



This is to certify that the
dissertation entitled

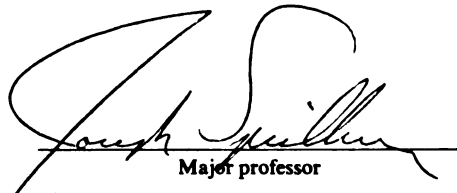
UNDERDEVELOPMENT AND HEALTH IN EL SALVADOR:
A COMMUNITY STUDY

presented by

Anne E. Ferguson

has been accepted towards fulfillment
of the requirements for

Ph.D. degree in Anthropology



Major professor

Dr. Joseph Spielberg

Date February 23, 1987



RETURNING MATERIALS:

Place in book drop to
remove this checkout from
your record. FINES will
be charged if book is
returned after the date
stamped below.

Feb 8 190 9 113 Aug 12 1901		
---	--	--

UNDERDEVELOPMENT AND HEALTH IN EL SALVADOR:
A COMMUNITY STUDY

By

Anne E. Ferguson

A DISSERTATION

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

DOCTOR OF PHILOSOPHY

Department of Anthropology

1987

Copyright by

ANNE E. FERGUSON

1987

ABSTRACT

UNDERDEVELOPMENT AND HEALTH IN EL SALVADOR: A COMMUNITY STUDY

By

Anne E. Ferguson

This study examines the relationship between macro socioeconomic and political processes and community social organization and health. It was conducted in El Salvador from August 1978 through July 1979. Research techniques included participant observation, a census, an illness episode survey, interviews with medical practitioners, and observations in pharmacies and at other sources of health care.

Part I outlines the relationship between the town and broad economic and political developments since 1932. Macro-level trends, including increased export crop production and dependent industrialization, were accompanied by the emergence of three classes: (1) a lower class of agricultural and other wage laborers, small-scale artisans, and tradespeople; (2) a middle class of the more successful artisans, tradespeople, and white-collar workers; and (3) an upper class of owners of large commercial enterprises and agricultural estates and those in semi-professional and professional occupations.

Part II examines the relationship between class standing and health status and use of medical resources. While little difference

Anne E. Ferguson

was found in the kinds of illnesses reported by class, the lower class experienced higher rates of illness and more deaths among children under the age of five years than did the middle and upper classes. Class differences in the use of medical resources also were found. The lower class was more likely not to treat illness or to treat it at home than were the middle and upper classes. In consulting medical practitioners, the lower class relied most heavily on pharmacy clerks, and the middle and upper classes sought care principally from physicians.

The health implications of dependent development were considered through an examination of the impact of marketing structures for pharmaceutical products on the medical sector. The easy access to prescription and other medications through pharmacies has altered local healing traditions and has given rise to cultural, social, and clinical forms of commerciogenesis, or commerce-induced illness.

The study concludes by examining the relationship between the medical system and the political and economic structure, and by suggesting directions for future research.

To Margaret E. and Robert S. Ferguson

ACKNOWLEDGMENTS

This research was supported by a pre-doctoral traineeship from the National Institute of Mental Health grant 5 T32 MH 15132-02 awarded to the Medical Anthropology Program at Michigan State University. I would like to thank my major professor, Dr. Joseph Spielberg, and the other members of my doctoral committee, Dr. Arthur J. Rubel, Dr. Brigitte Jordan, and Dr. Rita S. Gallin, for the advice they have given me in preparing this dissertation. Dr. Rita Gallin was especially helpful in providing critical comments and encouragement. I owe special thanks to my husband, Merritt Sargent, who is a constant source of good humor and support, and to my Salvadoran friends, Julio and Ana Salazar and their family, who generously provided me with a home away from home during the research process. I am most indebted to the many families in Asunción who participated in the study.

TABLE OF CONTENTS

	Page
LIST OF TABLES	x
LIST OF FIGURES	xiii

Chapter

I.	PROBLEM STATEMENT AND THEORETICAL PERSPECTIVE	1
	Choice of Research Site	6
	Micro-Macro Analysis in Anthropology: A Review	9
	Community Studies	9
	Medical Anthropology Investigations	12
	Micro-Macro Analysis: Objectives and Methodology of the Current Study	20
PART I		
II.	ASUNCION: HISTORICAL BACKGROUND AND OVERVIEW OF NATIONAL DEVELOPMENTS, 1932-1979	25
	The History of Asunción: Pre-Conquest Era Through 1932	26
	National-Level Socioeconomic and Political Developments: 1932-1979	40
	The Political Context	40
	The Economic Context	46
	Health Status and the Organization of Medical Care: An Overview	65
	Conclusion	78
III.	ASUNCION: DEMOGRAPHIC AND SOCIOECONOMIC OVERVIEW	81
	The Department and the Region	82
	Asunción: Physical Organization	87
	The Community Census	91
	Population Characteristics	93

	Page
Economic Organization	99
Occupations of the Household Heads	99
Occupations of Other Family Members	113
Educational Characteristics	118
Housing Characteristics and Ownership of Consumer Goods	127
Conclusion	136
IV. ETHNICITY AND CLASS	138
The Indigenous Community	138
Indians in Anthropological Perspective	139
Asunción in the 1950s: Adams's Survey	142
Folk Catholic or Popular Celebrations	146
Indian Households: Methodological Issues and Residential Characteristics	160
Social Class Divisions	163
Methodological Considerations	166
Social Class: A Perspective From the Community . .	195
Conclusion	199
V. DOMESTIC ORGANIZATION	202
Religious Affiliation	202
Civil Status and Household Organization	209
Civil Status	213
Household Organization	228
Conclusion	245
PART II	
VI. HEALTH STATUS AND THE USE OF MEDICAL RESOURCES	249
Medical Anthropological Paradigms	250
Health Status: Methodological Considerations	252
Health Status: An Overview	256
Class Differences in Use of Health-Care Resources . .	270
Home Treatment	270
Use of Medical Practitioners	276
Class Differences in Work Patterns and Household Organization: Implications for Perception and Treatment of Illness	282
Conclusion	290

	Page
VII. THE ROLE OF PHARMACIES IN THE DELIVERY OF HEALTH CARE .	292
The Multinational Pharmaceutical Industry in Developing Countries: Health and Economic Consequences	293
Pharmacies' Role in the Delivery of Health Care . . .	397
National Business and Regulatory Structures	299
Pharmacy Owners' Relationship to National Drug Distribution Networks	305
Purchasing Patterns and Prescribing Practices . . .	314
Customer Services	328
The Introduction of Western Medicine	331
Medicalization and Commerciogenesis	335
Cultural Forms of Commerciogenesis	337
Social Forms of Commerciogenesis	340
Clinical Forms of Commerciogenesis	343
Conclusion	345
VIII. SUMMARY AND CONCLUSIONS	348
Summary	348
Implications and Directions for Future Research . . .	360
Middle American Community Studies	360
Medical Anthropological Investigations	361
Policy Implications	366
APPENDICES	
A. STRATIFICATION PROCEDURE	371
B. HOUSEHOLD COMPOSITION	373
C. COMPLAINTS INCLUDED IN THE ILLNESS CATEGORIES	375
ENDNOTES	378
BIBLIOGRAPHY	390

LIST OF TABLES

Table	Page
2.1 Ten Leading Causes of Death in El Salvador in 1975 . . .	66
2.2 Ten Leading Causes of Out-Patient Consultation in 1975 .	67
2.3 Ten Leading Causes of Hospitalization in 1975	68
3.1 Regional Variations in Mortality and Natality Rates, 1976	85
3.2 Cases of Malnutrition in Children Under Age Five, 1976 .	86
3.3 Population of the Municipality, 1930-1978	94
3.4 Occupations of Household Heads	100
3.5 Occupations of Household Members 15 Years and Older by Household Heads' Occupational Sector	115
3.6 Household Heads' Level of Education by Occupational Sector	121
3.7 School Attendance of Children 8-15 Years of Age by Occupational Group	126
3.8 House Type by Occupational Sector	133
3.9 Radio, Television, and Motor Vehicle Ownership by Occupational Sector	135
4.1 Ethnic Group by <u>Barrio</u>	162
4.2 Occupational Composition of Strata I and II (the Lower Class)	171
4.3 Educational Characteristics of Strata I and II (the Lower Class)	173
4.4 Housing Characteristics of Strata I and II (the Lower Class)	174

	Page
4.5 Radio, Television, and Motor Vehicle Ownership in Strata I and II (the Lower Class)	176
4.6 Occupational Composition of Strata III and IV (the Middle and Upper Classes)	183
4.7 Educational Characteristics of Strata III and IV (the Middle and Upper Classes)	185
4.8 Housing Characteristics of Strata III and IV (the Middle and Upper Classes)	187
4.9 Radio, Television, and Motor Vehicle Ownership in Strata III and IV (the Middle and Upper Classes) . . .	188
5.1 Religious and Ethnic Affiliation of Household Heads by Class	204
5.2 Civil Status and Ethnic Group of Household Heads by Class	216
5.3 Age and Ethnic Group of Household Heads by Class	219
5.4 Marital Status of Household Heads by Age and Class . . .	220
5.5 Religious Affiliation and Ethnic Group of Household Heads by Marital Status	223
5.6 Civil Status and Ethnic Group of Female Household Heads by Class	225
5.7 Household Composition and Ethnic Group by Class	231
5.8 Nuclear Family Types by Ethnic Group and Class	233
5.9 San Isidro, Guatemala, Female-Headed Households by Type and Percentage of Category	239
5.10 Asunción, El Salvador, Female-Headed Households by Type and Percentage of Category	241
5.11 Household Composition and Ethnic Group of Female Household Heads by Class	242
6.1 Age and Sex of Patients at the Asunción Health Center, January and May 1979	255
6.2 Causes of Death in Asunción, January-December 1978 . . .	258

	Page
6.3 Reasons for Consultation at the Asunción Health Center, January and May 1979	259
6.4 Cases of Malnutrition in Children 0-4 Years of Age, January and May 1979	261
6.5 Class Differences in Reported Illnesses	263
6.6 Illness Rates by Class	266
6.7 Natality and Child Mortality Rates by Class	268
6.8 Ethnic Differences in Illnesses Among Lower-Class Households	269
6.9 Class Differences in Home Treatment	271
6.10 Ethnic and Class Differences in Home Treatment	275
6.11 Types of Medical Resources Used by Class	279
6.12 Types of Medical Resources Used by Lower-Class Households by Ethnic Group	283
7.1 Number of Customers and Average Amount Spent at Pharmacies	316
7.2 Types of Illnesses Treated at Pharmacies	318
7.3 Total and Average Amount Spent by Illness Category at Pharmacies	320
7.4 Relationship Between Age of Patient and Type of Medicine Recommended at Pharmacies	323
7.5 Price Differences by Source of Supply of Medicine: Patients Treated for Grippe at Pharmacies	325

LIST OF FIGURES

Figure	Page
2.1 Map of El Salvador	28
3.1 Map of Asunción, 1979	90
3.2 Population Pyramid for Asunción, 1978	95
3.3 Average Number of Completed Years of Education by Household Heads' Age Group	123
3.4 House Ownership by Occupational Group	128
4.1 Annual <u>Cofradía</u> Calendar	150
4.2 Percentage of Ladino and Indian Households by Stratum . .	193
7.1 Distributional Network for Pharmaceutical Products . . .	303
7.2 Sales Offers: The Case of Gesterra	304
A.1 Construction of Stratification Index Variables	371
A.2 Socioeconomic Strata by Clusters	372

CHAPTER I

PROBLEM STATEMENT AND THEORETICAL PERSPECTIVE

This study is about the embeddedness of health and illness in the socioeconomic and political fabric of the nation and international capitalist system. It was conducted in Asunción, El Salvador, from August 1978 through July 1979.¹ The intent is to situate Asunción in its regional and national context and to show that the organization and functioning of its medical sector and the health status of its population are inextricably linked to wider-society processes. That is, health status and the organization of the medical system in the town have developed in complex relationship with changes in other local, national, and international institutions and structures.

The present study consists of two parts. In Part I, the relationship between Asunción and the broader political economy of the country over the last 50 years is outlined. National-level trends such as increased production of crops for the export market and a process of dependent industrialization are reviewed, and their impact on the class structure and on the organization and functioning of domestic units in Asunción is considered. The information in Part I provides the background to consider the health ramifications of El Salvador's development strategy in Part II. Here the relationship

between class standing, health status, and use of medical resources in Asunción is examined. As a case study of the process of dependent development, the effects of the penetration of the multinational pharmaceutical industry on health-seeking behavior and on the organization of the medical sector are considered.

In the seven years since the field research for this dissertation was conducted, many changes have occurred in El Salvador. In 1979, the country was on the brink of a civil war whose outcome remains uncertain today. Before the Sandinista victory in Nicaragua, anthropologists and other academics displayed little interest in El Salvador or other Central American countries. Few general works on the region existed, and there were few book-length studies of the countries. With the exception of Guatemala, there were even fewer community-level ethnographies. The intervening seven years have witnessed an outflowing of books and articles on the region reflecting, on the one hand, Nicaragua's successful revolution and, on the other, the region's consequent increased strategic importance to U.S. foreign policy and military strategists. Works on El Salvador are now numerous (Gettleman, Lacefield, et al. 1981; North 1981; Armstrong and Shenk 1982; Baloyra 1982; Montgomery 1982; Diskin 1983; Russell 1984--to mention only some of the book-length studies available in English). Most of these books focus on the roots of the rebellion--macro-level social and economic processes. The civil war has limited the conduct of long-term or detailed community studies. Thus, while a great deal of information on the country is now available, relatively

little is known about the ways social life on the local or community level is organized in response to many of the broader political and economic trends. This investigation helps to fill that gap.

If the amount of available information on the region has grown, it has been accompanied by a broadening of the debate concerning the nature of capitalist penetration into the region. By the late 1970s dependency theory, particularly the development of underdevelopment school, had come under increasing criticism from modes-of-production, dependent development, and world systems analysts all offering refinements in the study of capitalist penetration. The field work for this dissertation was conducted under the sway of these debates. Its purpose was to examine the impact of macro-level socioeconomic processes on community-level social organization and, more specifically, to study the impact of the pharmaceutical invasion on the town's medical sector. While originally based on the assumption that the impact of generalized socioeconomic and political developments should be reflected in changes in the town, during the course of the investigation and in subsequent years my interpretation has shifted somewhat. My concern and that of many other anthropologists (Nash 1981, DeWalt and Pelto 1985) has moved away from "the impact on" approach toward a more dialectical one which credits local responses and initiatives for change and is concerned with the interaction between the local-level and the broader political economy.

