So insufficient are the average household's harvests that serious squabbles have broken out as to whom has what rights to the limited CONASUPO corn which is sold in the village. Almost every week the CONASUPO truck delivers 6000 to 8000 kilograms of corn into Amotepec. Despite phenomenal price increases during the time when this research was conducted,[11] the week's delivery would generally be completely sold out in less than four hours. According to the CONASUPO truck drivers, no other town in the region buys so much corn as Amotepec. In fact, some communities' CONASUPO stores were reported to contain corn which had lain unsold for months.

Virtually every household in Amotepec either cultivates a small garden containing flowers and medicinal herbs, or else has access to the garden of a neighbor or relative. Fruit (especially peaches and bananas) are grown in very small quantities. Cottage industries produce

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[10]An ejido is a type of government-regulated land use wherein a community (or a portion thereof) holds land in common that may be used collectively or individually.

[11]From 1974, when the CONASUPO store opened in Amotepec, until February 1981, corn sold at 2.20 pesos per kilogram. In February 1981 the price rose to 3.50 pesos/kilogram. In January 1982 it rose to 4.80, and one month later rose again to 6.80 pesos/kilogram. Thus, the price of corn, the most important staple in an Amotepecan's diet, more than tripled in roughly one year's time.

very limited quantities of ceramic bowls and pitchers, straw mats and baskets, and unleavened bread. While a very few of these products are sold in the village (never outside the village), the vast majority are utilized by the producer's family, relatives, and friends. Until fifteen or twenty years ago, Amotepec pottery was also sold in nearby villages and hamlets (often transported on the salesman's back), but this is no longer done.

Amotepec's agencias (hamlets)

The municipio of Amotepec is comprised of four nucleated settlements. In addition to the administrative headtown, three outlying hamlets are also contained within the municipio. As indicated in Table 7 (page 173), these hamlets are considerably smaller than the headtown of Amotepec. They are also politically relatively powerless. By federal law, and in actuality, they are politically subordinate to the cabecera.

The hamlets affiliated with Amotepec appeared to be relatively autonomous vis-à-vis the headtown. In all of my time in the municipal town hall, I observed very little business that concerned the hamlets. Although the hamlets were considered to be allies of the municipio in its differences with San Pedro, I observed no overt indications of this. In fact, the social and political relations between Amotepec and its hamlets could best be characterized as mutual disinterest, with each settlement living quite independently of the others.

Marriages of Amotepecans with hamlet residents were extremely rare. Social interactions between residents of the different settlements were largely restricted to religious holidays which would draw great numbers of visitors to the host settlement for religious

ceremonies, basketball tournaments, drinking, and other forms of socializing. During my fieldwork in the Chinantla highlands I hiked to each of Amotepec's hamlets more than once. The long distances and rugged foot trails (with the exception of Totomoxtla) discouraged the COPLAMAR clinic personnel from visiting the hamlet residents, and vice versa (as will be seen in Chapter VIII).

In comparison to Amotepec, the three hamlets are much more oriented towards subsistence agriculture, with very few of the hamlet residents working as itinerant peddlers. This is partially explained by the fact that the nearest bus (in Amotepec) is too distant (1 to 2 1/2 hours walk) to conveniently carry the large bundles of sales items which are sold by Amotepecans. More importantly, however, the scarcity of travelling salesmen among the residents of Amotepec's hamlets is due to there being relatively less pressure on the land in these hamlets as compared to Amotepec.

Their relative availability of productive agricultural land is evidenced by the fact that hamlet residents virtually never purchased CONASUPO corn, in marked contrast to Amotepec residents (discussed below). One result of the hamlets having sufficient land is that they have not been forced to go outside of their hamlets for economic reasons. In comparison with the residents of the cabecera of Amotepec, the residents of the municipio's hamlets are relatively unfamiliar with urban Mexico. The implications of this as they relate to health services <u>coverage</u> are returned to in Chapter VIII, where the COPLAMAR clinic's coverage of Amotepc's outlying hamlets is discussed.

The hamlets are included in this study primarily because they comprise a significant component of the <u>official</u> "coverage" of the

COPLAMAR clinic in Amotepec. As will be seen in Chapter VIII, being an officially "covered" hamlet means almost nothing in terms of benefitting from the clinic's services.

Recent development

The 1970s was a decade of significant changes in Amotepec. Due to then-President Luis Echevarria's emphasis on rural development schemes, and by virtue of being within the catchment basin of the Papaloapan development project, the following services were introduced. In 1972 the old school, which was destroyed by a cyclone in 1969, was replaced by a completely new structure consisting of four one-story buildings. The final ten kilometers of road into Amotepec were completed during 1972-1973, and the following year (1974) the CONASUPO store opened its doors. In 1975 electricity lit the town. In the same year, bus service into Amotepec began on a weekly basis, road conditions permitting. In 1979 the clinic which is the main focus of this dissertation was constructed.

Decisions affecting daily life in Amotepec, including decisions regarding the changes noted above, are made as a result of a consensus of opinion of influential adult males. The most important males include the town elders (who have served at least four cargos), the present town cargo holders (especially the president, the secretary, and the sindico, all of whom will become elders upon completing their present cargos), and the leaders of the Mexico City contingent. Throughout the year informal gatherings involving most of these influential men occur often, both in Amotepec and in Mexico City. Once a year a formal assembly is held in Amotepec to discuss and decide on matters affecting the village. These matters include such things as legal disputes currently before the

judicial system; local issues such as what to do about a particular town drunk, the damage to crops caused by domestic animals running free, and the status of the village treasury; and concerns involving the state, such as desired improvements for the road, school, and municipal buildings. Amotepec has a five-year plan enumerating its goals and priorities, and this plan is evaluated annually. Obtaining a health clinic had been a priority of Amotepec for a number of years before the goal was realized.

How decisions are made in Amotepec depends on the particular issue of concern, and the degree of urgency involved. In the case of the health clinic, widespread sentiments favoring such a health facility had existed for years prior to the arrival of the COPLAMAR clinic, and such an amenity was a clearly acknowledged priority among the townspeople. Accordingly, various petitions to government agencies had been filed before the town received its new clinic. Decisions to prioritize such things as a clinic or a school or (presently) a new municipal building and a sanitary sewage system are the result of the input and influence of the town elders, the current authorities, the Mexico City Amotepecans, and other adult males in the village.

Decisions about what to do about such things as San Pedro's kidnapping of Amotepec's sindico, or the invasion of Amotepec by truckloads of armed soldiers, however, are much more urgent and must often be made without consulting all interested parties. In such cases, available town elders and acting authorities make every attempt to communicate with the Mexico City leaders because of their greater experience with, and knowledge of, matters involving state systems. Depending on the degree of urgency, the Mexico City leaders often board the first available

bus for Oaxaca City (arriving nine hours later) where they will either meet with Amotepecans in Oaxaca City or else hire a private taxi to take them directly to Amotepec (a four hour journey, weather permitting).

It is accurate to say that the Amotepec residents are much more actively involved in determining the priorities of the village, and the Mexico City residents are much more important for the skills they possess which help in pursuing and obtaining the villagers' goals. Given the distances involved between Amotepec and Mexico City, and given the unreliability of the telephone system, there are occasions when communication is extremely slow. Compounding this problem for Amotepec is the fact that most of their urgent problems involve nearby San Pedro, and the only vehicular access to Amotepec passes through the heart of San Pedro, where San Pedranos have been known to obstruct Amotepecans who wish to pass through. Because of this, Amotepecans occasionally prefer to walk three or four hours between the federal highway and Amotepec on rugged trails rather than risk harassment by passing through San Pedro.

The citizens of Amotepec have struggled long and hard to obtain most of the services they now have. Municipal presidents and other influential villagers generally had to make repeated solicitations, involving numerous visits and several forms to be filled out. For example, in order to get electricity installed in Amotepec, the village president (who had to serve a three-year term because his successor died shortly after assuming office) had to make several appearances in the town of Tuxtepec, where the Papaloapan commission had the appropriate offices. Much to his frustration, on numerous occasions the person with whom he was scheduled to meet at a certain time on a certain

date would fail to keep his appointment, which meant that the Amotepec president had to return at another date. (Similar frustrations were reported by the two municipal presidents who held office during my fieldwork period.) Once the necessary bureaucratic obstacles were cleared and the required financial deposit was made, the villagers still had the considerable task of physically transporting and installing the extremely heavy forty-foot concrete utility poles throughout the village. Each pole required forty men and great effort to move to its required location, especially those poles that had to be hauled uphill. Similarly, when Amotepec finally got approval for a road to be constructed into the village (nearly a decade after the road reached rival San Pedro), the roadbuilding equipment quit some three kilometers short of Amotepec, requiring the villagers to finish with pick and shovel what they felt the bulldozer should have done. (Amotepecans believe that the unanticipated early departure of the heavy equipment was an evil deed for which the caciques of San Pedro are responsible).

Amotepec has unquestionably acquired an impressive array of amenities and services in the past decade. However, in spite of, or more probably because of, the struggles which the Amotepecans endured in their quests for improvements in their village, they have very mixed feelings about them. While they are fully aware of the impressive quantity of changes which have occurred in their midst in the past decade, they have serious criticisms about their quality. They appreciate the superficial value of the services in terms of helping the village to appear as an unlikely candidate for subordination in the event of any future municipio consolidation. However, they would like more than mere appearances. Having endured several years of complicated

negotiations in order to obtain the services in most cases, the villagers feel that they didn't get all of what they had been bargaining for.

In addition to extracting patience from the Amotepecans, the government agencies also required significant cash and/or labor for most things they provided. For example, Amotepec had to pay approximately 150,000 pesos in order to obtain their electricity in 1975 (or roughly 300 pesos per family, or more than a week's wages at unskilled labor).

Second-class Mexicans

Nearly all Amotepec residents see advantages in the many innovations which have appeared in the cabecera in the past decade. However, while most Amotepecans feel that the village is now a better place to live than it was before the numerous changes occurred in the 1970s, there is wide-spread sentiment throughout the cabecera that nearly everything they get from the government is "second-class" in some way. Furthermore, these same people who feel they are repeatedly being delivered second-class services view themselves as second-class Mexicans, and they resent it.

Most men and many women in Amotepec have lived and worked in urban areas in Mexico, and therefore have considerable exposure to urban services and facilities. They feel that the facilities that they have asked for, waited for, worked for, and often paid for in Amotepec are generally inferior to the urban equivalents. For example, the Amotepec school, while "modern" in appearance, has no electricity, leaving the afternoon classes in the dark between 5 and 6 p.m. during the winter months.

Also, the schoolteachers in Amotepec are generally believed to be lazy and incompetent, and are felt to be working in so isolated a place as Amotepec only because they are unable to get hired in a more desirable and more demanding urban school. Second-class teachers get sent to second-class places to teach second-class people. Parents in Amotepec say that "our kids leave school [even after six years] as dumb as burros," and they say that their children will not really learn Spanish until they live in an urban setting. Once or twice a year the school director makes a heartfelt (and chastising) plea to the community, asking the parents to speak Spanish in their homes so that their children will become more proficient in Spanish, thereby enabling them to function better in school, where the schoolteachers know no Chinantec. The director's pleas are disliked and ignored.

The school director's pleas are one reflection of the federal government's desires to "Mexicanize" the nation's Indian population (Stebbins 1977). By providing monolingual Spanish-speaking teachers to instruct only in Spanish, using textbooks written only in Spanish and emphasizing the dominant national culture, it is clear that the federal officials have little regard for the Chinantec language and culture. This effort at linguistic and cultural imperialism has not made great inroads into the daily lives of Amotepecans. I know of only two homes in Amotepec where Spanish is commonly spoken among the residents, and even there Chinantec dominates. The government's disregard for the Chinantec culture, and its suggestion that people should stop speaking their native language, have only served to heighten Amotepecans' dislike for the dominant non-Chinantec ruling class, and have reinforced their feelings of being second-class Mexicans. As we shall see later

in this study, the COPLAMAR clinic in Amotepec represents another example of a foreign institution being transplanted from urban origins to a place where much of its orientation is inappropriate.

Two other examples of how Amotepecans feel they are being treated like second-class citizens involve the road into Amotepec and the CONASUPO store. The road into Amotepec, which is the most appreciated change affecting the cabecera in the past several years, is also considered to be substandard, or second-class. Amotepecans deeply resent the government for not maintaining the road in better condition. The final six miles of dirt road into Amotpec often becomes so hazardous in places that passengers in the twice-weekly bus are genuinely fearful of injury or death, should the bus roll down the steep mountainside. Also, the road, even at its best, is so poor that the CONASUPO truck which delivers corn once a week is unable to carry a full load into the village, which deeply upsets the villagers. As appreciated as the road into Amotepec is, and as proud as the federal government is of each new kilometer of road which it opens, one indication of the government's responsiveness to the perceived needs of the rural sector is seen in the fact that the road which reached Amotepec in 1973 was first formally solicited by Amotepec in 1942.

The CONASUPO store in Amotepec is another example of a recently obtained government service which is both widely used and deeply resented. The store sells a variety of items, including corn, rice, beans, sugar, and soap. By far the most popular item, however, is the corn. It was not uncommon for the average weekly shipment of six tons of corn to be completely sold out the very afternoon it arrived. Most Amotepecans do not grow sufficient corn on their small property

holdings, so they buy their corn at the CONASUPO, when it is available. (Additional corn may also be purchased at the two larger general stores in Amotepec, but at a significantly higher price.) However, there was almost never enough corn available at the CONASUPO store to meet demand, and the villagers were extremely disappointed with the government's unwillingness to supply them with more corn.

During my fieldwork the demand for CONASUPO corn in Amotepec was so great that the arrival of the delivery truck often caused vigorous (and occasionally injurious) shoving and pushing for access into the store. The situation became so serious that it was necessary to devise a rationing system with claim tickets issued to all families, to ensure that everyone had equal access to the corn. This system required each family to be limited to 25 kilograms of corn, which was an insufficient weekly ration for most families' needs.[12]

Not only did Amotepecans feel slighted in terms of the quantity of corn provided by the government, but also in terms of the corn's quality. The presence of stones, sticks, dirt, and other debris among the corn required careful cleaning, and occasionally an entire bag of 75 kilograms would be found to be too far spoiled to even use for pig feed. These things all contributed to the Amotepecans' feelings of being second-class citizens receiving second-class attention from their government.

Of most relevance to this study is the government-provided health clinic in Amotepec, the most recent example of government services to

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[12]The economic crisis and resultant austerity program in Mexico in 1982 restricted CONASUPO deliveries to the extent that each family's ration in Amotepec was cut back to fifteen kilograms per week, thus exacerbating the family's situation (R. Gardner, personal communication, 1982).

reach into Amotepec. COPLAMAR,[13] the government development agency responsible for the new clinic, implicitly and explicitly acknowledges the second-class nature of their targeted population, referring to them as "marginal" people living in "deprived zones." The COPLAMAR clinic in Amotepec, like the other government services which came to the village before it, is generally viewed by the villagers as a second-class substitute for a legitimate health care facility. The people for whom the clinic exists complain about numerous shortcomings, especially concerning the resident physician and the pharmaceuticals dispensed there. The COPLAMAR clinic, and the perceptions of those people "covered" by it, are considered in detail in Chapters VI and VII respectively.

The feelings of being second-class Mexicans receiving second-class services from the government are widespread in Amotepec. It is quite likely that Amotepec's distrust of outsiders (noted in Chapter II) reflects the nature of their historical interactions with outsiders. This is suggested by Bevan, who, after five expeditions into the Chinantla, speculated that:

> It would be an unpleasant task to analyze the extraordinary fear of the Chinantec for strangers, and to discover that it is based not only on mere fear of the unknown, but on actual experience. Perhaps some government commission has visited them many years ago. The members did not pay for food willingly supplied, or gave some decision against this village in a boundary dispute. Perhaps an official declared the village had transgressed some law of which it was entirely ignorant, and imposed a fine. Perhaps some "person of reason" sold to them a "Municipal Telephone," already antiquated and useless when it was installed. At all events, whether his fear be the long inherited

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[13]COPLAMAR is an acronym for Coordinacion General del Plan Nacional de Zonas Deprimidas y Grupos Marginados, or the General Coordinating Board for the National Plan [to aid] Deprived Zones and Marginal Groups. COPLAMAR is discussed in detail in Chapter VI.

> and reasonable dread of the Spaniard or the result of more recent experience, there is no doubt but that the Chinantec is mortally afraid of strangers,--and this because he expects to be fleeced or in some way ill-treated. His fear is a sorry indictment of gente de razon! (Bevan 1938:18).

Every Amotepec man who has worked as a laborer in the plantations of Valle Nacional or as a bracero in the United States has poignant tales to tell about the difficult work conditions, and the low pay that made it almost impossible to return to the village with much money saved. Present-day authorities in Amotepec recount with angry humility the awkward inferiority which they are made to feel when dealing with "sophisticated" bureaucrats in their urban offices.

These feelings of inferiority are constantly reinforced in numerous ways. For example, Amotepec's requests to government offices usually go unanswered, be they for more school teachers, road repairs, church restoration, sewage drainage pipes, or a new municipal building. Yet, while the government responds to Amotepec only when it chooses to, Amotepec is required to respond to federal mandates without question. For example, all Amotepec males at age eighteen are obligated to serve one year in military service. Also, government officials regularly come into Amotepec to collect taxes on houses and vacant lots (much to the bewilderment and frustration of some, who cannot understand why they must pay taxes (which they see as rent) on something they own. In addition, in the very recent past the government imposed a 10 percent "value-added" tax (IVA) to many items sold throughout Mexico. While this tax is not charged in Amotepec, the villagers must pay this tax on certain items purchased in urban areas.

These government intrusions into the lives of the people of Amotepec serve to reinforce their feelings that they deserve to share

fairly in the fruits of progress in the nation.[14] The villagers of Amotepec (and especially those who travel outside of the village) are regularly exposed to government propaganda telling them that rural Mexicans like themselves have been neglected for too long, and that the inexcusable injustices of the past are now being rectified. And yet, despite the significant changes which have occurred in the village in the past decade, the villagers feel as though they are not receiving their fair share of the national wealth.

Despite the government's increased emphasis on rural development in Mexico during the 1970s, government figures show that the rural poor in Mexico are no better off (and in some ways are worse off) than they were at the beginning of the decade (Grindle 1981).[15] Similar sentiments are expressed by a Mexican anthropologist who has studied the impact of capitalist penetration in the Sierra Juárez. The net effect of such penetration, writes Luna (1980:49) is that "the conditions of isolation, marginalization, and exploitation that permeated the region were not eliminated by the Revolution--to the contrary they were made worse.[16]

There is widespread cynicism in Amotepec about the government's interest in the poor people, as compared to the middle and upper income

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[14]Mexico's economic growth rates during the 1960s and most of the 1970s were among the highest in the developing world. However, as Davis (1977) has shown for another developing country in Latin America (Brazil) which experienced sustained high economic growth rates during these same decades, such economic "miracles" are not without their victims, namely, the poor.

[15]Unfortunately, figures on government investment in the highland Chinantla were unavailable.

[16]As will be seen later in this dissertation, the health services provided in Amotepec since 1979 through the COPLAMAR clinic have not necessarily improved the health status of the villagers "covered" by them.

urban groups. Many Amotepecans believe that the government responds to the educated sector out of fear, and accordingly meets their demands. Meanwhile, the demands of the "ignorant Indians, who don't even know enough to complain" (as one villager put it), are ignored.

It is widely agreed among Amotepecans that any improvement in Amotepec which requires government participation is virtually impossible to obtain without repeated pestering, cajoling, reminding, and bribing of the proper bureaucrats. Amotepecans share a widespread suspicion of corruption in government officials, and they feel that the government will only respond to a small poor village like Amotepec if the bureaucrats see a possibility of enriching themselves. The following comment is representative. "The government only helps us if there is money to be put in their laps--great amounts of money. Otherwise the government does nothing for us." Amotepecans feel that they get back only a slight amount of the tax money that they pay the government each year. And some, such as the immediate past-president of the village, believe that "the government does not help Amotepecans, it exploits them" by extracting money and labor far in excess of what the Amotepecans get in return.

A final important example of how Amotepecans feel vis-à-vis the nation and the government bureaucracy is found in the judicial system. Virtually every discussion of how Amotepec people feel about justice in Mexico revealed sentiments that "there is no justice in Mexico" for the poor people. "The only justice in Mexico is [bought with] money," say the Amotepecans. They firmly believe that the only significant factor which influences how judges handle disputes is which side pays the biggest bribe. Dennis (1976a), who has studied land disputes in the Valley of Oaxaca, supports the Amotepecans' view, showing that the only winners in such problems are the judges, representing the judicial system.

State penetration into the tiny village of Amotepec has taken many forms. In recent years, due in part to the revenues generated by the state-owned petroleum industry, rural development programs and health services have been introduced into Mexico's "marginal and deprived" zones. The villagers of Amotepec had long been soliciting most of the changes which finally occurred during the 1970s. Yet, ironically, they feel that they have won hollow victories, considering the shortcomings that have accompanied each of their struggles.

This chapter has presented an overview of the history and present-day conditions in Amotepec, the site of this research. It is intended to provide the reader with an understanding of the historical forces which have contributed to the contemporary situation which I observed between 1980 and 1982. Bearing this in mind, we turn now to the primary focus of this study, the provision of government health services for an indigenous population. This discussion begins by considering health status and health services in rural Mexico from an historical perspective (in Chapter IV). After this general discussion, health conditions and treatment options in the Chinantec village of Amotepec are examined in detail (in Chapter V). While these next two chapters have been divided in such a way as to separate health conditions in rural Mexico in general from health conditions in Amotepec, occasional reference is made from the general to the specific (and vice versa). This is done so that the reader may better compare Amotepec with what has been reported for rural Mexico in general.

CHAPTER IV

HEALTH STATUS AND HEALTH SERVICES IN RURAL MEXICO: PAST AND PRESENT

Prior to the Mexican Revolution of 1910-1917, Mexico's rural areas received virtually no government assistance in terms of health services. The revolutionary consititution of 1917 addressed not only the peasants' demands for "land and liberty," but it also made health an "abstract right" of the people (Musselwhite 1981:120-121, 146), and it guaranteed health care for all Mexicans (Kreisler 1981:9,91). However, these constitutional guarantees have yet to be realized by millions of Mexicans, especially poor and rural Mexicans who suffer from malnutrition, ill health, and scarcity of health care services. The conditional nature of Mexicans' right to health care can be seen in the constitution's Article 123 (secion B,XI,(d)) which states that "members of a worker's family shall be entitled to medical attention and medicines, in those cases and in the proportions specified by law" (Peaslee 1970: 947 (a translation), emphasis added). The disparity between constitutional promises and the contemporary reality is easily explained. A political scientist who has worked for several years with Mexican government health agencies writes that "While it is the unquestioned duty of the State to provide health services to every citizen of Mexico, the implementation of this mandate is left to the political leadership" (Kreisler 1981:87). As will be seen below, health benefits in Mexico have generally been granted to those sectors of the population which

are able to command the attention of the government, leaving Mexico's poorest people largely neglected.

During the late 1930s, "the idea of health care as a right of the entire population began to be discussed" (Lopez Acuña 1980a:84), and the administration of President Lázaro Cárdenas began extending health care services to some of Mexico's rural areas at this time. In 1937 two public welfare agencies were created to aid the poorest sector of the population. In the early 1940s these were merged into the Secretaría de Salubridad e Asistencia (SSA, the Department of Health and Welfare), the only government-provided health care option for most of the poor Mexicans then, offering curative medical services at little or no cost. To this day SSA is responsible for the health care of two-thirds of all Mexicans, and must provide for them with only about 15 percent of the public sector health resources (Musselwhite 1981:181-182).

In 1943, Mexico created its first social security institute, the IMSS (the Instituto Mexicano del Seguro Social), in response to the demands of unionized industrial workers. The IMSS remains the single largest social security agency in Mexico, although others have since been created. The IMSS, which is responsible for the industrial, commercial, and service sectors of the labor force, accounts for 75 percent of all the Mexicans who are covered by any social security agency (Wilson 1981:122,160). The next largest social security agency in Mexico is the ISSSTE (Instituto de Seguridad y Servicios Sociales para los Trabajadores del Estado, or the Institute of Social Security and Services for the Workers of the State). The ISSSTE was created in 1960 to provide coverage for salaried government workers, and presently accounts for 17 percent of all insured Mexicans (Wilson 1981:122).

The remaining 8 percent of the insured Mexicans are covered by virtue of affiliation with one of the following four groups: railroad workers, petroleum workers, electrical workers, and the military branches.[1]

In addition to the welfare coverage for the poor (SSA), and social security coverage for non-government (IMSS) and government (ISSSTE) employed workers, there exists the option of private medicine (for those who can afford it). For the vast majority of rural Mexicans there is no social security coverage. For most rural Mexicans the option of private medical treatment is both expensive financially and costly in terms of the travel involved and time lost away from productive activities. Given these constraints, it is not surprising that rural inhabitants often try other remedies before seeking private practitioners of western medicine (Cosminsky 1972, Young 1978, 1980, 1981a,1981b).

This study focuses on the relationship between the State and the peasantry, as exemplified by the historical circumstances impacting on the health status of the villagers in Amotepec, Oaxaca. The impact of externalities on the lives of the peasants is emphasized in this study because the conditions of poverty (especially in terms of environmental sanitation and nutritional deficiencies) experienced by most rural Mexicans significantly affect their health status. These impoverished conditions are due in no small part to the ways in which the state has interacted with (or neglected) the rural sector. The COPLAMAR clinic is scrutinized in this study because it represents the latest government

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[1]None of these government social security institutions reaches into Amotepec, except to cover the federally employed schoolteachers and clinic personnel.

program to arrive in Amotepec, and because it purports to redress some of the inequalities experienced by "marginal" Mexicans.[2]

There are considerable differences between the health services offered by Mexico's social security agencies (IMSS, ISSSTE, and the four others listed on the previous page) as compared to those offered by the welfare agency (SSA). Approximately one-third of the Mexican populace is covered by social security health services, yet they receive 85 percent of the total public sector health budget (Musselwhite 1981: 180). The SSA, on the other hand, as noted earlier, must provide welfare health services for two-thirds of the nation's people (its poorest) with only about 15 percent of the public sector health resources (Musselwhite 1981:181-182).

With such a disproportionate share of the health resources, the social security agencies, not surprisingly, are universally regarded as superior to SSA (Kreisler 1981, Musselwhite 1981, Spaulding 1979, Wilson 1981). For example, in 1968 the 9.3 million middle-class Mexicans covered by IMSS and ISSSTE accounted for 62 percent of all diagnostic tests, despite comprising only 20 percent of the population. Another example of the skewed distribution of health resources to the disadvantage of the poor sector is seen in that only 20 percent of Mexico's doctors and nurses work for SSA (the agency responsible for 66 percent

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[2]Until September 1979, no government health clinic had ever existed in Amotepec. Although private practitioners of medicine are occasionally sought out by the peasants of Amotepec, the great majority of their health treatment-seeking strategies involve self-treatment, indigenous practitioners, and the government-provided COPLAMAR clinic. The COPLAMAR clinic in Amotepec is discussed in detail in Chapter VI.

of the nation's people).[3] More than half of Mexico's physicians are employed by the IMSS and ISSSTE, while approximately twenty five percent of Mexico's doctors are exclusively in private practice (Lopez Acũna 1980a:90).[4] The favored status of the IMSS and the ISSSTE can be explained in part by the fact that their members have been required to contribute to its coffers, and in part by the fact that both groups are sufficiently organized so as to constitute a politically powerful force whose demands cannot be ignored by the federal government.

While the availability of a physican's services is not as important to one's health status as environmental sanitation and adequate nutrition, statistics on doctors in Mexico are enlightening. For example, Mexico has fewer than half as many physicians per capita as does the United States. Also, the United States has almost ten times as many nurses per capita, and nine times as many assistant nurses per capita as does Mexico (Lopez Acuña 1980a:90). These aggregate statistics do not reflect the urban concentration of Mexico's doctors. For example, Mexico's four largest cities, with 20 percent of the nation's people, have fully 50 percent of the nation's doctors (Musselwhite 1981:95). This leaves nearly half (1,121) of Mexico's 2,383 municipios without any doctor (Lopez Acuña 1980a:90). Stated another way, in 1976 greater Mexico City had a ratio of one doctor for every 474 inhabitants, while

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[3]Of course the government could (if it desired) encourage more physicians to work for SSA by creating more positions with attractive salaries and other benefits.

[4]These figures do not include Mexico's unemployed doctors. Nor do they apparently include the pasantes de medicina working with COPLAMAR. However, the approximately 2000 COPLAMAR pasantes comprise scarcely 5 percent of the total number of licensed practicing physicians (36,962) in Mexico (Lopez Acuña 1980a:90-91), and thus do not significantly affect the statistics presented here.

the largely rural states of Oaxaca, Guanajuato, Tlaxcala, Guerrero, Zacatecas, and Chiapas all had ratios of doctors to inhabitants of between 1:4,000 and 1:4,600 (Ramirez 1981:85).

In June of 1983, Mexico's Secretary of Health and Welfare (SSA) stated that roughly 15 million of Mexico's 71 million people have "no access to [western/scientific] health services of any kind," and a spokesman for Mexico's National Union of Doctors stated that perhaps the figure is closer to 20 million neglected Mexicans (New York Times, June 17, 1983). Others go even further. For example, a political scientist who interviewed numerous health officials during a year of research in Mexico City writes: "[Mexican] government officials have admitted that half the population has never received [western/scientific] health care services of any kind as late as the late 1970s" (Musselwhite 1981:91, emphasis added).

The lack of physicians in rural areas, and the relative absence of physicians for Mexico's poor sector, cannot be attributed to a shortage of trained personnel. To the contrary, Mexico's 54 medical schools annually graduate roughly 8,000 physicians, who must compete for only 2,000 positions within the various health services, leaving 6,000 doctors who must go into private practice or be unemployed (Lopez Acuña 1980a:90). Unemployed physicians have been recently estimated to number 18,000 in Mexico (New York Times, June 17, 1983). This suggests that the government is not willing to create rural positions whose salary is sufficiently attractive to encourage these doctors to accept such employment.