This orientation is reflected in the second major aim of the study, which is to contribute to the growing resurgence of interest in

critical medical anthropology (Baer 1982) or the social relations of sickness (Young 1982). The conceptualization of ill health as essentially a social phenomenon is not new. In the mid-nineteenth century, Rudolf Virchow, one of the founders of cellular pathology and a leading exponent of social medicine, argued that "medicine is a social science, and politics is nothing more than medicine in larger scale" (1958: 106). Virchow and other leaders of social medicine such as Engles (1973) emphasized that political, economic, geographic, climatic, and physiologic factors interacted to cause disease. They repeatedly drew attention to what they regarded as the most important causative factors of ill health--the material and social conditions of people's everyday lives occasioned by the developing capitalist system and class relationships. To treat illness, they advocated far-reaching structural reforms.

This view of health as an essentially social phenomenon amenable to social remedies fell into disrepute by the end of the nineteenth century. Technological developments in the 1870s and 1880s led to the discovery of bacteria, the formulation of the germ theory of disease, and the theory of specific etiology. Taken together, the effect of these developments was to abstract illness from its social framework and reduce it to an individual, biological event (Berliner and Salmon 1980, Waitzkin 1979, Berliner 1975). As Navarro states:

Within that theoretical construct, causality was defined as an association of the observable phenomena, with the subject for investigation being the micro-agents analyzed under the microscope. In focusing on the micro level, the macro social conditions were conveniently put aside (1985: 527).

Thus the rise and institutionalization of the Western biomedical system in Europe and in the U.S. and its subsequent adoption as the basis for health-care delivery in the majority of developing countries has obscured the environmental and social roots of most illness processes.

Today, as Young notes, the ideological grip and power of clinical medicine remain strong:

. . . the success of ideological practices such as clinical medicine lies not in their capacity to confront and refute rival views, but in the power to push these views to the margins of reasoned discourse. Through these practices, socialized knowledge of medicine is made to seem not so much "wrong" or "counter-productive" (which would at least suggest some common ground between conventional and socialized views) as "not medicine at all" or an attempt to "politicize" medicine and science (1982: 275).

Only recently have more inclusive or multifactorial theories, represented by the works of social epidemiologists, some social scientists, advocates of holistic medicine, and Marxist scholars, again gained an audience. Navarro is perhaps the best-known representative of this perspective writing in English on Latin America. In his capacity as editor of the International Journal of Health Services and in numerous publications, he has called attention to the relationship between broader patterns of resource distribution and the class structure on the one hand and the distribution of health-care facilities and levels of morbidity and mortality on the other (1974, 1976a, 1976b, 1985).

In anthropology, there has also been a growing interest in the social origins of ill health and healing, although the dominant

paradigm underlying most studies focuses on the role of cognitive models or beliefs especially as they affect clinical encounters (Young 1982, Hahn and Kleinman 1983). Yet, there is new interest in the social parameters of medicine and health. This is reflected in works by Young (1978, 1980, 1981), Frankenberg (1980), Taussig (1978, 1980), Scheper-Hughes (1984), Browner (1985) Frankenberg and Leeson (1976), Baer (1982), and Morsy (1979, 1981). The present study represents a contribution to this new holism.

This introductory chapter begins with a discussion of the choice of the research site. The relevant literature on micro and macro levels of analysis in anthropology and in medical anthropology then is reviewed. This is followed by a brief overview of the major topics investigated during the course of the research and the methodology employed.

Choice of Research Site

El Salvador was selected as the research site for a variety of reasons. First, in comparison to Mexico and Guatemala where there is an abundance of book-length community studies available (Chambers and Young 1979), only a small number of in-depth Salvadoran community studies exist. Those by Adams (1976), Huizer (1963), Marroquin (1966, 1974), White (1969), Durham (1979), and ethnographic surveys by researchers at the Museo Nacional David J. Guzman in San Salvador (De Guevara 1973, 1975) are the only ones in published form. Thus, as noted above, relatively little is known about local-level social organization or health-related behavior in the Salvadoran context.

Second, the country was chosen as the research site because the effects of many of the broad trends in Central America--especially the growth and diversification of export agriculture and the penetration of multinational and transnational firms--are writ large there. The effects of many of these trends, including increasing landlessness, unemployment, and growing dependence on the importation of technology, have direct ramifications for human health, in some cases leading to high levels of malnutrition and infectious disease. These health consequences are particularly severe in El Salvador because of the great inequality in resource distribution and the concentration of wealth and property in the hands of a few.

Finally, the country provides one of the better contexts in Central America to examine the effects of the penetration of multinational pharmaceutical firms on a community-level system of health care. Beginning with the inception of the Central American Common Market in the early 1960s, El Salvador, along with Guatemala, experienced a rapid growth in foreign investment in the manufacturing sector. A number of multinational chemical and pharmaceutical firms established production facilities in the country. The free-trade zone created by the Common Market facilitated the importation into the region of other medicines manufactured by multinationals.² In addition, products continue to be imported directly from companies in the developed countries, and a small number of Salvadoran firms produce medications for local use. This diversity of supply sources permitted study of the effects of different private-sector marketing

networks for medicines on the organization of the medical sector and on health-seeking behavior.

The choice of Asunción, located in the southwestern Department of Sonsonante, as the site for the community study is related to the above-mentioned factors. First, the town is of general anthropological and historical interest. It has played an important role in Salvadoran history as a center of Pipil civilization, as a major producing region for early Colonial export crops, and as a seat of a large peasant uprising in 1932. Asunción is one of the few remaining Salvadoran communities where vestiges of indigenous social organization persist, although in a much-attenuated form. As will be seen, many of the socioeconomic and political developments in the nation during the past 50 years have had a direct impact on Asunción's social structure and the health status of its population. Conversely, through the participation of some of its population in the leadership of the 1932 peasant revolt, Asunción has had an impact on the overall course of development pursued by the Salvadoran government and military.

Second, and more specific to the medical sector, pharmacy owners in Asunción relied on two different distributional networks in stocking their stores, thus allowing comparisons to be drawn regarding the impact of marketing networks on health care given to clients. Further, because the town has a wide range of alternative and western health-care resources, it was possible to examine the use of pharmaceuticals and pharmacies in a pluralistic medical setting.

Micro-Macro Analysis in Anthropology: A Review

Community Studies

In their 1979 review of Meso-American community studies, Chambers and Young found two trends in the literature of the preceding decade. First, they noted a focus on the theme of change and persistence and, within this context, the adoption of a problem-oriented approach in contrast to the earlier tradition of holistic description. Second, they drew attention to the recent trend to consider the community within a broad context. They stated: "We now seem to realize that to understand what goes on within a community we must examine what goes on beyond a community's boundaries" (1979: 64). This view increasingly is echoed by researchers employing a wide array of theoretical orientations from cultural ecology, systems theory, political economy, and more eclectic approaches. For example, the volume Micro and Macro Levels of Analysis in Anthropology, edited by DeWalt and Pelto (1985), addresses this issue. Contributors with diverse theoretical orientations all contend that the community cannot be studied as an isolate and that larger global processes affecting the local level must be taken into account. Many recent overviews of the anthropological literature also have drawn attention to the pervasiveness of global processes and the need to address them in field work (Nash 1981, Barlett 1980, Smith 1984).

In part, this perspective is an outgrowth of studies conducted in the late 1960s and early 1970s by Frank (1967, 1975), dos Santos (1973), Stavenhagen (1975), and others of the dependency school.

These researchers were reacting against the basic tenets of the predominant theory of development at that time, modernization theory. Proponents of the modernization approach held that underdevelopment resulted from the lack of diffusion of appropriate values, technologies, and skills from the developed to the developing countries and the persistence there of dual economies and cultures. One of the most well-known works reflecting these views is Rostow's Stages of Economic Growth (1962). Research by dependency scholars and others, however, indicated that underdevelopment was due to the nature of the satellites' integration into the capitalist system as suppliers of cheap raw materials and labor rather than their lack of articulation with the metropolitan centers.

This analysis has been extended and modified by world systems proponents such as Wallerstein (1974, 1975, 1980) and by modes-of-production analysts such as Amin (1976, 1977), Mandel (1970), and Laclau (1971). Most dependency, world systems, and modes-of-production researchers propose that capitalism has been the integrating force in the world since the seventeenth century, but they differ in their explanations of the workings of the system. Wallerstein and Frank, for example, call attention to the maximization of surplus in the core or metropolis on the basis of inequalities in the basis of exchange. Wallerstein, in particular, argues that there is only one mode of production--the capitalist world system. This view contrasts with the uneven-development thesis proposed by Amin and Mandel. They contend that a variety of modes of production co-exist and are united by

capitalism. In contrast to Wallerstein, these researchers and others such as Trimberger (1979) recognize specific combinations of pre-capitalist, semi-capitalist, and capitalist modes of production (Nash 1981: 399).

Anthropologists have begun to more critically define their area of contribution and expertise in studying the operations of the world system. Dependency theorists and world systems analysts have been criticized because they often posit a single, usually passive, relationship between the world system and the communities in the periphery.³ For example, Nash (1981: 408) notes two pitfalls in the world systems approach: The outcome seems predictable from the model, and the mobilization of counter forces is doomed to failure. Trimberger argues that, in contrast to world systems and dependency theory, modes-of-production analysis overcomes these limitations:

. . . this model opens the way for understanding between distinct social formations in the world system and a dynamic which is not unidirectional. Precapitalist relations of production are subordinated and distorted by the impact of capitalism, but they too have their own dynamic which has an impact on capitalist development and may serve as the material basis for the genesis of resistance to capitalism (Quoted in Nash 1981: 399).

Smith also provides a critique of a whole-hearted adoption of the world systems perspective in her consideration of social and economic transformations in western Guatemala from the Colonial era to the present. She suggests that anthropologists, in their eagerness to embrace a global view, risk substituting a new kind of global functionalism for the older community-integration functionalism. Smith calls attention to anthropologists' unique areas of expertise:

. . . anthropologists are usually privileged to see, and often record, how people make their own history--how people form local-level institutions that are often opposed to the interests of capitalism, how these institutions are sometimes the means by which peasants or other groups resist capitalist incorporation and, thus, how they are responsible for the particular kind of capitalism extant in peripheral social formations (1985: 84).

In a similar fashion, Bennett argues that local systems are not simply passive recipients of global processes. He contends anthropology's major contribution lies in the study of the adaptational nexus: "how local people cope with external influences and how they strive to modify these forces in Third World countries" (1985: 46). Increasingly, then, anthropologists have drawn attention to the fact that the micro level is not passively shaped by macro-level forces and that capitalism is a sociocultural as well as an economic construction.

Medical Anthropology Investigations

This same trend is observable, if on a small scale, within the field of medical anthropology. Young (1982) provides a recent overview of major trends in this field. He identifies two major subareas in medical anthropology, one employing a biological and the other a sociocultural orientation. Within the sociocultural field, Young distinguishes between works which adopt empiricist epistemologies and those that rely on nonempiricist epistemologies. He suggests that these two approaches are separated by different premises. Empiricist-oriented researchers believe they are uncovering facts about the world, while nonempiricists see their analyses as products of a particular social and historical context.⁴

Young discusses three approaches within the nonempiricist tradition: traditional anthropological investigations, the anthropology of illness, and the anthropology of sickness. In the traditional investigations, sickness events are studied as vehicles to understand other constellations of facts. Examples include the classic ethnographies of Evans-Pritchard (1937) and Turner (1968). In the second approach, the anthropology-of-illness school, represented by the works of Kleinman (1980), Hahn and Kleinman (1983), Fabrega (1974), Good (1977), and Good and Good (1981), theoretical orientations similar to those in many traditional ethnographies are employed. Cognitive structures, values, beliefs, and world views are seen as key explanatory concepts in understanding health behavior. Because this represents a major subfield within medical anthropology and because it has served as the backdrop for the development of alternative approaches, it deserves more detailed review.

Anthropology-of-illness advocates generally give primacy to the study of how individuals make sense out of and adapt to illness, disease, or other worrisome personal circumstances. Cognitive structures are a primary focus of many of these studies. Good, for example, has pioneered the study of semantic illness networks--the network of words, situations, symptoms, and feelings that are associated with an illness and give meaning for the sufferer (Young 1982: 263). Kleinman has delineated explanatory models (EMs)--sets of beliefs which address etiology, onset of symptoms, pathophysiology, the course of the illness, and treatment. Kleinman, Good, Fabrega,

and others reject the physicalist reductionism of the biomedical model and adopt a scheme whereby, in Kleinman's words:

In the language of our model, disease denotes a malfunctioning in or maladaptation of biological and/or psychological processes. Illness, on the other hand, signifies the experience of disease (or perceived disease) and the societal reaction to disease. Illness is the way the sick person, his family and his social network perceive, label, explain, evaluate and respond to disease (1978: 88).

Kleinman uses the term "sickness" as a blanket term for disease and illness.

Frankenberg (1980) and Young (1981, 1982) have called attention to the strengths of the anthropology-of-illness approach. These include the elucidation of the connection between sickness and people's statements about sickness and the distinction between disease and illness which avoids the biological reductionism of biomedicine. This distinction represents a useful framework for teaching medical practitioners the meaning of illness and the limitations of the biomedical model for clinical practice.

Yet, these authors also have drawn attention to the limitations of the approach, particularly the focus on the individual as the arena of significant events and the clinical/curative orientation. Young (1982: 269) finds that while the disease/illness scheme avoids the physicalist reductionism of the biomedical model, it nonetheless shares with it a focus on the individual. Neither requires writers to give accounts of the ways in which social relations shape and distribute sickness. For example, regarding the work of Kleinman and Good, Young states:

Look at it from their point of view: (a) their theoretical interests focus on clinical events and the healing (illness) process; (b) looking outward from the clinical setting, social relations can be seen to radiate dyadically, i.e. between patient and practitioner, patient and individual family members, and so on; and (c) while there are social factors that lie outside this circle, they can be deferred indefinitely without seriously affecting our ability to study the healing process (1982: 269).

In a similar vein, Frankenberg (1980: 199) notes that this approach reduces social reality to a series of dyadic relationships radiating from the clinical encounter. Young (1982: 280) summarizes his objections to the anthropology of illness by noting that the key concepts used in this endeavor--illness, healing, efficacy, explanatory models, and semantic illness networks--cannot be understood in relationship to one another. That is, by themselves they do not constitute an adequate system for describing medical beliefs, experiences, events, or behaviors.

The third approach, the anthropology of sickness, provides a holistic model. Proponents of this approach argue that what is missing from the anthropology-of-illness equation is an understanding of the social relations which produce the form and distribution of sickness in society. In somewhat different fashions, Young and Frankenberg propose the study of the ways in which disease is made social--the social relations of sickness or what Young terms the anthropology of sickness. Both rely on a three-part paradigm in which disease retains its meaning as organic pathology and illness continues to refer to how disease and sickness are brought into the individual consciousness, but sickness is redefined. Young (1982: 270) terms sickness a process through which worrisome behavioral and biological

signs are given socially significant outcomes, in other words, a process for socializing disease and illness. Frankenberg (1980: 199) uses sickness to refer to the total societal context in which disease is inserted. He offers the following illustration of the meanings of illness and sickness:

By using the concept of illness, we enable the physician to see how his view differs from the patient—and how he can impose his cure. The concept of sickness enables us all including physicians to see more clearly the significance (in U.S. public medicine) of, for example, the maleness and whiteness together with the class position of the physician and the femaleness, blackness and subordination of the patient. Neither black woman nor white professional male steps outside society when they step into the consulting room (1980: 199).

While these authors agree on the need to "socialize" medicine, they do so in different fashions. Young is interested primarily in what he terms medical productivity: "the direct and indirect impact of particular clinical practices and perspectives on levels of morbidity and mortality of the population at large" (1982: 278). Essentially, then, he accepts the terrain defined by the anthropology-of-illness proponents--the clinical encounter, healing, curing--and suggests that the horizons of study be broadened to include how power relations, class, and other social factors impinge on it and what the overall effects are for the distribution of illness and disease in society.

In contrast, Frankenberg proposes an approach which relates medical anthropology more closely to research and theory in other branches of anthropology. He rejects the notion that medical anthropologists' special domain lies in the study of small-scale

social processes and cognitive structures and suggests instead that they situate their investigations within the context of the recent work on development and modes of production. More specifically, Frankenberg proposes that there is a relationship between modes of production and medical systems:

The economy of health care (traditional or Western), the ideology of beliefs and practices relating to disease and of the concept of disease itself, the politics of healer-patient and patient-patient relations, like other aspects of economy, ideology and politics, are all subject to and the subject of changes in the nature of production relations and the relationship between one set of production relations or mode of production and another (1980: 197).

These more generalized or macro-level parameters, then, are regarded as integral to the study of medical systems and medical pluralism.

Morsy makes similar observations. In arguing for the need to expand the parameters of the field beyond the traditional focus on local-level beliefs, values, and cognitive systems as they relate to health in the Middle East, she notes:

But, these researchers must recognize, as none have to date, the dialectical relations between these beliefs people so firmly hold and the social conditions under which they live. The error of the literature is to isolate these belief systems from social conditions. In short, the limitation of studies of competing medical systems in the Middle East lies, not in their concern with indigenous medical beliefs, as such, but in their emphasis on such beliefs to the neglect of the political economic context (1981: 161).

Taussig (1978) makes similar forceful observations about the relationship between nutrition, health, and foreign aid in Colombia.

Janzen (1978a, 1978b) also draws attention to the need for more macro-analysis in medical anthropology in order to study change in the

structure of medical systems. In his study of the Kongo medical institutions within Zairian national society, he shows that the formation of the units studied in micro-level analysis depends largely on exogenous forces extending over a greater social scale than the local community and clinical practice.

Thus, there is a growing awareness in the field of medical anthropology of the macro-level socioeconomic and political parameters of medicine and the social origins of ill health. Although medical anthropologists are relatively new to this endeavor, as indicated above, the field of inquiry itself has an extensive history and has many adherents in other social science and medical disciplines. The works of Elling (1977, 1978, 1981), Gish (1979), Waitzkin (1974, 1976, 1979), Waitzkin and Waterman (1974), Doyal (1979), Turshen (1984), and Navarro (1974, 1976a, 1976b, 1985) probably have had the greatest impact on medical anthropology.

Anthropologists interested in the political economy of health have pursued two different paths of investigation. Some, such as Baer (1982, 1985) and Onoge (1975), have largely accepted the terrain of the political economists and have become anthropologists doing political economy. Other researchers have sought the nexus points between anthropology and political economy. Like Nash (1981), Smith (1985), and Bennett (1985), who are concerned with micro-macro articulations, they have attempted to delineate anthropology's areas of expertise in studying the world system and the impact of capitalism on health.

The clearest articulation of this point is found in work by Frankenberg (1980) and Morsy (1979). Both have termed anthropology the "missing link" in the study of the political economy of health. Frankenberg contends that anthropology is unwise to limit itself to the study of social processes at the local level:

... for it seems to me that it can potentially reveal the "missing link" without which the analysis of major social change founders (for lack of an anchor chain); what effects are produced at the local level by national and international processes; and what is coming from the local level in return (1980: 206).

These authors, and others such as Scheper-Hughes (1984), seek to discover the broad roots of ill health through the investigation of asymmetrical power relations in society.

This brief review of recent trends in medical anthropology has indicated that, similar to trends in other branches of anthropology, there is growing recognition of the relevance of macro-level processes for the study of health and illness and growing concern with identifying medical anthropologists' special areas of contribution to the study of world systems and micro-macro relationships in the health field. As indicated above, the origins of this interest in medical anthropology stem from the works of Janzen (1978a, 1978b), Frankenberg (1974, 1980), Young (1978, 1981, 1982), and others who are grounded in social anthropology, and from anthropologists such as Morsy (1978, 1979, 1981), Taussig (1978, 1980), and Baer (1982, 1985), who are grounded in political economy and the anthropology of development.

Micro-Macro Analysis: Objectives and Methodology
of the Current Study

The general purpose of this investigation is to examine the relationship between macro-level socioeconomic and political processes in El Salvador and community organization. The study deals with broad issues of development such as the expansion in export-crop production and dependent industrialization. It attempts to show how these trends have influenced Asunción's class structure and what the implications of these trends are for health status and the organization of the medical sector.

The investigation consists of two parts. In the first, the relationship between Asunción and the broader political economy of the country over the last 50 years is outlined. Chapter II examines the history of Asunción through 1932 and reviews the national-level socioeconomic and political trends since that date. Chapter III illustrates the impact of these trends in Asunción. It presents an overview of the community's major demographic and economic characteristics in 1978-79. Chapter IV extends the analysis of the impact of the major economic and political trends by examining the resulting class and ethnic structure in Asunción. Information on the social organization of the indigenous community is presented, the class structure is delineated, and the relationship between class and ethnicity is explored. This class framework is used in Chapter V to consider domestic organization.

The information in Part I provides the background to situate the investigation of health status and the use of medical resources

reviewed in Part II. Here the health ramifications of El Salvador's development strategy are examined in the context of Asunción. Chapter VI reviews the health status of the population, paying particular attention to class differences in reported illness and to the relationship between domestic organization and health status. Here also the organization of the medical sector and the use of health-care resources are considered. Chapter VII focuses on pharmacies--endpoints in an international system of distribution and sale of medicines, major sources of health care, and keys to understanding pluralism in the medical sector.

Currently, there is considerable interest in the development of methodologies for studying micro-macro relationships. Numerous strategies have been proposed to operationalize this research perspective. These include specific diachronic investigations of communities and regions (Smith 1985, Taussig 1978); quantitative and qualitative studies of the dimensions of exchange between the micro and the macro context (Bennett 1985); studies of brokers and other mediators between the community and the world system, such as regional class structures and state and political institutions (Smith 1985); studies of formal and informal networks that link people competing for resources and power (Whiteford and Montgomery 1985); and studies to identify linking concepts such as power, class, cultural brokers, and commodities (DeWalt 1985). Pelto and DeWalt (1985) present the fullest treatment of these methodologies to date.

Although some of these strategies had not been formalized at the time of this field work, many of these techniques were employed. First, the present analysis is diachronic. Although there are no other long-term community studies of Asunción which would offer a point of comparison, historical accounts of the town are relied on as a means of gauging change in socioeconomic organization. Second, local-level class and ethnic structures are seen as resulting from, and also mediating, the impact of national and international processes on the community. Third, much as class and ethnicity are viewed as important nexus points in studying the effects of the broader political economy, household structure and organization are seen as nexus points for the study of health-seeking behavior and health status. Fourth, in studying the health sector, efforts are made to identify and examine other nexus points between the local context and the broader global system. Pharmacy personnel and pharmaceutical company sales representatives are considered to function as brokers between western and alternative medical traditions. Private-sector marketing networks for pharmaceutical products are considered as important linking mechanisms between the local, national, and international levels. Thus, health status and the configuration of the medical sector in Asunción are seen as resulting from a dynamic interaction among a series of forces originating at the international, national, and local levels.

A range of field research techniques was employed. General socioeconomic and demographic information was gathered through a

census of one-fourth (525) of the households in Asunción and through reviews of national and municipal government documents. Information on health status was collected from the health center records, municipal birth and death records, formal and informal interviews with health-care providers, observations at pharmacies and at the health center, and an illness episode survey involving a stratified sample of 72 families. More detailed information on each of these research techniques is provided in the relevant chapters.

As is the case with most anthropological investigations, the technique that provided the most valuable information was participant observation. Without the insights gained from participant observation, it would have proved difficult to interpret the findings of the more formalized research techniques. More important, the confidence between the researcher and the community, which is implicit in participant observation, allowed the field work to be carried out. The period of 1978-79 was one of growing government repression in El Salvador. In Asunción, and in many other communities, this took the form of severe government curtailments of civil liberties, kidnappings, and sequesterings of cars and trucks by the right and the left, burning of buses and other modes of transportation by the left, and murders, mutilations, and bombings by right-wing death squads. During 1979, nearly 30 people in Asunción were threatened by these death squads, and six were injured or murdered. Only mutual confidence permitted completion of the research endeavor.

PART I

CHAPTER II

ASUNCION: HISTORICAL BACKGROUND AND OVERVIEW OF NATIONAL DEVELOPMENTS, 1932-1979

This chapter provides an overview of Asunción's history from pre-conquest times through 1932 and a consideration of national socioeconomic and political developments since that date. It gives the necessary background for a more detailed consideration of the social organization and health-related characteristics of the community in 1979, and it presents the macro-level parameters that have given rise to the growth of export-oriented agriculture, dependent industrialization, and increased foreign investment in the economy.

The chapter is divided into three sections: the town's history through 1932, national economic and political developments from 1932 to 1979, and characteristics of the official medical delivery system and disease processes in the country. Community and national-level developments are examined in the context of their articulation with the world market economy. Attention is drawn to the relationship between economic and political processes, the organization of the medical delivery system, and the health status of the majority of the population.

The History of Asunción: Pre-Conquest Era Through 1932

Asunción was founded by Náhuatl speaking peoples who migrated to the western portion of present-day El Salvador after the collapse of the Toltec Empire in the middle of the eleventh century. Relying on information provided by the chronicler Fray Juan de Torquemada, Lardé y Larín states that:

After the collapse of Anáhuac's Toltec empire, the last ruler of Tula, Topilzín Acxítl Quetzalcóatl, emigrated to Central America and founded Escuintla in Guatemala and Tecpan-Izalco and Cuzcatlán (1050) in El Salvador; hence the indigenous community of [Asunción] dates from at least the early part of the second half of the XI century, A.D. (Quoted in De Guevara 1975: 203-204, author's translation).

By the time of the Spanish Conquest, these indigenous people, who became known as the Pipil, had subdued and incorporated the surrounding Mayan communities. Relatively little is known about the social structure of this period. It appears that the area west of the Lempa River was divided into two or three mini-states, one centered in the region around Asunción. Each state presumably had a hierarchy of religious officials and secular headmen. Families were grouped into clans (capulli), and social gradations of commoner, serf, and slave may have existed. Economic activities revolved around the production of maize, beans, chile, squash, and cocoa. It appears that a system of markets using cocoa beans as currency had developed (White 1973: 22). In 1550, 26 years after the Conquistador Pedro de Alvarado first entered the area that is now El Salvador, Asunción had a population of some 4,500 inhabitants and was the largest Indian community in the region (De Guevara 1975: 204). Nevertheless, by this time the

population had already declined due to warfare with the Spanish and epidemics of disease.

The region in which Asunción is situated (Figure 2.1), known in Colonial times as Los Izalcos, first fell under the jurisdiction of the Audencia de los Confines and later under the Audencia de Guatemala. Throughout the Colonial period, and well into the nineteenth century, the community was divided into two separate but contiguous administrative units--one Ladino and the other Indian.¹ Archbishop Pedro Cortés y Larraz, who visited the town in 1770, reported that the majority of the indigenous population resided in Asunción while the Spanish lived in Dolores. Each ethnic group had its own hierarchy of officials and communal lands. In addition, there was also a local municipal government (alcaldia municipal) structure which represented the town as a whole (Lardé y Larín 1957: 90, Brown-ing 1971: 89-90). After independence from Spain, the indigenous and Spanish communities were briefly unified, but in 1853, at the request of the indigenous population, an executive decree again created two governmental units. In 1862, when the town was granted the title of city (ciudad), it retained the dual form of organization, and it was not until 1869 that an executive decree once more created a single municipal structure (De Guevara 1975: 205).