Health care services in Mexico are unequally distributed between three large social groups of unequal power and influence (Lopez Acuña

1980a:87-88). In the first group are the wealthier Mexicans who generally utilize private health care services. Private sector health services, while more costly than public medical care, have several advantages for those who can afford the higher costs, including greater personal attention, no long waiting periods and bureaucratic obstacles, and (especially as compared to SSA) generally higher quality care (Kreisler 1981:127). The second group includes the middle class industrial and urban workers covered by the various social security institutions. The third group comprises the poor sector in Mexico, those who have no access to social security health services and who cannot afford regular private physician consultations.

These three groups (as distinguished by the health care services they most commonly receive) can be grouped into two health populations. Generally speaking, the wealthy and middle class Mexicans experience low infant mortality and good nutrition, while suffering from "diseases of development" (i.e. those diseases associated with developed countries) such as heart ailments and cancer. The other group, the poor Mexicans, experience high infant mortality and poor nutrition, while suffering the "diseases of poverty" such as gastro-intestinal and respiratory ailments (Musselwhite 1981:128). While this study concentrates on a village within Mexico's poor sector, in order to more meaningfully understand the conditions experienced by the poor, it is essential to recognize the influence of the more powerful classes in Mexico on the health status and availability of health services for the rural poor.

Having presented a brief overview of the development and present status of the provision of Mexico's various formal health services, we turn now to a discussion of Mexico's rural sector in recent times. In

the past few decades, small but significant changes in orientation in the federal government resulted in the creation of new levels of health care services in the countryside. By tracing their historical development, a better understanding can be gained of how the COPLAMAR clinics came into existence when they did.[5]

In 1960, under the presidency of López Mateos, Mexico's welfare agency (SSA) was significantly reformed, reflecting a new philosophy of extending the delivery of health care to rural areas. Prior to 1960, SSA provided health services only in urban and semi-urban places (excluding all places with populations smaller than 2,500). The 1960 reform expanded SAA coverage into communities smaller than 2,500 people with rural health centers (Centros de Salud Rural).[6] These centers were rarely staffed by full-time doctors, but were generally visited weekly by a physician or a nurse (Kreisler 1981:131-132). This extension of health services to the least politically powerful segment[7] of the Mexican population was extraordinary, and served as a harbinger of programs which have followed, ultimately resulting in 2,105 COPLAMAR clinics, including the one in Amotepec which will be condisered in detail in Chapter VI.

In 1973 President Echevarría, influenced by the hundreds of poor rural communities he visited during his presidential campaign of 1970,

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[5]This discussion has benefited from four political scientists who have examined public health policies and services in Mexico in the 1970s and earlier. I am indebted to Kreisler, Musselwhite, Spaulding, and Willson for their contributions here, especially regarding the historical development of these concerns.

[6]It should be recalled that roughly 40 percent of Mexico's population continues to live in rural communities of fewer than 2500 people.

[7]This is not to say that the rural population covered by these rural health centers has no political power.

followed the lead of López Matoes and extended the SAA health services to an even more rural level. Under his new plan, communities with populations under 1,500 people were eligible for a rural health post (Casa de Salud) served by a visiting doctor. Again, the beneficiaries of the new rural health posts were the most politically impotent sectors of the Mexican population. It is important to realize that there may a great difference between being "eligible" for health services (or being "covered" by them) and actually benefitting from them. Regarding Echevarría's program, Kreisler writes: "Although coverage was indeed extended to rural areas and over 4 million additional political clients could avail themselves of IMSS services, these were no more than potential or at best sporadic users of these very rudimentary, primitive, and inexpensive services" (1981:228). In other words, for very little investment, the Echevarría administration was able to appear to be delivering health care to over 4 million rural people without actually having to deliver much in the way of health services.

Echevarría's 1973 program, called "the program of social solidarity" (Solidaridad Social), was designed to extend health care to rural regions not covered by SSA or IMSS. While this program was under the auspices of IMSS, it was not organized as a social security program. Rather than covering only individual workers and their families, this innovative program incorporated entire communities. Rather than extracting cash contributions from "covered" individuals, this program required the male heads of household of the affected communities to provide up to ten days of labor annually to some health-related community project (Wilson 1981:133). These services were extended to some of the most remote parts of Mexico, and by 1978 were reported to have reached

roughly 3.3 million people (as compared to 19.2 million Mexicans receiving conventional social security health care) (Wilson 1981:133).

By 1976, when Echevarría left office, 310 rural medical units (COPLAMAR 1981:46) at this lowest level were in operation, "providing daily first-aid service" (Kreisler 1981:157). Significantly, this new IMSS "welfare" coverage into Mexico's remote rural regions contained the stipulation that the newly covered poor population not be eligible for referral to any other (more urban) IMSS facilities (such as hospitals), but could only be referred to other "welfare" facilities run by SSA. Therefore, "an entirely new and separate strata of rather basic health service facilities" was constructed for this newly covered poor population (Kreisler 1981:156), including rural hospitals and rural medical units (i.e. clinics).

One possible explanation for why the rural sector was excluded from the existing IMSS facilities is seen in the political consequences of not doing so.[8] Federal policy makers were cognizant of "the almost certain opposition of the politically consequential regular IMSS membership" if they were required to share their services with non-contributors.[9]

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[8]It is interesting to speculate as to why IMSS did not share its existing facilities with the newly "covered" rural sector. One explanation is concern with overcrowding. Another explanation is that the IMSS constituency (which is required to make regular "contributions" toward their facilities) did not wish to share their facilities with "free-loaders." An additional explanation is that the largely middle-class urban-based IMSS constituency did not wish to share its facilities with lower-class rural people for reasons of class or ethnic discrimination. Unfortunately, I lack the necessary data to suggest which of these explanations most accurately explains the IMSS decision to not share its facilities.

[9]It has been noted that Mexico's IMSS facilities and services are vastly superior to those of the SSA. According to a political scientist who was involved with the health care system of Mexico throughout the 1970s, "IMSS is a truly national glamor organization...It claims to have the best facilities and best trained personnel in Latin America, and its current director claims that by 1982...it will have facilities and personnel equal to any in the world" (Kreisler 1981:153).

"Therefore the establishment of separate but unequal services became a political necessity" (Kreisler 1981:153). As will be seen below, this "program of social solidarity," and its peculiarities, formed the model on which much of the COPLAMAR clinics' program (created during López Portillo's presidency (1976-1982)) was based. Despite the exclusion of the rural poor from referral to the IMSS' superior facilities, the establishment of these rural health facilities under López Mateos and Echevarría has been seen as representing "further steps on the road to fulfillment of the promises of the Revolution" (Kreisler 1981:184). To what extent this is actually the case depends on the extent to which these rural health facilities actually improve the health status of the rural sector. Unfortunately, as we shall see later in this dissertation, the new health services in Amotepec appear to be ignoring serious health problems in the community.

While the extension of health services to the rural sector may someday, if not now, benefit the rural poor, political scientists who have critically evaluated the provision of health services in Mexico (Kreisler 1981, Musselwhite 1981, Spaulding 1979, Wilson 1981) agree that <u>political</u> considerations <u>far</u> outweigh <u>humanitarian</u> concerns as regards the extension of health care services to Mexico's politically powerless rural sector. "The [1973] extension of health services to the uninsured and rural workers was done at no expense in service whatsoever to the politically powerful middle class IMSS membership or the bureaucrats of ISSSTE" (Kreisler 1981:185). The numerous social programs which have been initiated to help the poor (whether regarding health or other social concerns) have largely been provided without any meaningful social transformation, and the status quo remains largely unchanged.

The COPLAMAR program (as we shall see in Chapter VI) promises to address and improve the injustices long experienced by the "marginal and deprived" rural sector,[10] and promises to deliver the long overdue constitutional guarantee of health to the rural population. This dissertation demonstrates that these promises are at best being only partially fulfilled, while at the same time certain benefits are accruing to the urban-based political and economic elite. To see how well the rural sector has fared to date, we turn now to consideration of the health conditions which most rural Mexicans currently face.

Health indices for Mexico's rural population reflect the impoverished conditions under which most rural Mexicans live. For example, rural Mexican children under the age of five are approximately twice as likely to be malnourished as urban Mexicans. Data complied by the World Health Organization in the late 1960s (based on a sample of 5,576 children) showed that 30.9 percent of all rural Mexican children were protein-calorie malnourished. (This figure is comprised of 27.5 percent who were found to be "moderately malnourished" and 3.4 percent who were "severely malnourished," meaning they were at least 60 percent below standard weight). In contrast to these figures for rural Mexican children, only 16.1 percent of all urban Mexican children were malnourished (14.8 moderately so, and 1.3 severely malnourished) (Aylward & Jul 1975:25). As we shall see below, there is no evidence to suggest that nutritional status has improved for Mexican children in recent years (and indeed it may have even worsened).

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[10]The primary stated objective of the COPLAMAR development agency was to allow the "marginal people in the deprived zones" of Mexico to "participate more equitably in the national wealth" (COPLAMAR 1978:xvii).

The southern state of Oaxaca has long been among Mexico's poorest states in terms of most social and economic indices (Whetten 1984, Wilkie 1970), and the state has the highest general mortality rate in the nation (COPLAMAR 1981:129). Health conditions reported for Oaxaca's rural population reflect their disadvantaged position as compared with the urban sector (Lopez Acuña 1980). However, it would be misleading to suggest that a dichotomy between rural and urban populations exists regarding health status in Mexico, for at least two reasons. First, Mexico's "rural" population frequently visits or lives in urban areas (Uzzell 1976), and therefore does not contrast completely with the urban population. Second, and more important, vast numbers of urban residents are equally as poor and unhealthy as their rural counterparts (Chávez 1982, Lopez Acuña 1980). Accordingly, a much more realistic dichotomy exists between poor Mexicans (whether in urban or rural areas) and rich Mexicans (living mainly in urban areas).

Health statistics for Mexico reflect an urban bias in terms of health and sanitation services and environmental conditions (Cañedo 1974, England 1978, Lopez Acuña 1982). However, the advantages found in urban areas as compared to rural areas are not equally utilized by all urban residents. Instead, the upper and middle classes enjoy disproportionate access to such benefits. The distribution of sewage disposal facilities illustrates this point.

Roughly fifty percent of Mexico's "urban" population (i.e. those living in localities with populations exceeding 2,500 people) benefit from sewage facilities (Lopez Acuña 1980b:21). By contrast, only one-quarter of one percent (or only 50,000) of Mexico's 20 million rural inhabitants have sewage disposal facilities.

Access to potable water is also much more scarce in rural Mexico. In the late 1970s it was estimated that barely one-third (34.4 percent) of all Mexicans living in localities with fewer than 2,500 inhabitants had potable water available to them, as compared to 87.5 percent of all residents living in cities of greater than 50,000 population (Ramirez 1981:85). However, these statistics mask the fact that the upper and middle class urban residents are much more likely to have sewage facilities than are the urban poor (England 1978:154).

Similarly, national statistics mask the uneven distribution of services among the economic classes. The Mexican census (1970) reports that 41 percent of the population lives in one-room dwellings with dirt floors, without electricity, and the census also reports that over two-thirds of all Mexicans have no bathroom (Lopez Acuña 1980b:21). It is highly unlikely that the urban wealthy sector lives under such conditions.

The ways in which unsanitary living conditions, poor housing, and inadequate nutrition impact upon health status have long been considered and understood (McKeown, Brown & Record 1972; Snow 1936). Similarly, contemporary scholars concerned with health care and health conditions have noted the importance of basic levels of necessities in order to reduce the risk of many common illnesses and diseases (Gish 1973, 1976; Graedon 1976:302; Navarro 1974). Even the COPLAMAR program responsible for the Amotepec health clinic (and over 2,000 other clinics in the republic) recognizes in their printed documents the importance of sanitation and nutrition in preventing the onset and recurrence of disease (COPLAMAR 1978, 1981). Unfortunately, COPLAMAR's actual practices (as will be seen in the example of Amotepec) put very little emphasis on this important component of health services.

In addition, numerous health professionals working toward improving health conditions of poor people around the world have emphasized the relative uselessness of highly trained physicians for ameliorating the most common rural ailments. They consistently note that the role of environmental conditions in preventing illness is far more important than having physicians in attendance, and they further note that relatively unsophisticated paramedics can quite easily be trained to competently treat the overwhelming majority of patient complaints (Akhtar 1975; Berhorst 1975; Gish 1976; Habicht 1979; Navarro 1974; Werner 1976, 1977, 1979). In one such program in villages in Guatemala, non-professional primary health care workers (with supervision and referral systems) were able to reduce infant mortality by two-thirds and mortality of one to four-year olds by three-quarters (Habicht 1979).

As will be seen later in this dissertation, judging from what was observed in Amotepec, the very recent COPLAMAR program in Mexico ignores (or at best pays lip service to) these basic tenets. Instead, the COPLAMAR program of health services attempts (with questionable success) to replicate the urban-based model of highly trained physician-provided curative care, leaving the causal factors of illness and disease largely unaddressed.

This chapter has examined health conditions and health services in rural Mexico from an historical and contemporary perspective. Before turning to a detailed analysis of the COPLAMAR clinic in Amotepec (in Chapters VII and VIII) we turn first to a discussion of health conditions and treatment options in Amotepec (Chapter V). By first becoming familiar with these matters as they exist in Amotepec, the appropriateness or inappropriateness of the COPLAMAR program's orientation and practices may be more meaningfully discussed and analyzed.

CHAPTER V

HEALTH CONDITIONS AND TREATMENT OPTIONS IN AMOTEPEC

Having discussed general health conditions and health services (both historically and in the present) for rural Mexico in the previous chapter, we turn now to considerations of health, illness, and treatment in the highland Chinantec village of Amotepec. While the primary focus of this chapter is on conditions in the village, occasional reference is made to conditions in rural Mexico in general. This is done so that the reader may make immediate comparison between the particular circumstance in Amotepec and the general conditions throughout the rural areas of the Mexican republic.

It is a major contention in this dissertation that the recent COPLAMAR health clinic in Amotepec (one of 2,000 such new clinics in Mexico) serves at best as a part-time emergency first aid station, and at worst creates the myth and misperception that such "marginal" people as those living in Amotepec have at long last become the recipients of their constitutionally guaranteed right to health (earned in the 1910-1917 Revolution). While the Amotepec health clinic does indeed offer curative health care, it does not address the underlying factors which contribute to the causation of the most common health problems in Amotepec. Unsanitary environmental conditions and inadequate nourishment are the root causes of the most prevalent physical ailments reported in Amotepec, and the government's new health clinic does almost nothing

toward ameliorating these conditions. In this chapter the health conditions and treatment options in Amotepec are examined and evaluated.

Health conditions in Amotepec

As was stated in the previous chapter, environmental conditions play an important part in determining one's health status. Accordingly, this section includes not only health status in Amotepec, but general information on environmental conditions and living conditions as well. The dwellings in Amotepec can be cool and damp in the winter months, when overnight temperatures commonly dip into the 40s (°F) and occasionally into the 30s. Approximately two-thirds of Amotepec's households have electricity in their homes.

Meals in Amotepec generally consist of tortillas and beans and coffee, with eggs consumed occasionally, and meat consumed only on festive days (perhaps every two or three months). Milk and cheese are virtually unknown. Fewer than one percent of the households have outhouses, and still fewer have inside bathrooms (I know of two). Amotepec's first sewage disposal pipes were installed during my fieldwork, and consisted of roughly 75 feet of piping which services the one household that paid for it. Most bodily wastes are eliminated outside the dwellings, and in the cornfields during those months when the cornstalks are high enough to allow for privacy. Children in Amotepec, who commonly go barefoot until reaching school age (five or six) typically spend hours each day playing in areas where human and animal wastes have been eliminated.

Amotepec has been fortunate to largely escape the ravages of one of the Chinantla's most debilitating diseases, namely onchoceriasis.

Onchoceriasis has a long and sad history among the Chinantec.[1] The incidence of onchoceriasis in Amotepec has always been much lower than that found in other highland Chinantec localities (such as San Pedro and Santiago). This is explained by the fact that onchoceriasis is contracted primarily at lower altitudes, and Amotepec owns no lowlands, whereas many residents of the highland cabeceras of San Pedro and Santiago spend several months each year at their lowland ranches. While onchoceriasis is rare in Amotepec, it is not unknown, partly because Amotepecans occasionally work in the lowland ranches of friends and relatives living in Amotepec's agencia of Totomoxtla.

For over forty years Mexican health agencies have been attempting to control onchoceriasis, and their campaigns have resulted in a remarkable reduction in incidence and prevalence between 1962 and 1977, according to the former head of the national campaign against onchoceriasis (Chávez Núñez 1979:714-715). An anthropologist who has studied the disease in the Chinantla has also reported that the infection rate has been dramatically reduced during a similar time period. (Gwaltney 1981: 24). So thorough are these efforts that campaign workers even visit "low-risk" Amotepec every few months to administer preventive medicines to school children. The public health team (three middle-aged males) usually had to walk at least the last ten kilometers into Amotepec when they came, because their work schedule rarely coordinated with the bus schedule. When asked about how Amotepecans generally respond to their free services, the men expressed bitter resentment at being so unappreciated. They said that in Amotepec people hide their children behind

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[1]The following authors have noted onchoceriasis in the Chinantla: Basauri 1940:556; Bevan 1938:2,30; Chávez Núñez 1979; Gwaltney 1970,1981; Luna 1980:87; Pérez Garcia 1956:Vol.1:245, and Vol.2:268; Strong 1934:50-51; Weitlaner and Cline 1969:551.

closed doors rather than receive the free treatment. The team was further displeased with the lack of hospitality offered them by the municipal authorities. The men had some difficulty obtaining meals, and their overnight quarters (provided by the authorities) consisted of a dirt floor in an unused municipal building. I attribute this level of "hospitality" primarily to Amotepec's general distrust of outsiders. Other overnight guests fared no better. In fact, only the visiting priest was allowed to use the relatively luxurious quarters adjacent to the church, quarters which consisted of a crude wood-slat bed, simple table with candle, and a hardened earth floor. The members of the health team reported that their reception in Amotepec is not typical. In fact, they said, in many villages in the Sierra Juarez they are so appreciated that when they attempt to leave they are begged to stay on for a few extra days. The contrasting reception in Amotepec is so unpleasant for them that they say they would prefer to never return, except for the children. They said that "the children should not suffer [from their absence] because of the ignorance of their parents," and so they will continue to work in Amotepec for the foreseeable future.

The villagers' attitudes toward the visiting health team did not exactly coincide with the harshness reported by the health team. I could find no reports of children being hidden from the men. In fact, many children <u>were</u> effectively treated because the public health team administered their medicines at the school during school hours, when most children were a captive audience. When asked about the onchoceriasis campaign, most parents agreed that it was an essential and important undertaking. However, at the same time they conveyed indifference or skepticism toward the actual health team which was

implementing the campaign. This apparent inconsistency may be explained as follows. Based on Amotepecans' repeated comments and overall world-view, their skepticism of the health team is most likely associated with their distrust in government programs in general, and with their distrust of outsiders who might in some way be employed by the nearby rival village of San Pedro, to the disadvantage of Amotepec.

While Amotepec has largely escaped the ravages of onchoceriasis, it has not been so fortunate as far as escaping one of rural Mexico's most pervasive problems, namely undernutrition. Reports on nutritional status of rural Mexican children estimate that from 31 to 90 percent of all rural Mexicans are malnourished, with various degrees of calorie and protein deficiencies (Aylward & Jul 1975:25; Daschbach and Green 1978: 543, Grindle 1981:33, Musselwhite 1981:53-54). In rural Mexico, "protein-calorie mulnutrition is the most prevalent nutritional disease state, with children the most overtly affected group" (Daschbach and Green 1978:543). In one study of first grade children in four rural Oaxacan villages, the great majority of them were found to be undernourished (Graedon 1976:295).

In Amotepec, the clinic's pasante found 68 percent of the children under the age of five to be undernourished. This finding was based on data obtained between September 1981 and April 1982, when the clinic personnel weighed a total of 149 children who came to the clinic for whatever reason (even if only to accompany their mother or a sibling). Their weight was plotted against their age, and their degree of

malnutrition was recorded.[2] Of the 149 children weighed, 63 (42.3%) were found to be first-degree undernourished (i.e. 10 to 25% below their theoretically desirable weight), 32 (21.5%) were second-degree undernourished (25 to 40% below their theoretically desirable weight), and 6 (4.0%) were third-degree undernourished (more than 40% below their theoretically desirable weight).

These figures suggest that Amotepecan preschool children under age five were somewhat more undernourished than the average rural preschooler in Mexico during the mid-1970s. At that time, government surveys (cited in Dashbach and Green 1978:543) found roughly 55 percent of all rural preschool children to be underweight for their age. These were broken down as follows: 42% were first-degree undernourished, 11% were second-degree undernourished, and 2% were third-degree undernourished. These figures are represented in Table 2, page 145.

The COPLAMAR clinic in Amotepec is run by a pasante[3] who is expected to live in the clinic throughout his year in the village. He is assisted by a local female bilingual auxiliary whose primary purpose is to act as an interpreter for those villagers who speak poor or no Spanish. She also performs minor medical and secretarial tasks. The

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[2]Data on undernutrition in developing countries must be viewed with some caution inasmuch as standards used for determining nutritional status may or may not be appropriate for the population in question. The chart which COPLAMAR's pasantes used for determining nutritional status does not state which standards it is derived from. However, it is almost certainly the Gomez system, which uses the Boston Growth Standard (Pollitt & Leibel 1980:181) as a reference population, but scales the well-nourished Boston weight-for-age data downward, taking into account the differences in nutritional status between the Boston sample and rural Mexicans in general (Griffiths 1981:15-16).

[3]Medical students in Mexico, upon completion of their formal training, are required to spend one year in "social service," often in very rural settings. Upon completing this year as a pasante, they receive their certification as physicians.

TABLE 2

UNDERNUTRITION AMONG PRE-SCHOOL CHILDREN IN AMOTEPEC AS COMPARED TO RURAL PRE-SCHOOL CHILDREN NATIONALLY

Nutritional status	Amotepec preschool children (ages 0-5)	Rural Mexican preschool children (ages 0-5)*
First-degree undernourished (10-25 percent below their theoretically desirable weight)	42.3%	42%
Second-degree undernourished (25-40 percent below their theoretically desirable weight)	21.5	11
Third-degree undernourished (more than 40 percent below their theoretically desirable weight)	4.0	2
Total considered to be undernourished (at least 10 percent below their theoretically desirable weight)	67.8%	55%
Total considered to be adequately nourished	32.2%	45%

*These figures come from Daschbach and Green 1978:543

personnel in the COPLAMAR clinic are required to keep daily records on patients' visits. Each patient who visits the clinic must provide the following information for the records: name, age (or year of birth), gender, name of head of household, and age and gender of head of household. The pasante (or occasionally the auxiliary) also records his diagnosis, and notes the number of prescriptions written out and filled each day. I was able to examine and copy pertinent information from the daily logs for the first 2,889 patient visits for the Amotepec clinic, covering virtually all of the patients to ever be treated at the clinic (or occasionally at their homes) from the clinic's beginning (September 6, 1979) to the day I left the village (May 15, 1982).[4]

An indication of the most common physical ailments in Amotepec (as diagnosed by the three resident pasantes to have worked at the clinic during its first 32 months) is gained by examining the records of the first 2,889 patient visits. These clinic records are examined from two data bases: those prepared by the clinic pasantes, and those tabulated by me.

The pasantes who worked at the COPLAMAR clinic in Amotepec were each required to report the ten most frequent infectious-contagious diseases seen. Their results are shown in Table 3 (page 147). These data reveal the predominance of gastro-intestinal and upper respiratory diseases, as they comprise 91.15 percent of these most common diseases.

[4]Occasional inaccuracies in clinic records were noted, including failure to enter some patients at all. However, I feel confident that these records were kept to within 90 to 95 percent accuracy. In my examinations of the patients' records, I ignored and did not record the patients' names, for reasons of confidentiality. In addition to these brief records which I viewed, the pasantes were required to keep a separate manila folder with more complete information on each patient (including a history, symptoms, complete diagnosis, and medicines prescribed). I was denied access to these records except on rare occasions. It is unlikely that these records contain information which would change the findings presented here.

TABLE 3

TEN MOST FREQUENT INFECTIOUS-CONTAGIOUS DISEASES REPORTED BY PASANTES IN AMOTEPEC'S COPLAMAR CLINIC FOR PORTIONS OF 1980, 1981, AND 1982*

1980		1981		1982	
Disease, # of cases		Disease, # of cases		Disease, # of cases	
Intestinal worms	58	Tonsilitis	79	Gastroenteritis	48
Amoebas	35	Gastroenteritis	61	Tonsilitis	43
Enteritis	34	Cough	52	Parasites	29
Tonsilitis	27	Common cold	39	Cough	12
Bronquitis	15	Parasites	35	Abdominal pain	10
Common cold	13	Scabies	25	Colds	9
Scabies	11	Bronquitis	21	Dental caries	9
Trichinosis	8	Amoebas	14	Common colds	8
Mumps	4	Mumps	4	Scabies	7
Moniliasis	4	Dysentery	3	Bronquitis	6
TOTALS	209		333		181
SUMMARY:					
Gastro-intestinal diseases	135		113		87
Upper respiratory diseases	55		191		78
	190		304		165
190/209 = 90.9%		304/333 = 91.3%		165/181 = 91.2%	

COMBINED TOTALS FOR ALL THREE YEARS' DATA: 659/723 = 91.15%

(In other words, 91.15% of the ten most frequent infectious-contagious diseases seen at the Amotepec clinic were either gastro-intestinal or upper respiratory diseases).

*Figures reported here reflect totals for only a fraction of each year shown, as tabulated by each pasante at the Amotepec clinic.

However, the pasantes' data only reflect the dominance of gastro-intestinal and upper respiratory ailments among the ten most common infectious-contagious diseases as seen at the Amotepec clinic. They do not reflect their importance relative to the entire caseload of the clinic. To determine this, I analyzed all patient visits to the clinic during certain months in 1979, 1980, and 1981. This data is shown in Table 4 (page 149). The findings support those of the clinic pasantes, inasmuch as they show that gastro-intestinal and upper respiratory ailments comprised 58.3 percent of all clinical diagnoses made at the Amotepec clinic during these periods.[5]

These data also reveal that 41.7 percent of all clinic patients were treated for something other than gastro-intestinal or upper respiratory ailments. These varied widely, and included the following (listed in descending order of frequenty): rheumatoid arthritis, diabetes, scabies, back pain, dental caries, skin ailments (various), epilepsy, and a broad variety of miscellaneous injuries and afflictions. These data are supported by those compiled by the clinic pasantes, who noted diabetes and rheumatoid arthritis as the most common chronic-degenerative illnesses, and reported the most common non-contagious illnesses to be malnutrition, anemia, back pain, and dental caries.

People who came to the Amotepec clinic were generally young, and were equally likely to be male as female. A random sampling of 987

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[5]These figures, when compared with national figures, suggest that Amotepecans suffer from the same kinds of health problems as many Mexicans. For example, in 1971, the leading causes of death in Mexico were infections and parasitic and respiratory diseases, which combined to account for 37.9 percent of all deaths reported. It is significant that about 45 percent of these deaths involved children under the age of five. "Malnutrition contributed to many of these early deaths," either directly or indirectly (Weil et al., 1975:176-177).

TABLE 4

GASTRO-INTESTINAL AND UPPER RESPIRATORY AILMENTS AS A PERCENTAGE OF ALL DIAGNOSES MADE AT THE AMOTEPEC COPLAMAR CLINIC DURING PORTIONS OF 1979, 1980, and 1981*

	Total diagnoses	Gastro-intestinal diagnoses	Upper respiratory diagnoses	Gastro-intestinal and upper respiratory diagnoses combined
Sept-Dec. 1979	158	42	37	79
% of total	100.0	26.6	23.4	50.0
Sept-Oct. 1980	179	62	46	108
% of total	100.0	34.6	25.7	60.3
Sept-Oct. 1981	184	73	44	117
% of total	100.0	39.7	23.9	63.6
COMBINED TOTALS FOR ALL THREE PERIODS ABOVE	521	177	127	304
% of total	100.0	34.0	24.3	58.3

*Figures reported here are based on author's analysis of pasante's diagnoses at the Amotepec COPLAMAR clinic.

patient visits during 1980 and 1981 shows that the majority (54%) of the clinic's patients are comprised of people under the age of sixteen. These figures are presented in greater detail in Table 5 (page 151). The concentration of patients in the younger age brackets is explained by the youthfulness of the general population in Amotepec (which is also shown in Table 5, page 151). For example, males under the age of 20 comprise 59.4 percent of the general male population in Amotepec, and comprise 59.5 percent of the males to visit the clinic. Similarly, females under the age of 20 comprise 56.9 percent of the general female population in Amotepec, and comprise 55.8 percent of the females to visit the clinic. As for gender, patients seen at the Amotepec clinic are almost equally divided between males (50.5 percent) and females (49.5 percent).

According to government documents, in 1975 the leading causes of death in the state of Oaxaca were the following: infectious and parasitic diseases (24%), respiratory ailments (10%), circulatory problems (7.4%), and digestive ailments (3.2%).[6]

The COPLAMAR agency in charge of delivering health services to millions of rural Mexicans has stated that deaths from these causes (as well as vitamin and nutritional deficiencies) "result from conditions of socio-economic poverty and poor sanitation services." COPLAMAR further states that conditions of poverty (wherein undernourished people live in crowded conditions without piped water or sewage disposal) "predispose the population to several types of infectious diseases"

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[6]From: "La población de México, su ocupación y sus niveles de bienestar." Serie: Manuales de información básica de la nación. Secretaría de Programación y presupuesto. Coordinación General del Sistema Nacional de Información. "n.d." (Estimated date: 1980).