This history of division into two administrative units reflects the ethnic differences present since Colonial times, differences that persisted in this part of El Salvador longer than elsewhere due, in large measure, to the region's mode of integration into the Spanish

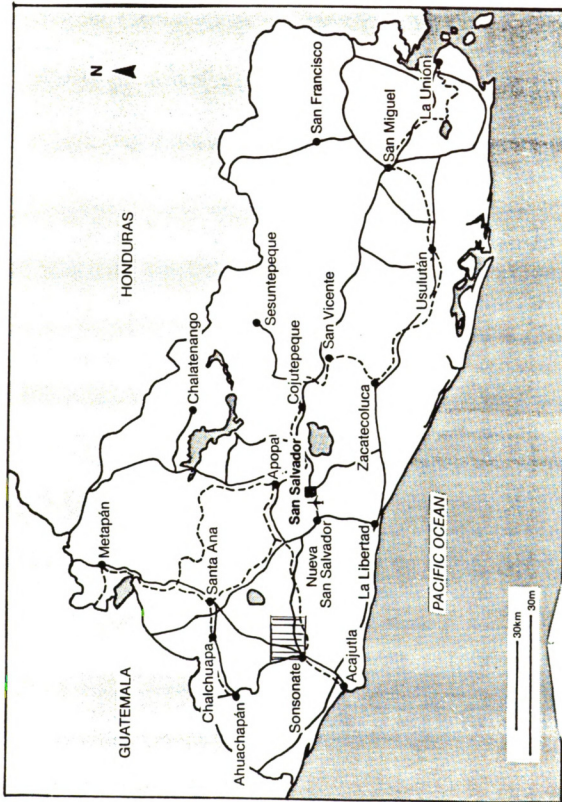


Figure 2.1.--Map of El Salvador. (Source: Maps on File. New York: Facts on File Publications, 1982.)

Empire. Unlike the Indian population east of the Lempa River, the Pipil were settled agriculturalists toward whom a policy of indirect rule was implemented as the most effective means of siphoning off wealth. In contrast to the northern and eastern parts of El Salvador where the Spanish established large estates (haciendas) which progressively encroached on Indian community lands and which relied on the indigenous population as laborers, in the Los Izalcos region the interests of Spanish merchants and traders won out over those of the holders of land grants from the King (encomenderos) and hacienda owners. Indigenous communities retained control over their lands to a greater degree than elsewhere and maintained much of their social structures but were required to pay tribute and to trade in agricultural products such as cocoa and balsam. The Spanish relied on indigenous headmen who were responsible for organizing the production of these crops and for the collection of tribute payments.

Although it was against Crown policy for Spaniards to settle in Indian communities, traders and merchants quickly established themselves in the larger towns in order to better supervise the collection of tribute and to trade more directly with the Indians. Spanish merchants had taken up residence in Asunción as early as 1549. Pineda provides a description of the economic activities at that time:

. . . Most villagers have cacao orchards . . . everybody owns mules which they use for carrying their harvest to [Asunción] where much cacao is taken . . . and they sell it to the Spaniards that are there; all the Indians here dress well and are well adorned with decorations and should be able to give double their present tribute (Quoted in Browning 1971: 56-57).

Throughout the sixteenth and into the early seventeenth century, the Los Izalcos region was the major cocoa and balsam producer in the Spanish empire, and Asunción was one of the most important trading centers in Central America.

The epidemics of disease that swept the area during this period brought about further declines in the number of Indians. MacLoed (1973: 87) reports that because of the resulting labor shortages, Indian owners of cocoa fields in Asunción paid high wages to attract workers from as far away as Verapaz in order to meet tribute payments. Browning suggests that population declines in the Los Izalcos region may have been somewhat less than in other parts of the country where labor requirements on Spanish haciendas had brought about the forced recruitment of Indian workers. This practice, which resulted in great disruption of indigenous social structure, may have caused high mortality (Browning 1971: 63).

While cocoa and balsam production tapered off during the seventeenth century due to declining population and to competition from other producing areas in the Spanish empire, these crops remained the most important source of revenue until the mid-eighteenth century. Lardé y Larín notes that in 1722 ashes from a newly formed volcano destroyed many of the cocoa fields around Asunción, causing the mayor to order them replanted (Lardé y Larín 1957: 478). The Spanish continued to rely on local headmen as a means of organizing labor and collecting tribute, a system that by this time had led to a type of class stratification within the indigenous community and to

exploitation of Indian workers by members of their own population. In a trip through the area in the 1770s, however, Archbishop Cortés y Larraz reported that land was being used primarily for the production of food crops and that little cocoa or balsam was being grown (Quoted in Browning 1971: 60).

Although by the end of the Colonial period the Los Izalcos region had sunk into relative obscurity, reliance on indigenous communities as direct producers of export crops had lasting ramifications. In the nineteenth century, this area was one of the few in El Salvador where Indians retained use of their language and dress and where vestiges of their social structure and land use patterns persisted.

At the time of independence from Spain, El Salvador inherited a land tenure system in which private property co-existed with communal rights granted by the Crown to Indian communities and Spanish municipalities. Both Indians and Ladinos had such lands in Asunción. In the early years after independence, the Salvadoran government sought to stimulate the production of a variety of export crops without significantly altering these land tenure patterns. By the mid-nineteenth century, this policy changed. Coffee, which was well suited to the hilly terrain and climate of the central highlands, began to receive preferential treatment, and a series of incentives were offered to encourage its production. Laws were passed granting individual title to parcels of community land planted in coffee and other export crops. In the areas best suited for coffee production, communal lands were progressively encroached upon by owners of large

estates. Anderson (1971) reports that this gave rise to a revolt of the indigenous community in Asunción in 1879.

By the end of the nineteenth century, coffee was the most important export crop, and the owners of the large coffee estates (fincas) were the most powerful political and economic group in the country. The emphasis placed on coffee reflected the prevailing liberal economic theory, which held that each country possessed certain natural advantages that when exploited would result in economic development and prosperity. During Colonial times, export production had been accompanied by a concern with the production of food crops for local consumption. In the late nineteenth century, this balanced approach gave way to a philosophy stressing the elimination of all obstacles to the expansion of export crops. The coffee growers' political and economic power led to a re-evaluation of the system of community-held property. The tierras comunes of the indigenous settlements and the ejidal grants of the Spanish municipalities came to be regarded as hindrances to progress and development. In 1879, the government conducted a survey that revealed the communities laid claim to roughly one-fourth of the country's land (Browning 1971: 190). In Asunción, the tierra común encompassed 38 caballerías or approximately 4,180 acres. Here, and in many other towns, communal lands were used primarily for the production of food crops such as maize and beans. Given the slash-and-burn agricultural methods that were often employed, large tracts of these lands were left fallow or were used for grazing.

The results of the national survey led the government to adopt a series of reform measures aimed at the conversion of communal lands to private property. In 1881, a decree was issued abolishing the tierras comúnes of the indigenous communities. The preamble to this law stated that the persistence of such traditional structures impeded agricultural development and the circulation of wealth and weakened family bonds and individual independence. Hence, they were contrary to the economic and social principles adopted by the Republic (Browning 1971: 205). In 1882, a similar decree abolishing the ejidal holdings was issued. In both cases, the lands were to be divided among the users and the remaining tracts sold. An announcement posted at the municipal building in Asunción survives from this period. It notified the townspeople, most of whom could not read, that properties had to be registered by August or rights to them would be lost:

To the Citizens of [Asunción]:

By August the six month period will have elapsed during which the law requires landholders to apply for registration of their titles. Therefore, all who hold lands in the ejidos of this town must present themselves to the major to make a verbal claim for the title of this land. Those who delay will lose their legal rights over the land (Browning 1971: 209).

These measures were followed by a series of decrees that permitted property owners to expel renters and squatters and that created a rural police force to aid in this process. Laws against vagrancy which obliged peasants to work for landowners also were enacted. These decrees later formed the basis for the 1907 Agrarian Law.

By the first decade of this century, the conversion of communal lands to private property was completed. Browning (1971: 174-175)

provides one of the most detailed analyses of this period. He notes that in a relatively short time the government succeeded in altering an agrarian system that had evolved gradually during the preceding four centuries, substituting for it a system based exclusively on the concept of private ownership. Both the land and its inhabitants came to be viewed as capital resources to be employed by a few for the accumulation of personal fortunes. The Salvadoran sociologist, Marroquín (1966: 189), stated that as a result of these measures land became concentrated in the hands of a small number of property owners while the vast majority of the rural population sank into poverty. The problem of land scarcity for small farmers and the pattern of seasonal migration in search of work during peak planting and harvesting times, so characteristic of twentieth century El Salvador, date from this period.

The consolidation of landholdings was characteristic especially of the central highland areas best suited for coffee production. In Asunción, which lies along the southern margins of this zone, many Indian and Ladino families were able to retain possession of small plots of lands although the degree of economic autonomy represented by community control over resources was destroyed. While not landless, the majority became dependent on seasonal work in nearby coffee fincas for part of their livelihood (Anderson 1971: 18).

Overall, the country's economic dependence on the export of a single crop increased as a result of these liberal reform measures. In 1901, coffee accounted for 76% of the total value of exports. By

1931 this had risen to 95.5% (Browning 1971: 222). The world Depression which began in 1929, however, brought about drastic declines in the international price of coffee. It precipitated a crisis that influenced the subsequent political, economic, and social evolution of the country and Asunción in particular.

One of the immediate consequences of the worsening economic situation took place in January 1932. This was the occurrence of a large peasant uprising followed by one of the most brutal repressions of such a movement in Latin American history. The revolt was centered in the southwestern coffee producing area where peasants had been affected by the loss of communal lands and were increasingly dependent on work on the coffee fincas. Agricultural wages fell dramatically in 1930 and 1931 as employers sought to pass losses on to workers. Anderson, who provides a detailed account of this rebellion, summarizes the reasons for campesino discontent. He notes that the breakdown of the communal land-holding structure, the miserable treatment accorded agricultural workers, the social dislocations caused by the coffee economy, the cultural hostility between Indians and Spanish in western El Salvador, and the class hostility between campesinos and landlords combined with the economic disaster of the Depression to provide the basis for the revolt (1971: 21).

The uprising was organized by Farabundo Martí and a small group of university students and labor leaders. While inspired by Marxist ideology, it was neither directed by international communists nor did it receive significant financial support from these sources. In the

late 1920s, as a means of gaining support for the leftist movement, popular universities had been organized in the countryside, and sympathetic school teachers were enlisted to disseminate information and to politicize and organize the rural population. The program advocated by the movement included the following types of measures: nationalization of the means of transportation and communication; a 36-hour work week; unionization and the right of campesinos to strike; security against unemployment for ill health, maternity, and old age plus the establishment of minimum wages; free universal education; cultivation of all available lands; progressive taxation; equal opportunities for women; and an end to the Indian caste system (Anderson 1971: 67). The revolt was planned sometime in 1931 after the military coup that overthrew president Arturo Araujo. Installed in his place was the first in a long line of military presidents, General Hernández Martínez. With Martínez as president, it became apparent that peaceful means of organizing and attaining power were no longer viable options.

One of the principal seats of the revolt was Asunción. Here, the leader of the indigenous community, Feliciano Ama, and a number of Ladinos, among them Eusebio Chávez and his son Leopoldo, had allied themselves with the leftist movement. While abolition of the communal lands had undercut the indigenous community's economic basis, social and political forms of organization, in particular the headman (cacique) system and the religious brotherhood (cofradía) structure, remained intact. These became the means by which the population was

mobilized to participate in the revolt. In the 1920s, at least half of the town could be considered culturally as members of the indigenous community. Feliciano Ama inherited the position of cacique, or ex-officio spokesperson for the Indian population, from his father-in-law, Patricio Shupan. Shupan had played an important role in Salvadoran politics through his ability to mobilize the Indian vote at election times. He died in 1924, shortly after a dinner at the presidential palace, and was accorded a large state funeral. The circumstances of his death caused suspicion and heightened ill feelings toward the government. By 1932, Ama's position as a broker was as powerful as his father-in-law's had been, and he was also the head (mayordomo) of the largest and most prestigious religious brotherhood, the Cofradía del Espíritu Santo. Anderson (1971: 20) notes that it was largely through this and other cofradías that leftist ideas were disseminated.

While Indians played an important role in the uprising that took place on the night of January 22, 1932, many Ladino community members whose economic circumstances were equally affected also participated. The uprising was motivated in large part by class antagonisms between campesinos and owners of large coffee fincas (Cuenca 1962). It appears that what Wolf (1969) terms "members of the middle peasantry" were the predominant local leaders of the revolt. On the night of the uprising in Asunción, the mayor was killed and one of his close associates was wounded and later died. Most of the activity in Asunción, as elsewhere, centered on the looting of shops, liquor stores, and

pharmacies rather than murders (Anderson 1971: 119, accounts of the uprising related to me during the research). In all, no more than 100 people were killed during the revolt in the country as a whole (Anderson 1971: 136).

By January 26, the government had regained control of the towns in the southwest and began retaliatory measures that left over 10,000 people, many of them Indian, dead.² In Asunción, Feliciano Ama and Leopoldo Chávez were hung in the town square across from the Church of Dolores. This was followed by a roundup of other suspected participants:

As most of the rebels, except the leaders were difficult to identify, arbitrary classifications were set up. All those found carrying machetes were guilty. All those of a strongly Indian cast of features, or who dressed in scruffy, campesino costume, were considered guilty. To facilitate the roundup, all those who had not taken part in the uprising were invited to present themselves at the comandancia to receive clearance papers. When they arrived they were examined and those with the above mentioned attributes seized. Tied by the thumbs to those before and behind them, in the customary Salvadoran manner, groups of fifty were led to the back wall of the Church of Asunción . . . and against that massive wall were cut down by firing squads. In the plaza in front of the comandancia other selected victims were made to dig a mass grave and then shot, according to one account, from machine guns mounted on trucks. In some cases, women and children refused to leave their men folk and shared their fate. An old Asunción resident, who was then a soldier in the army, says that there is no doubt that the guardia behaved much worse than the rebels, shooting anyone they came across (Anderson 1971: 131).

Although the revolt had been motivated largely by class antagonisms, in the aftermath ethnic divisions were accorded paramount importance. Newspapers carried accounts stressing the racial components of the uprising, labeling Indians as barbarians unworthy of citizenship.

Postcard-size pictures of Ama's hanging were sold in San Salvador. In Asunción and other predominantly indigenous communities in the southwest, Indians who had survived the massacre gave up visible signs of their ethnic identity almost overnight in an effort to protect themselves from further reprisals.

To summarize, the town's history from the time of the Spanish conquest through 1932 reflects the economic and political exigencies of the larger society into which it was integrated. In the Colonial period, patterns of resource extraction which centered on indigenous production of cocoa and balsam led to the retention of modified indigenous sociocultural and political-economic forms of organization to a much greater degree than elsewhere in El Salvador. With independence from Spain in the early nineteenth century, the country retained and expanded its role as a producer of primary agricultural products for the world market. The liberal philosophy that dominated nineteenth century politics led to the abolition of community-held lands as these were regarded as obstacles to the further expansion of the coffee economy. In Asunción, these measures undermined the economic basis for the maintenance of separate indigenous and Ladino communities. By 1932, shared economic circumstances resulted in the formation of class antagonism between campesinos and owners of large coffee fincas that cross-cut ethnic distinctions. While sociocultural and political characteristics of indigenous society persisted and, in fact, represented an important means by which the Indian population

was mobilized to participate in the revolt, these were seriously undermined as a result of the subsequent government repression.

National-Level Socioeconomic and Political Developments: 1932-1979

If the world Depression triggered events that had tragic consequences in Asunción, it also had ramifications for the country's subsequent socioeconomic and political development. An overview of these processes is provided in this section. Attention is drawn to the alliance of interests between the military and civilian elite that has resulted in an expansion and diversification of export crop production and a type of dependent industrialization characterized by increased penetration of multinational corporations and reliance on foreign-manufactured technology. This discussion is followed by a consideration of how recent political and economic developments are reflected in the disease processes most characteristic of El Salvador and in the organization of the official medical delivery system. Together, these two sections provide the background for an examination of the socioeconomic and demographic characteristics of Asunción in Chapter III.

The Political Context

The 1932 peasant uprising in Asunción and in other parts of the southwest had a lasting impact on Salvadoran life. Fear of another revolt has been a guiding force behind much of Salvadoran government policy and legislation. This viewpoint is shared by Elam (1968), White (1973), Wilson (1970), Durham (1979), Browning (1971), Armstrong

and Shenk (1982), Montgomery (1982), Baloyra (1983), and other investigators concerned with the country's recent history. General Hernández Martínez's assumption of power in 1931 marked the initiation of a succession of military governments that persisted through late 1979.³ This represented the only case of such permanent military occupancy of a government in Latin American history.

In effect, beginning during the Martínez presidency an accommodation was reached between the military and the civilian elite whereby the military retained control over important political offices but carried out policies that reflected the interests of the upper class. Key aspects of the economy, such as the production and sale of coffee, are managed by semi-autonomous institutions controlled by the elite rather than by government ministries, and powerful private associations, such as the Eastern Region Farmers' Front (FARO) and the National Association of Private Enterprise (ANEP), exercise a decisive influence on government legislation.

In keeping with the fears inspired by the events of 1932, until 1950 all forms of unionization among rural and urban workers were prohibited. This policy remained in effect through 1979 with regard to campesino organizations other than those specifically sanctioned by the government. In 1950, the Agrarian Law of 1907 was updated. The vagrancy laws, giving the National Guard rights to maintain order on private estates and to arrest workers who failed to fulfill their obligations to landlords, were reaffirmed as were the rights of local

officials to arrest "malefactors" (Americas Watch Committee and the American Civil Liberties Union 1982: 7).

In the early 1960s, the rural-based paramilitary organization, the Nationalist Democratic Organization (Organización Democrática Nacionalista--ORDEN), was created by the Ministry of Defense to better monitor and control the activities of the campesino population. By the mid-1970s, it was estimated to have between 80,000 and 100,000 members who carried out espionage and terrorist acts against anti-government peasant groups. Because of their ties with government security forces, ORDEN members remained largely immune to prosecution on criminal charges (Americas Watch Committee and the American Civil Liberties Union 1982: 40).

Efforts to limit organization among rural workers reflect the basic ruling-class policy that has been in effect from the late 1920s through the early 1970s. White (1973: 96) characterizes this as the application of the amount of repression judged necessary to maintain privilege and to prevent those advocating social reforms from attaining power. This is combined with a corresponding degree of political and economic concession. The purpose is to attract as many popular representatives as possible to work within the system and to give the appearance of a government favoring the people while not seriously undermining the position of the elite. The proper mix of concession and repression at any given time is determined by factors internal and external to the country. These latter include matters such as U.S. stance on social issues and human rights in Latin America and the

international market price for export crops, both of which represent factors that the government must take into account in setting policy. Baloyra (1983) provides a similar analysis, terming the form of political control exercised by the ruling class in El Salvador a form of reactionary despotism.

Since 1932, a series of military coups replacing governments erring on either the side of repression or concessions has maintained this political order. This has been accompanied by an electoral process in which parties advocating a redistribution of property and wealth have been excluded from participation and officially recognized opposition candidates denied office through electoral fraud.

In 1950, President Osorio founded an official party, the Revolutionary Party of Democratic Unification, modeled after the Institutional Revolutionary Party in Mexico, to facilitate the transfer of power between administrations.⁴ After a military coup in 1961, the Salvadoran party was changed to the Party of National Reconciliation (PCN) but continued to fulfill the same functions. Until the military coup that overthrew the government of General Romero in October 1979, the PCN was controlled by the president and leading military officers who chose the candidate to succeed the incumbent. While providing top government posts to members of the armed forces, the party also offered a means of advancement for civilians willing to work with the regime. In essence, this organization represented a way by which civilian and military personnel drawn from the lower and middle

classes were brought into an alliance with the elite to run the country.

In 1963, a measure was adopted granting proportional representation in the Legislative Assembly. This served to stimulate the development of other political parties willing to work within the system. White (1973: 198) notes that the effect was to channel opposition activities into the legislature and away from organizations that the government found less controllable.

By the mid-1970s, successful efforts at co-optation had broken down. Massive electoral fraud on the part of the government demonstrated that little could be accomplished through participation in elections. In the 1972 presidential campaign, José Napoleón Duarte, a Christian Democrat, and Guillermo Manuel Ungo, a Social Democrat, ran as presidential and vice-presidential candidates proposing to end 40 years of military rule and to institute social reforms. Although they won a majority of the popular vote, the PCN candidate, Col. Arturo Armando Molina, was declared the victor. Duarte and other members of the opposition were detained, tortured, and forced to flee the country. The 1977 presidential campaign was similarly marked by intimidation, violence, and fraud. With most opposition parties refusing to participate, General Carlos Humberto Romero of the PCN was declared the winner.

In part as a consequence of these electoral charades, by the mid-1970s a number of left-wing guerrilla groups and mass popular organizations formed and began to gain sufficient support to threaten the

established order. Participants included campesinos, urban slum dwellers, workers, students, teachers, and some middle-class professionals. The first of the guerrilla groups to emerge was the Popular Forces of Liberation (FPL) formed in 1970 by members of the Salvadoran Communist Party and university students. This was followed by the Revolutionary People's Army (ERP) in 1971 and the Armed Forces of National Resistance (FARN) in 1975. Allied with these groups were mass popular organizations that developed during the same period. The Front for United Popular Action (FAPU), composed primarily of urban workers, was established in 1974 and became associated with FARN. This was followed by the Popular Revolutionary Block (BPR) in 1975, a broad-based coalition with support especially among the campesinos, which became linked to the FPL. In 1978, the February 28 Popular League was organized, drawing support especially among slum dwellers in San Salvador and associated with the ERP.⁵

By November 1977, growing popular support for these organizations led President Romero to institute the Law for the Defense and Guarantee of Public Order. The measure, which was in effect during the first seven months of this research project, abridged civil liberties and resulted in the abuse of power on the part of governmental security forces. It was repealed in February 1979 and replaced three months later by a State of Siege. During 1978 and 1979, government repression of popular demonstrations and left-wing resistance rapidly escalated. This period was characterized by murders, kidnappings, bombings of government and military installations, disruptions of the

public transportation system, and embassy take-overs. It culminated in the murder of 23 demonstrators at the Cathedral in San Salvador and the killing of 14 demonstrators outside the Venezuelan Embassy in May 1979. An estimated 1,000 people lost their lives as the result of the civil strife during the year.

The Economic Context

Participation in the mass popular organizations and the violent clashes between these and government security forces are an outgrowth of the economic policies pursued by the military and civilian elite since 1932. These policies have resulted in growing underemployment, unemployment, and poverty. By the late nineteenth century, El Salvador had regained its pre-conquest level of approximately 783,000 inhabitants, making it the most densely populated country on the Latin American mainland. By the early 1960s, the population had increased to 2.5 million, and by the late 1970s it had reached an estimated 4.8 million or approximately 190 people per square kilometer (Browning 1971: 250, Durham 1979: 6).

Government measures designed to stimulate economic development have not reflected the needs of the people. Instead, the size of the population rather than the distributional dynamics of resource allocation is frequently pointed to as the major source of the country's political and economic problems (Durham 1979). Torres Rivas (1983) has characterized what has taken place in El Salvador and other Central American countries, with the exception of Nicaragua, as a complex process of growth without development, enrichment without

distribution, and production without social benefit. Because changes in the economy are of fundamental importance in understanding the class structure and the disease profile of the country and of Asunción, they will be reviewed in some detail.

Since 1932, coffee has retained its position as the leading export. At that time, it occupied 16,523 hectares whereas by 1966 this area had expanded to 140,100 hectares (Durham 1979: 36). The Depression brought about consolidation of coffee fincas. An estimated 28% of small and medium-size producers lost their properties through default on debts and loans (Anderson 1971: 9). In El Salvador, the same families that own the largest fincas are also the major coffee processors and exporters. Through 1979, coffee planters were exempt from income tax which applied to everyone else. They paid only a coffee export tax. Because this was not a progressive tax, the largest coffee growers paid less than they would if they had been subject to income taxes, while the smaller growers paid more (White 1973: 125).

In the 1970s, El Salvador was the leading coffee producer in Central America and the third largest producer in Latin America.⁶ The drastic fall in coffee prices occasioned by the Depression, however, pointed out the dangers of dependence on a single export crop. Since that time, and especially after World War II, efforts have been made to diversify agricultural exports and to encourage industrialization. Both developments have occurred largely in response to changes in the international market economy and have benefited primarily the small

Salvadoran upper class and their counterparts in the developed countries.

The diversification of the agricultural export sector centered on increased cotton and sugar cane production. Initially, large-scale cultivation of these crops was stimulated by disruptions in international trading networks. During World War II, normal supply channels for cotton goods to El Salvador were interrupted, and a small domestic textiles industry developed that spurred the demand for locally produced cotton. Whereas cotton had been grown on a small scale since pre-conquest times, the discovery of synthetic pesticides and improvements in the control of malaria and yellow fever made commercial production feasible along the Pacific coastal belt.

Before these developments, campesinos displaced from the spread of coffee in the highlands could gain access to land in this zone as resident workers (colonos), renters, sharecroppers, or squatters on large estates. The region was used for food crop production by small farmers and for cattle grazing. Cotton cultivation for export purposes got underway after the Pacific coastal highway was complete in 1958. Overall, between 1935 and 1965 cotton production expanded from 1,444 to 110,792 hectares (Durham 1979: 32; also see Williams 1986). In contrast to coffee fincas which are privately owned, a large portion of the cotton in the 1960s was grown on lands rented on a short-term basis by urban speculators.

The increased acreage in cotton led to the eviction of the small-scale agriculturalists who had previously occupied this zone

(Satterthwaite 1971, Durham 1979, Browning 1971, Williams 1986). With the exception of picking, cotton production is completely mechanized and, hence, offers only limited seasonal work opportunities for those who lost access to land. Browning (1971: 239) states that attempts to provide these people with permanent salaried employment have met with opposition, as such measures would reduce the number of workers available during harvest season. Eviction of small-scale producers also resulted in a decrease in food supplies. During the peak cotton-producing era in the 1960s, El Salvador became a net importer of food for domestic consumption (Durham 1979: 33). Although cotton was the second leading export crop in the 1970s, and although it diversified the agricultural export sector, it did so at the price of increased numbers of landless agricultural workers and decreased local food supplies.

Much the same point can be made regarding the other major effort at diversification, sugar cane. Lands used for this crop expanded from 10,000 hectares in the 1930s to 28,000 hectares in 1971, and export production increased 1,000% during the same time period (Durham 1979: 44). Export production received a boost in the early 1960s after the Cuban revolution disrupted normal U.S. supply channels and El Salvador gained a quota on the U.S. market. Sugar cane has been the third leading Salvadoran export since 1966. It is especially suited for growth on lands too low for coffee and too high for cotton.

While much of the increased production has occurred on land holdings over 50 hectares, sugar cane represents a medium-size

enterprise in comparison to the other leading export crops. Similar to the situation with cotton, expansion of sugar cane contributed to the displacement of small-scale agriculturalists who had previously worked lands under a variety of tenancy arrangements. This also has occurred with regard to other export crops of more minor importance, such as sesame and tobacco (Durham 1979: 44, Williams 1986).

In addition, properties devoted to cattle grazing contribute to small farmer land scarcity. In the 1970s, lands in pasture or left fallow encompassed a larger area than those used for food crop production (Organization of American States, et al. 1976). While there are some large cattle haciendas, many estate owners maintain herds on portions of their property not suited for export crops. Some owners have modernized operations, especially after 1972 when El Salvador gained a quota on the U.S. meat market. Williams (1986) and DeWalt (1985) explore the socioeconomic and political effects of the boom in cattle raising in Central America. It appears, however, that the impact of this has been greater in the other Central American countries than in El Salvador.

To summarize, since 1932 efforts to diversify agricultural exports have resulted in the displacement of small farmers from the land. Because owners of large estates adopt machine-intensive methods when feasible, few new jobs have been created and the number of landless rural workers has grown.

Government efforts designed ostensibly to aid the campesino population, such as minimum wage legislation and agrarian reform

measures, have done little to ameliorate this situation. To abolish what it regarded as the feudal remnants of the colono system, in 1965 the government included certain categories of agricultural laborers under the minimum wage law. The regulation covered those permanently employed on estates and established piece rates for temporary workers during harvest periods. Before this legislation, permanent farm employees (colonos) were allowed to construct dwellings on the premises and received two meals a day in addition to a low wage. As a result of the measure decreeing higher wages for these employees, landowners found it more profitable to reduce the number of resident workers to those needed during the slackest period of the year and to rely instead on temporary hired laborers. These workers' wage rates remained unaffected except during harvest periods. Because the wage rates established for women and children were nearly equivalent to those for men, the law also had the effect of reducing their employment opportunities. Permanent workers who were able to maintain their employment (usually the most skilled) may have benefited from this measure, but nearly half of the resident work force lost their jobs and dwellings (White 1973: 124-25). Between 1961 and 1971, the number of colonos declined from 55,000 to 17,000 (Simon and Stephens 1981: 6-7).

An increase in rental and leasing arrangements has accompanied this decrease in the number of colonos. The number of renters rose from 33,000 in 1951 to 76,000 in 1971. More than 98% of renting occurs on plots of less than five hectares, and most plots are small, ranging from one to two hectares (Colindres 1976: 466).