TABLE 5

POPULATION DISTRIBUTION BY FIVE YEAR AGE GROUPS IN AMOTEPEC AND FOR PATIENTS ATTENDED AT THE COPLAMAR CLINIC IN AMOTEPEC

Population seen at Amotepec COPLAMAR clinic as patients@					General poupulation distribution in Amotepec#			
Males	%	Females	%*	AGES	Males	%	Females	%*
114	11.0	110	10.4	0-4	111	14.1	121	15.7
204	19.7	179	17.0	5-9	161	20.4	160	20.8
189	18.2	192	18.2	10-14	132	16.7	103	13.4
110	10.6	108	10.2	15-19	65	8.2	54	7.0
39	3.8	78	7.4	20-24	23	2.9	30	3.9
41	4.0	66	6.3	25-29	33	4.2	50	6.5
56	5.4	73	6.9	30-34	33	4.2	44	5.7
45	4.3	53	5.0	35-39	42	5.3	45	5.8
71	6.8	62	5.9	40-44	48	6.1	26	3.4
45	4.3	43	4.1	45-49	32	4.1	39	5.1
41	4.0	22	2.1	50-54	21	2.7	22	2.9
18	1.7	15	1.4	55-59	31	3.9	22	2.9
30	2.9	26	2.5	60-64	23	2.9	23	3.0
9	0.8	14	1.3	65-69	13	1.6	8	1.0
14	1.4	10	0.9	70-74	10	1.3	7	0.9
9	0.9	3	0.3	75-79	3	0.4	10	1.3
2	0.2	2	0.2	80-84	7	0.9	5	0.5
0	0.0	0	0.0	85 +	1	0.1	1	0.1
1,037	100.0	1,056	100.0		789	100.0	770	99.9
(49.5%)		(50.5%)			(50.6%)		(49.4%)	

@These figures reflect 2,093 patient visits, and include multiple visits by many patients.

#These figures total 1,559, and reflect most, but not all, of a census conducted by the cabecera authorities in April 1982.

*Total does not equal 100.0% due to rounding.

(COPLAMAR 1981:129-130)). It is a central contention of this dissertation that the COPLAMAR health program, while explicitly recognizing the importance of proper sanitation and adequate nutrition, provides health services in Amotepec which do very little toward ameliorating these critical conditions of poverty, thereby leaving the population predisposed to illness and disease.

Treatment options in Amotepec

The overwhelming majority of Mexico's 97,580 localities are without the services of a locally available resident physician or pasante. Until 1979, Amotepec had never had a resident pasante, and had rarely been visited by one. However, since "time immemorial" there have likely been illness and curing options in Amotepec. How people in Mexico have chosen from a variety of curing options has been the focus of many investigations (McClain 1977; Young 1978, 1980, 1981a, 1981b: Young & Garro 1982).[7] People in Amotepec share a characteristic reported by the above-noted scholars, namely that of pragmatism.

In Amotepec there is a strong historical tradition and continued appreciation for herbal medicines. This preference may be accounted for by two factors. First, a great variety of flora is readily available in this "luxuriant" northern end of the Central American tropical rain forest (Schultes 1941).[8] Second, the distance from Amotepec to the nearest physican (two or three days' walk until recent decades)

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[7]Cosminsky (1979) and Woods (1977) have done similar research in Guatemala.

[8]Schultes' article refers to the lowland Chinantla. However, the ecological diversity found in this geographically precipitous terrain makes Schultes' comments applicable in the vicinity of the municipio of Amotepec. Also, Amotepecans still go to the lowland Chinantla, where they obtain medicinal plants not available in the highlands.

made it imperative that some other manner for dealing with illness and disease be available.

There are presently five part-time healers (curanderos) in Amotepec, three males and two females.[9] One male healer is considered to have exceptional skills, as his abilities include not only knowledge of herbal remedies, orations, and pulsing, but also familiarity with injections and patent medicines. However, this most renowned healer is often absent from Amotepec for weeks at a time, working in his fields some three hours' walk downslope from Amotepec. While he occasionally is sought out when he is not in town, more often people will seek other local healers or healers residing in nearby villages in the Chinantla highlands, such as Maninaltepec, Soledad Tectitlan, and Santiago (but not San Pedro).

The nature of the illness complaint influences the choice of healer sought. For example, virtually all villagers know that physicians (whether in Amotepec or elsewhere) are untrained in certain illnesses experienced in Amotepec (such as susto, mal ojo, mal aire, mal dá, envidia, and brujeria). Amotepecans also know that physicians are ignorant of herbal medicines, as well as pulsing and cleansing. Therefore illness complaints requiring knowledge of the above are almost never taken to physicians. Instead, family members, friends, or one of the village healers is sought out. If no cure is forthcoming from these village residents, the patient is often transported to a nearby Chinantec-speaking village for treatment by a healer. Or, if the patient has the strength and the financial resources, a trip to an urban healer might be undertaken.

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[9]There are also four empirical midwives (all female). They are not included here because pregnancy and birth are not considered illnesses.

As is shown in Table 3, and as is discussed on page 148, the clinic in Amotepec is presented with a wide variety of illnesses and diseases. Before going to the clinic, most Amotepecans are likely to try a home remedy for their ailment, and/or consult a local healer, depending on the nature of the ailment. In many instances the afflicted person (or responsible parent) is sufficiently satisfied with this treatment, and the clinic is not utilized. For example, when one of Amotepec's past presidents (a man age 40 who was active in the efforts to bring a clinic to the village) seriously cut his hand with a machete, he preferred to bandage it himself with his own (unsterile) cloth rather than visit the clinic which is merely a ten minute walk from his house.

Home remedies often involve medicinal herbs, and/or things purchased in the village. The small general stores in Amotepec stock a limited supply of items (such as Alka-Seltzer, and Mejoral (a sort of aspirin)) which are frequently utilized. There is no pharmacy in Amotepec (the nearest one being approximately five hours distant by bus), but many villagers have a "medicine chest" stocked with a few patent medicines.

The people of Amotepec utilize their various treatment options in an eclectic and pragmatic way, taking advantage of the available resources as they see fit. Their eclecticism may be seen in the things they use (prayers, patent medicines, herbal medicines, eggs mixed in beer, to name a few) and in the personnel they seek out (local and extra-local curanderos, the local clinic pasante, and distant physicians) in their attempts to relieve pain and suffering. However, despite the 2,889 visits made by patients to the clinic during its first 32 months (an average of three visitors per day), there is

widespread dissatisfaction with the personnel and the pharmaceuticals dispensed there, as will be discussed in detail in Chapter VII.

Two examples of the extent to which Amotepecans will go to alleviate illness demonstrate how serious the distrust or dissatisfaction in pyhsicians can be. One Amotepec native became ill while working in Los Angeles, California. He sought help at two different hospitals there, but found the pills and liquids prescribed by the California physicians to be ineffective. After several weeks of continued discomfort, he decided to fly to Oaxaca from Los Angeles (an expensive journey). Upon arriving in Oaxaca, he took a taxi into Amotepec (another expensive journey), arriving in his native town the very same day he left California. The man felt his condition was serious enough to warrant the expenses involved, as he believed he required the skills of a Chinantec curandero. While in Amotepec he did not visit the clinic's pasante. When asked why not, he replied, "If the doctors in California cannot help me, how is this youth (jovencito) at the clinic going to be able to help me?" Instead, he was treated by a local healer, and relatively quickly he recovered from his ailments. Soon after, he returned to Los Angeles to continue his work there.

The second example of the extent to which Amotepecans will go to alleviate suffering without resorting to western bio-medicine involves brujeria (loosely translated as witchcraft). According to several informants, in 1968 Amotepec experienced an alarming rate of deaths among children. Over one hundred small children were said to have died in less than one year, and there were days when two or three youths would die. Informants reported that the small, high-pitched bell in the church tower which is used to announce the death of a small

child was constantly ringing during this time. In seeking to understand this horrifying "epidemic," Amotepecans eventually came to a consensus that the deaths were being caused by brujeria. It was determined that two Amotepec men were responsible for the deaths. The municipal authorities located the brujos (loosely translated as witches), killed them, and buried their remains a great distance from the cabecera. At the same time, the children stopped dying, and the community felt that they had effectively eliminated a most serious community hazard.[10]

The fact that prior to 1979 there was no resident pasante in Amotepec should not be taken as an indication that Amotepecans were until that time unaware of western/scientific medicine. The arrival of the COPLAMAR clinic in 1979 hardly signaled Amotepecans' first exposure to physicians and patent medicines. For decades, Amotepecans have been seeking out the services of private physicians and government health services[11] in urban areas throughout the republic. Furthermore, in recent decades the missionary-linguists who lived in Amotepec provided

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[10] I was unable to obtain a definite "western/scientific" explanation for this "epidemic" involving great numbers of children.

[11] On paper, all Mexicans are eligible for some sort of government health services. All federal salaried workers are entitled to health services provided by ISSSTE. All other salaried workers are covered by IMSS. All other Mexicans, including the Amotepecans, are eligible for SSA coverage. As noted earlier, the SSA facilities are universally considered to be the least desirable health care services. The inferiority of the SSA facilities can be explained by the fact that SSA depends fully on federal funding (from tax revenue), while IMSS and ISSSTE are aided by contributions from its membership. As was noted above, the social security health services (dominated by IMSS and ISSSTE) receive 85 percent of the total public sector health resources (to cover about one-third of the Mexican population) while the remaining two-thirds of the Mexican population covered by the SSA must make do with about 15 percent of the public sector health budget.

(in Chinantec) affordable western medicine to great numbers of Amotepecans in the village.[12]

This chapter has discussed health conditions and treatment options in Amotepec. It was seen that unsanitary living conditions, poor housing, poor education, and inadequate nutrition (all present in Amotepec) impact negatively on health status. While some illnesses are treated by curanderos in and near Amotepec, emphasis here is placed on the new COPLAMAR clinic, which is run by a non-native fifth-year medical student.[13] The preceding chapter traced the historical development of formal health services in rural Mexico. With this having been done, we turn now to consideration of the COPLAMAR program in general (it being the most recent health innovation in rural Mexico), and the particular COPLAMAR clinic in Amotepec.

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[12] The popularity of these "donated" services was made abundantly clear to me during my first days in the village. As word spread throughout the village that there was a new "gringo" in town, people flocked to me with an overwhelming variety of ailments which they fully expected that I could cure, because of the success they enjoyed from the earlier gringos in Amotepec, the last of whom left town just months before I arrived. This level of enthusiasm for seeking medical assistance from a stranger indicates not only great trust in the missionary-linguists' curative abilities, but also serious dissatisfaction among many with the "free" services of the new health clinic, which had been operating for a year at the time of my arrival in the village.

[13] Pasantes are prohibited by law from receiving salaries for their "social service" year. However, they do receive monthly remunerations, called fellowships (<u>becas</u>) which are thought of as paychecks.

CHAPTER VI

THE COPLAMAR PROGRAM

Introduction

Chapter IV discussed several forms of official health services in Mexico, and showed that the rural population has been relatively underserved throughout the twentieth century. Chapter V examined health conditions and treatment options in the highland Chinantec village of Amotepec. This present chapter focuses on the most recent treatment option in Amotepec, namely the COPLAMAR clinic which began operating in September of 1979. Before discussing the particular clinic in Amotepec, however, the COPLAMAR program in general is first presented.

In the early 1970s, greater attention began being placed on health services for Mexico's rural sector.[1] During that time, innovative approaches to rural health services were implemented, and they served as forerunners for what followed in the late 1970s in Amotepec and elsewhere. This chapter describes and analyzes the COPLAMAR development program implemented during the presidency of Lopez Portillo (1976-1982), with emphasis on COPLAMAR's rural health clinics.

The purpose of this chapter is to suggest that while such clinics may have great potential for delivering rural Mexicans their constitutionally guaranteed right to health, the clinic analyzed in Amotepec does a rather inadequate job of it. Conversations with supervisors

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[1] Even so, as recently as 1976 only eight percent of the Ministry of Health budget was for rural areas (Marta Fernandez, personal communication, March 7, 1980).

familiar with scores of COPLAMAR clinics in Oaxaca suggest that the shortcomings observed in Amotepec frequently exist in other COPLAMAR clinics as well.

In the preceding chapter it was shown that the majority of the problems which are treated at the COPLAMAR clinic in Amotepec involve gastro-intestinal and upper respiratory diseases, ailments which have been reported to be widespread throughout rural Mexico. We have also seen that undernutrition is a serious problem in Amotepec, as it is for the majority of the rural Mexican population. This is significant because an undernourished body is not only more susceptible to these common ailments but also less able to overcome them. Unfortunately the COPLAMAR program does little toward addressing the root causes of these most common ailments in Amotepec. Environmental sanitation and improved food resources are not seriously promoted by the COPLAMAR program in the village. This is the case despite the fact that COPLAMAR officials recognize the importance of such health-related measures as environmental sanitation and nutrition. For reasons which are discussed later, the COPLAMAR program in Amotepec emphasizes curative care, leaving causal factors basically unimproved.

This chapter closes with the suggestion that while the rural clinics (judging from what I learned in Amotepec) do not perform their stated objectives well, they do serve other purposes, whether accidentally or intentionally. For example, such clinics provide government officials with an opportunity to proclaim that something is being done about the social injustice which is all to apparent in rural Mexico. It is possible that powerful and moving rhetoric may be used in an

attempt to placate frustrated rural Mexicans, hoping to make them more tolerant of their conditions, and less likely to contribute to political instability in the countryside.[2]

This is not to suggest that the COPLAMAR clinics are doing nothing in terms of providing health services. To the contrary, it has been stated here that the clinic in Amotepec treated 2,889 patients for a variety of ailments during its first 32 months. However, we have seen (Chapter V, pages 148) that the majority of the patients (58.3%) were diagnosed with gastro-intestinal and upper respiratory ailments whose root causes are found in the impoverished living conditions experienced by the people in their daily lives. While the Amotepec clinic unquestionably does provide treatment for a wide variety of ailments, these often amount to little more than emergency first-aid services which only temporarily (at best) relieve symptoms while not addressing the environmental and nutritional factors which contribute to their onset and recurrence.

This assertion is supported by longitudinal data presented in Table 3 (page 147), which shows the ten most frequent infectious-contagious diseases reported by pasantes in the Amotepec clinic during 1980 through 1982. This assertion is also supported by longitudinal

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[2]Amotepecans have varying and ambivalent opinions about the government programs and services which affect their lives. Many villagers with whom I spoke were so cynical about their government that they were not swayed by the rhetoric. If anything, the rhetoric served to anger them all the more. Others, however, were inspired by government proclamations. It is important to note, however, that regardless of how the rural sector receives the rhetoric, it likely influences the urban middle and upper classes (Kreisler 1981), leading them to believe that the rural sector is no longer being neglected. In the event of rural unrest, these urban classes would be more inclined to support repressive measures utilized by the government. This point is returned to in Chapter IX.

data provided in Table 4 (page 149), which shows how the Amotepec clinic case load is dominated by gastro-intestinal and upper respiratory diseases. In Table 3 it is seen that, in portions of 1980, 1981, and 1982, the ten most frequent infectious-contagious diseases seen at the Amotepec clinic are persistently dominated by gastro-intestinal and upper respiratory diseases, accounting for approximately 91 percent of these most common diseases. In other words, gastro-intestinal and upper respiratory diseases are the overwhelmingly most common of the most common diseases seen at the Amotepec clinic.

Table 4 (page 149) also reflects the persistence of gastro-intestinal and upper respiratory diseases in Amotepec, showing that these diseases account for between 50 and 63.6 percent of all diagnoses made at the Amotepec clinic during the periods analyzed for 1979, 1980, and 1981. Furthermore, despite the efforts of the pasantes, it is seen that these ailments do not appear to be decreasing, but rather account for an increasing percentage of patient diagnoses over this three year period. In order to better understand the dynamics of the COPLAMAR program which is responsible for the delivery of health services in clinics such as the one in Amotepec, we turn now to a discussion of the formation and orientation of the COPLAMAR program.

Formation and orientation of the COPLAMAR program

The COPLAMAR program was created in early 1977 by Presidential Decree. The discussion of the COPLAMAR program presented here draws heavily from COPLAMAR documents (1978,1981) obtained in Mexico City and Oaxaca City, as well as from the federal government's official report concerning the legislation creating COPLAMAR (Diario Oficial, Sepetmber 5, 1979). The primary stated objective of the COPLAMAR

development agency was to allow the "marginal people in the deprived zones" of Mexico to "participate more equitably in the national wealth" (COPLAMAR 1978:xvi-xvii). This objective was to be undertaken by developing rural resources and industries, an endeavor which would be aided by providing certain infrastructural improvements. In effect, COPLAMAR was to act as a rural development agency.

Approximately 20 million rural Mexicans were seen as potential beneficiaries of a broad range of activities. The COPLAMAR program involves a wide variety of rural development programs, including the promotion of agricultural and timber resources, industry, communications and transportation, as well as education, health, and human affairs. While this dissertation focuses on COPLAMAR's health services, it should be understood that these comprise only a small fraction of COPLAMAR's interests. The various activities included in the COPLAMAR program in the state of Oaxaca are shown in Table 6 (page 163). The table reflects the relatively low priority given to the health status of the rural sector insofar as budgetary emphasis is concerned. However, as has been so effectively shown for Mexico by Wilkie (1970), projected expenditures do not necessarily reflect actual expenditures. I have been unable to obtain figures reflecting actual outlay of funds for the various COPLAMAR sectors shown in Table 6.

As is also the case with the figures used by Wilkie (1970), the COPLAMAR figures regrettably do not differentiate or distinguish between urban and rural expenditures. Furthermore, these figures do not convey how the projected health sector funds are to be allocated within that broad classification. Therefore, COPLAMAR's projected outlay of 42 million pesos for the state of Oaxaca says nothing about

TABLE 6

COPLAMAR BUDGET FOR 1978-1982 (State of Oaxaca only)*

Sector	Pesos (millions)	Percent of total
Agriculture & Timber	191.9	33.8
Industry	154.1	27.1
Communications & Transportation	104.0	18.3
Education	53.2	9.4
Health	42.0	7.4
Human Affairs	19.3	3.4
Commerce	3.3	0.6
TOTAL	567.8	100.0

*The states of Oaxaca and Chiapas are among Mexico's poorest in terms of many indices, including health measures. Oaxaca has more new COPLAMAR clinics (239) than any other state except Chiapas (252) (COPLAMAR 1981:94). Accordingly, it is probable that the COPLAMAR budgets for other states (with fewer clinics) would allocate an even smaller percentage of their budget toward the health sector than that shown above for Oaxaca.

what portion of those funds is to go toward urban programs as contrasted with rural programs. For example, the relative emphasis placed on rural health clinics as compared to urban hospitals is unstated. Similarly, these figures do not reveal the relative importance of such competing priorities as administrative costs, salaries, pharmaceuticals, and capital expenditures on buildings, vehicles, and equipment. Nevertheless, despite these shortcomings, the COPLAMAR budget figures shown in Table 6 are useful in that they represent the proposed relative importance of the various sectors for the state of Oaxaca. The fact that the health sector accounts for only 7.4 percent of Oaxaca's total COPLAMAR budget suggests that it is a relatively low priority sector. By comparison, 79.2 percent of this budget is proposed for sectors involved with agriculture and timber (33.8%), industry (27.1%), and communications and transportation (18.3%), suggesting the COPLAMAR's emphasis is on the production of marketable resources.

While the COPLAMAR program encompasses an enormous range of activities and agencies, this study concentrates on one component of it, the delivery of health services through its 2,105 rural health clinics. The COPLAMAR program established goals of constructing 890 new rural health clinics in 1979, and 800 more in 1980, which when added to the 310 existing rural clinics built during the Echevarria administration,[3] would total 2,000 clinics.[4] In addition, 41 rural hospitals were constructed to serve as referral hospitals for patients whose health needs could not be adequately attended to by the pasantes in the rural clinics.

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[3]The 310 rural clinics built during Echevarria's term served as a pilot project for the COPLAMAR clinics (COPLAMAR 1981:95).

[4]These goals were met and slightly surpassed.

The rural clinics were designed with the intention of providing the following services: general outpatient consultations, pharmaceuticals, mother-infant care and family planning, health education, nutritional information, sanitation promotion, immunizations and control of communicable diseases. The rural hospitals were designed to provide the following services for referred patients: special outpatient consultations, hospitalization, pharmaceuticals, obstetrical and gynecological care, pediatrics, surgery, internal medicine, preventive medicine, and dental services.

In order to deliver health services to the millions of Indians targetted by their program, COPLAMAR enlisted the expertise of Mexico's National Indian Institute (INI) and Mexico's Social Security Institute (IMSS) in 1979. The IMSS is in charge of supervising the clinic operations, personnel, and pharmaceuticals. The INI has assisted in the provision of medical services for Indian populations for decades. Until the creation of COPLAMAR in 1977, the INI was responsible for all matters concerning Mexico's indigenous population. However, as a result of the bureaucratic power struggles being played out during the early portion of Lopez Portillo's presidency, the INI (along with several other agencies) soon became incorporated as a part of COPLAMAR. With each new presidential regime in Mexico there is considerable reshuffling of administrative personnel within the bureaucracy. There is also great competition among bureaucrats for power, prestige, and resources (Smith 1979). The case of the INI being swallowed up by COPLAMAR reflects this competition. Viewed from outside, however, it appears that the reorganization is being done in order to better serve the public (and in the case of COPLAMAR, the rural poor). The INI,

once in charge of Indian affairs (including health services) is now reduced to an advisory role insofar as the delivery of health services to indigenous communities is concerned, helping COPLAMAR select localities most suitable for constructing clinics.

In October of 1980, the first year of the provision of health services by IMSS-COPLAMAR was formally analyzed and published (COPLAMAR 1981). It was noted that as of October 1980 there were 2,105 rural clinics operating in 31 federal states,[5] covering 20,000 communities, and serving 11.3 million Mexicans (COPLAMAR 1981:43). This chapter presents the fundamental structure of the COPLAMAR clinics, and the two chapters which follow this evaluate how effectively one particular rural clinic was serving (and benefitting) its "covered" population.

It will be recalled that Mexico's rural population is widely dispersed in thousands of very small communities. Accoring to 1979 census estimates (COPLAMAR 1981:39), 39 percent of Mexico's 68 million people live in some 97,615 communities smaller than 2,500 people. This is broken down into roughly 15 million Mexicans who live in 86,594 localities smaller than 500 people, and 11.5 million Mexicans who live in 11,021 localities of between 500 and 2,500 people. It has been estimated that prior to the construction of COPLAMAR's 2,105 new rural health clinics there were only 1,700 health centers providing services to Mexico's (then) 30 million rural residents. Generally staffed by pasantes, these health centers were within "easy reach" of only 15

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[5]The more "Indian" states of Chiapas, Oaxaca, Puebla, Tlaxcala, Hidalgo, San Luis Potosí, and Guerrero account for 49 percent of the COPLAMAR clinics. Ethnically, 38.4 percent of the covered population are Indians ("indigenas") and 61.6 percent are non-Indians ("mestizos") (COPLAMAR 1981:95).

percent of the rural population, leaving 25.5 million Mexicans without easily accessible health care in 1977 (Correu Azcona et al. 1980:247-148).

COPLAMAR's program attempts to provide accessible physician care for nearly half of these 26.5 million rural Mexicans in the following way. Each of the 2,105 COPLAMAR clinics is intended to cover a "zone of influence" of about 5,000 people (COPLAMAR 1981:42). Recognizing the "isolation and inaccessibility of some regions," COPLAMAR allowed for an acceptable range of coverage of between 2,500 and 8,000 people (COPLAMAR 1981:43). Each "zone of influence" includes not only the locality in which the clinic is built (and where the pasante resides) but also includes any number of outlying localities (almost always of a smaller population than that where the clinic is located).

Each COPLAMAR clinic is intended to have one pasante and two bilingual female auxiliaries (a regular and a substitute). Each pasante, having finished his or her formal medical school requirements, is given a brief training course (a maximum of three weeks) before entering the rural community where he or she is expected to live and work for one year. According to the IMSS-COPLAMAR report on the first year's functioning of the clinics, each pasante's training included instruction in medical and social anthropology, preventive medicine, and family planning, among other things.

However, judging from observations and conversations with the pasantes in Amotepec, and also with clinic supervisors, the training course is almost entirely devoted to administrative priorities, making certain that the pasantes are familiar with the great volumes of documents and forms which they are required to fill out daily, weekly,

monthly, quarterly, or annually, depending on the form. The "instruction" in medical and social anthropology is slighted, if mentioned at all. In the place of formal instruction, each clinic is provided with a few paperback books which could be considered as part of a pasante's training, even though they are in no way required to read them.[6]

The bilingual auxiliaries who are employed in the clinics are seen as essential by the COPLAMAR program planners. They are seen as "bridging the gaps" between traditional and western medicine, and as facilitating the "penetration of [western] medical services" into indigenous communities (COPLAMAR 1981:9). Auxiliaries working in indigenous zones are preferably 16 to 40 year old bilingual females who have completed primary school and are natives of the community where the clinic is located (COPLAMAR 1981:51).

Of the 11.3 million Mexicans intended to be covered by the COPLAMAR clinics, 4.3 million (or 38 percent) were "captured" during the program's first year (September 1, 1979 to August 31, 1980). The "captured" population refers to all those family members of all patients who attended any clinic during the first year. During the program's first year there were 3,266,273 patient-visits recorded in all of the COPLAMAR clinics combined.[7] These patients received 3,334,873 prescriptions, which were filled immediately at the clinic. Nearly half (47 percent) of all patients received an injection. The COPLAMAR year-end report states that this figure is higher than they would like

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[6]These books included Aguirre Beltrán (1980), Collado Ardón (1976), Dubos (1959, in Spanish), and Illich (1976, in Spanish).

[7]It is impossible to estimate how many different patients this figure includes, because some patients made several visits to the clinic during the year.

to see. The report does not explain why COPLAMAR would like to see fewer injections given, but it does say that in many cases the pasante had no alternative form of medicine to provide (such as pills) because of problems in supplying the clinics with such medicines (COPLAMAR 1981: 96).

Despite the fact that the COPLAMAR family planning progam is a "national-level priority," only 12,017 births were attended by clinic pasantes during the first year (an average of 5.7 births per clinic), and only 36,744 women "entered" the family planning program (an average of 17 per clinic) (COPLAMAR 1981:100). These figures are much lower (on the average) in those states with greater indigenous populations covered (and especially for Oaxaca, Chiapas, Veracruz, and Guerrero).

The COPLAMAR year-end report provides an insight into the living conditions of the people covered by the clinics. Their survey involves all of the 746,130 family dwellings covered by COPLAMAR's 2,105 clinics. The following characteristics were reported for these dwellings: 80 percent are one or two room dwellings, 76 percent have dirt floors and walls of mud or adobe, 30 percent have access to piped water, and only 13 percent have sewage disposal.

According to the plan, each community is required to form a health committee which is supposed to promote the health programs of the clinic and to insure that the community properly maintains the clinic's grounds (COPLAMAR 1981:102-103). The federal legislation which created the COPLAMAR clinics contains a stipulation requiring all heads of household in each community and hamlet "covered" by a clinic to donate up to ten days of labor each year in exchange for the medical services and medicines available at the clinic. (During the period of my

fieldwork, COPLAMAR's demands on villagers' labor amounted to only one or two days per year per household head). According to the legislation, not all of the "donated" days need consist of physical labor. In fact, up to four of the ten (maximum) days may be "paid" with some alternative health-related activity. These alternative activities are determined by COPLAMAR, and may include such things as listening to the pasante give a talk on family planning, nutrition, environmental santitation and housing improvements, and even small farming and reforestation (COPLAMAR 1981:117). However, in Amotepec the adults almost never had the chance to hear such talks, because the pasantes there were so disinterested in delivering them. Furthermore, the supervisors did not sufficiently motivate or pressure them into doing so.

Interestingly, the legislation creating the COPLAMAR clinics states that these ten days (maximum) of obligatory labor should not interfere with a person's "normal productivity activity." As will be seen in a later chapter, <u>if</u> COPLAMAR were to demand the full ten days of unpaid labor from their "covered" population, it is questionable whether Amotepecans would comply. The heads of household with whom I am familiar in Amotepec would have great difficulty finding ten idle days which they could donate toward the clinic's activities without seriously disrupting their normal work schedules.

Furthermore, the labor value involved in ten working days is significant. At the time of my fieldwork a man could earn an average

wage of 150 pesos per day at unskilled labor.[8] Thus, ten day's labor would cost a man 1,500 pesos per year in potential wages lost. Therefore, approximately two million rural Mexican heads of household would be obligated to donate up to three billion pesos of labor value per year. Considering that the COPLAMAR system of health clinics cost 1.13 billion pesos in its first year (of which 83 percent was capital investment and 17 percent was operating expenses (COPLAMAR 1981:14)), the 11.3 million "beneficiaries" would be paying rather substantially for their "free" health services.

This perspective is not lost on the villagers of Amotepec. They recognize the economic value of their labor time, because communal labor has long been a fact of life for them. For those who can afford it, it is possible to buy out of one's communal work obligation either by paying the community authorities a fine equivalent to one day's wages or by hiring a laborer to work in one's place. The 3,151 people covered by the Amotepec clinic comprise approximately 564 households. If each head of household "contributed" ten days labor, the total wage value of such labor power would be 846,000 pesos per year!

The COPLAMAR clinic in Amotepec

Having presented a general overview of the COPLAMAR program to deliver health and health services to millions of "marginal" Mexicans by means of 2,105 rural clinics, we turn now to an examination of one

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[8]When I first arrived in Mexico in September of 1980, one U.S. dollar was worth approximately 23 pesos. By February 1982 the peso had slowly devalued to 26 pesos to the dollar. In February 1982 the peso devalued sharply, to 42 pesos to the dollar. Since that time the peso has continued to fall, until now one U.S. dollar is worth over 150 pesos. The figure used in the text above applied to 1981, when the peso was worth approximately one twenty-fifth of a U.S. dollar.

specific clinic located in the highland Chinantec locality of Amotepec located in Oaxaca's Sierra Juárez. The purpose of this portion of the dissertation is to describe one particular clinic and compare its "reality" with the "ideal" clinic designed by the program's planners. It will be seen that while much of what exists and occurs in the Amotepec clinic closely parallels expectations, several differences exist as well, despite voluminous regulations and monthly visits to the clinic by supervisors.

Amotepec was selected as a site for a new COPLAMAR clinic by INI officials in Oaxaca. Their decision was based on Amotepec's size and perceived need for such services. With a cabecera population of 1,570 (in 1970) it was one of the largest, if not the largest, localities in the region with no government health services of any kind.[9] When INI officials added Amotepec's municipio hamlets and three hamlets from the other two highland Chinantec municipios (see Table 7, page 173), the "covered" population totaled 5,409, a figure which conforms nicely with COPLAMAR's preferred average clinic coverage of 5,000 people.[10] As for Amotepec's perceived need for health services, the COPLAMAR program planners operate on the assumption that any and all rural villagers would benefit from one of their clinics. The people of Amotepec shared this assumption, and in fact had been soliciting various state and federal agencies for a health clinic for years.

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[9]Similar-sized localities in the region typically have an SSA clinic, staffed by a nurse. Typically, a physician will visit the clinic once a week.

[10]As Table 7 (page 173) shows, the 1979 COPLAMAR population figures greatly exceed the 1970 census figures, especially for the cabecera of Amotepec. Population growth during the 1970s does not account for the discrepancies in the figures, and I believe that the COPLAMAR figures are grossly overstated.

TABLE 7

LOCALITIES "COVERED" BY THE COPLAMAR CLINIC IN AMOTEPEC*

Locality covered by clinic	Municipio	1970 census population	COPLAMAR's population#
Amotepec (cabecera)	Amotepec	1,570	3,200
San Miguel Maninaltepec	Amotepec	283	550
Totomoxtla	Amotepec	234	200
Santa Maria las Nieves	Amotepec	94	100
La Reforma	San Pedro	235	309
San Martin Buenavista	San Pedro	388	600
Soledad Tectitlan	Santiago	355	450
TOTALS		3,159	5,409

*Localities include the cabecera of Amotepec, and all three agencias in the municipio of Amotepec, as well as other agencias in the municipios of San Pedro and Santiago.

#Population figures used by COPLAMAR and INI when determining whether to place a clinic in Amotepec in 1979. (Data obtained at IMSS-COPLAMAR offices in Oaxaca City, May 18, 1982). I cannot account for why these figures are so much larger than the 1970 census figures.

Unfortunately, the COPLAMAR program planners did not consult with their "target" population concerning what their priorities were regarding health services.

The Amotepec municipal authorities were informed of the government's decision to locate a clinic in Amotepec, and a village-wide assembly was held on July 1, 1979, at which time the potential beneficiaries were informed of their rights and obligations associated with the clinic.[11] Each community where a new clinic was to be built was obligated to provide a parcel of land for it. In Amotepec, descendants of the Revolutionary War General Pedro Castillo donated a suitable parcel located at one edge of the village, immediately adjacent to the cemetery. For each clinic the federal government provided all the necessary equipment and construction supervision,[12] and the localities provided unpaid laborers. After the Amotepec villagers had levelled off a place on the hillside for the clinic, construction proceeded rapidly. All supplies were trucked into Amotepec from distant urban supply points, including prefabricated aluminum walls, doors, windows, cement mix, plumbing fixtures and piping, furniture, electrical necessities, cabinets, pharmaceuticals, instruments, and even grass seed, bricks for a sidewalk, and a flagpole with a Mexican flag.

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[11]Assemblies occur in Amotepec for certain regular occasions (such as when new municipal authorities assume office). Assemblies also occur for a variety of other issues, such as when the school director proposed taxing each village household 30 pesos to cover unexpected expenses. Attendance at assemblies is optional, and fluctuates widely with the topic and the time of year. On July 1 Amotepec is relatively vacant, as lowland crops are being harvested at this time.

[12]Construction for all clinics was supervised by pasantes de carreras tecnicas (people who have finished formal training in technical careers, but have not yet been certified) (COPLAMAR 1981:70).

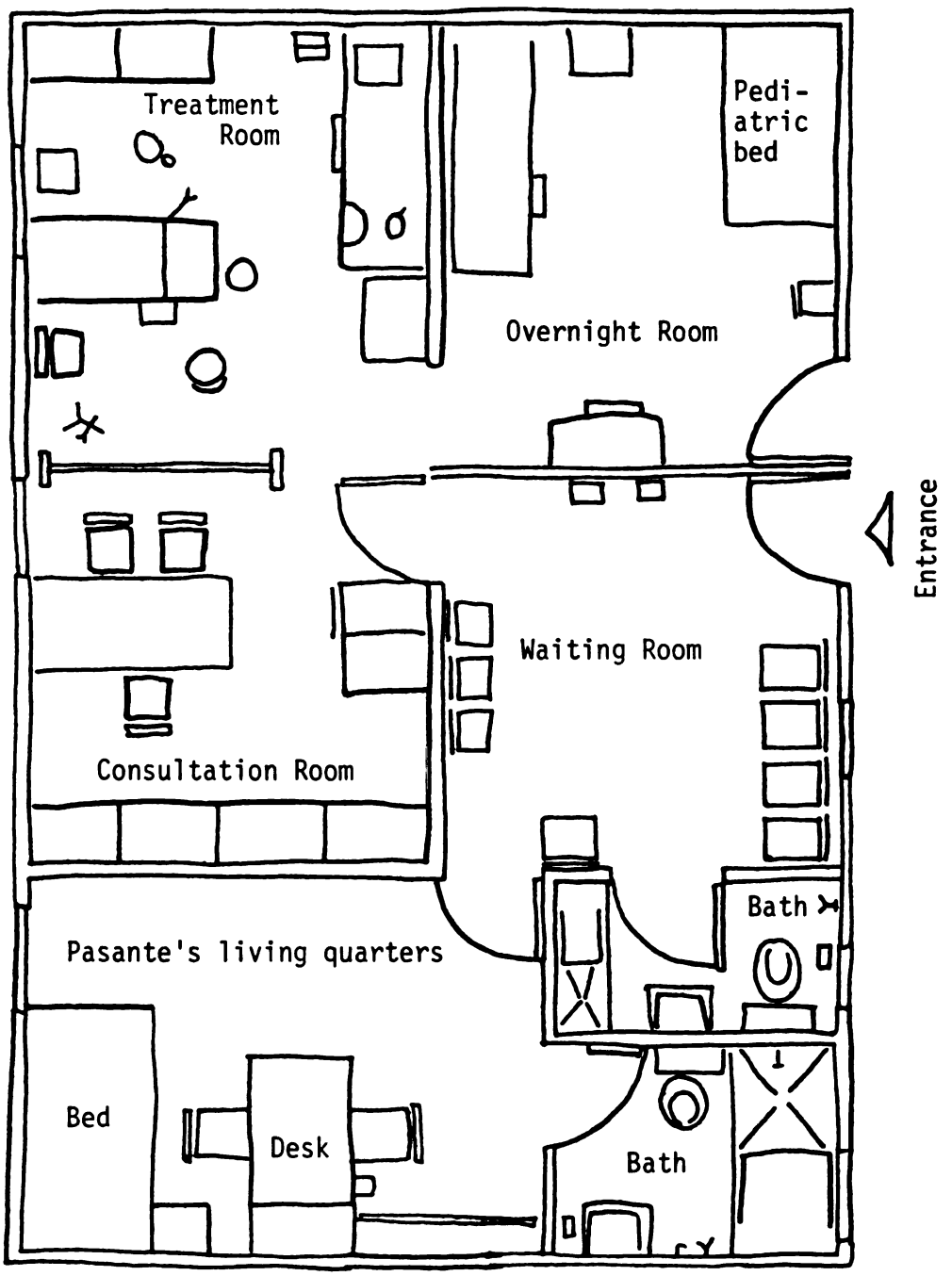
The clinic in Amotepec is unlike any other structure in the village, except for the relatively new government school. The clinic's white aluminum walls, large glass windows, red aluminum roof, brick sidewalk, flagpole, and facsimile of a lawn made it (and also the school) distinct from the village's mostly unpainted adobe dwellings. The interior of the clinic is also "foreign." Instead of a dirt floor, there is smooth cement, emitting the smell of the morning's application of disinfectant, which is intended to sterilize the interior. Instead of dark earthen walls, there are more white aluminum walls and large glass windows. Instead of a traditional altar with flowers, burning candles, and pictures of saints, there are pictures of the Mexican president and posters of blonde children washing their hands in modern sinks (which are found in Amotepec only in the clinic and the school). Instead of simple wooden chairs, there are modern plastic chairs (see Figure 3, page 176). Instead of the noises of animals and Mexican "country" music, the pasante's tape recorder plays the tunes of the Beatles and other more contemporary North American and British musical groups singing in English.

On September 6, 1979 the Amotepec clinic opened for business, staffed by a pasante and an auxiliary. This first pasante lasted scarcely one month before abandoning his position. Although I never met the first pasante, I was told by his replacement and by villagers that he was extremely uncomfortable in such a rural setting, having been given no idea as to what he would be facing in such a "remote" community.

The second pasante fared much better, after an uncertain beginning. During his first several days in Amotepec, this pasante told me that he

FIGURE 3

THE COPLAMAR CLINIC IN AMOTEPEC



repeatedly had doors closed in his face when he went to houses asking to buy a meal. He lived on cookies and soda pop until people began to trust him. By the time he left Amotepec (after one year) he had become quite comfortable in a setting completely in contrast to his hometown of Guadalajara (population 2.2 million) where his wife and small child resided during his period of social service.

The third pasante (who worked in Amotepec during most of my stay there) was also from a modern urban center (Cordoba, Veracruz; population 100,000). While he never became as comfortable in Amotepec as his immediate predecessor (and was far less liked by the villagers), he decided to continue working at the clinic for a second year beyond his obligatory year of social service. This unexpected happening is explained by the fact that he fell in love with the clinic's substitute auxiliary, and did not want to leave her. By the time I left Amotepec in May of 1982, this pasante had become engaged to be married to the substitute auxiliary. While he told me that he definitely planned to marry her, many villagers doubted he ever would, and suspected he was merely using the young girl until he left town for good.[13]

None of the pasantes in Amotepec learned much Chinantec. Many patients (especially women) spoke very limited Spanish. In such cases, the bilingual auxiliary is essential. In order to select Amotepec's regular auxiliary, COPLAMAR's recommendations had to be bent, and for the substitute auxiliary they were all but ignored. Before the clinic opened, Amotepec was supposed to select three females who were bilingual, aged 16 to 40, with a primary school certificate. These three

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[13]Despite subsequent letters to the pasante, I do not know whether the marriage ever took place.

were to be sent to Oaxaca City for a 3 week training period, after which they would be tested to see which one would be the primary auxiliary (working Monday through Saturday) and which would be the substitute auxiliary (working Sundays, holidays, and whenever the regular auxiliary was absent).

Amotepec, however, could find only one female who met these requirements and was interested in applying for the job. Most women in Amotepec do not finish primary school. Those who do often subsequently leave Amotepec to pursue a secondary education, or to work in urban areas. Those few women who remain in Amotepec generally marry and have children, thus making a full-time job outside the home unthinkable. The one girl who was interested in Amotepec fortunately passed the tests with high marks, and has been working at the clinic since the day it opened. During the clinic's second year, a substitue auxiliary was hired (with the approval of the pasante who quickly fell in love with her). She was both underaged (age 15) and underschooled (third-grade education), but the pasante eagerly volunteered to work extra hours with her to train her to do a satisfactory job.

The Amotepec clinic officially "covers" a population of 3,159 people. The COPLAMAR planners recognized that providing medical attention and health promotion "require close and sustained contact between the population and the health services," and accordingly suggested that the maximum "desirable" distance between the rural clinic and any outlying "covered" hamlet not exceed 60 minutes walking time. However, all but one of the hamlets which are considered "covered" by the Amotepec clinic are well beyond the recommended walking distance (one way trip) of one hour (see Table 8, page 179). Only

TABLE 8

"COVERED" HAMLETS' ACCESSIBILITY TO THE COPLAMAR CLINIC IN AMOTEPEC

Hamlet	Affiliated Municipio	1970 census population	Hours walking time to clinic (one way trip)
Totomoxtla	Amotepec	234	1
San Miguel Maninaltepec	Amotepec	283	2 1/2
Soledad Tectitlan	Santiago	355	1 1/2
San Martin Buenavista	San Pedro	388	2
Santa Maria las Nieves	Amotepec	94	1 3/4
La Reforma	San Pedro	235	2 1/2

Totomoxtla, one hour distant from the clinic, meets the COPLAMAR guidelines. All of the "covered" hamlets (except for Soledad Tectitlan, which is connected with Amotepec by road) are reached by rugged mountain trails requiring careful footing, especially during the rainy season (November to April). In addition, San Miguel Maninaltepec is at times inaccessible during the rainy season when the Rio Grande rises to dangerous heights.

Accordingly, the distances from the outlying hamlets to the clinic are so great that (as will be seen later) their residents almost never benefit from its existence. Nevertheless, all adult males in these covered hamlets are required to perform (if asked) up to ten days of communal work (not to interfere with their normal work activities). Although such requirements are not necessarily enforced, clinic supervisors occasionally remind the hamlet residents of their obligations via written correspondence delivered to hamlet authorities. Despite the fact that pasantes are required to visit the covered outlying hamlets once a month, most hamlets were visited once or twice a year (if at all), usually on the occasion of a basketball tournament, which preoccupied the pasante to the exclusion of performing medical services.

The excessive distances between outlying hamlets and the Amotepec clinic are replicated in the excessive distance between the Amotepec clinic and the referral hospital. The COMPLAMAR plan calls for the rural hospitals to be located in towns of at least 10,000 people. They are intended to serve a coverage of 200,000 people, none of whom should be more than 3 hours walk or ride from the hospital. As of October 1980,41 such hospitals had been built, and were said to be covering about 51 percent of the rural population covered by the 2,105 clinics

(COPLAMAR 1981:46). However, for the people in Amotepec, nearly triple that time is needed. To reach the referral hospital, Amotepecans must ride the twice-weekly bus to Oaxaca City (a 7 hour ride) and then change busses and ride for another hour to Tlacolula (a regional market center).[14] For that half of the population covered by the Amotepec clinic who live in the outlying hamlets, a walk of between 1 and 2 1/2 hours into Amotepec to catch the bus must be included in their travel time. Despite leaving Amotepec at 7 a.m. on the bus, it is impossible to reach the referral hospital in time to be admitted that same day.

Given the time and distance involved, it is perhaps not surprising that during the clinic's first 2 1/2 years of operation, only one Amotepecan has utilized the referral hospital, and that was only because the patient was transported to it directly by the clinic supervisor (in his Jeep) because he felt it was essential. Other Amotepecans who have needed emergency care have stopped in Oaxaca City and sought the services of other physicians, rather than travel farther to Tlacolula, despite the costs involved in Oaxaca. One final encumbrance involved in utilizing the referral hospital is that patients must have a note signed from their rural clinic pasante in order to be admitted to the hospital. Thus, if one becomes ill while in Oaxaca City, one may not simply ride the bus one hour to the free health services of the referral hospital, but instead one must endure the lengthy bus ride back to Amotepec to obtain the proper papers from the pasante (who may not even be in the village!).[15]

[14]There is an IMSS hospital in Oaxaca City. However, as noted in Chapter IV, people covered by IMSS-COPLAMAR clinics are not eligible for referral to IMSS facilities. Amotepecans cannot use the IMSS hospital in Oaxaca City, but must instead bus to Tlacolula if they want to use their "free" referral hospital.

[15]It is possible that these requirements would be waived in an emergency situation.

There is yet another level at which the Amotepec "covered" population does not receive the coverage intended by the program planners. The Amotepec clinic is not only too distant from its "covered" hamlets and its referral hospital. It is also too often closed to the public (or open, without the pasante being present). Official COPLAMAR regulations require the Amotepec clinic to be open daily from 8 a.m. to 1 p.m. and from 3 p.m. to 6 p.m., Monday through Saturday. Pasantes with the COPLAMAR clinics are required to work in the clinic during these times unless visiting an outlying covered hamlet on work-related business. Working Sundays is optional, but the pasante must be in the community on Sundays in case of emergencies.

Each pasante is allowed four days vacation per month, plus three days per month to attend a required meeting in the state capital. An additional 14 days of vacation is granted annually. Thus, a pasante should be in the village about 265 days (or 73 percent) of the year.

Amotepec's third pasante took great liberties with these regulations. During his first year in the village, this third pasante was out of the village 58 percent of the time, an absentee rate more than double that allowed by regulations. After repeated threats by his supervisors, this pasante reduced his absenteeism considerably during his second year in Amotepec. It should be noted that the preceding pasante who worked in Amotepec for a full year of social service kept regular hours and workdays, and often worked on Sundays as well. He also returned to Amotepec occasionally after terminating his obligation there, to participate in festive holidays. When he did so, he associated amiably with the villagers, who enjoyed his company. The third pasante, however, not only ignored the required work days and

working hours, but often would be publicly drunk during working hours. Thus, patients became unable to rely on the clinic being open (or the pasante being present and sober).

This chapter has described the Amotepec clinic as it was created, and as it was intended to function. Certain shortcomings about the clinic and its operations have been pointed out. It has been suggested that while such clinics as the one in Amotepec may have the potential to provide rural Mexicans with their constitutionally guaranteed right to health, the reality of the Amotepec clinic shows that such potential is far from being realized. As will be discussed more fully in Chapter VIII, it is an important contention of this dissertation that COPLAMAR clinics like the one in Amotepec, while not adequately meeting their stated objectives, are serving other functions. For example, because of the existence of the new rural clinics, federal and state governments are able to claim that rural injustice is being seriously addressed and corrected. Such rhetoric may serve the ruling class by reducing the likelihood of rural unrest.

Before examining this interpretation, however, we turn first to an examination of how the "covered" population feels about the clinic in Amotepec, and how they feel about the clinic's personnel and the pharmaceuticals it dispenses. This is then followed by a critical analysis of the villagers' observations, from the perspective of an outsider (the author) who resided in the village for over fifteen months.

CHAPTER VII

VILLAGERS' PERSPECTIVES ON THE COPLAMAR CLINIC IN AMOTEPEC

Throughout this dissertation references have been made to how the people of Amotepec feel about various aspects of their lives. This chapter focuses on how Amotepeceans view their lives, and especially on how they view the most recent example of state penetration in their village, namely the COPLAMAR clinic. After presenting Amotepecan's perspectives on the new clinic, it is shown that their perspectives on other government services in their village are quite similar. This argument is supported by briefly considering two other forms of state penetration in Amotepec, namely the federal road and the CONASUPO food staples store.

It is the purpose of this chapter to share with the reader a sense of the feelings which villagers repeatedly convey of being "second-class" citizens of Mexico receiving "second-class" services from their government, whether health services or other services. This ideological conceptualization of being "second-class" Mexicans is reinforced by the nature of state penetration in Mexico, and is exemplified by the ways in which the COPLAMAR clinic impacts upon the villagers of Amotepec. Before considering this argument in depth (in Chapter IX), the next two chapters analyze the Amotepec health clinic as experienced by the villagers (Chapter VII) and by outside observers (Chapter VIII).

In reading the remaining three chapters of this study it is important for the reader to bear in mind the historical and geographic

factors (presented in earlier chapters) which have affected life in the highland Chinantla for centuries. We have seen that as early as the year 1603, highland Chinantec Indians were forced to relocate their residences and worship a new god at the insistence of the Spanish Crown. In more recent times the Mexican state has actively penetrated the region for economic and political reasons. In the mid 1950s, an all-weather road was constructed into the highland Chinantla because of national interests in the region's timber resources. This opened up the region for later installation of several other forms of state presence. During the 1970s new roads, schools, potable water, electricity, and health clinics reached into remote villages for the first time, thus providing the nation with several new forms of linkages with the rural population. This chapter discusses and analyzes the impact which these various innovations (especially the health clinic) have had on the villagers of Amotepec. A discussion of the forces which contributed to the arrival of these various forms of state penetration is deferred until the concluding chapter (IX).

Since at least 1973 the Amotepec municipal authorities had been officially requesting some sort of government-provided health post or clinic in their locality. Prior to that time, and up until the COPLAMAR clinic arrived in 1979, there was no official provision of western medicine in Amotepec. Instead, villagers had to go to health posts in the cabeceras of the adjacent highland municipios of San Pedro (with whom Amotepec has had long-standing disputes) or Santiago (with whom Amotepec has been on good terms). They also often chose to travel greater distances to such urban centers as Oaxaca City, Mexico City,

Tuxtepec, or Veracruz in order to obtain consultations and pharmaceuticals for a variety of ailments.

However, while there was no official outlet for the provision of western medicine in Amotepec prior to 1979, there was during the 1960s and 1970s the frequent provision of western medicine by a North American missionary-linguist who resided in Amotepec off and on during those decades. Throughout my fifteen months residence in Amotepec, I heard repeated reference to this missionary, and without exception people appreciated his provision of medical treatment. When evaluating various aspects of the new clinic, Amotepecans would often compare the clinic with the recently-departed missionary. As will be seen below, the missionary, despite his relative lack of training in formal medicine, was almost always preferred by the villagers for medical treatment, for a variety of reasons, including his command of the Chinantec language, his established long-term commitment to the community, and his concern about the patients whom he treated.

When Amotepec was officially awarded a COPLAMAR clinic in 1979, villagers were required to help in its construction by providing unremunerated labor. The COPLAMAR legislation, as noted above, requires each head of household included in the clinic's "coverage" to provide up to ten days of unpaid labor toward the clinic each year. This concept of corvée labor is identical to the villagers' long-standing system of tequio, wherein communal labor is utilized for local civic projects. Construction materials for the clinic, consisting largely of prefabricated sheet metal walls and roof, were delivered to Amotepec by government trucks. The villagers' labor contribution included preparing a location for the clinic (which required levelling a portion of a

hillside), building a pathway to it, and helping in the actual construction of the clinic. In addition, the villagers also helped pour the clinic's cement floor, and planted grass seed in a small area around the clinic. These projects, while numerous, were accomplished without any Amotepec head of household having to contribute the full ten days of unpaid labor stipulated in the COPLAMAR legislation.

It is interesting and instructive to note that several informants told me that up until the time that the clinic actually began functioning, most villagers did not believe that its services and pharmaceuticals would be provided at no out-of-pocket expense to the patients, even though they had been told this all along. Villagers in Amotepec were almost universally distrustful of, and cynical about, government intervention in their lives. This distrust and cynicism applied even to such apparently benevolent programs as the provision of health services. Based on their experiences throughout their lifetimes, and reinforced by their ancestors' experiences, the villagers of Amotepec have come to blame outsiders (both neighboring villagers and distant government politicians) for their disadvantaged position vis-à-vis these outsiders.

Because of the great familiarity which Amotepecans have with urban Mexico, they are keenly aware of their second-class status. One might assume that these feelings of inequality vis-à-vis Mexico's urban-based power sector might be soothed by the arrival of a modern government health facility. However, due to past experiences, the villagers of Amotepec accepted the COPLAMAR clinic with suspicion. One purpose of this chapter is to convey to the reader the fact that villagers in Amotepec, having seen the COPLAMAR clinic function for more than two

and one-half years, repeatedly conveyed to me their disappointment with what they have received, and they also repeatedly reflected their deep-felt cynicism about the ruling class which provided them with it. Rather than feeling as though their government was acting benevolently and responsibly by providing them with a new health clinic, the villagers felt once again betrayed by the promises made to them (in official proclamations) which led them to believe that they were equally deserving of first-class services as anyone in Mexico. However, having seen their clinic in action, they are left with the feeling that they have been given a second-class product, which only reinforces their feelings of being second-class Mexicans.

After having seen the clinic actually operate for this length of time without charging anything, the villagers in Amotepec now realize that they do not have to pay when they go.[1] However, Amotepecans also realize that such services are not "free," inasmuch as they feel they are paying for their clinic in several ways. First of all, they believe that they deserve a government health clinic. They have heard repeated government proclamations about the "injustices" which have persisted for too long in Mexico's rural regions. Their government has told them that the new health clinics are finally addressing the injustices related to health.

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[1]Patients who live in the outlying "covered" hamlets occasionally offered to pay for clinic services. To my knowledge, payments were never accepted in Amotepec or in the hamlets. It is clear that residents of the outlying hamlets have far less understanding of the functioning of the COPLAMAR clinic than do the Amotepec villagers. People from the hamlets rarely utilize the clinic (See Table 9, Chapter VIII). As will be discussed in Chapter VIII, these hamlet residents are far less "covered" by the clinic than the Amotepec villagers.

The villagers believe that their government owes them health services for several reasons. First, the government rhetoric tells them that, as Mexicans, they have the right to basic health services. Second, because of their regular payments into the government treasury (in the form of annual property taxes, the value-added (IVA) tax, and other items such as street-vendor permits), they feel they have paid for a government health clinic. Furthermore, Amotepecans contribute to the nation-state by serving for one year in the military at age 18, and they feel that doing so entitles them to basic benefits such as health care. Finally, because of the tequio (communal labor) which they are compelled to perform for the clinic, they feel in yet another sense that they deserve quality services. During my residence in Amotepec I frequently heard these sentiments expressed in a variety of ways:

> "The government doesn't do anything unless there is money in it for them. The government helps [rural people like us in Amotepec] if there is money put in their hands--big bundles of money. The government is maintained by the money which pueblos like ours give it. Pueblos like Amotepec are not helped very much by the government. The government bureaucrats "eat" twenty percent of whatever funds are supposed to go toward helping the marginal pueblos."
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> "The government collects taxes on our houses every year. They keep most of the money we give them, and return just a little of it for such things as roads and electricity."
>
> "The tax collectors are in town collecting money from all the home owners. Can you imagine having to pay a tax on something you already own?!"
>
> "In order to get anything from the government it is necessary to continually pester them about your desires. Otherwise they'll forget you," (Spoken by the village president).
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> "The Mexican government doesn't help the [rural] people one bit. Even though the CONASUPO, the clinic, the

> school, and the electricity are beneficial, it is wrong to say that the government helps the people. Instead, the government exploits the people. Government people get their positions through family connections or money, regardless of whether they are qualified, and they respond only to bribes" (Spoken by Amotepec's immediate past-president).
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> "The government exploits peasants, but it knows that it better not exploit them too much, because if the government makes our lives too difficult, who will grow the corn [and other important foodstuffs] for them?"
>
> "The soldiers are really just slaves [mozos] of the rich. Just look at the banks where the rich people keep their money. You see soldiers guarding it with rifles."
>
> "There is no justice in Mexico, and especally in Oaxaca. The millionaires can kill peasants, and then easily buy their freedom from the government officials."
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> "The government runs everything in Mexico, and keeps the profits for itself. The government controls the petroleum, the lumber, the sugar cane, and tobacco, and doesn't pay a fair wage for the work done, or a fair price for the timber [for example] bought. These rich people run everything."

Accordingly, the people of Amotepec feel strongly that they have a right to a health clinic, and they feel that they are constantly paying for it with their labor and taxes. Now that they have a locally-available government health clinic (which they feel they have earned through their financial contributions to the government), the Amotepec villagers have largely found it to fall short of their expectations and desires in a number of ways. Their complaints include dissatisfaction with the clinic's personnel (i.e. the pasante and the auxiliaries), the clinic's pharmaceuticals, and the clinic's frequent inability to cure persisting ailments. These will be discussed in turn.

Clinic pasantes

During the clinic's first 32 months (September 1979 to May 1982), two different pasantes worked in Amotepec long enough to make a lasting impression on the villagers. (In addition, there was a third pasante--the original one--whose stay in Amotepec was extremely brief.) The first long-term pasante came from Mexico's second largest city, Guadalajara, where his wife and small child remained during his twelve months of social service in Amotepec. He is described as extremely conscientious and dedicated to his job, working all the required days and hours, leaving the village only on legitimate business or vacations.

The second long-term pasante also came from an urban setting (Cordoba, Veracruz). He remained in Amotepec not only for his required year of service, but for a second year as well, apparently because he had fallen in love with the weekend female auxiliary. (It is possible that he was required to repeat his year of social service, but I was unable to confirm this.) He was generally described as extremely neglectful toward his job and his patients, often failing to open the clinic during working hours and also frequently leaving the village for extended unauthorized vacations.

The villagers in Amotepec noticed these differences between the two pasantes, and clearly preferred the more conscientious pasante's orientation and dedication to his work and patients. Amotepecans definitely disliked the second pasante's absenteesim, and felt that "he is out of the pueble more than he is here." The villagers were right. As noted in Chapter VI, during his first year in the village this second pasante was out of the village 58 percent of the time. This is more than double the maximum legitimate absence from the

village (which is 27 percent of the time). (Legitimate absences include vacations and monthly meetings in Oaxaca City.)

Amotepecans also definitely disliked the second pasante's public drunkenness, which often interferred with working hours, exacerbating his absenteeism from the clinic. "The doctor is drunk so much of the time that it has damaged his brain." Finally, villagers did not like the second pasante's personality. They found him impersonal to the point of rudeness, much too hurried (especially considering that he saw an average of only three patients per day), and too unconcerned with their health problems. (For example, he did not try to hide his annoyance at being called away from his television by a patient.)

By comparison, the first long-term pasante was extremely reliable, relatively amiable, and conscientious. He generally worked on Sundays, for example, even though they were optional workdays. He opened the clinic punctually, took his allotted mid-day lunch break, and regularly returned to the clinic on time for the afternoon shift. He also socialized more with the townspeople (both at the clinic and in the village) and participated in other aspects of their lives, such as eating meals in their homes, and attending religious ceremonies. With rare exceptions, Amotepecans felt much more comfortable with him as a person than they did with his successor (the second long-term pasante). For example, people commonly remarked that the first pasante was a "good person," whereas the next one was not. The first one was seen to be "very friendly," "very open," "very responsible," "always at the clinic" [during working hours], and "interested in helping." In contrast, the second pasante was seen as "very closed," "very cold,"

"very lazy" [regarding his work], "usually not at the clinic" [when he should be], and "very bothered to attend to a patient."