Colindres provides an overview of the kinds of payments required for use of these small properties:

The forms of paying rent vary: if the rent is in money, the renter has to pay C75 to grow sesame and sorghum, C80 to grow beans or rice, C100 to grow melons, C125 to grow watermelons, C150 to grow cotton, C160 to grow sugar cane. Thus, to grow export crops the renter has to pay a higher price. To the degree that the rent is paid in kind, the possibilities expand: when the land is rented for the whole year, the renter has to give four fanegas of corn, 12 medios of sorghum and four loads of wood to the owner; if the land is used only during the growing season, in addition to his labor, the renter has to contribute 50% of the inputs--50% of the harvest goes to the renter and 50% to the land owner (Colindres 1977: 46, author's translation). (One fanega equals between 360 and 400 pounds; one medio is approximately 16 pounds.)

Much of this rented land is of poor quality. Nonetheless, it produces more than 50% of the corn, beans, and sorghum in the country (Simon and Stephens 1981: 54).

Government efforts to institute what it terms agrarian reform have not increased access to land for those who were displaced by the spread of coffee, cotton, and sugar cane. Three points regarding the succession of programs from 1932 through 1979 deserve mention. First, there were no serious efforts toward expropriation of properties. In all cases, the government attempted to carry out reforms without altering the existing agrarian structure.⁷ The land reform program enacted under pressure from the U.S. during the presidency of Molina called for limited expropriation and generous compensation. It was shelved due to opposition from ANEP and FARO. This measure would have affected some 56,000 hectares, most of it used for cotton production and cattle grazing. Properties included in the projects the

government has undertaken were purchased from owners willing to sell. Between 1932 and 1950, 26 haciendas or an estimated 35,168,683 hectares were acquired in this way (Browning 1971: 275). After that, only a small amount of land was added to the reserve due to increases in property values and diminished state revenues accorded to the program.

Second, agrarian reform projects have not made land available to those who did not previously have access to it. In most cases, the haciendas purchased by the government were already occupied by colonos, renters, sharecroppers, and squatters who were then offered the opportunity to purchase their plots.

Third, little financial or technical assistance was made available to program beneficiaries, and few efforts toward developing cooperatives were instituted. Large estates were simply divided into plots ranging from two to six hectares and sold to users. As observers such as Browning (1971) and Simon and Stephens (1981) have indicated, confirmation of title to these small properties does not take into account systems of land rotation necessary to maintain soil fertility. In the absence of programs providing fertilizers and other necessary inputs, crop yields on small plots decline rapidly. Efforts to form cooperatives failed in large measure because of government distrust of campesino organizations. Where these were attempted, they were closely supervised and controlled by state officials and allowed campesino members little participation in the organizations' design or functioning (Simon and Stephens 1981: 12).

As a consequence of these policies, Browning (1971) notes that the reform programs led to the reconcentration of land in the hands of a few. Beneficiaries who were unable to meet their payments or those whose lands were unsuited to agriculture in the first place, or became exhausted from repeated use, sold their properties to others.⁸

Overall, from 1932 through 1979 diversification of agricultural exports further displaced the campesino population. As a result of increased coffee, cotton, and sugar cane cultivation, the adoption of labor-saving machinery on large estates, and policies such as the 1965 minimum wage legislation, the number of permanent workers on estates declined. The number of small-scale renters of marginal lands increased, and there was a rapid growth in landlessness. In the late 1970s, approximately 50% of the economically active population was engaged in agriculture, and, of these, over 40% were landless day laborers (jornaleros). Government land reform programs, which are best considered small-scale colonization projects, did not significantly increase access to land for this population. The 1971 census indicated that more than 48% of the farms in the country were small units of less than one hectare, while 1.5% of farms held almost 50% of the total agricultural land (Durham 1979: 38). Because these figures are based on the number of properties, not the number of owners, and because many owners of large estates have more than one property, this figure underestimates land concentration (Colindres 1977). The combination of small holdings (minifundia) and sharp seasonal fluctuations in the need for workers on large estates produces what the

International Labor Organization terms a chronic underutilization of labor. More than 50% of the rural work force is underemployed more than two-thirds of the year (Programa Regional del empleo para América Latina y el Caribe 1977: 472).

These changes in the structural composition of the rural labor force help explain growing campesino participation in mass popular organizations. The decrease in the number of colonos and the increase in temporary rental arrangements weakened the vertical and usually paternalistic ties between peasants and landowners that previously helped maintain the rural social order. The increase in those dependent solely on agricultural day labor also represents a rupture in traditional structural relationships. In the past, many rural households depended for their livelihood on a combination of small plots for food crop production and temporary wage labor on large farms. Decreased access to land has undermined this pattern and undoubtedly made the economic situation of many more precarious. Thus, the expansion and diversification of the agricultural export sector has resulted in the breakdown of older social-structural relationships. It has fostered the development of horizontal bonds such as those found in anti-government peasant and worker leagues and mass popular organizations.

Finally, growing numbers of rural Salvadorans have migrated to urban centers and to other countries. Migration to Honduras was already in progress in the late 1920s. Wilson (1970: 129) estimates that at that time there were 12,000 Salvadorans in Honduras,

comprising nearly 10% of the total labor force. At the outbreak of the Soccer War between El Salvador and Honduras in 1969, the number had grown to 300,000. Between 1930 and 1950, an equal number moved to urban areas in El Salvador, especially the capital (Durham 1979: 56). Both temporary and permanent migration outside the Central American region also has increased. By 1979 there were as many as 500,000 Salvadorans in the U.S. and 10,000 laborers working in Saudi Arabia on temporary contracts (Diario de Hoy 1979). These migration patterns reflect the diminished access to land and lack of employment opportunities in rural areas.

A second change in the economy of particular relevance to this investigation centers on efforts to promote industrialization. Beginning in the early 1950s, a series of trade agreements were drawn up among the Central American countries, culminating in the creation of the Central American Common Market in 1964. As an outgrowth of the movement toward economic integration, a free trade zone was declared, tariff barriers among the countries were reduced, and exemptions on import duties and tax incentives were accorded to investors who established manufacturing enterprises. The rationale for the Common Market's formation was to promote the more autonomous or inward-directed development of the region. Reliance on consumer goods manufactured in the developed market economies would be replaced by local production (SIECA 1974: 6). Given the small population in each of the countries, and the even smaller number of those who could afford manufactured goods, it was believed that import substitution

industrialization could be successful only if a market of regional scope were created.⁹ Because the Central American Common Market provides a context in which penetration of foreign and multinational corporations has occurred and because the type of industrialization it has promoted has cultural as well as economic and political ramifications, it merits brief consideration.

Before the inception of the Common Market, Central American countries traded more directly with nations outside the region than they did with one another. Each exported agricultural products to the developed countries and imported finished manufactured goods. With the formation of the Common Market, however, the region's articulation with the world market economy and the relationship among participating countries were altered. The creation of the free-trade zone along with financial incentives to encourage industrialization resulted in the development of a small manufacturing sector and in considerable growth in intra-regional trade. While each country's extra-regional exports continued to be of the traditional variety, the importation of finished products from the developed countries was reduced and replaced by the increasing importation of technology, raw materials, semi-elaborated products, and machinery used in the newly established industries. Torres Rivas notes that to call this import substitution industrialization is a misnomer:

. . . since it has not meant development of an endogenous capacity to use local raw materials to manufacture goods previously imported from abroad. Import substitution here means the replacement of finished products by semi-finished components

which has made possible the introduction of industries whose basic productive process is carried out in the industrial metropolis (1983: 10).

Development was greatest in the traditional manufacturing sector, or those establishments associated with the processing of primary agricultural products such as foods, beverages, textiles, shoes, and tobacco. The intermediate sector represented by the chemical, pharmaceutical, paper, and petroleum industries was second in importance. Although some traditional manufacturing establishments existed before the Common Market, this second branch of industry owed its origin largely to the financial incentives offered to attract foreign capital. The least amount of development occurred in the metal-mechanical, or capital goods, branch of industry (Colindres 1977).

As an outgrowth of the Central American Common Market, foreign investment in the region increased from \$388.2 million in 1959 to \$755.3 million in 1969 (Colindres 1977: 142). U.S. companies accounted for 80% of these investments while Japanese, Canadian, German, Dutch, Mexican, and Colombian companies provided the remaining 20% (Colindres 1977: 140). Before the creation of the free-trade zone, foreign companies invested primarily in agriculture, transportation, and communications. Since then, a shift has occurred toward investment in the manufacturing, commercial, and banking sectors. In evaluating the effects of these changes on dependency relations, Colindres states that:

This new type of development carries with it a greater dependency on the more developed countries and particularly on the United States because the pressures are greater and the opportunities for maneuver reduced. Given the need to export traditional

agricultural products and, in addition, to import capital goods, machinery, techniques and a good part of the primary and the semi-elaborated products from the United States, our vulnerability consequently has increased (1977: 120, author's translation).

The growing penetration of foreign capital and, in particular, the establishment of joint ventures financed by local and international companies, has created more direct economic links between the Central American upper classes and their counterparts in the developed market economies.

A second consequence of the Central American Common Market was a change in relations among participating countries. Industrialization was greatest in Guatemala and El Salvador, where there was a larger industrial base than elsewhere. In both countries, wealth was highly concentrated in a small upper class, and authoritarian governments exerted control over the working class and labor organizations. In addition, 60% of Central America's population resides in Guatemala and El Salvador, giving them large internal markets.

By the mid-1960s, a metropolitan-satellite relationship began to take shape between Guatemala and El Salvador on the one hand and Honduras, Nicaragua, and Costa Rica on the other. This was especially the case in the relationship between El Salvador and Honduras. Most of El Salvador's exports to Honduras were manufactured goods, while the majority of her imports from Honduras were foodstuffs and raw materials. When Salvadoran cotton production underwent a decline in the late 1960s and food production increased, the balance of trade between the two nations became highly unfavorable to Honduras (White 1973: 183-84). In part, this growing disparity underlay the Soccer

War which erupted between the countries in 1969.¹⁰ The war led to a long-term break in relations between the two nations which disrupted the functioning of the Common Market and contributed to a crisis in its evolution. By the mid-1970s, however, interregional trade had begun to increase again, and investments were made in more sophisticated technological sectors (Torres Rivas 1980: 37).

In El Salvador, industrial development has been greatest in the intermediate and traditional manufacturing sectors, particularly the food, textile, chemical, petroleum, paper, and pharmaceutical industries. As is the case for the Central American region as a whole, foreign investment has increased and undergone a shift in its orientation. It rose from \$43 million in 1959 to \$114.6 million in 1969, an increase of 166.5%. While in 1959 only .7% of foreign capital was in manufacturing, by 1969 this had risen to 43.7% (Colindres 1977: 141-42). The North American Congress on Latin America (NACLA) reports that over half of twentieth century foreign investment in El Salvador was made in the 1960s (1980: 11). A number of large multinational corporations, among them Nestle, ALCOA, Cargill, International Harvester, Kimberly Clark, Xerox, ITT, Monsanto, Exxon, IBM, and Texas Instruments, established operations in the country.

As the list suggests, much of this investment is of U.S. origin. In the late 1970s, there were approximately 80 U.S. corporations with an estimated \$100 million worth of holdings in El Salvador. While this was small compared with U.S. investments in other parts of Central America and the Caribbean, here, as elsewhere in the region, profits

were high. The rate of return for 1980 was approximately 29% as compared to 17% for U.S. investments in other parts of the world (Hansen and Brevetti 1982: 8).

In recent years as the Central American Common Market has been disrupted by the political turmoil in the region, the country has established a free-trade zone and attempted to attract industries which assemble goods manufactured in the U.S. and other countries for export back to those countries. For example, Texas Instruments and Dataram moved assembly plants from Curaçao and Malaysia to San Salvador in order to take advantage of the free-trade zone and the plentiful supply of cheap labor (Stoltz Chinchilla 1980: 5, Hansen and Brevetti 1982: 8).

In addition to these direct investments, U.S. firms are the major purchasers of Salvadoran export crops. Companies such as Hills Brothers and Proctor and Gamble buy over one-third of the coffee crop. Finally, as Torres Rivas (1983) and Colindres (1977) note, U.S. corporations are also the primary source of Salvadoran imports.¹¹

In regard to pharmaceuticals, three large multinationals, Bayer, McKesson, and Merck, have established operations in El Salvador and export products to other countries in the region. Imports of finished medications from these and other large firms have increased dramatically from \$6,713,000 in 1967 to \$23,392,000 in 1975. In that year, expenditures on medicines averaged 1.28% of the GNP and accounted for 3.91% of total commodity imports. The comparable figures for Latin

America as a whole were .55% of GNP and 2.51% of commodity imports (Piachaud 1980: 188).

Salvadoran law requires that, outside of the free-trade zone, foreign companies establish partnerships with local businesses which must contribute 50% of the investment capital. The concentration of wealth has facilitated the process of industrialization as the agrarian and commercial elite were in a position to participate and benefit directly from partnerships with foreign firms (Baloyra 1983). As White (1973: 173) indicates, these joint ventures link Salvadoran industrialists with international capital both politically and economically.

On the whole, because many new industries rely on importing partially elaborated products and because they are likely to use sophisticated technology and machinery, they have not contributed greatly to increased employment opportunities for the lower classes. Colindres (1977: 128) reports that when those employed in seasonal industrial work related to coffee, cotton, and sugar cane processing are excluded, there were only 26,931 permanent workers and 6,402 administrative employees in the industrial sector in 1971. Industrialization has contributed to the formation of a small category of skilled workers who, along with government and administrative personnel, officers in the military, semi-professionals, and some office and shop employees, comprise the middle class.

The problem of land scarcity for small-scale farmers, combined with a type of industrial development which has created relatively few

jobs, has resulted in increased numbers of people seeking employment in small-scale commercial, trades, and service activities. Nonetheless, it is likely that the process of dependent industrialization has had a negative impact on many of those employed in these occupations. As products that previously were made on the local level by artisans and tradespeople are replaced by manufactured goods, those engaged in these activities are relegated to less rewarding and remunerative repair work. Tailors, seamstresses, weavers, shoemakers, and others have seen their businesses and standards of living decline. At the same time, more people have been forced to enter these occupations and to earn their livings working as vendors of various sorts. Further, income derived from the local production and sale of goods used to circulate among the middle and lower classes. As White (1973: 224) points out, it is now more likely to be siphoned off to the owners of the newly established manufacturing plants and their foreign partners. Finally, industries established with the aid of foreign capital often produce goods designed for the consumer tastes and needs of developed countries. As will be discussed in greater detail with regard to medicines, this gives rise to a form of cultural domination wherein locally manufactured items are regarded as inferior in quality to internationally recognized brands.