Given these significant differences between the two pasantes, it is perhaps surprising to learn that the villagers were generally quite dissatisfied with each of them as regards their provision of medical services. While the first pasante was more sociable, more sober, and more often in the clinic, neither pasante was felt to be a competent practitioner of medicine.[2] Both were suspected of not being "real" or "legitimate" doctors (which in a sense they were not, inasmuch as they had not yet received a medical diploma or license, but only a carta de pasante, allowing them to conduct their social service duties). Both were believed to lack curing skills, and people resented the government for sending them such incompetent practitioners. Some of the dissatisfaction which the villagers felt toward the pasantes is reflected in the following statements:

> "They don't know much about medicine."
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> "All they know how to do is give shots and pills, but they know nothing about herbal medicines and pulsing."
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> "They are so young [both aged 25], they haven't learned to cure yet."
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> "They have been sent out here to this rincon [isolated rural area] to learn how to treat people so that when they return to the cities they will not make mistakes on city people."
>
> "They are working out here in this rincon because they are not good enough for city folks, who would see through their incompetence immediately and would take actions to see that their fraud is exposed."
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> "Educated people would know how to remove him from his post, but we are Indians, and we are too ignorant to know how to remove him."

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[2] Similar concerns have been reported about pasantes working in the state of Durango, in northern Mexico (Tsu 1980:148).

People frequently complained to me about the incompetence of the pasantes, and wished that their municipal authorities would report the incompetence to supervisors or others who could address the shortcomings, preferably by replacing the pasantes with a "real" doctor (for whose services they would be willing to pay). (This point is returned to below.)

The widespread sentiments in Amotepec of dissatisfaction with the pasantes' incompetence are not idly derived. Reports of ineffective or even harmful treatments administered by pasantes in the clinic are easily obtained in Amotepec, and some informants even go so far as to say that they would "die first before I ever go back to the clinic again." Examples of these complaints include the following.

> "He [the pasante] couldn't even do an injection properly. He put the needle right in the middle of my sore, and made it ten times worse."
>
> "He [the pasante] has no understanding of herbal medicines. His pills and injections didn't help me at all. In fact, they made me worse. So I finally cured myself with herbs. I'll die first before I ever go back to the clinic again."
>
> "He doesn't even know how to cure infant diarrhea."
>
> "I was treated at the clinic for rheumatism, but a month later it was bad again. I think the doctor doesn't know what he's doing. [The missionary] knew how to cure twenty times better than the doctor [at the clinic] does."
>
> "He treated my nephew once for a minor wound. The doctor's treatment [at the clinic] nearly caused my nephew to die. He was eventually cured by a curandero here in the pueblo."
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> "My brother almost died from the doctor's treatments at the clinic. He will never go there again."
>
> "I had a swollen hip, and went to the clinic, where the doctor injected me. That only made my pain worse. I eventually got better by rubbing herbs on my hip."
>
> "The doctor couldn't cure my diarrhea, but herbs quickly did. He is very ignorant of herbs."

> "The doctor doesn't know anything about medicine. He just went to secondary school and a few more years after that. The only thing he knows how to do is drink, and he doesn't do that very well."
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> "The doctor doesn't know how to cure much at all. Only a few people have good luck with him. Most people prefer to go to Oaxaca [City] or Mexico [City] to get cured, if possible."

Two brief outsider's observations will be made at this point, although they will be discussed more thoroughly in the following chapter. First, several comments quoted above reflect the strong tradition of herbal medicine in Amotepec. The botanically rich habitat avilable to the people of Amotepec, supplemented with herbs from elsewhere in Mexico, have served them for centuries. The COPLAMAR clinic in Amotepec dispenses no herbal medicines, and the pasantes who have worked in Amotepec have no demonstrated appreciation of their value. The people of Amotepec recognize curative properties in herbal remedies for many ailments. However, they also respect the curative powers of patent medicines, and in many instances prefer them to herbs (and at times they use both herbs and patent medicines for the same ailment). But their confidence in the clinic's medicines is shaken when they fail to produce the desired effects, and when this happens the villagers fall back on what they are most familiar with, namely herbal medicines.

Second, some comments quoted above reflect the nature of chronic ailments. As was seen in Chapter V, many of the most common ailments reported in Amotepec are chronic diseases such as upper respiratory infections and gastro-intestinal problems. Western medicines such as those provided by the COPLAMAR clinic are capable of treating the <u>symptoms</u> of such ailments. However, they do nothing about the unsanitary environmental conditions and the undernutrition which COPLAMAR

recognizes as playing such an important role in the onset of such ailments. Accordingly, patients treated at the Amotepec clinic for chronic ailments are often only temporarily relieved of their symptoms. When the symptoms recur, the patients blame the pasante for failing to effectively cure them. As will be seen later, an outsider's view of this suggests that the fault lies not with the pasante, but with larger forces contributing to the persistence of unsanitary environmental conditions and undernutrition which adversely impact upon the health status of Amotepec's residents. By treating symptoms rather than causes, the COPLAMAR clinic in Amotepec is leaving intact the very conditions which need to be addressed if the villagers' health status is to be significantly improved.

The dissatisfaction that villagers feel toward the clinic personnel was occasionally expressed to the Amotepec authorities. The village president would infrequently discuss these complaints with the clinic pasante. However, for reasons discussed later in this chapter, the village president was reluctant to be very forceful with the pasante. To my knowledge, no villager ever made an unsolicited complaint about the pasante to any COPLAMAR supervisor. However, on the one occasion when a supervisor went through the village asking people about the pasante, people were quick to volunteer their displeasure.

Clinic auxiliaries

The people of Amotepec also were not impressed with the clinic's two female auxiliaries. However, no one ever blamed them (natives of Amotepec) for their incompetence. They were seen as very young girls (ages 16 and 20) who had had no training in medicine and who, therefore, could not be faulted for what they could not deliver. However,

intra-village political factions occasionally emerged in the minds of some patients because the main (weekday) auxiliary was the daughter of one of the leading anti-pueblo organizers. While most informants rarely made the following point, an occasional person would state that some Amotepecans believed that this auxiliary was sometimes distributing the clinic's pharmaceuticals differentially, depending on the political alliance of the patient. For example, it was believed by some informants that a patient aligned with the auxiliary's anti-pueblo minority faction would be given "good" (unexpired) medicines, while people from the faction opposing this auxiliary's father would be given worthless or harmful (expired) medicines.

This dissertation has emphasized the extent to which political factions influence life in Amotepec. However, in this particular instance regarding the primary auxiliary's differential distribution of medicines, only a few villagers volunteered this information. Others, when asked about the possibility, generally replied that the thought had never occurred to them, or that they doubted she was doing this. Many villagers did not consider this 20 year old female to be a meaningful extension of her father's political alliance, and therefore could not be seen as a threat.

As has just been mentioned, the people of Amotepec had reservations about the clinic's medicines. In general, people felt they were second-class pharmaceuticals which the government was sending them because they had been rejected by urban residents. The following comments from informants illustrate the villagers' distrust of the clinic's medicines.

> "The pills at the clinic are sometimes old [outdated, and therefore ineffective] because there is very little turnover [of pharmaceuticals] here in Amotepec, as compared to

> a pharmacy in the city where people are constantly coming and going day and night, buying medicines."
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> "The medicines at the clinic are second-class, and when they are expired, they turn to poison."
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> "The clinic doesn't have real medicines there, just pills, and they don't work for anything."

Thus, the clinic's medicines frequently were seen as ineffective or even harmful. Some Amotepecans would pruchase medicines in the cities rather than risk the free equivalent from the clinic. Villagers also felt that their clinic was undersupplied with medicines. For example, one man's young daughter was badly burned on her arm, and she was taken to the clinic only to learn that the necessary medicines were not available there, but could be obtained in Oaxaca City or Tlacolula. Other villagers would purchase medicines in the cities which were not available at the Amotepec clinic, and bring them up to the village to have them injected there (either at the clinic, or more often, by other villagers).

The world view of the highland Chinantec differs in many ways from that of a non-Indian Mexican. For example, regarding health and illness, there are certain ailments which afflict the Chinantec (such as brujeria and susto) for which most urban Mexican physicians have no appreciation or understanding. Amotepecans have learned from experience that Mexico's urban-trained physicians (and pasantes such as those in Amotepec) have no training in these kinds of "non-scientific" or "folk" illnesses. While Amotepecans do not expect physicians to be able to treat them for such ailments, they do see this as an another illustration of the incompetence of the clinic's pasantes. For example, as one woman put it,

> "The doctor [at the clinic] doesn't know how to divine illness. My child wouldn't eat, and the doctor gave her vitamins. My child rejected the vitamins, and got no better. I finally took her to a curandero, who devined susto. The curandero cleansed my child by rubbing her body with an egg, and she quickly got better."

Again, the above complaints about the shortcomings of the Amotepec pasantes apply equally to both of the long-term pasantes, in spite of the fact that one pasante was much more available and interested in treating the village population.

Despite the numerous serious grievances prevalent in Amotepec as regards the new health clinic, it is not the clinic per se which troubles people, but rather the personnel and the government officialdom which controls it that bother Amotepecans.

> "The clinic is a good thing, but the doctor doesn't know how to cure very much compared to doctors in Oaxaca [City]."

> "The government doesn't care about the campesinos. All they care about is fattening their own pockets [with money]."

In other words, people definitely want a clinic in their village, but they want it to produce effective treatment. As will be seen later, this wish on the part of the Amotepecans, while understandable, may be unrealistic, given the impoverished living conditions in Amotepec, and the influence which they have on disease.

Furthermore, it would be incorrect to suggest that the pasantes in Amotepec have been totally ineffective and universally unappreciated. Villagers (admittedly infrequently) did tell me of successful outcomes which resulted from clinic visits. Also, some people reported that the clinic's vaccinations have helped reduce infant mortality, saying that

prior to the arrival of the clinic, small children died much more frequently, due to lack of government vaccines.

Pasantes' perspectives on delivering health care in Amotepec

We have seen that the villagers in Amotepec were quick to complain about a variety of things involving the clinic, and especially regarding the pasantes and the pharmaceuticals. We turn now to consideration of how the pasantes in Amotepec felt about their situation and the people whom they were expected to live with and treat.

Both pasantes who worked in Amotepec for at least a year were upper-middle class Mexicans who had received their formal medical training at institutions located in large metropolitan centers which are geographically and culturally distant from the Chinantec locality of Amotepec in Oaxaca's Sierra Juárez. Neither pasante felt he was anywhere near sufficiently prepared for living in and practicing medicine in such a relatively isolated rural Indian community. Both pasantes said they were almost totally unaware of the existence of Indian communities in Mexico, and neither had any idea of the social, cultural, economic, and geographical isolation which they would feel while living in Amotepec. Regarding the practice of medicine in the COPLAMAR clinic, both pasantes reported that their medical training was oriented around highly technical equipment and laboratory apparatus, in marked contrast to the "simplified" facilities which they were expected to use in Amotepec.

Both pasantes viewed the villagers as superstitious and stupid, and they felt that the average Amotepec native was quite unhygienic. In a written report about his observations, the first pasante wrote that the people in Amotepec "bathe once a month at most, and don't

change their clothes or brush their teeth or wash their hands," observations which were repeated by the second pasante in his report.[3] Both pasantes had no idea before arriving in Oaxaca that there are people living in Mexico who speak another language other than Spanish. As one pasante put it, "I had read all about the Aztecs and the Conquest, but I knew that those people were all dead." Accordingly, both pasantes were often frustrated in their attempts to communicate (in Spanish) with Amotepecans, many of whom are not proficient in Spanish.

Among the many expectations which COPLAMAR has of its pasantes in rural health postings is the expectation that they will actively convey to their communities repeated suggestions on how to approximate certain health habits of urban middle-class Mexicans. To accomplish this, the COPLAMAR program requires its pasantes to regularly (at least monthly) present to some segment of the community an informal talk (platica) on some health-related topic. Among the suggested topics were the following: nutrition, personal hygiene, immunizations, sanitation, and family planning. Ideally, according to one supervisor, these talks would occur at least twice each week, even if only to a few people or a single family in their home. The COPLAMAR objective was to spread throughout the community, at whatever pace possible, and awareness of practices which could improve the healthfulness of living conditions in the village.

The first long-term pasante in Amotepec conscientiously undertook this obligation, even though he doubted whether many people understood

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[3]While there may be people in Amotepec who fit this description, my experience in the village suggests that most Amotepecans are considerably more hygienic than the pasantes give them credit for.

or cared about these topics. ("Only about 15 or 20 percent of these people really understand Spanish," he believed.) The second pasante, however, used this "linguistic barrier" as an excuse for not presenting these talks to the community during his stay in Amotepec, except on rare occasions. Accordingly, the villagers were deprived of exposure to these important health concepts.

Both pasantes experienced a great deal of frustration in Amotepec, both personal and professional. Personally, the adjustment from an urban Mexican environment to a rural Chinantec setting was enormous. Professionally, the pasantes felt frustrated in several ways. For example, they felt inundated with paperwork, most of which appeared irrelevant to them. "We practically have to fill out a paper for every breath we take!" Moreover, they felt that the urban-based program planners were completely unaware of the reality of their rural settings. "The people who make up our requirements have probably never been to the Sierra. If we ask them a question about how to provide better services for the villagers, they don't have the slightest idea what we are talking about."

The urban bureaucrats are not only seen as uninformed. They are also viewed by the Amotepec pasantes as basically uninterested in rural health care delivery, and more interested in exercising power over others (such as pasantes) and in enriching themselves (if possible) by means of corruption. Significantly, this last point was mentioned by both pasantes as one reason why they doubted that the new rural clinics would ever be shut down, because they felt that vested interests other than the villagers are benefitting from their existence (such as bureaucrats, politicians, and pharmaceutical companies). In addition, one

pasante added that the Mexican government needed such clinics for "propaganda" purposes as well (to be able to cite the clinics as examples of government concern for the rural poor).

The pasantes were frustrated in their attempts to deliver medical treatment as well. For example, local beliefs occasionally interfered with the provision of treatment as learned in medical school. The first pasante illustrated this by pointing out that he eventually learned why his patients reacted so strongly to his tongue depressors: In Amotepec the long-standing treatment for tonsilitis is to vigorously rub the mouth cavity and throat with herbs, which involves great discomfort for the patient. Whenever the pasante would attempt to explore a patient's mouth with a tongue depressor, patients feared that it would be similarly painful.

The widespread use of, and confidence in, medicinal herbs in Amotepec also frustrated both pasantes. Having been trained in clinical medicine, neither pasante had any confidence in the efficacy of medicinal plants. "Herbs can't cure anything. People here are just superstitious." And yet the villagers of Amotepec have not only utilized herbs for centuries, but also more recently have begun to rely on the sale of medicinal herbs for an important part of their cash income. It is important to reiterate that these same Amotepecans whose lives are so connected to herbal medicines are the same people who want a government health clinic in their village. This apparent contradiction is explained in part by their pragmatic approach to health maintenance and in part by regional-level political expediency (discussed in Chapter III).

Both pasantes were also frustrated by their inabilities to practice the medical techniques they had learned during the course of their medical education. The second pasante was also frustrated because he received repeated warnings from his supervisors that he might be removed from his post because of inadequate performance of his duties. He protested to me that he was the innocent victim of forces over which he had no control. He felt that all of his problems (and all of the villagers' complaints to the authorities and to the supervisors) were directly attributable to the existence of two political factions in Amotepec.

Because the weekday auxiliary at the clinic happened to be the daughter of the leader of the "anti-pueblo" faction, she was capable of making life difficult for the pasante (by continually providing her father with accounts of the pasante's behavior and lack of diligence). I have no information (other than the pasante's allegations) that she ever did this. In view of the fact that the "anti-pueblo" faction in Amotepec is said to have vigorously and underhandedly opposed virtually every "improvement" undertaken in the village in recent years, the pasante's argument is plausible. However, the clinic is an exception to the behavior of the "anti-pueblo" faction, because I never once heard any accounts of any opposition to the clinic, and I frequently heard accounts of their opposition to all other recent changes in the village.

The pasante was extremely uncomfortable and concerned about whether or not his supervisors would penalize him or remove him from Amotepec for his inadequate performance (although he was not concerned enough to modify his behavior significantly). Whenever I asked him

questions about his supervisors, or his performance, he would not talk to me even in a whisper until he had led me away from any other listening ears, and then he would uncharacteristically make me promise confidentiality before responding. He was definitely seriously concerned about keeping his job, and feared that his months of social service might be forfeited if he were removed from this Amotepec post. Nevertheless, as will be seen in the following chapter, the pasante often resorted to deceit, trickery, and lying rather than genuinely respond to the threats of his supervisors.

Supervisors' perspectives on delivering health care in Amotepec

The Amotpec clinic was one of twenty clinics in a zone visited regularly by a team of supervisors. The visits occurred approximately every month, and were usually unannounced. Rarely would the same supervisory team appear twice in a row, although one supervisor did make several repeat visits during my time in the village. Like the two pasantes who were supervised in Amotepec, the supervisors themselves were different from the others.

For several months the supervisors were relatively uncritical of the clinic's operation, and whatever complaints they lodged were presented more as friendly suggestions than as orders. (The supervisors' complaints were handwritten in a simple notebook which was left in the clinic. To my knowledge the supervisors made no copy of these complaints. I do not know if their criticisms were reported to administrators in Oaxaca City or elsewhere, but I assume they were at least occasionally written up and turned in to COPLAMAR officials.)

Eventually, however, as the second pasante became increasingly negligent in the performance of his duties, complaints from the supervisors became increasingly serious. Nevertheless, some supervisors openly admitted to the pasante (in my presence) that it was merely their job to convey their suggestions (or complaints) to the pasante, but that he should not take them "personally" and that he could respond to them however he pleased. The clear implication was that these particular supervisors would not cause him any problems, regardless of what he did.

However, one certain supervisor was exceptionally conscientious and energetic, and lambasted the pasante more than once for his "inexcusable incompetence." I am unable to explain why this particular supervisor was so conscientious compared to the other supervisors. I suspect that her dedication to her job is more a result of internal (personal) motivation than it is due to external forces (such as pressures from her superiors). One thing that distinguished this supervisor from the others is that while all other supervisors would visit only the clinic (and perhaps the municpal authorities), this exceptional supervisor would (before going to the clinic) first spend several hours walking through the village, asking people in their homes about their opinions of the pasante's performance. Only later would she visit the clinic and (always) the authorities, having armed herself with quite a different impression of the pasante than he himself would attempt to provide her with. Perhaps not surprisingly, the pasante was quite upset about this, and went to some effort to try to protect himself from this happening again.

One way in which the pasante attempted to protect himself from this supervisor's inquiries is demonstrated in how he manipulated a

village-wide census to his potential advantage. It so happened that at this time of the year the pasante was required to coordinate with the village authorities on their census, with one of COPLAMAR's main objectives being to try to impress upon the villagers the importance of certain sanitary measures such as washing hands, penning animals, and keeping dust down. Despite being explicitly ordered by his supervisor to remain at work in the clinic while others (e.g. the municipal authorities and the clinic Health Committee) conducted this census, the pasante left the clinic unattended in order to participate in the census. The pasante seized upon this opportunity to participate not out of a desire to help the villagers, but rather to promote his own situation. Instead of concerning himself with improving their sanitation (and thereby reducing the opportunity for the onset of illness), he took pains (through a trusted interpreter, namely his girlfriend, the weekend auxiliary) to beg each household (except those in the "anti-pueblo" opposition) to support him if any supervisor should ever ask them about his performance in the future.

This particularly energetic supervisor was as dedicated to trying to improve the health status of rural Mexicans as she was dedicated to trying to get the Amotepec pasante to perform his duties. For example, when she would ask the pasante why he had not done a particular required task (such as talk with people in their homes or in a public assembly about hygienic practices), the pasante would reply that the people in Amotepec aren't ready for anything like that. "It would take years for them to want to do anything like that," he would say. Undaunted, the supervisor would retort that it didn't matter if something would take decades or even centuries to happen. In fact, she

would say, "That is all the more reason to begin now. Nothing will ever happen until someone begins to try to help it happen." This supervisor had no tolerance for what she saw as laziness on the part of the pasante, and she more than once publicly humiliated him in front of the municipal authorities and others (including me).

Village authorities' perspectives on delivering health care in Amotepec

Finally, in addition to the views of the villagers, the doctors, and the supervisors regarding the Amotepec clinic, it is important to include the perspectives of the Amotepec authorities (and especially the village president), who are ultimately responsible for whatever actions the village as a whole takes.

The Amotepec authorities (including two presidents) who held office during my stay in the village had very little understanding of how the clinic (and the pasante) was supposed to function in Amotepec. This was vividly portrayed at one point (March 27, 1982) after the municipal president had been in office for over nine months, when he summoned the pasante to his office to ask him (several times) what his duties were supposed to be. For example, despite his months in office, and despite the fact that the clinic had been functioning in Amotepec for two and one-half years, the village peresident did not know whether the pasante was required to make housecalls. Interestingly, when asked, the pasante stated that he was not required to make house-calls, to which the president's assistant interjected that the clinic supervisors had told him just the opposite. At this point the pasante realized that he could not be sure of bluffing the village authorities, and so he assumed a much more humble and cautious demeanor.

Eventually this discussion led to another (more significant) level of concerns on the part of the village president and the pasante. The president revealed to the pasante that the supervisors were suggesting to him that perhaps the Amotepec pasante should be removed. This information was of great personal concern to the pasante. However, the president explained that while he would be sorry if the pasante were expelled from his duties, the president's personal concern was that the clinic itself might be removed from Amotepec. Clearly, the president did not want to have this occur during his term in office (or at any time, for that matter), given the long-standing desire on the part of the villagers to have a clinic in Amotepec, and given the bureaucratic difficulties he would surely face if he were to have to attempt to have the clinic reinstalled in the village.

These circumstances amount to a new twist on an old theme, that of a village president being involuntarily forced into a role of middleman between groups with varying interests (Dennis 1973). In this case, the Amotepec president wears three hats. First, he is the leader of his Indian community, elected on the premise and promise that he will defend the community's interests (including retaining the desired clinic). Second, as official head of the village (in the eyes of officialdom) he is subject to threats made by the COPLAMAR clinic's supervisors, and must respond to their wishes or else risk alienating them to the point of perhaps losing the clinic. Third, he represents the only real local threat to the pasante, inasmuch as only he (and his highest-level fellow authorities) can lodge complaints that would be seriously considered by a meaningful audience (such as COPLAMAR officials).

However, the village president, with only three years of primary schooling, rudimentary reading and writing skills, and Spanish that is (in his words) "not very elegant," is generally uncomfortable in challenging an urban-based highly-schooled pasante who is much more experienced at manipulating bureaucratic obstacles to his advantage. The village president frequently indicated how ill-at-ease and humiliated he often felt (or was made to feel) when dealing with urban officials in a variety of offices regarding such issues as education, roads, church restoration, sewage disposal drainage systems, and CONASUPO supplies, to name a few.

Accordingly, the village president was in an awkward position regarding the clinic and its pasante. He dared not be too critical about the pasante to the supervisors, for fear the supervisors would not only remove the pasante, but also remove the clinic. And yet he knew of the pasante's blatant neglect of his duties, and was well aware of the community's general dissatisfaction with the situation. However, he could not effectively pressure the pasante to improve his performance for several reasons. First, he had only a vague idea as to what the pasante's required duties were. Second, he had no experience in supervising or overseeing people who were socially "superior" to him (in terms of formal education, ethnic identity, income potential, fluency in Spansih, and urban contacts). Third, the pasante had carefully cultivated a friendship with the president since his earliest days in the village, to the point where the president felt indebted to the pasante (both for the beers he had regularly bought for him, and for the promises the pasante had made regarding helping the president expedite certain matters involving urban agencies). In effect, the

pasante had very wisely and cleverly engineered a "friendship" with the only person in the village who could ever seriously hurt him. In fact, on at least one occasion, the president publicly defended the pasante's medical skills, saying "The doctor knows his medicine. People here [in Amotepec] can't expect him to perform miracles. Pills and injections can't cure all of their problems." As is stressed in the following two chapters, the village president is absolutely right when he says that it would be miraculous if the clinic's pharmaceuticals could cure all of the villagers' health problems, many of which are seriously affected by unsanitary living conditions and undernourishment (which medicines do not address).

The village authorities (and especially the president) are clearly operating from a disadvantaged position vis-à-vis the COPLAMAR officials. Official COPLAMAR documents state that clinics such as the one in Amotepec should belong to the villagers themselves. However, as this section has shown, local units of government such as that constituted by the Chinantec Indians of Amotepec exercise very little power in influencing how national-level programs such as the COPLAMAR clinic influence their lives. Even in such cases as this where the COPLAMAR program explicitly states that the local unit should have primary responsibility for a government-provided service, in reality the power remains in the hands of the urban-based units, as represented by the clinic pasantes and the COPLAMAR supervisors.

Summary of chapter

This chapter has presented a variety of perspectives on the Amotepec clinic. The village authorities view the clinic as an asset, and are unwilling to challenge an unsatisfactory pasante (who they know is only

temporary), not for fear of losing him, but for fear of losing the clinic. The different clinic supervisors variously view the clinic partly as a potentially helpful medium for addressing the serious illnesses which affect many Amotepecans, and partly as a necessary place to visit in order to assure themselves a place in the bureaucracy. The two long-term pasantes who have lived in Amotepec view the clinic as an unfortunately unavoidable place to fulfill their obligatory term of social service, and they view their clientele as unsophisticated, superstitious, and unhygiencic people living in a locality with very few redeeming qualities. Lastly, the villagers, who had long solicited the government for a clinic, are glad to finally have one in their village. However, as we have seen, they are greatly dissatisfied with the performance of the pasantes, and with the effectiveness of the pharmaceuticals. The villagers are the reluctant recipients of what they see as yet another "second-class" government service, as reflected in the poor quality pharmaceuticals and underqualified personnel which have been provided for them.

That the villagers in Amotepec should find their new clinic and its services to be of "second-class" quality is in keeping with their perceptions about most other government-provided services. As was noted in Chapter III, Amotepecans generally believe that they are receiving poor imitations of urban equivalents in many ways. In addition to the COPLAMAR clinic, two other examples are mentioned here. First, the road into Amotepec is seen as inadequate, and is in fact often impassible after periods of extended rain. Furthermore, the CONASUPO truck drivers who deliver valued corn and other staple goods into Amotepec refuse to transport heavier loads of merchandise (desired

by the villagers) because they say (with reason) that the road is too unsafe to do so, as they fear that their trucks might overturn and roll down the steep mountain slopes. Second, the insufficient quantity of CONASUPO corn which does make it into the village is seen by the villagers as being substandard in quality and cleanliness. They frequently complain that they are only being sold the corn at the slight discount because urban Mexicans would not accept such poor quality corn.

These feelings of receiving "second-class" services only serve to reinforce the feelings among Amotepecans of being "second-class" Mexicans. Because most Amotepec men (and many women) have traveled extensively thoughout Mexico or lived for extended periods in urban areas, they have been repeatedly exposed to urban services of all kinds. The men who travel door-to-door peddling herbs and spices throughout southeastern Mexico, for example, have vivid images of upper and middle-class life styles and services in urban areas. Some women who have worked as domestic servants for wealthy families in Mexico City have not only seen what upper-class Mexico City homes are like, but have also spent extended periods with these families in such resort locations as Acapulco.

This chapter has presented an analysis of the Amotepec clinic from the perspective of the villagers who use it or who are otherwise involved with it (i.e. pasantes, supervisors, village authorities). In summary, the people for whom the clinic was provided feel that it is inferior to the medical services available to urban Mexicans, and the "second-class" nature of the clinic's services, personnel, and pharmaceuticals serves to reinforce their feelings of being "second-class" citizens who are repeatedly being underserved by their government. Having viewed the Amotepec clinic from these perspectives, we turn now

to an examination of the clinic from the more removed perspective of an outsider.

CHAPTER VIII

ETIC ANALYSIS OF THE AMOTEPEC COPLAMAR CLINIC

This chapter examines the COPLAMAR clinic in Amotepec from an etic, or outsider's, view. By doing so, the observations reported in the preceding chapter are viewed in a more critical light. In this chapter several different aspects of the clinic are discussed. The stated goals of the COPLAMAR clinics are compared with the actual situation in Amotepec in terms of the provision of medical services and health promotion in the clinic. Also, this chapter examines the "coverage" experienced by the outlying hamlets which are officially "covered" by the Amotepec clinic. Finally, the impact of the referral hospital (to which Amotepec patients may be sent) is also evaluated. The reader is reminded that the material presented in this chapter is especially pertinent to the theoretical orientation utilized in this dissertation, namely state penetration, a thorough discussion of which is reserved for the concluding chapter (IX).

Effectiveness of COPLAMAR's health-related objectives

As stated in Chapter VI, the enabling legislation for the COPLAMAR clinics called for the provision of the following services: general outpatient consultations, pharmaceuticals, mother-infant care and family planning, health education, nutritional information, sanitation promotion, immunizations and control of communicable diseases. Each of these are evaluated below.

Regarding general outpatient consultations, during the clinic's first 32 months in Amotepec, 2,889 patient-visits were recorded by the various pasantes who worked there, for an average of roughly three patients per day. The clinic's "catchment," combining the population of Amotepec (1,570) and the outlying covered hamlets (1,589), totaled 3,159. This catchment population is below the desired "zone of catchment," but well above the acceptable minimum of 2,500 people (discussed in Chapter VI). Given this potential patient pool, and the low daily patient load, the clinic's supervisors felt that such low visitation rates made the clinic barely viable and very expensive for the government to maintain.

"Salaries" for the clinic pasante and auxiliary comprise a part of the overall clinic expenses incurred by the federal government. In addition, other clinic-related expenses paid by the government include pharmaceuticals, equipment and supplies, supervisors' salaries and vehicles, as well as administrative overhead. Because federal law requires pasantes to perform their social service without pay, COPLAMAR pasantes received a "living allowance" of 11,480 pesos per month (in March 1982). The primary auxiliary was paid 6,500 pesos monthly, and the weekend auxiliary made considerably less.

In other words, the combined monthly salaries of the clinic pasante and primary auxiliary amounted to 17,980 pesos, or 215,760 pesos annually. If this amount were divided equally amont the approximately 564 households officially "covered" by the Amotepec clinic, each household would be responsible for 382.55 pesos annually, or the rough equivalent of 2.55 days of labor (assuming the average wage of 150 pesos per day for unskilled labor (cf. Chapter VI)). Given the average

Amotepecan's present "contribution" of one or two days of labor toward clinic-related matters annually, the Amotepec heads of household are indirectly subsidizing (in lost potential wages) roughly half of the salaries paid to the clinic's pasante and auxiliary. If COPLAMAR officials should ever insist upon the villagers providing the full ten days of labor which they are entitled to ask the "covered" population to contribute, the villagers would, in effect, be required to "contribute" (in terms of lost potential income) roughly four times (10 divided by 2.55) the amount of the salaries of the clinic's pasante and auxiliary. Considering that most Amotepec males who work as itinerant peddlers make much more than the 150 peso daily wage figure used here, the amount of lost potential income is even greater than what I have conservatively estimated above, meaning that the villagers in Amotepec are subsidizing their own "free" health care even more. These calculations are included here to show that COPLAMAR's "free" health services are not free at all, except in the sense that patients are not required to make direct out-of-pocket cash payments for services.

For each general outpatient consultation, clinic personnel were required to record the name, age, and gender for each patient. In addition, this same information was recorded for each patient's head of household, and all other members of the household head's immediate family, regardless of whether any of these people ever visited the clinic. All the people so recorded were referred to as the clinic's "captured" population. In other words, if a mother brought her infant child to the clinic for any kind of treatment, not only would the infant be included in the "captured" population, but so also would the mother, her husband (the head of household), and any other children

they had in their family, regardless of whether they had ever visited the clinic or not. (Irrespective of repeat visits to the clinic, no person could ever be "captured" more than once.)

In effect, the "captured" population refers to all those people who have either been treated at the clinic at least once, or who have an immediate family member who has been so treated. COPLAMAR officials utilize the concept of a "captured" population as an indication of the numbers of people who have benefitted from their services, presumably on the (not unreasonable) assumption that all family members benefit from the treatment of any family member. The "captured" population results in a significantly larger number of "beneficiaries" than does the treated population, thus allowing COPLAMAR officials to claim greater "coverage" than they would otherwise be able to claim.

After 32 months of operation, the Amotepec clinic had "captured" 2,626 (or 83 percent) of the 3,159 total possible covered population. This figure is comprised of 521 heads of households and 2,105 dependents. In other words, some representative of 521 different families has received some kind of treatment at the Amotepec clinic during its first 32 months. Over this time period the usage of the Amotepec clinic has been remarkably consistent, with no appreciable increase or decrease in patient visits through the first two and two-thirds years. This consistent patient load requires explanation. If the villagers were satisfied with the health services provided, one would expect an increase in patient visits over time (assuming a constant incidence of perceived illness). On the other hand, if villagers were totally displeased with the clinic, patient visits would logically fall off. It is my feeling that this constant patient load during the clinic's

first 32 months reflects Amotepecans' ambivalence about their clinic. While the villagers clearly have serious misgivings about the services proffered, they nevertheless have not completely abandoned it. In fact, some of the people who complain about it continue to use it (if only rarely).

As for the provision of pharmaceuticals, virtually every patient who came to the Amotepec clinic received some form of medication. However, as noted in the preceding chapter, there was a feeling among Amotepecans that the clinic's supply of pharmaceuticals was both insufficient and of questionable effectiveness. Amotepecans not only wanted a wide variety of pharmaceuticals, they also wanted effective ones. Some Amotepec men would purchase various drugs in Oaxaca City before busing back to Amotepec, despite the fact that equivalent medicines could often be obtained for free at the clinic in Amotepec. Occasionally the medicine they brought with them from the city required injecting, in which case the people would more often pay a local person a nominal fee for the injection rather than have it done for free at the clinic.

There is no question that the COPLAMAR clinics have a limited selection of pharmaceuticals. The clinic, it should be remembered, is only one of 239 in the state of Oaxaca. It is located in a rather out-of-the-way mountainous region of the state, requiring a demanding seven hour drive (round trip) in a private vehicle (or twice that in a public bus) from the state capitol. The clinic has no refrigeration, no X-ray machine, and no laboratory facilities (and had no electricity during its first year of operation). Given these circumstances, it is hardly surprising that such a clinic would not be stocked to handle every

emergency.[1] However, people in the Amotepec clinic would frequently ask the pasante for a particular medication (often by showing him the emply old container), and would be told by the pasante that the clinic did not have that particular brand of that medication, but did have another manufacturer's equivalent product which they could have for free. People were occasionally skeptical of the clinic's equivalent medicine, and lamented their distance from a "real" pharmacy in the cities.

It will be recalled that Amotepecans also distrusted the clinic's pharmaceuticals on the suspicion that they were "expired" (outdated) medicines. In their cynical view of government assistance programs, their explanation for why clinic medicines were free was that they must not be worth anything to the sophisticated urban people (who would not use outdated medicines), and so they might as well be given away to less discriminating consumers, such as the Chinantec Indians in and around Amotepec. From an outsider's view, however, the question of outdated pharmaceuticals is quite different. As best as I could determine, the COPLAMAR system is very carefully monitoring its medications to insure that no expired medicines are distributed. The supervisors who visited the Amotepec clinic regularly removed from the clinic any medications which were approaching the expiration date. These medications, according to clinic supervisors, were taken to the COPLAMAR referral hospital in Tlacolula, where the greater volume of patients would enable these medications to be dispensed before they expired. So careful were the

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[1]The Mexican government's recent austerity program (begun in 1982) has contributed to a shortage of medicines in Mexico, because many medicines are made from imported materials (New York Times, June 17, 1983).

supervisors regarding this concern that I never saw any expired medications in the clinic. They were all removed well in advance of expiration.

This discrepancy between the villagers' complaints about the clinic's ineffective medicines and the supervisors' careful monitoring of them is explained in terms of the distrust of government services which is so widespread in Amotepec. This distrust reflects the inferior (second-class) status which Amotepecans feel vis-à-vis the urban middle and upper classes. Based on long years of previous experiences with governmental bodies, and confirmed regularly by Amotepec males who travel widely throughout the republic seeing health clinics and other governmental services in urban areas, Amotepecans have come to be skeptical of anything provided by their government. The fact that the pharmaceuticals are provided "free" only adds to their suspicions, as they assume that their government would not freely give them anything that was valued by urban Mexicans.

The Amotepec clinic has been rather ineffective in providing mother-infant care and family planning. Despite the COPLAMAR program's high interest in this particular aspect of their services, the target population has been reluctant to respond. In Amotepec, for example, only 13 women had ever recieved birth control assistance (always in the form of birth control pills), and no more than three of these women continued to return to the clinic for more pills beyond the first three months. One factor cited by the clinic pasante when asked to explain the low utilization rate was the fact that COPLAMAR regulations required both spouses to agree to any birth control devices before either partner would be issued them. The pasante reported that

many women who were interested in birth control could never obtain the consent of their husbands.

Furthermore, during the clinic's first 32 months in Amotepec, only three births were attended by pasantes. This figure is not at all unusual for COPLAMAR clinics, inasmuch as the average number of births attended by the COPLAMAR clinics during the first year was 5.7, and several states averaged fewer than three births per clinic during the first year (COPLAMAR 1981:96).

The next three types of health services which the COPLAMAR legislation included were all very minimally pursued in Amotepec. Health education, nutritional information, and sanitation promotion were basically ignored by the clinic personnel. As noted in Chapter VII, COPLAMAR's pasantes were expected (and required) to regulary discuss with some component of their respective communities about some health-related matter involving health education, nutrition, or sanitation. Unfortunately, this requirement was ineffectively monitored by the COPLAMAR supervisors in Amotepec, and the pasantes received no apparent penalties for not complying with this aspect of their rural social service.

An additional structural possibility for Amotepecans benefitting from COPLAMAR's expertise in health education, nutrition, and sanitation is the clinic's Health Committee (Comite de Salud). COPLAMAR's program planners envisioned the community Health Committee as an essential component of a successful health clinic for two reasons. First, the Health Committee was expected to actively mediate between the plans and activities of the clinic and the "covered" population. Second, the Health Committee was expected to serve as an intermediary

between the village population and the COPLAMAR system. Unfortunately, the Health Committee in Amotepec existed only on paper during the clinic's first year, and did not exist at all after that. Despite the supervisors' repeated reminders to the second long-term pasante about the importance of forming a Health Committee, after 18 months at the clinic this pasante had not progressed beyond the point of promising to do something about it "soon." By not having a Health Committee, the clinic had no one to help coordinate cleanup campaigns, census matters, and compilations of records and statistics (which were occasionaly done by the non-Chinantec school teachers). More importantly, the clinic personnel and supervisors had no formal mechanism through which they could be receiving important feedback from the community at large.

The reader is reminded that COPLAMAR documents repeatedly make reference to the importance of preventive health measures, environmental sanitation, and nutrition as they relate to health status. And yet, as we have seen, there is clearly a major discrepancy between what COPLAMAR says it must do, and what it is actually doing in Amotepec. Explanations for this discrepancy relate to the particular forms of state penetration represented by the COPLAMAR clinic in Amotepec, a discussion of which is deferred until Chapter IX. At this point, however, it bears repeating that because the COPLAMAR program does so little toward reducing or eliminating these critically important factors which contribute to the onset, persistence, and recurrence of many common ailments, an enormous opportunity to ameliorate rural health status is not being taken advantage of.

The COPLAMAR program's master plan envisioned the community Health Committee as a very important linkage between the health services

recipients (the villagers) and the health services providers (the pasante and COPLAMAR). Ideally, a Health Committee would be able to work with the pasante in such a way as to convey to him (and thus to COPLAMAR) how the villagers felt about the clinic and its services. Similarly, in an ideal situation, the Health Committee would also serve to convey information to the villagers reagrding various health measures which the clinic would like to promote. Unfortunately, the Health Committee in Amotepec performed none of these functions. Two factors help explain this. First, the COPLAMAR program, despite its interest in Health Committees, failed to provide the supervision and incentives necessary to ensure that the Amotepec pasante (and others like him) actually pursue the benefits of such a committee. Second, and more importantly, the COPLAMAR program and its priorities were formulated without meaningfully consulting the "target population," and without involving them in any important way. The COPLAMAR program's externally-derived health services priorities left the Amotepec villagers very uninvolved with the clinic. Where COPLAMAR had hoped to maximize community participation, it has accidentally minimized it.

The final service which COPLAMAR clinics are supposed to be providing for the "covered" population is immunizations and control of communicable diseases. This part of the clinic's operations was very conscientiously pursued by the Amotepec pasantes. The Mexican government is seriously committed to this aspect of health services, and has regular nationwide vaccination campaigns against a variety of illnesses, especially for school children (most of whom are easily vaccinated when congregated in school). The Amotepec clinic supervisors, in coordination with these occasional campaigns, would deliver a large package of

hundreds of individually sealed needles and hundreds of individual vaccine containers. Within a few days of their arrival, the pasante in Amotepec, with the assistance of one or both clinic auxiliaries, would take them to the school and vaccinate all of the children who were of the appropriate age.

Not all of the vaccinations in Amotepec took place in the school. Occasionally the municipal loudspeaker would announce to the villagers that free vaccinations would be available at the clinic for various age groups. I am aware of only one vaccination campaign (tetanus) that included adults. Whether the vaccinations were for adults, children, or infants, the Amotepec pasante told me that the announcements (which he prepared) made on the municipal loudspeaker failed to draw many people to the clinic for their shots.

Considering that the village of Amotepec comprises only half of the clinic's "covered" population, a disproportionate number of vaccination campaigns took place there. To my knowledge, only three of the six outlying hamlets "covered" by the Amotepec clinic have <u>ever</u> benefitted from a vaccination campaign, and each of these three "vaccinated" hamlets has only been included in one vaccination campaign. In contrast, the village of Amotepec was the target of numerous vaccination campaigns during the clinic's first 32 months, occurring approximately every four months on average. In short, the COPLAMAR clinic is very actively attempting to immunize the Amotepec population (and especially the younger children), but the people living in the outlying hamlets (comprising half of the clinic's covered population) are only minimially benefitting from these efforts.

As noted earlier, the villagers of Amotepec frequently complained about the second pasante's absenteeism, drunkenness, and unprofessional conduct, and they also complained about both pasantes' incompetence. Their perceptions about the second pasante's absenteeism, drunkenness, and unprofessional conduct are easily supported by empirical data. The second pasante was definitely out of the village more than he was in it during his first year at the clinic (as noted in Chpater VI). He was also publicly drunk on several occasions, and behaved in such a way as to not endear himself to the local population. For example, he would often get drunk with one or more schoolteachers (who, like himself, were not natives of the Chinantla) and would occasionally speak unfavorably of the village, its inhabitants, and their customs.

Even while he was in the village, his attendance at the clinic suffered due to his occasional drinking binges. This usually meant that he would spend the day sleeping in his room (away from the clinic), but on at least one occasion he became so intoxicated that he hit a villager in the face with his fist while on the front steps of the church. Even when sober, the pasante frequently chose to remain in his room rather than attend to patients at the clinic. When I would visit him on these occasions, he would frequently be watching cartoons on his television, and would tell me that he simply did not feel like working.

All COPLAMAR clinics include living quarters and private bathing facilities (see Figure 3, Chapter VI) which all pasantes are required to occupy. However, neither pasante in Amotepec lived in the clinic. Instead, they each lived with the schoolteachers in the center of town, a five-minute walk from the clinic. When the supervisor insisted that

the second pasante live in the clinic, and threatened (unknown) "serious consequences" for non-compliance, the pasante went through the façade of returning the clinic mattress to the clinic, and putting clothes and other personal effects in his clinic quarters, but he continued to live with the dozen or so schoolteachers with whom he enjoyed socializing. This poignantly illustrates some of the difficulties faced by the clinic supervisors.

At times this second pasante's disdain for his duties and his patients was most insensitive and unprofessional. Two examples which I personally observed are provided here. To understand the first example it should be stated that the clinic in Amotepec is located in a place which makes it visible from most places in town, including my residence. Because the clinic's front door was always wide open whenever any clinic personnel was there, it was always easy to tell whether the clinic was open at any time of the day. On one October weekday morning in 1981 I noticed that the clinic had not yet opened as of 10 a.m. Knowing that the pasante was in town, I was puzzled, because the clinic's regular hours are from 8 a.m. to 1 p.m. and 3 p.m. to 6 p.m. While the pasante did not keep strict hours, he (or an auxiliary) generally opened the clinic before 10 a.m. I went to the clinic to see if perhaps the pasante was working with the door closed for some unknown reason. I found the clinic door locked, and found an aggravated older woman waiting outside. She told me she had been waiting for the pasante for about two hours. I asked her if she had looked for the pasante in his room, and she replied that the pasante would not want to be bothered there. (Villagers almost never did so.) She definitely wanted to see the pasante, and I told her that I would try to find him and tell him

that she was waiting for him, for which she thanked me. I went to the pasante's room (a five-minute walk away) and found him watching television cartoons with the twelve-year old brother of his girlfriend (the weekend auxiliary). I told him about the woman who had been waiting, and he said he would attend to her, while giving no indication of wanting to leave his program. I dismissed myself and kept careful track of the pasante and the clinic until noon. By this time the pasante had not yet left his room, the clinic had not yet been opened, and the disappointed woman had given up waiting for her consultation.[2]

The second example of the pasante's insensitive and unprofessional behavior which I choose to include here occurred during a weekday in March of 1982 during the late afternoon (around 5 p.m.). During this time the pasante is expected to be working at the clinic. However, he chose to participate in a community dance program in the center of town. Preparation for the program involved daily afternoon rehearsals for about two weeks. While it is perhaps laudatory that the pasante was active in this public community event, it was clear to me (and others) that the pasante was doing it only because one of the other dancers was his girlfriend. and because he welcomed any excuse to avoid being at the clinic. Given the light patient load at the clinic, it is perhaps understandable and acceptable that the pasante occasionally be allowed to alter his working hours. However, what I witnessed on this particular day is far less appropriate behavior for a pasante.

During this particular rehearsal a man came through the door and waited for an opportunity to speak with the pasante in private. When

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[2]If the pasante had been living at the clinic, it is much more likely that patients such as this one would have been treated. This is clearly one reason why the COPLAMAR supervisors were so adamant in their (unsuccessful) insistence that the pasante reside in his residence.

the opportunity came, he told the pasante that his wife was "gravely ill" and needed to be seen by him. The doctor coldly replied that he was busy, and would not be able to do so. (The pasante's presence at this rehearsal way anything but essential. Other participants were frequently absent, and the pasante had long ago learned his part and needed no further practice.) The rehearsal continued for another hour, after which the pasante went to the nearest store to drink beer with a schoolteacher, apparently having forgotten all about the man's wife.

Other accounts of unprofessional behavior could be included here.[3] For example, I frequently saw the pasante avoid treating patients at the clinic by closing the door to his bedroom, where he would sometimes watch television. If his girlfriend-auxiliary could not handle the patient's problem, she would excuse herself from the patient, slip into the pasante's bedroom (being careful not to open the door widely), and return with a diagnosis and prescription a short time later. On other occasions a patient would arrive at the clinic without the pasante having seen him or her in time to hide in his bedroom. On these occasions the pasante would display visible displeasure to the patient, and would coldly address him or her by saying "What do you want?"

These few examples presented above suggest that the villagers' complaints about the second pasante's absenteeism, drunkenness, and unprofessional conduct are not without foundation. However, as far as the villagers' perceptions that both pasantes were medically incompetent, my observations are less supportive. Certainly the second

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[3]The incidents shared here were all observed by me. Numerous similarly unflattering reports were shared with me by several reliable villagers, suggesting that this kind of behavior was not uncommon.

pasante's lackadaisical and at times unethical performance of his duties in Amotepec contributed to Amotepecan's speculation about his lack of knowledge and abilities. However, I have no reason to doubt his competence.[4]

It is important to emphasize that the pasantes' failure to cure persistent ailments in Amotepec does not necessarily mean that they performed their medical duties incompetently. Rather, it is at least equally plausible to suggest that the nature of the ailments and the prevalence of environmental conditions favoring the persistence and recurrence of common ailments in Amotepec may be much more responsible for the villagers' dissatisfaction than the skill level of either pasante. This point will be reconsidered and discussed in greater detail in the concluding chapter (IX).

Certainly another component of the villagers' feelings about the clinic's pasantes being incompetent relates to the pasantes' lack of understanding of certain "folk illnesses" which occur in Amotepec. As was mentioned earlier, Mexican medical schools train their students in a highly technical and scientific orientation, with no attention to such non-western ailments as susto, mal de ojo, mal aire, and brujeria. Yet these ailments regularly affect people in Amotepec, and those afflicted want relief from them, and they would prefer that their own local "doctor" (as they call the pasante) have at least some understanding of these ailments.

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[4]There was only one patient-visit incident from which I was able to get a second opinion. An American friend of mine who shared part of my fieldwork experience with me incurred a skin infection on her hand. A dermatologist in California who saw the same infection a few weeks later independently arrived at the same diagnosis and prescription offered by the Amotepec pasante. While this does not prove either practitioner right (both could have conceivably been identically wrong), it does suggest competence on the part of the pasante.

These numerious grievances held by Amotepecans, compounded by the fact that pasantes are typically only in a rural village for one year before leaving, causes considerable frustrations on the part of the villagers. After years of petitioning their government for a health post, what they have been given is far from satisfactory in their eyes. While the services and medicines are provided free of charge, villagers feel that they are paying for them anyway. The villagers feel they have the right to health and health care, and believe they deserve it, considering the sums of money they must give the federal government in the form of property taxes, sales taxes, and the like. In addition, the villagers pay for the clinic in another way, via obligatory "donated" labor toward clinic-related matters, as was noted earlier in this chapter.

Each year the village collectively decides which communal work projects should be undertaken during the coming year. These projects generally demand an average of from five to ten days of tequio (communal work) per household each year. Any additional demands on the villagers' time would be much less favorably received if the villagers did not believe in the project on which they were required to work. Because COPLAMAR does not consult with the Amotepec authorities and the town elders, the programs proposed by COPLAMAR are much more susceptible to being rejected by the community as a whole. The centralized nature of the COPLAMAR bureaucracy inhibits community participation and thus increases the chances for unappreciated priorities which COPLAMAR might pursue.

The ten days of tequio which each Amotepec head of household could be required by law to give to the clinic annually has yet to be demanded

of Amotepecans. Since the initial construction of the clinic in 1979, I estimate that the average household head has had to provide at most two days of tequio annually toward the clinic or clinic-related health projects. If COPLAMAR ever did try to demand the full ten days of unpaid labor from each head of household, I believe that the villagers' response would depend on what tasks they were asked to perform. If the ten days of labor were solicited for some project in which the villagers had no interest, they might find ways to avoid compliance. If, on the other hand, the ten days of labor were to go toward installing a sanitary drainage system (something which the village has been actively soliciting from the government), there would certainly be a more positive response.

As for an outsider's perspective on the various COPLAMAR supervisors who visited the Amotepec clinic during my 15 months residence in the village, with the sole exception of the particularly dedicated female supervisor discussed in Chapter VII, these low-level bureaucrats were either uninterested or unable to ensure that the rural clinics provided many of the important health services which the COPLAMAR program promised. Working at the lowest level of the COPLAMAR bureaucracy, many of these supervisors had served as pasantes immediately prior to beginning their employment as supervisors. Their responsibilities included such mundane things as making sure that the clinic wastebasket was properly located. (The Amotepec pasante was once reprimanded because his wastebasket was along the south wall when regulations required it to be along the east wall!)

The supervisors also made similarly trivial demands of the village authorities (on those occasions when they bothered to confer

with them). These included the request that a fence near the clinic be relocated a few meters back from its existing position, for "aesthetic" reasons. (The village authorities agreed that it should be done. Yet it was never even begun during the following six months prior to my departure, and the supervisors never mentioned it again.) Furthermore, the clinic supervisors provided the Amotepec municipal authorities with official forms which they were expected to fill out every six months, reporting on what tequio projects were performed, and how many man-days of labor were involved. COPLAMAR officials suggested several public works projects through their supervisors, including building latrines, public bathroons, and cleaning of the streets and footpaths in town. These suggestions were basically ignored, and the supervisors did not follow up on them.

The supervisors were effective in at least one aspect, however. Their careful monitoring of the clinic's pharmaceuticals (ensuring that none expired) demonstrates the importance which COPLAMAR placed on this matter. Another incident which occurred near the end of my fieldwork in Amotepec demonstrates the ineffectiveness with which the COPLAMAR supervisors more typically performed their duties. On this occasion in March of 1982 a particular supervisor inventoried the clinic's equipment and supplies, and found them to be greatly deficient. This supervisor was shocked to learn the extent to which the Amotepec clinic was understocked after nearly 2½ years in operation. The supervisor said that he would report these shortages the next day, so that they could be remedied as soon as possible. However, when I left the village in May 1982, nothing had been done about these shortages. In addition, it should be noted that all COPLAMAR clinics were originally intended

to be equipped with radios that would allow communication with urban health centers. However, not one of COPLAMAR's 2,105 clinics had been so supplied as of May 1982, according to clinic supervisors.

Perhaps most striking to an outside observer was the supervisors' repeated inability to intimidate or inspire the second pasante to improve his performance. Even the most energetic and threatening of the clinic's supervisors was unable to compel the pasante to modify his behavior significantly, or to cause him to carry out his responsibilities in a more appropriate way. Accordingly, with the importance exception of the supervisor's excellent job of preventing pharmaceuticals from becoming outdated, the impact of the supervisors on the Amotepec clinic was minimal.

The primary responsibility of the clinic supervisors appeared to be merely to note problems, tell them to the pasante, and little more. The supervisors appeared to have little power to enforce their requests. Although they surely had the power to report any shortcomings they observed, there was very little evidence that the supervisors were making efforts to see that the shortcomings were being rectified. Furthermore, there was little evidence that the suvervisors were expected by their superiors to actively pursue any improvements in the clinic. In fact,the supervisors always left their written reprimands in the clinic, and only rarely made additional copies of these reprimands for themselves or for the state offices in Oaxaca City.[5] It is possible that the supervisors did not submit their reports because they

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[5]I do not know if the supervisors compiled a report for their superiors after they left the Amotepec clinic.

had become disenchanted with the bureaucratic inefficiency and its inability to respond to their previous reports.

The ineffectiveness (or powerlessness) of the COPLAMAR supervisors is explained as follows. Just as the pasantes should not be held responsible for all of the health problems and shortcomings of the Amotepec clinic, the COPLAMAR supervisors should not be held responsible for the problems in the clinic. The supervisors are a powerless component in a massive bureaucracy. Ultimately, the functioning of the lowest levels of the bureaucracy reflect the priorities of the program planners and implementers, on whose shoulders the primary responsibility rests. The centralized nature of the COPLAMAR bureaucracy is reflected in the fact that I never once heard a COPLAMAR supervisor inquire as to what kinds of projects the villagers of Amotepec might be interested in. The clear implication is that the program planners and implementers are not interested in such information. This is significant because it reflects the nature of state penetration in Amotepec.

The penetration of the Mexican state via the COPLAMAR clinic not only affects the lives of Amotepecan villagers, but also affects the functioning of national-level political and economic spheres of influence. These factors will be discussed in detail in Chapter IX, but suffice it to say at this point that this form of state penetration impacts upon the lives of the Chinantec villagers by imposing yet another representation of the national culture which aids (both subtly and overtly) the government's long-standing goal of "Mexicanizing" the Indian population. At the same time, this state penetration affects national-level political and economic forces by creating the illusion

(if not the fact) of a placated and ameliorated peasant population who is now less likely than ever to create rural unrest which could disrupt the nation's economic "progress," which is so dependent upon "nervous" foreign capital investment.

The COPLAMAR clinic's coverage of Amotepec's outlying hamlets

The preceding discussion concerned itself primarily with the delivery of health services in Amotepec, the village where the COPLAMAR clinic is located. Yet the COPLAMAR program planners designed their rural health program with the idea of covering outlying hamlets as well. We turn now to a consideration of the effectiveness of their coverage.

As was seen in the earlier chapter (VI) on the COPLAMAR program, the Amotepec clinic provides official health coverage for six outlying hamlets. The combined population of these hamlets (as shown in Table 7, Chapter VI) is slightly larger than the Amotepec population. However, the "coverage" experienced by the population living in Amotepec contrasts sharply with the "coverage" of the outlying hamlets. A central point of this portion of the dissertation is that, to the extent that what I have seen in and around Amotepec can be generalized, it is erroneous and misleading for Mexican government officials to claim that COPLAMAR clinics are providing health care services to millions of previously uncovered rural people. In reality, great numbers of these people remain basically unaffected by the clinics. COPLAMAR supervisors suggest that the situation which I observed in Amotepec is not atypical of what they have observed in other COPLAMAR clinics in the state of Oaxaca.

The COPLAMAR guidelines state that in order to effectively deliver health care services to any outlying "covered" hamlet, it should not be more distant than one hours walk from the clinic. Yet only one of the six hamlets included in the Amotepec clinic coverage lies within this maximum "desirable" distance. As can be seen from Table 8 (Chapter VI), the remaining five hamlets are located an average of two hours walking distance from the clinic (one way). Furthermore, with the exception of Soledad Tectitlan, which may be reached by walking along a vehicular road, the footpaths connecting these outlying hamlets with Amotepec are still every bit as rough as reported by Ford (1947) more than thirty years ago. In the rainy season (May to November) the steep trails are extremely hazardous.

However, travel time and difficult access to the clinic in Amotepec are not the only factors which influence the outlying "covered" population in their decisions about whether to go to the clinic. Local political alliances are also very important. As is shown in Table 7 (Chapter VI), the six covered hamlets are politically affiliated with three different municipios. Three of the hamlets covered by the clinic are agencias of Amotepec. Of these three agencias, only Totomoxtla residents are likely to utilize the Amotepec clinic. They are likely to do so because they live only one hours walk from the clinic, and because they are politically aligned with Amotepec. The other two agencias which are politically aligned with Amotepec (namely, San Miguel Maninaltepec and Santa Maria las Nieves) are located much farther away from the clinic (see Table 8, Chapter VI), and require walking over much rugged and steep foot paths than if one is coming from Totomoxtla. These physical obstacles discourage people in these hamlets from

visiting Amotepec not only for medical treatment, but also for other things, such as socializing and buying things in stores.

Residents from the two hamlets which are politically affiliated with the municipio of San Pedro rarely come to Amotepec, not only for reasons of physical distance and difficult trails, but also because they are politically affiliated with a municipio which has been feuding with Amotepec for decades. As was noted earlier (Chapter III), Amotepec and San Pedro have been involved in disputes for many years, and these disputes are of sufficient intensity that most people from these hamlets do not feel comfortable in Amotepec. While the clinic pasantes in Amotepec would surely not have turned away a patient from an agencia of San Pedro, the patient would likely be uncomfortable coming to Amotepec for health services (or for any other reason, for that matter). During my fifteen months residence in Amotepec, the only times that San Pedro residents came into Amotepec (except for the incident reported in Chapter I (page 12)) were when one of the caciques (with some friends) would drive into town in his truck every few months (never getting out of it), only to circle the church (the end of the road) and then leave town by the same (only) road via which they came. (This was done primarily to show Amotepecans that they were not afraid to come into Amotepec whenever they pleased, indicating that they felt they could go anywhere they pleased at any time.) The COPLAMAR program planners almost surely had no idea of these local-level political disputes when they assigned these two San Pedro agencias to be included in the coverage of the Amotepec clinic.