To summarize, since World War II, El Salvador has undergone a modernization process characterized by diversification of the agricultural and industrial sectors. In analyzing the causes of resource scarcity, Durham (1979) found that while overall agricultural

production has stayed abreast of population growth, increases in export crop production have contributed to the stagnation of food crop production. Food crops, and the small-scale producers who grow them, have consistently lost out to export crops and the owners of the large agricultural estates. In the manufacturing sector, dependent industrialization stimulated by the formation of the Central American Common Market led some observers to contend the country was experiencing rapid economic development (Raynolds 1967). Most observers agree, however, that only a small proportion of the population has benefited and that this inward-directed development represents simply another stage in El Salvador's on-going dependency relationships vis-à-vis the developed countries, particularly the U.S. (White 1973, Colindres 1977, Stoltz Chinchilla 1980, Richter 1980, Torres Rivas 1980, 1983).

In El Salvador, the process of industrialization represents an expansion of interest on the part of the agrarian elite rather than a challenge to its position. The same families that are the major growers and exporters of agricultural products are those who have the capital to participate in industrial development and form partnerships with foreign investors (Baloyra 1983). Further, because only a small proportion of manufactured goods are exported beyond the Central American region, the agricultural export sector continues to generate the majority of foreign exchange. While industry is dependent on the agrarian structure, it is this same structure that represents a major obstacle to further industrial expansion. Most observers agree that, in the absence of structural reforms to bring about a more equitable

distribution of property and wealth and create a greater demand for manufactured goods, the market is too small to permit further expansion along the lines of import substitution (Stoltz Chinchilla 1980, Richter 1980, Torres Rivas 1980, Feder 1971, White 1973).

Health Status and the Organization of Medical Care: An Overview

The developments outlined above are reflected in the organization of the official medical delivery system and in the country's health statistics. In this final section, attention is drawn to the relationship between general health status, the medical care system, and the socioeconomic and political structure.

El Salvador's national health statistics reflect many of the socioeconomic and political processes at work in the country. Of particular importance are the increasing poverty and marginalization of many inhabitants, resulting from the country's agricultural and industrial development policies. This has given rise to a well-organized and militant opposition and to increased levels of government repression. In 1975, the leading causes of illness and death were diseases associated with poverty: upper respiratory infections and various forms of gastroenteritis and diarrheal disease. Tables 2.1, 2.2, and 2.3 present this information.

Since that time, statistics reflect an even more direct form of government repression. Deaths resulting from civil disturbances and government repression of the political opposition have replaced the diseases of poverty as the leading cause of mortality.

Table 2.1.—Ten leading causes of death in El Salvador in 1975.

	Number	Percent
1. Gastroenteritis and diarrheal diseases	4,296	13.6
2. Bronchitis, emphysema, and asthma	1,313	4.2
3. Homicides and lesions intentionally provoked, legal interventions	1,178	3.7
4. Pneumonias	1,045	3.3
5. Perinatal deaths	923	2.9
6. Cardio-vascular disease	893	2.8
7. Other illnesses of the digestive tract	775	2.4
8. Malignant tumors	763	2.4
9. Cerebro-vascular illnesses	669	2.1
10. Traffic accidents	579	1.8
Symptoms and states of undefined origin	10,032	31.7
Others	9,210	29.1
Total	31,676	100.0

Source: Ministerio de Salud Pública y Asistencia Social, Departamento de Estadísticas de Salud, Salud Pública en Cifras Anuario, 1976: 33.

Table 2.2.--Ten leading causes of out-patient consultation in 1975.^a

	Number	Percent
1. Illnesses of the teeth and gums	237,066	13.4
2. Gastroenteritis and diarrheal diseases	144,996	8.2
3. Acute respiratory infections	118,230	6.7
4. Bronchitis, emphysema, and asthma	90,970	5.1
5. Influenza	47,574	2.7
6. Anemias	40,584	2.3
7. Wounds and lacerations	32,628	1.8
8. Skin and subcutaneous infections	29,616	1.7
9. Respiratory tuberculosis	24,264	1.4
10. Inflammatory eye infections	22,518	1.3
Symptoms and states of undefined origin	47,874	2.7
Others	930,098	52.7
Total	1,766,418	100.0

Source: Ministerio de Salud Pública y Asistencia Social, Departamento de Estadísticas de Salud, Salud Pública en Cifras, Anuario 1976: 36-37.

^aConsultation at Ministry of Health out-patient facilities.

Table 2.3.—Ten leading causes of hospitalization in 1975.

	Number	Percent
1. Childbirth without complications	40,334	20.6
2. Gastroenteritis and diarrheal diseases	14,656	7.5
3. Illnesses of the genital tract	11,680	5.9
4. Complications of pregnancy, birth and puberty	9,622	4.9
5. Pneumonias	8,756	4.5
6. Miscarriage and abortion	8,528	4.3
7. Neurosis, personality disturbances, and other non-psychotic mental problems	6,428	3.3
8. Wounds and lacerations	5,262	2.7
9. Bronchitis, emphysema, and asthma	3,896	2.0
10. Fractures	3,802	1.9
Others	83,044	42.4
Total	196,008	100.0

Source: Ministerio de Salud Pública y Asistencia Social, Departamento de Estadísticas de Salud, Salud Pública en Cifras, Anuario 1976: 36-37.

Overall, while the birth rate remains high (39.3 per thousand in 1976), the death and infant mortality rate have declined during the last 30 years. In 1976, the official mortality rate was 7.3 per thousand, and the infant mortality rate was 55.3 per thousand (El Salvador, Ministerio de Salud Pública y Asistencia Social, Departamento de Estadísticas de Salud 1976). As is the case in other developing countries, official figures underestimate the real situation. Many births and deaths are not attended by western medical personnel, nor are they reported to authorities.

Declining mortality rates should not necessarily be equated with overall improvements in living or health standards. These declines may be accompanied by increased levels of malnutrition and morbidity among certain social classes (Gish 1979). Studies conducted elsewhere in Latin America indicate a relationship between socioeconomic processes such as increased cash cropping and proletarianization and growing levels of malnutrition and illness. Laurell et al. (1977) conducted a study of the effects of the rural development process on morbidity in two Mexican villages. They found that morbidity was greater in the more developed village characterized by cash cropping and a high percentage of migratory wage labor than in the less developed, predominantly subsistence-oriented agricultural village. The researchers suggest that these socioeconomic processes define groups of high and low morbidity more clearly than do sanitary conditions and access to professional medical care. Studies also suggest a relationship between size of land holding and incidence of

malnutrition. In a study of four Guatemalan villages, Valverde et al. (1977) examined the relationship between fathers' occupation and nutritional status of two- and three-year-old children. They found that prevalence of malnourished children was greatest for landless agricultural workers, intermediate for small-scale farmers, and least for merchants and skilled workers. With regard to farmers, they reported that more children of those owning 0 to 1.9 hectares showed signs of moderate malnutrition (the children were below 75% of the normal weight-for-age ratio) than did children of families with 2.0 to 4.9 hectares and above. While the investigators did not take into account the many intervening variables involved, this study and other investigations by Gross and Underwood (1971), Rawson and Valverde (1976), and Laurell (1981) do suggest that increases in land concentration, cash cropping, and migratory wage labor brought about by wider socioeconomic and political developments influence malnutrition and morbidity rates in rural communities.

The only Salvadoran study of this kind was conducted by Durham (1979) in the municipality of Tenancingo, Department of Cuscatlán. Durham examined the relationship between size of land holding and child mortality rates over a two-generation span for 258 agricultural families. In both generations, there was a strong correlation between the size of a family's landholding and child mortality (defined as those under the age of 16). In the past generation, the average child mortality rate decreased from 27.3% for those who owned .25 hectare to 17% for those owning 3.5 hectares or more. The same pattern existed

for the present generation. The average child mortality rate decreased from 24.5% for those owning .01 to .9 hectare to 13.6% for those with 3.5 hectares or more. While overall child mortality rates declined from 27.3% in the past generation to 21.6% in the present, the influence of land base was more pronounced in the present generation. This was because the greatest declines in mortality between generations occurred among families owning the larger farms. Although the intervening social and cultural factors that would help explain these correlations were not examined in detail, this study suggests that size of landholding influences peasant families' abilities to survive and reproduce.

The increased acreage in export crops and the decline in lands available to small-scale farmers for food crop production have resulted in high malnutrition levels. In a nationwide survey, investigators from the Institute of Nutrition of Central America and Panama (1969) observed a high incidence of delayed growth and mental retardation among Salvadoran children resulting from inadequate levels of protein. They reported that 80% of children under the age of five suffered from first-degree malnutrition (weight 10% to 24% below normal standards), 38% showed signs of second-degree malnutrition (weight 25% to 39% below normal standards), and 5% suffered from third-degree malnutrition (weight 40% or more below normal standards). A change in staple food consumption has occurred as small farmers have been relegated to renting marginal lands. Between 1932 and 1971, the production of sorghum, a crop that grows well on steep slopes and

depleted soils, has increased more rapidly than has maize production (Durham 1979: 24). In many areas, less nutritious sorghum tortillas have replaced maize tortillas as the daily staple.

Government policies in the industrial sector also have health ramifications. The process of dependent industrialization experienced in El Salvador is associated with commerciogenic (commerce-induced) diseases. The most widely publicized of these is the promotion of infant feeding formulas which has resulted in increased malnutrition and death in many developing countries (Bader 1976, Jelliffe and Jelliffe 1977). Other commerciogenic illnesses result from some large corporations' practice of selling products to developing countries that have been ruled unsafe for use in the country of origin and from the misuse of products which can occur when they are transferred from one setting to another very different one. As will be discussed more fully in Chapters VI and VII in regard to pharmaceutical products, although the macro-level parameters of these practices have received attention, relatively little is known about their impact on the local or community level.

Favar's (1972) study, "Ecological Implications of Insect Control in Central America: Agriculture, Public Health and Development," is one of the few investigations which considers the impact of technology transfer in the region. He examined pesticide use in agriculture and in the malaria eradication program in three peasant communities on the Guatemalan Pacific coast. High levels of pesticide contamination, especially DDT, were found in breast milk samples taken from 49 women

in the communities. On the basis of these samples, Favara (1972: 282) reported that the nursing children consumed an average of 84.2 times more DDT each day than was deemed safe at the time by WHO/FAO standards. Child mortality rates among these families were double those of the nation. The major source of contamination was the malaria eradication program's practice of spraying dwellings with DDT. Another important source was the use of DDT and other products for pest control in agriculture. Favara found that small-scale farmers and their families understood few of the risks associated with the use of pesticides and lacked the means to take necessary precautions. This study suggests that a synergistic interaction exists among infectious disease, malnutrition, and environmental contamination that results in high incidences of child mortality. More generally, it points to what Favara terms "the effects of diffusion of unsuitable technological innovations imposed on a population who lack adequate defense mechanisms against such intrusions" (1972: 365).

An important and often neglected point concerning the illness processes characteristic of El Salvador is that the provision of curative medical services does not result in long-term solutions to health problems unless accompanied by measures altering the social determinants of disease. What takes place instead is a cycle of disease-treatment-disease that overloads medical facilities and drains personal and state finances (Segall 1975, Gish and Feller 1979). In this light, the approach used by the Salvadoran government in meeting the health-care needs of the population will briefly be reviewed.

The official medical delivery system is modeled along western lines, emphasizing the trained physician and hospital-centered curative services. Only a small part of the national health budget is used for environmental and preventive programs. In 1970, the government allocated 94.4% of its public-sector per capita spending on health care to curative services and only 5.6% to programs designed to improve waste disposal and water supply (Navarro 1974: 17).

Access to the health facilities of the officially sanctioned medical system follows class lines. Upper-class families often rely on practitioners and medical facilities in the U.S. for major problems and on private-sector physicians and hospitals located in San Salvador for more routine treatment. This same pattern is characteristic of some middle-class families, especially those with relatives in the U.S. As is the case elsewhere in Central America, most physicians practice in the capital and other large cities. Ferrer Denis (1968) reported that 90% of doctors were located in San Salvador and two other major urban centers. Care provided by private-sector physicians and hospitals is similar, in many respects, to that found in the developed countries.

In addition to private-sector physicians, some of the middle class have access to hospitals and clinics run by the Social Security Institute (ISSS), National Telecommunications Administration (ANTEL), and other government agencies. Modeled along the lines of the British National Health Service, these separate systems were designed as alternatives to the Ministry of Health network of hospitals and

clinics. Under the ISSS system, employers and employees make contributions that are subsidized by the government. In 1979, 4.9% of the population, mostly those employed in government agencies and in white-collar and some well-paying manual jobs, were covered by these programs. While Roemer (1971) argues that social security programs favoring certain groups are a necessary stage in attaining effective distribution of personal health services for all, other investigators suggest that these programs have been used by governments to gain the allegiance of certain segments of the labor force (Navarro 1974, Rimlinger 1971). In El Salvador, where little coordination exists among these separate systems or between them and the Ministry of Health, it seems clear that such a proliferation of special-interest facilities represents a misuse of government funds.

The second source of public-sector health care is the system of free hospitals, clinics, and health posts run by the Ministry of Health throughout the country. Government expenditure for this branch of medical services, which covers 84% of the population, was \$5.23 per capita as compared to \$35.51 per capita for the ISSS system in 1970 (Navarro 1974: 23). Ministry of Health facilities are staffed by part-time physicians and by medical students, who are required to serve one year in the public system as part of their training. Since the early 1970s, the government has extended its public system through the construction of new hospitals, health centers, and health posts. Although more facilities are available, they are understaffed, run short of medications, and, at health centers and posts, lack equipment

for routine laboratory tests. Doctors are assigned a daily patient quota. It is not unusual, however, for them to see paying clients and pharmaceutical company sales representatives during regular hours, thus reducing time spent with the clients the facilities were designed to serve.