The sixth hamlet included in the Amotepec clinic's coverage is Soledad Tectitlan, an agencia of Santiago, a municipio which is on

friendly terms with Amotepec. However, while residents of Soledad Tectitlan have no policital reasons for avoiding Amotepec, the travel time involved for them (a three hour round trip on foot) discourages most people from coming. In addition, Soledad Tectitlan is situated closer to the cabeceras of both Santiago and San Pedro, where other government health posts have existed prior to the arrival of the COPLAMAR clinic in Amotepec. My few conversations concering how residents of Soledad Tectitlan utilize these government posts in Santiago and San Pedro suggest that they are not discouraged from seeking health services in San Pedro, depsite the rivalry which exists between these two highland municipio cabeceras. Unfortunately, I was never able to stop in Soledad Tectitlan to pursue this question with its residents because I did not want to arouse suspicions among Amotepecans as to why I was visiting a village located close to rival San Pedro.

A final consideration influencing whether anyone from an outlying hamlet makes the trip to the Amotepec clinic is the possibility that the pasante may not be in the village (or even if he is, he might not be at the clinic). During the year of the first pasante's social service in Amotepec, the clinic had a reputation for being reliably staffed and almost always open (even on Sundays). However, the frequent and extended absences of the second pasante during his first year in Amotepec eventually became known in the hamlets, and people began to question whether it was worth the long walk to the clinic, given the odds of the pasante not being available. (The reader is reminded that these outlying hamlets had no telephone or telegraph by which to confer with Amotepec.) Accordingly, the hamlets contributed very little to the

numbers of patient-visits recorded at the Amotepec clinic. This is represented in Table 9 on the following page.

While the outlying hamlets are intended to be primarily "covered" in the sense of being fairly accessible for the patients to come to the clinic, the COPLAMAR program planners also intended for the clinic pasante to visit each covered hamlet on a regular monthly basis. In Amotepec this expectation was not met. The first pasante who spent an otherwise rather diligent year at the Amotepec clinic did not visit any of the hamlets until the last few weeks of his year, when he visited three hamlets one time each. These visits were the result of a mandatory vaccination campaign which he could not avoid.

The second pasante was similarly remiss in his visits to the hamlets. In fact, late in his first year at the clinic he still did not even know which hamlets were included in his clinic's coverage. (This fact also reflects how infrequently some of the hamlets utilize the Amotepec clinic.) However, near the end of his first year he made visits to four of the hamlets (all but La Reforma and Soledad Tectitlan). Three of these four visits were due almost entirely to the fact that the Amotepec basketball team (of which he was an integral and enthusiastic part) competed in tournaments in three hamlets. In fact, on one occasion he asked a clinic supervisor for permission to go to a hamlet for a basketball tournament, and his request was emphatically turned down because his absence would leave the clinic unattended the entire day (the auxiliary being out of town on official business). Despite these explicit orders <u>not</u> to go, the pasante went anyway and played in the tournament. He did not see any patients while at the hamlet, and it is doubtful whether the supervisors ever learned of his disobedience.

TABLE 9

THE COPLAMAR CLINIC'S UTILIZATION BY AMOTEPEC'S OUTLYING HAMLETS

Hamlet	Affiliated Municipio	Population	Hours walking time to clinic	Estimated* patient-visits per month
Totomoxtla	Amotepec	234	1	4
San Miguel Maninaltepec	Amotepec	283	2½	2
Soledad Tectitlan	Santiago	355	1½	2
San Martin Buenavista	San Pedro	388	2	1
Santa Maria las Nieves	Amotepec	94	1 3/4	0
La Reforma	San Pedro	235	2½	0

*The Amotepec pasantes were supposed to record the "home town" of each patient who came to the clinic. However, with very few exceptions, the pasantes recorded "Amotepec" for all patients, regardless of whether or not they came from elsewhere. However, the clinic auxiliaries, who know where people live, provided me with the estimates shown above, regarding the frequencies of clinic visits by residents of the outlying hamlets. I consider these estimates to be quite reliable. In all, I would estimate that fewer than 10 percent of all Amotepec clinic patient-visits involved people from the outlying hamlets, despite the fact that these six hamlets comprise over 50 percent of the clinic's "covered" population.

The fourth hamlet which this pasante eventually visited (San Martin Buenavista), he visited twice. The first visit was made in conjunction with a mandatory vaccination campaign. He chose to voluntarily return a few weeks later, solely because of the availability of animal skins there, which he wanted to purchase for Christmas gifts for his family. While there he did see patients for two hours. However, so interested was he in the animal skins (especially deer skins) that at one point he abruptly abandoned a patient when he glimpsed a man outside who he knew had some skins for sale.

There were other indications that the pasante had higher priorities than delivering health when he would visit these hamlets for basketball tournaments. For example, during the first (and only) time that he visited Santa Maria las Nieves, the pasante was humbly approached by a native female schoolteacher who asked him if he could return to the hamlet on a regular basis ("or at least once," she implored) to address the community at large on any number of health-related issues in which she assured him that her fellow villagers would be most interested. Throughout her polite pleadings the pasante remained aloof and disinterested, and finally left her (to play basketball) with the possibility that he might be able to return the following month (which he did not do).

The supervisors would occasionally remind the Amotepec pasante of his obligation to visit these outlying hamlets on a monthly basis, and they would even tell him that "repercussions" would be felt if these requirements were not fulfilled. The supervisors do have the power to delay or prohibit a pasante's certification, which would mean that a pasante would be required to repeat his year of social service in order

to practice medicine. However, this ultimate threat which the supervisors possessed was not sufficiently threatening to the point that the pasante heeded their requests. I do not know whether the pasante's lack of responsiveness to the COPLAMAR supervisor's threats was due more to his confidence that such threats would never be carried out, or more due to the pasante's indifference as to whether they would ever be carried out.

The pasante was generally very confident about his ability to outmaneuver his supervisors, and this may account for his lack of concern about them. Even on the occasions when the especially vehement and threatening supervisor questioned the Amotepec pasante about his neglect of the outlying hamlets, he was able to manipulate the situation so as to reduce his obligations. He did this by exaggerating the hiking times involved in reaching the hamlets (even to the point of doubling the time needed for a one-way trip!). By so lying, he was able to have the supervisors reduce his obligatory visits to the hamlets to one visit every two months, except for the closest hamlet of Totomoxtla (one hours walk away).

One other illustration of how the outlying hamlets were very poorly "covered" by the Amotepec clinic involves the formation of health committees there. We have seen that the village of Amotepec was supposed to have an active Health Committee, but such was not the case. The Amotepec pasante was expected to have formed Health Committees in each of the outlying hamlets as well (and was supposed to meet with them monthly during his regular visits to the hamlets). However, the Amotepec clinic was well into its third year before any pasante formed any Health Committee in any outlying hamlet, and the effort

involved (and the end result) poignantly demonstrate the difficulties inherent in such an undertaking.

The first (and to my knowledge, only) Health Committee formed outside of Amotepec was in Totomoxtla, the hamlet nearest to the clinic. The only reason that the pasante even attempted to organize a Health Committee in any hamlet was due to pressures from the very threatening supervisor. I accompanied the pasante on his impromptu afternoon hike to Totomoxtla. Upon arrival, he explained his mission to a man in the hamlet's town hall. The pasante was told that such a committee would all be arranged for him within three weeks. I returned with the pasante three weeks later, and the Totomoxtla officials acted as through they had never seen him before. The pasante reminded them of his mission, and said that he would return in one week with the official papers for forming a Health Committee.

When we returned one week later, the pasante indeed took with him a document which he had typed in triplicate, with places prepared for members of the health committee to enter their names. This time, upon arrival we found the municipal building locked, and no one in sight. The pasante eventually found a rather inebriated "policeman" (policia) who, after some considerable effort, managed to remove a well-worn whistle from his pocket which he used to announce to the hamlet authorities that they should come to the town hall. A half-hour later, two men ambled into view. The pasante explained his mission once again, and conveyed his need to have five men to form a Health Committee. The two men quickly explained that they were not office-holders in the hamlet. The pasante then attempted to explain to these men that it did not matter what their status was, but the men showed no signs of

understanding this message. Instead, they dismissed themselves saying that they would send some of the authorities to talk with the increasingly frustrated pasante. Another half-hour later two officials did appear, and seized the opportunity to try to have the pasante fix the hamlet's generator-driven record player (there being no electricity in Totomoxtla).

On this third visit to Totomoxtla, after three and one-half hours of waiting, explanations, distractions, interruptions, misinterpretations, and excuses, the pasante finally managed to obtain the "signatures" (some men being unable to write their names) of five men who thereupon became Totomoxtla's official Health Committee. This was accomplished only after considerable persistence on the part of the pasante, who did not want to have to return to Totomoxtla a fourth time. He had to repeatedly assure the men that they would have no obligations or responsibilities, which was in fact the case. (The pasante never had any other interaction with this "Health Committee" to my knowledge. His interest was in satisfying the demands of his supervisor, not in organizing people in the hamlet to discuss health-related issues.) Even with the pasante's considerable assurances to the effect that members of the Health Committee would have no duties, the more senior office-holders in Totomoxtla refused to commit themselves to the written document. Instead, they managed to pressure others (including a 15 year old boy) into conforming with the wishes of the pasante.

Great efforts were required by the pasante to form this basically artificial "Health Committee." The pasante persisted in the exercise only because of his supervisor's insistence. The ludicrousness of

forming such a Health Committee in Totomoxtla is all the more apparent when the reader is reminded that the much larger village of Atomepec, where the clinic is located and where most of the clinic's patients come from, still has no Health Committee. The misplaced priorities on the part of the COPLAMAR supervisors (and/or their superiors) reflect the bureaucracy's lack of understanding of the functioning of their health care facilities at the local level.

This discussion of Health Committees is intended to demonstrate that while the intentions of the COPLAMAR program planners were certainly good when they proposed that each locality covered by a clinic have a Health Committee, such committees are of questionable value unless they are effectively organized and supervised, which was clearly not the case in Amotepec. Not only are they worthless in cases such as we have seen here, but they are actually detrimental in that they create resentment by making demands on villagers without returning anything to them. This is especially the case in the outlying hamlets where the residents are much less familiar with the clinic and its personnel, and scarcely benefit from it.

The preceeding discussion of the COPLAMAR clinic's coverage in Amotepec's outlying hamlets is better understood if the reader is reminded that (as stated in Chapter III) Amotepec's hamlets have very informal and disinterested relations with their cabecera. In addition, it was noted previously (also in Chapter III) that the hamlet residents have much less need to leave their homelands than do the land-pressed cabecera residents. The result of these two factors is that the hamlet residents (as compared with the cabecera residents) have relatively little understanding of the new COPLAMAR clinic in Amotepec. While the

cabecera authorities have not gone to any apparent effort to inform the hamlet populations about their new clinic, neither have COPLAMAR personnel made noticeable efforts to do likewise.

The COPLAMAR clinics' referral system, and its impact on the Amotepec covered population

As noted in Chapter VI, the COPLAMAR program of health services includes not only rural health clinics, but also regional referral hospitals. All people officially "covered" by the Amotepec clinic (including the six outlying hamlets) are technically eligible for admission to a new referral hospital in Tlacolula (one hour southeast of Oaxaca City), built especially for COPLAMAR clinic patients. However, as we have seen, only one person included in the Amotepec clinic's coverage was ever admitted to the referral hospital during the clinic's first 32 months of operation. This low utilization rate is less due to the covered population not needing the services of the referral hospital than it is due to other factors all relating to inconvenience, outlined below.

First, just as the outlying hamlets are generally far more distant than the recommendations proposed by COPLAMAR, so is Amotepec far more distant (8 hours in 2 buses, not including time involved in changing buses in Oaxaca) than the recommended maximum distance to the hospital (which is 3 hours travel time). The reader is reminded that the travel time to this referral hospital is an additional one to two and one-half hours longer for that half of the "covered" population which lives in the hamlets outside of Amotepec.

Further complicating the matter is the inconvenient bus schedule. Buses leave Amotepec for Oaxaca only twice a week, and their departure

time from Amotepec (7 a.m.) makes it impossible to reach Oaxaca City, disembark and board another bus for Tlacolula, and reach the referral hospital in time to be seen the same day. Accordingly, meals and lodging expenses must be added to the bus costs. For this reason (and others discussed below), Amotepecans prefer to obtain medical services and pharmaceuticals in Oaxaca City (at personal expense) rather than go to Tlacolula where they are "free." Interestingly, the highland Chinantec who are "covered" by the IMSS-COPLAMAR clinic in Amotepec are forbidden from using the IMSS hospital services in downtown Oaxaca City for political reasons which are returned to in the concluding chapter.

Finally, the bureacratic obstacles facing the Amotepec peasant who wishes to be seen at the Tlacolula hospital may be great. As noted previously, patients may not be admitted at the Tlacolula referral hospital without the proper referral documents signed by the pasante in the rural COPLAMAR clinic. The clinic auxiliaries are not empowered to sign such documents in the pasante's absence, which was a serious obstacle during the Amotepec clinic's second year of operations when the pasante was more often absent from the village than he was in it.

This requirement is also unfortunate in that an Amotepecan who may fall ill when outside the village (which frequently happens) may not go directly to Tlacolula's referral hospital to be seen (even though he or she may bus right past it). Instead, he or she must return to the Amotepec clinic, obtain authorization from the pasante (if he is there), and then return to Tlacolula via Oaxaca City. This process involves great inconvenience in terms of financial expense, time lost, and the discomfort of two long bus rides. This inconvenience is especially

unfortunate given the great numbers of Amotepecans whose economic pursuits require them to spend large amounts of time outside of the village throughout the year. If they were able to visit the Tlacolula (or any other COPLAMAR) referral hospital without first going to Amotepec, there is no doubt that such services would soon be more frequently ulitized.

In effect, then, the option of the referral hospital does not exist for the Amotepec "covered" population. In fact, the only Amotepecan ever to go to the hospital was taken there (for free) directly by the regional clinic supervisor who happened to be going there from Amotepec in his Jeep (a four hour drive). When there arises in Amotepec a need for someone to have emergency medical care which cannot be handled by the local clinic, people turn to the two local truck owners in town[6] for rides into the city, rather than wait for the bus. On at least one occasion in Amotepec the pasante was faced with a patient (a pregnant women in labor) whose complications were beyond his capabilities. He did what he could with his limited supplies, and then urged the woman's husband to get her to a hospital. The pasante explained about the option of the Tlacolula hospital (and its free services) to them, and provided them with the proper authorization documents for admission. This couple secured the cooperation of one of the local truck owners who agreed to drive them to the city for help. They stopped in the district capitol of Ixtlan (half way to Oaxaca City) seeking help, but could find none. They continued on to Oaxaca, where they went directly to the SSA hospital, even though they had to pay for services there.

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[6]They also turned to the antropologist when he had his car in the village.

The free services to which they were entitled at the referral hospital were not pursued because of the extra hour of travel time (and additional expense) involved. Had they been eligible for free services at the IMSS hospital in Oaxaca City, they would have almost certainly opted for it, rather than paying for services at the SSA hospital.

While there are many COPLAMAR clinics which are more favorably located in relation to their referral hospitals, there are also great numbers of clinics which are located in much more remote places than the Amotepec clinic, including places which are not accessible by vehicle (and which involve several hours walking to reach) and have no electricity.[7] While these places would seem to be even more unlikely to utilize their referral hospitals, the COPLAMAR system does have helicopters which are apparently available for emergency evacuations (COPLAMAR 1981). The COPLAMAR clinic in Amotepec has no radio communication with which to summon this air service, however. Nor is the clinic prepared to request such services by means of written communication which could be delivered to Oaxaca City by any resident or bus driver. Such air service could only arrive in Amotepec if it were requested by either the Amotepec pasante or a COPLAMAR supervisor. This never occurred during the first 32 months of the clinic.

Summary of the chapter

In the previous chapter, villagers' views on the Amotepec clinic were presented. In this chapter, these villagers' views have been

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[7]According to clinic supervisors who have worked in several different zones in the state of Oaxaca, pasantes working in these conditions have even greater adjustments to make in their rural postings than do the pasantes working in Amotepec, which is accessible by road and is serviced with electricity.

evaluated from an outsiders' viewpoint. It was shown here that many (but not all) of the Amotepecans' complaints about the clinic's pasantes were supported by reliable data. This chapter also evaluated the effectiveness with which the COPLAMAR clinic in Amotepec is delivering the health services called for in the COPLAMAR legislation. It was seen that consultations, pharmaceuticals, and immunizations are far more regularly delivered than health education, nutritional information, sanitation promotion, and mother-infant care and family planning.

Despite all the shortcomings experienced by Amotepecans (who live where the clinic is located) as regards the clinic's delivery of health services, it was shown that they are much better served than the other half of the "covered" population which lives in hamlets some one to two and one half hours outside of Amotepec. Finally, the referral hospital which is supposed to be available to those people "covered" by the Amotepec clinic was shown to be so inconvenient as to be almost non-existent.

The following chapter concludes this dissertation by critically examining the role of state penetration, and its impact on the Mexican peasantry and Indian population. Drawing on data from one particular highland Chinantec village in Oaxaca, the recently installed government-run COPLAMAR health clinic is viewed as the latest in a series of linkages between the center and periphery in Mexico. Several issues are examined in terms of the three components of state penetration presented in Chapter I (Corbett & Whiteford 1983). First, the COPLAMAR program is examined in terms of how such a development program might serve to benefit Mexico's ruling class, whose privileged position is perpetuated by the preservation of the status quo. Second, the COPLAMAR

clinic in Amotepec is reconsidered in terms of how it has impacted upon the "covered" population in unanticipated ways. Third, the larger question of how effectively COPLAMAR clinics can deliver health services (and ultimately, improved health status) to Mexico's "marginal" rural population is considered.

The extent to which Amotepecans want the nation-state to penetrate into their village and daily lives (in terms of health services) is also presented in the concluding chapter, and alternatives to COPLAMAR's present physician-based curative orientation are considered. In addition, the prospects for improved health status and health services in rural areas such as Amotepec are addressed. Finally, the importance of this medical anthropology study is noted in that (1) it provides critical micro-level data which complements the macro-level data presented by political scientists who are concerned with Mexican health issues, and (2) it addresses the often overlooked critical impact which the nation-state has on the well-being of the "marginal" rural population. The influence of micro-level social dynamics (including inter-village feuding and intra-village factions) on the delivery of health services in Amotepec demonstrates that the goals and priorites of federal bureaucrats are often at variance with those on the receiving end of national programs which penetrate the rural hinterlands.

CHAPTER IX

STATE PENETRATION AND ITS IMPACT ON HEALTH STATUS

Introduction

This final chapter examines and critically evaluates how the penetration of the Mexican state affects the lives of the rural population. This will be done by considering the particular example of a new COPLAMAR health clinic which is located in a highland Chinantec village in northern Oaxaca. The COPLAMAR clinic represents the most recent linkage between the highly centralized Mexican state and its peripheral, "marginal" hinterlands.

This concluding chapter examines the COPLAMAR development program in terms of its stated objectives as well as its unstated impact. This is done first by considering who is benefitting from its health-related programs. It will be seen that while the villagers of Amotepec derive some benefits from their COPLAMAR clinic, Mexico's elite ruling class is also benefitting from this investment in rural Mexico. Their benefits include: 1) facilitating the extraction of valued resources from rural areas, 2) providing for the possibility of a healthier reserve supply of labor, and 3) publicly demonstrating the ruling class' commitment to the rural sector, thereby potentially reducing the possibility of unrest or revolt in the countryside.

In addition to asking who is benefitting from the COPLAMAR health clinics, in this chapter certain unanticipated consequences of the COPLAMAR clinic in Amotepec are presented. In this section it is

shown that the clinic has affected Amotpecans in ways quite unexpected by program planners. These include: 1) Amotepecans' desires to have a clinic for political reasons, in order to better protect themselves from possible incorporation into an unfriendly neighboring municipio, 2) increasing the cynacism and frustration which the Amotepecans feel toward their federal government because they find that their clinic not only provides health services in an extremely unsatisfactory manner, but also fails to cure their persistent and recurring ailments, and 3) the COPLAMAR clinic, by providing what are seen as "second-class" health services, reinforces Amotepecans' feelings of being "second-class" Mexicans. Amotepecans' feelings about state penetration are included. It is seen that Amotepecans do desire, and feel they have earned the right to, numerous state-provided services, including a health clinic. However, it will be seen that they want these services for reasons which differ in many ways from the objectives of the state. Following this, considerations of alternative forms of health care delivery are discussed, and it is seen that the COPLAMAR services in Amotepec are not addressing certain factors which are crucial to improving the health status of the villagers. Finally, this chapter concludes by assessing the prospects for improved health status for Mexico's "marginal" population. Before turning to these questions, however, a brief discussion of rural development in Mexico since the 1940s, and especially in the 1970s, will place these issues within a larger context.

From World War II until very recent times, Mexico's annual economic growth has averaged 6.3 percent, an exceptional rate of economic expansion (Kate & Wallace 1980:1). However, despite this

incredible sustained economic growth, it has been estimated that 67 to 80 percent of the population in Mexico City cannot afford basic food, shelter, and health care (Musselwhite 1981:51). As we have seen, rural Mexicans are widely agreed to be at least as impoverished as their urban counterparts.

The contrasts in living standards between the wealthy and the poor in Mexico are indeed striking. Despite being the fourth largest producer of petroleum in the world (Street 1981:374), Mexico continues to have millions of undernourished and underemployed citizens. Amidst Mexico's islands of prosperity there are oceans of poverty. The wealth which does exist in Mexico is far from equally distributed. In fact, few countries in the world have a more unequal income distribution than Mexico. Economists using a Gini index[1] have found that "in only eight countries in the world were the shares of national household income of the top five percent of households greater, and the shares of the poorest 40 percent of households smaller, than in Mexico" (Felix 1977:111).

During the 1970s things continued to worsen for the poorest Mexicans. According to figures provided by Mexico's Foreign Trade Bank (Banco Nacional de Comercio Exterior), "whereas in 1958 the richest 5 percent of the [Mexican] population had an income 22 times that of the poorest 10 percent, 20 years later the gap had more than doubled" (cited in Bizzarro 1981:370). In 1977 the richest 5 percent of the Mexican population enjoyed 25 percent of the national income

[1]The Gini index reflects a country's income equality distribution. The index for developed countries in recent years has been between 0.25 and 0.4, while for developing countries the Gini index has been in the 0.2 to 0.7 range. Mexico's index in the 1960s was above 0.6 (Felix 1977:111).

while the poorest 10 percent made do with only one percent of the national income (Gonzales Casanova 1980:202).

In Mexico, the wealthier sectors of the population are concentrated in urban areas. Vast numbers of poor Mexicans also live in urban areas, as noted previously. Mexico's rural areas, however, are inhabited almost exclusively by the poor. The Mexican revolution was fought in part because of the enormous concentration of land ownership in the hands of the few. At the time of the revolution, one percent of the Mexican population controlled 97 percent of the land, leaving 99 percent of the population to share 3 percent of the land (Gonzales Casanova 1980:195). In 1970, after more than five decades of agrarian "reform" and revolutionary promises, fully 60 percent of Mexico's agricultural lands were still held by only 11 percent of the population (Gonzales Casanova 1980:200).

During the 1970s the Mexican government placed greater emphasis on its rural areas than it had at any time since the 1930s, when Cárdenas was president (Grindle 1981:1). Of special interest to the government were the millions of rural poor who clearly had not shared in the impressive growth which the Mexican economy had enjoyed since the 1940s. In addition to the provision of health services such as those examined in this study, federal government programs also penetrated into the rural areas with such services as schools, feeder roads, piped water systems, subsidized food staples, electricity, and agricultural assistance programs. During the 1970s the plight of the peasantry was emphatically and publicly acknowledged, first by Echeverría and later by López Portillo (Grindle 1981:15).

However, despite the heightened emphasis on Mexico's rural poor, a 1979 study by Mexico's National Nutrition Institute found that nearly 90 percent of Mexico's rural population suffered various degrees of calorie and protein deficiency, and that (with the exception of the north of Mexico) the level of calorie consumption had declined or remained unchanged for rural Mexicans over the previous 20 years (cited in Grindle 1981:33). Similarly, environmental and economic conditions (such as employment, education, housing, and health) were also not noticeably improving during the 1970s in rural Mexico (Grindle 1981:33).

As this dissertation has shown, poverty conditions (especially unsanitary living conditions and inadequate nutrition) can have serious health consequences. The COPLAMAR program recognizes the disadvantaged situation of millions of rural Mexicans, and represents an unprecedented investment in Mexico's "deprived zones and marginal areas." The rural clinics and referral hospitals represent a part of this commitment. With this in mind we turn now to a reconsideration of the COPLAMAR program of health services. Having seen that previous rural development programs have not noticeably benefitted the rural sector, the following section considers what potential benefits might acrue to the urban-based providers of such programs.

COPLAMAR's stated goals and unstated impact: For whose benefit?

As was explained in Chapter VI, the primary stated goal of the COPLAMAR development program was to help the "marginal people" in Mexico's "deprived zones" to "participate more equitably in the national wealth" (COPLAMAR 1978:xvi-xvii). This objective was to be achieved primarily by developing rural resources and industries, and

secondarily by attending to other rural needs such as education and health. Given the enormously unequal distribution of Mexico's wealth (as reflected in the Gini index, and as is so strikingly evident in Mexico's urban areas), such goals are unquestionably well-intentioned. However, as has been pointed out by the residents of Amotepec, as well as by scholars (e.g. Grindle 1981), the promise of an improved standard of living in the countryside is no guarantee that improvements will be realized.

The provision of health services such as we have seen with Mexico's COPLAMAR development program is an example of an activist, politically centralized state penetrating into its rural hinterlands. The process of state penetration has been conceptually divided into three categories: ideological penetration, institutional transformation, and structural penetration (Corbett & Whiteford 1983:12-16). Examples of each of these categories of state penetration are to be seen in COPLAMAR's provision of health services. As for ideological penetration, the clinic in Amotepec clearly is in harmony with the government's goal of "Mexicanizing" the Indian population. The delivery of western medicine by urban-based pasantes with urban-derived medicines involves both subtle and blatant spreading of the values and behaviors of the dominant national culture. As for institutional transformation, the COPLAMAR clinics are performing in such a way as to potentially transform traditional medicine as it is presently constituted.

The COPLAMAR program recognizes very little of value in traditional medicine. However, the COPLAMAR program does call for each clinic pasante to work with indigenous healers and traditional midwives. (This was not done in Amotepec.) In addition, COPLAMAR has

plans to incorporate herbal medicines into its pharmacopoeia. According to an official at the IMSS-COPLAMAR offices in Oaxaca City, a pilot program investigating the usage and efficacy of herbal medicines in highland Chiapas is already underway (Angel Arevalo Vargas, personal communication, May 18, 1982).

To the extent that the COPLAMAR program successfully pursues these efforts, the traditional indigenous system of healing will have been penetrated and incorporated into the dominant western medical system. As for structural penetration, the COPLAMAR clinics clearly represent the latest in a long series of government programs which further link the rural populace to the dominant urban culture. By providing the option of western health services on a (supposedly) daily basis, the COPLAMAR clinic in Amotepec provides the villagers with yet another manifestation of the dominant national culture.

The nature of state penetration in Mexico is heavily influenced by the priorities of the nation's political elite. The discussion (in Chapter IV) of the history of the development of official health services in Mexico showed that organized efforts on the part of the working class resulted in the formation of various social security programs. The highland Chinantec Indians, however, are less well organized. In fact, given the intensity of the long-standing disputes among the highland Chinantec municipios, it is unlikely that they will be coming together for any mutual purpose for years to come. Given this information, it is logical to ask why the federal government has been so actively penetrating the highland Chinantla in recent years. The answers to this question are complex, and likely include a sincere desire on the part of the federal government to both improve the

the well-being of the rural sector and increase the "national wealth" by exploiting whatever resources exist in the hinterlands. The dramatic increase in oil revenues during the 1970s provided valuable economic resources which facilitated these pursuits.

While development programs in Mexico during the 1970s and early 1980s have not been noticeably effective in improving living standards for the rural areas into which they have penetrated (Grindle 1981), they may well have been effectively performing other functions. That is to say, while the COPLAMAR clinics may not have been effectively providing health services or improving health status for Mexico's rural population, they have been serving in several unstated subtle capacities, to the potential benefit of the urban-based elite ruling sector.

For example, COPLAMAR's "development" of Mexico's rain-fed "marginal" areas emphasizes the extraction of values resources, including agricultural crops, timber, and mineral resources (as shown in Table 3, Chapter VI). Related to this is Mexico's concern about reducing its annual food imports. An increase in the production of foodstuffs would help alleviate Mexico's balance of payments deficit, which benefit the national government.

As for the local "indigenous" population, the COPLAMAR development program has no provisions for them to be the primary beneficiaries of the wealth to be extracted from their "deprived" zones. One way in which the rural poor could conceivably benefit from the COPLAMAR activities would be by being employed in activities related to the extraction of resources in their region. This has not yet occurred in Amotepec, and there is no reason to believe that it will ever

happen. This potential employment for wages is not to be confused with the unpaid tequio labor which is required of the population "covered" by COPLAMAR clinics. The beneficiaries of the clinics' health services, by maintaining their clinics without pay, are in effect subsidizing their own "development" with the most easily extractable resource they have, namely their labor power.

Instead of the wealth of these rural areas going directly to benefit the disadvantaged rural population, the COPLAMAR development program assumes that the state (and its associated commercial sector) is best suited for managing the wealth, with the "understanding" that a fair share of it will be returned (or will "trickle down") to them. Such has not been the case in past development programs in rural Mexico, and there is no reason to believe that any significant change is in the offing. In the words of a political scientist, "social security in Mexico is less a program designed to redistribute income than it is a device for maintaining the relative growth of important sectors of the economy" (Wilson 1981:234).

Yet COPLAMAR states that its primary objective is to allow the "marginal people in the deprived zones [to] participate more equitably in the national wealth" (COPLAMAR 1978:xvi-xvii) by developing rural resources and industries. In the absence of any information regarding <u>how</u> these rural development projects will allow the rural population to share more equitably in Mexico's wealth it must be assumed that the program planners expect that some wealth will indeed "trickle down" to the poorest sector. Having seen that past programs have failed to do so, there is no reason to assume that this program will benefit the "marginal" poor any more than past programs have, despite COPLAMAR's promising statements.

The health services provided by the COPLAMAR clinic, if not actually doing so, at least have the potential to provide Mexico's industrial capitalist economy with a more healthy reserve of available laborers, to the benefit of Mexico's ruling classes. As has been demonstrated by de Janvry (1981) and de Janvry & Garramón (1977), the peasant sector in Latin America in general (and in Mexico specifically) functions in a dual capacity. Their "functional dualism" refers to their simultaneous status as sub-subsistence peasant producers and erratic wage earners. This situation of semi-proletarianization serves the interests of the capitalist sector (Whiteford & Quesada 1979) by providing it with a reserve supply of labor whose maintenance and reproduction costs do not need to be fully provided for.

Also, the COPLAMAR health services program, with its highly visible new health clinics, is used by the government as a demonstration of its commitment to the well-being of the rural population. As we have seen, "the government's responsibility for the general welfare has its foundation in the 1917 Mexican Constitution with the premise that health and social well-being are a right, not a privilege" (Daschbach & Don 1978:119). To this end, government officials proudly proclaim that the 2,105 new COPLAMAR clinics are proof that the constitutional guarantee of health for all Mexicans is finally being realized by millions of long-neglected rural residents. However, as we have seen in the village of Amotepec, such is not the case.

Nevertheless, the <u>appearance</u> of doing something about rural health conditions may be quite beneficial to the state, regardless of the effectiveness of the services provided. By virtue of <u>appearing</u> to address past injustices in the countryside, the COPLAMAR program is in

effect telling the peasantry that things are getting better for them, and that meaningful change is underway and must not be jeopardized by complaints. Also, the COPLAMAR program tells the larger Mexican population that the government is actively working to improve the lot of the disadvantaged rural sector. In this way, the potential for rural unrest is reduced, and the legitimacy for supressing rural instability is increased. (This point is returned to below.) The COPLAMAR program, while implemented by López Portillo in the late 1970s, has its origins in the early 1970s, a time when Echeverría was deeply concerned about the volatility of Mexico's rural sector (Grindle 1980:197-223, Grindle 1981:11). Political stability is especially important given the nature of Mexico's economic growth strategy, which is dependent on "nervous" capital (which is very sensitive to the potential for unrest) (Musselwhite 1981:265-266).

The COPLAMAR health clinics potentially benefit Mexico's ruling class in several other ways as well as those noted above. For example, the family planning programs which are a major component of COPLAMAR's health services, if effective, would be of enormous benefit to the government, because of its concern about feeding, housing, and employing its future populations. Also, such new clinics may potentially serve to encourage rural residents to postpone or abandon plans to migrate to already overcrowded urban centers. The medical establishment also benefits from COPLAMAR's perpetuation and expansion of the western scientific model of medicine, emphasizing curative treatment. This is so because curative medicine provided by highly trained physicians perpetuates their dominant view of how to treat ailments, in contrast to public health personnel or paramedical healers who represent an alternative approach to the same issues.

Pharmaceutical interests also benefit from supplying the 2,105 clinics and 41 regional hospitals with their products. Mexico's health care orientation in 1973 was found to be "highly dominated by the in the influence of the drug and medical supplies industries" (Lopez Acuña 1980a:88). This 1973 survey on health research in Mexico showed that only 4.3 percent of the research projects were in the field of public health, while most research was clinically based and mostly sponsored by drug companies.

Finally, the imposing of western medicine on indigenous communities represents yet one more intrusion on the part of the capitalist-oriented national economy into the lives of traditionally subsistence-oriented people (who are now also active part-time itinerant salesmen) such as those under study here. The reader is reminded of the earlier discussion (in Chapter II) of the analogous Spanish imposition of their religion and morals on the highland Chinantec at the turn of the seventeenth century.

Brief reference was also made in Chapter II to the Papaloapan development project which displace tens of thousands of Chinantec and Mazatec Indians under the guise of bringing "backward" peoples into the "national economic development" (Barabas & Bartolomé 1973:4). As was noted earlier, this penetration by the state had an enormous impact (whether intentional or not) on the language, kinship, and social organization of people who for hundreds of years had had "an integrated relationship with a cosmos of their own conception" (Barabas & Bartolomé 1973:13). In other words, the end result of the Papaloapan project was to eliminate the culture of the affected peoples, while at the same time incorporating them into a dependent

capitalist economy. This form of ethnocide is in some ways replicated in the COPLAMAR clinics, which have no sensitivity or respect for traditional Chinantec beliefs and practices.

The COPLAMAR rural development program makes it clear that its goal is to incorporate Mexico's marginal poulation into the national economy. Such a priority is precisely in keeping with Mexico's policy of indigenismo, (discussed in Chapter I), involving the integration of socially and culturally segregated ethnic groups into the national society and economy. The COPLAMAR clinic in Amotepec is but the most recent in a series of government efforts to "Mexicanize" the highland Chinantec Indians of Oaxaca's Sierra Juárez. Much as the Spanish conquistadors penetrated the highland Chinantla in their 1599-1603 resettlement campaign, the new COPLAMAR clinic in Amotepec represents the latest illustration of how the less powerful Chinantec are affected by more powerful outside interests who stand to benefit from such penetration.

Unanticipated consequences of the COPLAMAR clinic in Amotepec

COPLAMAR's provisioning of health services in Amotepec has had unanticipated consequences. In Chapter III historical and contemporary conditions in and around Amotepec were presented. The reader will recall the intense and at times lethal rivalry between Amotepec and its neighboring municipio of San Pedro. Also, it was noted earlier that there is frequent mention in the state of Oaxaca of consolidating any of its 571 municipios which does not have a population of at least 10,000. Fear of having to share a municipio with hated San Pedro, and worse yet, fear of being politically dominated by San Pedro, has resulted in Amotepecans being extremely concerned about being equal or

superior to San Pedro in every possible way. Therefore, inasmuch as San Pedro had for several years had a health post in its cabecera, Amotepec was most pleased to be awarded a COPLAMAR clinic. While Amotepecans most certainly had been soliciting for a clinic (and were delighted to get one) for health-related reasons, they were well aware of the potential political advantages which accrued to them as a result.

The preceding example of an unanticipated consequence of having a COPLAMAR clinic in Amotepec is quite harmless, or even irrelevant insofar as the villagers' views about the federal government are concerned. However, what follows here reflects how government assumptions may be incorrect. The COPLAMAR program planners must have assumed that villagers would be most appreciative of "free," and "locally available" western medical care and pharmaceuticals. Certainly a village such as Amotepec, which had nothing of the kind and had been requesting just such a clinic for years, would be expected to be very grateful for having their wishes met. However, as we have seen, the COPLAMAR clinic in Amotepec has served to heighten the frustrations and cynacism which the villagers feel toward their government. Far from curing their ailments, the common belief in Amotepec is that the pasante is incapable of performing like a doctor in most cases, and that the pharmaceuticals are quite often ineffective.

While the villagers are familiar with western medicine, and definitely want it provided to them in their village, they want effective medicine and effective personnel, neither of which they believe has yet been provided them. They want to be free of their persistent and recurring ailments once and for all, and they expect

their COPLAMAR clinic to be able to do this for them. Their expectations are heightened by the rhetoric of their government, which tells them that their unjust suffering is now being attended to by professional personnel.

By being the passive recipients of what appears to them as "second-class" health services, the villagers of Amotepec are once again reminded of their "second-class" status in Mexico. Where their ancestors were once "first-class" Chinantec Indians, they are continually reminded that they are inferior beings in the larger nation of which they are forced to be a part. Their daily lives are filled with constant reminders of their second-class status: the dangerous road which they travel when leaving and returning to the village; the schools which made no acknowledgement of their Chinantec heritage and culture; the CONASUPO store which delivers too little corn (of inferior quality) to them too infrequently; the telegraph system which has been out of service for more years than it has functioned; the crumbling old church which state inspectors refuse to examine despite repeated requests on the part of the village authorities; the "potable" water system which sometimes delivers brown water; the priest who must be paid to come to the village every few months, and when he comes he reminds his "flock" how inferior they are compared to what they should be; and the urban officials who treat them with disrespect and remind them that their command of the Spanish language is "not very elegant." In sum, far from being a valued and appreicated donation from their benevolent government, the COPLAMAR clinic in Amotepec is viewed as a frustrating reminder of their inferior and powerless place vis-à-vis the urban ruling class who remain unapproachable.

It should be clear at this point that Amotepecans, despite their resentment toward the government services which they have recieved, are not opposed to the state penetrating their lives. In fact, they made great efforts (and paid large sums) to request that the state enter their village with a road, a new school, electricity, potable water, a CONASUPO store, and a new clinic. What Amotepecans are opposed to, however, is the kind of state penetration which they have been receiving. What they have been given is, in their opinion, an inferior ("second-class") approximation of the urban equivalent of several services. However unreasonable the Amotepecans' expectations may appear, they are based on their strong beliefs in having the right to first-class services (by virtue of having made several forms of "payments" for them). Furthermore, the Amotepecans' expectations are influenced by the glowing promises which government proclamations convey to the rural sector. In the case of the recent COPLAMAR clinic, the promise was that the recipients would finally be able to experience improved health status. However, few improvements in health status have been reported in Amotepec. Instead, the clinic is seen as the latest in a series of institutional forms of state penetration which have heightened the frustrations of the rural villagers, while reinforcing their feelings of being "second-class" Mexicans.

In addition to the unanticipated consequences of government intervention in the lives of Amotepecans reported above, other highland Chinantec Indians have also been reported to have experienced the penetration of the state in unexpected ways. Rubel (1983), for example, shows how the assumptions and aspirations of the federal government's Ministry of Health (SSA) were quite different from the assumptions

and aspirations of the villagers in the highland municipio of Santiago. Rubel shows that the concerns of the villagers of Santiago were social and political in nature (being especially concerned about defending their lands from a neighboring municipio), and these concerns were not necessarily related to SSA's efforts to improve the villagers' health. Rubel appropriately notes that the penetration of the SSA health services into Mexico's hinterlands facilitates the federal "government's larger political goals of rural transformation, national consolidation, and centralization of political power in Mexico City" (Rubel 1983:5), and he further notes that pasantes in rural areas such as Santiago (and Amotepec) represent yet another linkage between the national government and the rural residents. However, it is seen in the case of Santiago that the village authorities, despite their infinitesimal size in comparison to the Ministry of Health, were able to influence the provisioning of health services in such a way as to further the goals of their municipio.

Another anthropologist who has worked among the highland Chinantec has written on another aspect of state penetration. Browner (1982) reports on how women in a highland village, excluded from formal roles in local-level political and civic deliberations, were able to effectively pursue some of their aspirations by allying themselves with representatives of the federally-provided services which they desired. The women's activities were contrary to the wishes of the male authorities, and the women were censured by them. This represents another example of some unanticipated consequences resulting from the state penetrating into the lives of the rural highland Chinantec.

Finally, another anthropologist working in the highland Chinantla provides another illustration of highland Chinantec Indians utilizing outside forces to strengthen their own positions in local and regional disputes. Bauer (1982) shows how residents of San Pedro have pursued various aspects of the federal land reform law in ways which have enabled them to claim land outside of their own political boundaries while at the same time protecting their own land holdings by pro-claining them to be communally held. Bauer's findings are supported by widespread sentiments in Amotepec to the effect that the caciques of San Pedro (who are said to control the San Pedro authorities) have repeatedly manipulated various federal agencies to their own benefit and to the detriment of adjacent Amotepec.

The recent introduction of the federally-provided COPLAMAR health services has impacted upon the villagers of Amotepec in unanticipated ways. The state expected that health services would be provided to the "covered" population on a daily basis. We have seen that this is only partially correct. The state did not, however, expect that Amotepecans would appreciate the clinic more for its potential political advantages than for its provision of health care. Nor did the state expect that Amotepecans, having requested a clinic, would be so sorely disappointed in the clinic's inability to cure common persistent ailments afflicting villagers (especially gastro-intestinal and upper respiratory ailments). Nor did the state anticipate that the villagers would be so deeply resentful of being presented with "second-class" services because of feeling that they had earned and been promised something better.

The future: Prospects for improved health status for Mexico's "marginal" rural population

This study has examined health status and health services in a rural Mexican community in highland Oaxaca. It has been shown that the health status of rural Mexicans is heavily influenced by unsanitary environmental factors and conditions of poverty. The leading causes of death in Mexico are similar to those experienced in the United States during the early 1900s. More than 30 percent of all deaths in Mexico are from pneumonia, influenza, enteritis, and diarrheal diseases (Daschbach & Connolly 1977:564-565). All of these diseases are closely associated with lack of potable water, unhygienic practices, inadequate housing, and undernutrition, conditions which prevail in rural Mexico. It has been seen in this study that the Mexican government in recent years has attempted to improve these conditions, but that their efforts have not significantly improved living conditions for the vast majority of the rural population.

The health needs of the rural Mexican population have long been neglected, despite constitutional guarantees of health. The recent government investment in 2,105 COPLAMAR health clinics represents an enormous commitment to the provision of health services in Mexico's rural areas. Unfortunately, as we have seen, the health services provided by the clinic in Amotepec fall far short of what is deemed necessary and desirable by the recipients of the services, and by outside observers. As was noted above, there is little reason to believe that conditions are significantly different in the other COPLAMAR clinics. COPLAMAR program documents recognize the importance of environmental factors, nutrition, and "social" medicine (COPLAMAR

1981:125, 132, 166), but in Amotepec these components of health services are not delivered. Instead, the clinic in Amotepec operates basically as a part-time emergency first-aid station, while at the same time adding to the frustrations of the villagers.

Mexico does have schools of public health. However, their numbers of graduates are infinitesimal when compared to the thousands of physicians graduated from Mexico's medical schools annually. Between 1967 and 1974 (the latest period for which I could obtain figures), Mexico's School of Public Health graduated only 438 people (Cañedo 1974:1132). Mexico's medical schools, by contrast, currently graduate approximately 7,000 physicians annually. Therefore, Mexico's schools of public health are presently unable to significantly benefit the nation's population which is in need of their services.

It is impossible to determine to what extent the COPLAMAR health services are a reflection of genuine compassion and concern about the disadvantaged condition of Mexico's rural population. Government speeches use moving rhetoric to announce that the injustices in the countryside will not be tolerated any longer, and the COPLAMAR health clinics and referral hospitals are cited as concrete examples of the dominant (PRI) political party's commitment to justice and equality. However, political scientists have interpreted such programs in other ways.

For example, as was discussed above, concern about political unrest in rural areas has influenced government policy-makers. While the rural population is unquestionably economically disadvantaged and politically not well organized, it does not necessarily follow that they lack at least potential political leverage (Purcell & Purcell

1980:202). Programs like the COPLAMAR health clinics have been termed "preemptive reforms," involving a "co-optative response by political elites to their fears of uncontrolled political mobilization by the less advantaged elements of society" (Coleman & Davis 1983:3).

Mexico's revolutionary past is a constant reminder of the possibility of future unrest in the countryside. The ongoing civil wars in Mexico's Central American neighbors to the south also serve to demonstrate to Mexico's political leadership the havoc which can result from dissatisfaction among the lower classes. Protest demonstrations occasionally occur in Mexico in both urban and rural contexts. However, the likelihood of "uncontrolled political mobilization" occurring in the highland Chinantec village of Amotepec is minimal.

Given the nature of the intra-village factions, it is uncertain whether Amotepecans could meaningfully unite on any particular issue. Moreover, considering the intensity of the ongoing inter-village feuds between Amotepec and San Pedro, there is little time or resources left for Amotepecans to devote to actively mobilizing against the state. This is all the more unlikely given the power which the state occasionally exercises (as when 60 to 100 soldiers unexpectedly invaded and terrorized Amotepec in June of 1979, killing two men and imprisoning nine others on charges of being "guerrilla sympathizers"). (This was discussed in Chapter III).

Nevertheless, the federal government, for relatively little financial investment, reaps certain benefits for its efforts. Highly "visible" public programs like the COPLAMAR clinics (in contrast to many public health measures which are far less "visible") have the advantage of being able to <u>appear</u> to be providing health benefits

without necessarily actually doing so (Wilson 1981:126). A program like the COPLAMAR health clinics is advantageous to the political elite because "its political payoffs are substantial for its comparatively low cost. The political payoff is high visibility government support for 20 to 25 million workers and their families" (Musselwhite 1981:286-287). Even in the case of Amotepec, where the COPLAMAR services are highly criticized by the villagers, Musselwhite's point holds. This is the case because, regardless of how the "beneficiaries" perceive the government health services, the very existence of such clinics provides the government with more reasons to claim that things have improved in the countryside.

To the extent that macro-level political priorities (rather than health-related priorities) influence the planning, implementation, and ongoing functioning of the COPLAMAR clinics, the health services provided by them are likely to be inappropriate and ineffective in addressing the health needs of the "covered" population. The COPLAMAR program emphasizes physician-provided curative health services to the neglect of nutritional and environmental health components. This emphasis reflects the priorities of Mexico's urban-based ruling sector. A political scientist who has written on how politics influences development in Mexico notes that "the economic development strategy which has emerged in Mexico over the past four decades is best understood as a reflection neither of offical party interests nor of the sectoral demands within the PRI, but rather in terms of interests and value-orientations of the country's self-renewing political elite" (Hansen 1974:130).

Some scholars (e.g. Wilkie 1970) perceive Mexico as a country wherein the political leadership since the revolution has moved steadily toward fulfilling the social and economic goals of the revolution. Others, such as Hansen (1974:121) view Mexican politics as largely "non-democratic, non-egalitarian, and repressive." As for the future of the poor sector in Mexico, Hansen believes that "the Mexican governing elite is inclined neither to democratize its political institutions nor to devote increased resources to raising the standard of living of 'marginal' Mexicans" (1974:122). However, in the years following Hansen's statements, considerable resources have been expended on Mexico's rural poor, as is evidenced by the COPLAMAR health services. In that sense Hansen's statements are incorrect. Yet, it must be emphasized that merely spending vast sums of money on the rural poor does not guarantee that the "beneficiaries" of such expenditures will enjoy a raised standard of living. In fact, as we have seen in Amotepec and for Mexico in general (Grindle 1981), it is questionable whether rural Mexicans' living standards have improved in the past decade in spite of the numerous federal programs which penetrated into "marginal" areas during that period.

The net result of a strategy which emphasizes the values and priorities of Mexico's political elite is that relatively powerless rural Mexicans such as those living in Amotepec continue to be the recipients of ineffective government services in which they have little say. Accordingly, the inequalities which have been noted between the urban middle and upper classes and the rural lower classes persist, including the provision of health services. As one Mexican physician has stated, "The Mexican health care system is built to serve the

health needs of the population in reverse: the greater the need, the less is the care....Medical care services [in post-revolutionary Mexico] have been an instrument of political mediation between the state and the social demands of the population" (Lopez Acuña 1980a:89).

Having seen in this dissertation the great disappointment and resentment which the COPLAMAR clinic has generated in Amotepec, one might wonder whether the federal government was investing its money unwisely. However, the COPLAMAR program of health services serves to mediate between the state and the demands of Mexico's rural sector in at least two ways. First, they indicate a responsiveness (however inadequate) on the part of the government to the expressed needs and desires of the populace. Second, their physical existence provides the state with additional justification for repressing any rural unrest which might occur. A stable political appearance is a critical factor in Mexico's economy due to its impact on foreign capital's interest in investing in Mexico, especailly given the political upheavals in Central America. To the extent that all parties concerned (the rural sector, the Mexican ruling elite, and foreign investors) believe that the social and economic injustices experienced by the rural sector in Mexico are being addressed, the potential for an attractive investment climate is increased. Even when a portion of the rural sector is dissatisfied with its new health services (as is the case in Amotepec) the COPLAMAR program still provides benefits to the Mexican political and economic elite.

These views are supported by others who have investigated the interrelationships among politics, economics, and health in Mexico. For example, a political scientist who has evaluated social security

and development in Mexico has concluded that the primary goal of Mexico's social welfare system is not (as has been widely supposed) "the reduction or amelioration of social and economic inequality" (Wilson 1981:240). Instead, he states that "the decision-making and distributional processes currently found in Mexico's social security system are, in large measure, designed to avert conflict, promote economic growth, and insure the survival of that nation's political elite" (Wilson 1981:239).

In Mexico's most recent economic crisis, the lower classes are once again being asked by the political leadership to demonstrate patience while they wait for their just share in the nation's wealth. Mexican president de la Madrid, on his first day in office, announced sweeping austerity measures designed to combat what he called Mexico's worst economic crisis in forty years (Sanders 1983). He warned the poorest Mexicans that their gains would be slow in coming. "While stressing that 'social inequality' remained one of Mexico's most serious problems, he said that little could be done to alleviate this while the [economic] crisis persists" (New York Times, December 2, 1982, pages A1, A6). Accordingly, the prospects for meaningful improvements in the health status and health services of rural Mexicans remain unclear and not promising. Until such time as rural Mexicans such as those living in Amotepec have a greater influence in the decision-making processes of their government, their health status and health services will continue to reflect their "second-class" position in Mexican society. Unfortunately, "the possibilites for a more equitable distribution of power in Mexico are stark" (Grindle 1977a:182).

It has been observed by Cañedo (1974) that there is little relationship between Mexico's frequency and distribution of disease on the one hand, and the orientation of the medical schools which are responsible for training medical personnel, on the other. Such has been shown to be the case regarding the health problems in Amotepec, and COPLAMAR's emphasis on curative medicine. While Mexico's system of education in the health field does not reflect the health situation in the nation as a whole, it does seem to represent the power relations in the country. The health status of lower-class Mexicans is not likely to be significantly improved by curative medical intervention which ignores the problems caused by unsanitary living conditions and inadequate diet. The impact of these conditions on rural Mexicans is that they continue to be exposed to chronic illnesses and diseases which impede their abilities to perform their daily tasks. While their symptoms may be temporarily relieved, conditions which invite a recurrence of illness persist.

Since the writing of the revolutionary constitution in 1917, it has been the unquestioned obligation of the Mexican state to provide for the well-being (including health services) of its entire population. However, the implementation of this duty has always been left to the political leadership (Kreisler 1981:87). The Mexican government is continually faced with making difficult decisions regarding the allocation of scarce and limited funds. The importance of health services for the rural sector must be weighed against competing alternative needs. Providing effective health services, beneficial environmental improvements, and sufficient nutritional intake for the millions of disadvantaged rural Mexicans is an enormous task. The

state of Oaxaca is especially challenging, given its 571 municipios, its numerous ethnic and linguistic groups, and its rugged geography which makes traveling difficult.

The COPLAMAR clinics such as we have seen in Amotepec provide unreliable services for the "covered" population, half of whom live too distant from the clinic to have reasonable access to its services. The option of hospital referral, while available in theory, is virtually non-existent in practice. The prospects for significantly improving overall health status in Amotepec are slight, because important unsanitary environmental conditions and nutritional deficiencies are being ignored. As the COPLAMAR program is presently oriented, there is no reason to believe that things will improve. Pasantes who are poorly prepared for the difficulties of rural living conditions will continue to share in the frustrations experienced by their clientele. Until the Mexican medical schools place greater emphasis on the health and social conditions of the rural populations where their pasantes are sent for year-long visits, these frustrations will continue. Furthermore, until such time as the "beneficiaries" of such government programs as COPLAMAR are included in decision-making processes, the chances for maximizing the beneficial aspects of such programs are minimized.

As a specific example, until such time as the COPLAMAR supervisors actively seek out the Amotepec authorities and other villagers (as for example through the Health Committee) and learn their opinions and ideas, the clinic will be excluding an essential source of information which could make the delivery of health services much more favorably presented in the eyes of the "target" population. Furthermore, until

the Amotepec residents (and especially the authorities) are clearly aware of the duties and obligations of the pasante who is there to serve them, they will not be able to derive the full benefits which they are due.

It has been noted in this study that one pasante in Amotepec was quite unsatisfactory in terms of absenteeism and drunkenness. It is not uncommon to hear similar reports about other pasantes in Mexico. On the other hand, I have also heard glowing reports about sincere and dedicated pasantes. Their responsibilities are demanding, and at times risky. During the time of my fieldwork I learned of three pasantes and one nurse who lost their lives when the vehicle in which they were riding to their rural posts was swept away in a raging river which they were attempting to cross.

I have every reason to believe that the first full-term pasante in Amotepec was very conscientious about his duties and obligations to the people he was there to serve. However, it cannot be stressed enough that even the most medically competent, dedicated, and culturally sensitive pasante could not be expected to improve the overall health status of the rural Mexican population, given the nature of the conditions which so heavily influence the onset, persistence, and recurrence of many of their ailments.

In other words, highly trained curative medical treatment is only part of what is required in Amotepec. At least as important, and probably moreso, is the need for public health programs which would significantly improve the undernutrition and unsanitary environmental conditions which prevail. While the COPLAMAR clinic recognizes the importance of such public health measures, and includes them in their

official documents, they are not being delivered in Amotepec. The pasantes in Amotepec are not well prepared to do much more than talk about such measures, and they are not even very well prepared to do that. Moreover, the supervisors do not ensure that the pasantes carry out this part of the COPLAMAR program. It is apparent that the higher-level COPLAMAR officials are not sufficiently concerned with this aspect of the delivery of health services to make certain that more is done in this regard.

By choosing instead to emphasize curative medical services, the conditions which contribute to the onset, persistence, and recurrence of Amotepec's most common diseases are left largely unaffected. As was seen in Chapter I, there are alternatives to the COPLAMAR orientation of physician-based curative medicine. Given the tens of thousands of small localities in Mexico where no physician has yet to be placed, and given the extremely poor "coverage" experienced by the residents of the hamlets around Amotepec, one must question the feasibility and advisability of this approach. As was seen in the opening chapter, the alternative of inexpensively trained medical personnel has been found to be highly appropriate for addressing the most common ailments which persist in Amotepec and other rural regions throughout the "underdeveloped" world.

Implicit in an emphasis on paramedical personnel is a decentralized orientation toward health care delivery. Mexico has been governed by a highly centralized bureaucracy for decades, and there is no reason to believe that decentralization is likely to occur soon. If the Amotepec villagers were allowed to voice their sentiments as to what form of emphasis they would like their government-provided health

services to take, they would in all likelihood express a preference for a highly-trained and experienced physician. This expressed preference should not be mistaken as disinterest in public health or paramedical programs, however. What Amotepecans want most of all regarding matters concerning health and illness is to be healthy. How they achieve this status is largely unimportant. From their perspective, however, physicians have the potential to cure ailments, and that is why they want a "first-class" physician. When Amotepecans say that the "doctor" in their village should know how to cure people, they are not expressing a preference for curative medical services so much as they are expressing a desire to be free of their persistent ailments.

Yet the fact that their ailments persist should not be blamed on the COPLAMAR pasantes. Rather, the greater responsibility for the poor health indices among rural Mexicans (and Amotepecans) lies with the health planners and the medical institutions which train pasantes to work primarily in highly technical urban settings, with almost no preparation in public health measures or low-technology health care delivery in cross-cultural settings. Of course the responsibility for these priorities is linked with the nation's political and economic elite who influence the orientation of such programs.

With a long history of being in a disadvantaged position when interacting with more powerful outsiders, the Chinantec Indians of Amotepec feel powerless to effectively challenge the system which frustrates them. However, the pasante in Amotepec is a convenient, immediately visible representative of the very system which they dislike, and they are quick to fault hin for "not doing what doctors are supposed to do--cure people!" But the pasante, while a convenient

scapegoat, is merely the most obvious representative of a much larger social system in which the rural poor have little power. As one health planner put it, "Is it reasonable to expect individuals [such as pasantes] to fulfill socially useful roles when there exists no context of social responsibility and community service within which to do so, but rather one of ever-increasing potential material reward for the upwardly mobile?" (England 1978:157). This same planner concludes that it is a myth to think that:

> governments are universally committed to improving the health of their populations and that the health planner operates simply as a technical expert within such a context of commitment. In many countries, few things could be farther from the truth. Technical knowledge is one thing--and an essential one--but without political will it is of little use. Where there is presently no such political will because governments represent the more powerful and more healthy rather than the less powerful and less healthy, then development will occur only through demands by the latter upon the former (England 1978:158).

Improving the health status of rural Mexicans requires significant redistribution of resources (especially food-related) and improved environmental conditions (especially pure water, adequate housing, and proper sewage disposal). These kinds of structural changes involve concerns outside of the medical establishment, including land redistribution programs, water agencies, education, roads, agricultural extension services, and financial assistance. In dependent capitalist economies such as Mexico's, the conflicts between class interests prevent the lower classes from enjoying a representative share of the country's health-related resources.

There exist examples of social transformations which have resulted in meaningful redistribution of resources and improved health status for the majority of the population. For example, the socialist

governments in Cuba, Tanzania, and Chile (during Allende's brief tenure), and most recently in Nicaragua, have all prioritized improving the health of the majority, by emphasizing environmental health services and adequate food resource distribution.

Many political scientists who have studied the distribution of health resources in Mexico (Kreisler 1981, Musselwhite 1981, Spaulding 1979, Wilson 1981) agree that the state often distributes medical care services when they are necessary to serve as political mediators between the state and various interest groups. The more politically powerful (or threatening) groups have been found to get the most attention.

The COPLAMAR services are presently being provided without any meaningful accompanying social transformation, leaving the status quo largely intact. The COPLAMAR clinic in Amotepec serves as a part-time emergency first aid station (with the important exception of its vaccination campaigns). The population living in Amotepec's outlying hamlets (comprising half of the clinic's "coverage") derives almost no benefits from the clinic. The referral hospital which is part of the COPLAMAR program provides no benefits to the Amotepec population, although it could, if present bureaucratic admission requirements were relaxed. Yet the COPLAMAR program's primary objective is stated to be to enable Mexico's "marginal" population to enjoy a greater share of the national wealth. We have seen that the villagers of Amotepec also want a greater share of the national wealth, and they feel they have a right to it. However, the COPLAMAR development programs' impact on the lives of the villager of Amotepec has not yet noticeably improved their lives, nor is it likely to in the near future, as presently constituted.

Until such time as Mexico's impoverished rural population gains more favorable access to important health-sustaining resources such as those outlined in this dissertation, there is little reason to believe that their health status will improve beyond what they currently experience as "second-class" Mexicans.

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