Outside of large cities, health centers and posts usually are open only certain days a week and then only for a few hours a day. In line with the policies of the donor agencies which provide some of the operating funds, most give priority to pregnant women, infants, and family planning efforts. Other adults and children often wait hours to receive care, only to be told that the doctor's quota is filled for the day. While they seem visible representations of the government's commitment to improve the health of the people, the centers and posts remain largely inaccessible to all but certain categories of patients.

In 1973, White reported that physicians represented a major obstacle to government efforts to train paramedical personnel. Since that time, a program to upgrade traditional midwives' skills was instituted and has met with some success. A pilot program designed to train community members as health aides in more isolated rural areas encountered problems. In 1979, it appeared unlikely that the Ministry of Health would assume program costs once U.S. Agency for International Development (A.I.D.) funding expired.

In addition to the official system, there is a wide range of alternative practitioners who treat illness and other forms of misfortune. Although it is illegal to practice medicine without a

government license, much of the health care continues to be dispensed by these alternative curers. Their role in the provision of medical services will be considered in Part II.

To summarize, growing landlessness, underemployment and unemployment resulting from expanded export crop production, and a process of dependent industrialization are reflected in high levels of malnutrition and may be accompanied by increased morbidity among the rural and urban lower classes. The official medical system, modeled along western lines stressing curative and individual-centered care, cannot deal effectively with the most prevalent illnesses. Most public-sector health funds are spent on curative rather than on preventive measures and result in a cycle of recurrent disease rather than long-term improvements in health standards. While the Ministry of Health has extended coverage by constructing new health centers and posts, the orientation toward family planning and maternal and infant care, coupled with shortages in staff, medicines, and equipment, discourages use of these facilities. Upper- and some middle-class families rely on private-sector physicians and hospitals located in San Salvador or in the U.S. Some members of the middle and lower classes have access to social security-styled medical services that were developed as alternatives to the Ministry of Health network. Government per capita spending on the ISSS system is considerably greater than its per capita spending on Ministry of Health services which provide care to the majority of the population. The official

medical delivery system, then, reflects the unequal distribution of resources that characterizes Salvadoran society as a whole.

Conclusion

In this chapter, Asunción's history from pre-conquest times through the 1932 peasant revolt and the subsequent national socio-economic and political developments were reviewed. Spanish reliance on indigenous community members as the primary producers of cocoa and balsam allowed modified indigenous sociocultural characteristics to persist in the Los Izalcos region to a greater degree than elsewhere in the country. However, the late nineteenth century liberal reforms, particularly the decrees abolishing community lands, undermined the economic basis for separate indigenous and Ladino communities. Loss of communal control over land, the growing dependence on wage labor, and the economic crisis provoked by the Depression combined to produce a large peasant revolt in Asunción and other southwestern towns in 1932. While both Ladinos and Indians participated, the indigenous population bore the brunt of the subsequent government reprisals. Those surviving the massacre rapidly abandoned indigenous dress, language, and other signs of ethnic identity.

The events of 1932 influenced the country's subsequent political and economic evolution. In the political sphere, the military assumed control over the presidency and top government posts for nearly 50 years. The alliance between the military and civilian elite resulted in a course of economic development that benefited the small upper class but resulted in the increasing impoverishment of the majority.

In the agricultural sector, small farmers lost access to land, food production declined, reliance on wage labor grew, and underemployment, unemployment, and rural out-migration increased as a result of expansion and diversification of export crop production. In the industrial sector, the movement toward economic integration and the formation of the Central American Common Market led the agrarian elite to diversify their interests through establishing manufacturing plants linked with foreign and especially U.S. capital. While import-substitution industrialization created a small number of new jobs, it undermined the economic well-being of many engaged in small-scale commercial activities and in artisan and trades occupations. It also marked a change in El Salvador's dependency relationship with the developed market economies. Before the 1960s, direct foreign investment was confined largely to the agricultural, communications, and transportation sectors. Since that time, investment has increased substantially, especially in the manufacturing sector. Although imports of finished consumer items were reduced, reliance on imported technology, raw materials, and semi-elaborated goods grew. Foreign and multinational involvement has contributed to a type of cultural imperialism that creates consumer preferences similar to those in the developed countries and leads to a devaluation of locally produced products.

These economic trends are reflected in poor standards of health among the urban and rural lower classes. Of particular importance are high levels of malnutrition, infectious and parasitic disease, and

large numbers of people injured or killed by government security forces. As most government spending is allocated to curative services rather than to public health or environmental programs, public-sector medical facilities are unable to deal effectively with the burden of recurrent illness that characterizes the majority of the population. Declining standards of living and health underlie growing participation in mass popular organizations whose aims are to bring about structural change and a more equitable distribution of property and wealth. It is against this background that Asunción's demographic, socioeconomic, and social organizational characteristics are considered in subsequent chapters.

CHAPTER III

ASUNCION: DEMOGRAPHIC AND SOCIOECONOMIC OVERVIEW

Asunción has been a relatively large and stratified community since the time of the Spanish Conquest. Until the abolition of communal properties at the turn of this century, ethnicity was a major variable in the stratification system. Since then, and especially since 1932, ethnic dimensions have diminished and have been superseded by social class divisions based largely on families' relationships to the productive process. These social class and ethnic divisions are fundamental in understanding the organization of social life. They underlie variations in family structure, kinship, and other associational bonds. They influence health and nutritional standards, and they play a role in decisions regarding use of medical resources.

To begin to conceptualize and discuss these social class divisions, this chapter presents an overview of Asunción's demographic and socioeconomic characteristics in 1978-79. The town is placed in its departmental and regional context. Then, information on its population structure and economic organization is reviewed. Locational characteristics and the effects of macro-level socioeconomic processes on demographic and occupational features are highlighted. Succeeding

chapters review characteristics of the indigenous population and other aspects of social organization.

The Department and the Region

Asunción is located in one of the western-most administrative units, the department of Sonsonante. The departments of Sonsonante, Santa Ana, and Ahuachapán comprise the occidental region (región occidental). As was the case in pre-conquest and Colonial times, this is one of the richest agricultural zones and most densely populated areas of the country. In 1971, the department of Sonsonante had an estimated 192 residents per square kilometer, slightly above the national average of 190 (De Guevara 1975: 11). Sonsonante's northern portion is transversed east to west by the Sierra Apaneca-Illamatepec mountains and is a principal coffee-producing area. In the central and coastal parts, there are numerous rivers and streams which, together with the rich volcanic soils, make the area well suited for sugar cane, cotton, tobacco, cereal grains, fruit, cocoa, and balsam production. Staple food crops of maize, beans, sorghum, and rice also are grown. Livestock raising is an important branch of agricultural activity, with large tracts of land in year-round pasture.

Land tenure patterns are of the classic latifundia-minifundia variety. In 1962, Menjivar reported that 94% of holdings were 14.99 hectares or less and occupied 14.5% of the cultivated area, while 3.8% of holdings encompassed 80.7% of the farmland (quoted in De Guevara 1975: 20). Generally speaking, small- to medium-sized holdings are used to produce food for family consumption and sale. Large tracts are

used for the country's major export crops of cotton, sugar cane, and coffee or for cattle grazing and dairy production.

In 1976, the department's population was 281,323. Of these, 178,593 (63.5%) lived in rural areas. The majority were small property owners, renters, or resident workers on estates (colonos), most of whom were also dependent on wage labor for their livelihood. Outside the peak harvest periods for sugar cane (December-March) and coffee (October-January), there was considerable rural underemployment. Wage rates for agricultural day laborers (jornaleros) ranged from C1.00 (\$0.40) to C1.50 (\$0.60) per day in the early 1970s (De Guevara 1975: 22).

Industrial activity is centered in and around the port, Acajutla, and the department capital, Sonsonante. Acajutla is El Salvador's leading seaport and has experienced moderate industrial development since renovation of its docking facilities in the 1960s. There are at least eight factories in the city, among them an oil refining facility, a cement plant, a fertilizer manufacturer, and a firm producing metal structures for construction purposes.

In Sonsonante, industries center on processing the region's primary agricultural products. They consist of small food, beverage, leather goods, and textile manufacturing plants. In 1971, there were 5,132 people employed in the manufacturing sector in the department. Wage rates were low. Weekly earnings averaged C35.53 (\$14.21) for males and C16.34 (\$6.53) for females (De Guevara 1975: 22).

Politically, the department of Sonsonante is divided into three districts: Sonsonante, Izalco, and Juayua. Each consists of municipalities (municipios) that are further subdivided into rural cantons (cantones) and hamlets (caseríos). The department's governor is appointed by the Ministry of Interior, while the mayors (alcaldes) of the municipalities are popularly elected every two years. The mayors appoint the canton and hamlet officials. In 1979, the vast majority of the elected posts were held by members of the official party, the Party of National Conciliation (PCN). In contrast to the capital and the eastern regions of El Salvador where slogans of the popular organizations were much in evidence, in Sonsonante walls and trees were more likely to display the slogans of the right-wing paramilitary organization, ORDEN. Participation in ORDEN was high and facilitated gaining access to market stalls, hospitals and clinics, and other forms of preferential treatment.

The low standard of living experienced by the majority of the population is reflected in official health statistics. Table 3.1 provides information on mortality and natality rates for the regions of the country in 1976. The occidental region had the highest natality, mortality, and infant mortality rates and ranked second in maternal mortality. The high mortality, however, contributed to the lowest growth rate, 30.6 per thousand, in the nation.¹

The incidence of malnutrition in the occidental region is also high compared to other areas of the country. Table 3.2 shows the number of new malnutrition cases in children under the age of five

Table 3.1.--Regional variations in mortality and natality rates, 1976.

	Country as a Whole		Occidental Region		Central Region		Metropolitan Region		Para-Central Region		Oriental Region	
	No.	Rate per 1,000	No.	Rate per 1,000	No.	Rate per 1,000	No.	Rate per 1,000	No.	Rate per 1,000	No.	Rate per 1,000
Natality	165,747	39.3	35,635	40.0	21,323	39.2	34,087	39.2	28,533	38.8	46,169	39.2
Mortality	30,807	7.3	8,360	9.4	4,281	7.9	7,035	8.1	4,465	6.1	6,666	5.7
Maternal mortality	131	.8	33	.9	15	.7	28	.8	22	.5	33	1.0
Infant mortality	9,168	55.3	2,794	78.4	1,356	63.6	2,288	67.1	1,112	39.0	1,618	35.0
Growth rate		32.0		30.6		31.3		31.1		32.7		33.5

Source: Ministerio de Salud Pública y Asistencia Social, Departamento de Estadísticas de Salud, Salud Pública en Cifras, Anuario, 1976.

diagnosed at Ministry of Health outpatient medical facilities in 1976. Because the figures represent only those children seen at these facilities, and because they presumably do not include those whose malnutrition was diagnosed before 1976, the table does not indicate the true magnitude of the problem. It demonstrates that the region ranked second in new malnutrition cases, with 16,609 (11.0%) of the 150,177 children under the age of five diagnosed as malnourished.

Table 3.2.--Cases of malnutrition in children under age five, 1976.

Region	No. Children Under Age 5 ^a	No. New Cases Malnutrition	% of Population
Occidental	150,177	16,609	11.0
Central	97,373	10,367	10.6
Metropolitan	125,159	16,279	13.0
Para-Central	129,657	9,765	7.5
Oriental	206,297	14,963	7.2
Total	708,663	67,983	9.6

Source: Ministerio de Salud Pública y Asistencia Social, Departamento de Estadísticas de Salud, Salud Pública en Cifras Anuario, 1976.

^aThese children were seen at the Ministry of Health outpatient facilities.

These high mortality and malnutrition rates may reflect an interplay of economic and sociocultural factors. Economically, the occidental region is the major coffee-producing area and the one in which the rural (campesino) population was most affected by the abolition of communal properties at the turn of this century.

Families whose lands were absorbed by the coffee estates (fincas) frequently became colonos. Many of these subsequently lost their jobs and residences as a result of the 1965 minimum wage legislation (White 1973). Most were reduced to earning their living as jornaleros.

Sociocultural and ethnic factors may compound the effects of worsening economic conditions. The majority of El Salvador's remaining indigenous population resides in the occidental region, particularly the department of Sonsonante. Unlike Mexico, where the indigenous heritage has been used to foster a sense of national identity, in El Salvador there is little official recognition or pride taken in the pre-Colombian heritage or its remaining descendants. Discrimination against the native population is common and may reduce their access to employment, rental of land, health care facilities, and other resources. For this population, ethnic barriers compound the effects of declining economic circumstances and, in part, may contribute to the high mortality and malnutrition rates characteristic of the department.

Asunción: Physical Organization

Asunción is located approximately seven kilometers northeast of Sonsonante and 56 kilometers west of San Salvador. It is bisected by the major highway that runs from Acajutla through Sonsonante to San Salvador. The residential and commercial center lies to the north of the highway along the lower slopes of the Izalco volcano. The physical surroundings are pleasant. The altitude, 440 meters above sea level,

produces somewhat cooler temperatures than those of neighboring Sonsonante. The volcano, lying to the north, is one of the country's best known tourist sites. Because the access road lies a considerable distance from town, however, few if any tourists visit the community. Atecozol Park is located one kilometer east of Asunción. With spring-fed pools and well-maintained gardens, it attracts many visitors and is an important source of revenue for many townspeople engaged in vending activities.

Although Asunción is located only a short distance from the department capital, it remains an important administrative and commercial center in its own right. It is a municipal and district seat, offering services to residents and to the campesino population in the surrounding 25 rural cantons. In addition to the local government offices, there are branches of the Ministry of Agriculture, a rural credit bank, and the Social Security Institute. A large health center, a national guard post, and a local military post are located in town, as are six public schools and one private Catholic school. Buses run between Asunción and Sonsonante every 20 minutes and between Asunción and other large urban centers, such as San Salvador and Santa Ana, at regular intervals during the day. Telephone and telegraph service is provided by the National Administration of Telecommunications (Administración Nacional de Telecomunicaciones, ANTEL).

Asunción has a small but active commercial center. There are half a dozen large stores (almacenes). Some are called "supers" and specialize in selling canned foods, beverages, toiletries, and other

household items. Others sell clothing, shoes, school supplies, and assorted merchandise. There are four pharmacies, a radio and television repair shop, a store specializing in the sale and repair of watches and clocks, two corn grinding mills, three medium-size restaurants, two state-licensed liquor stores, and numerous small to medium-size stores (tiendas) in the center of town. Asunción has a covered municipal market that is open on a daily basis, but the principal marketing day is Sunday. A movie theater, soccer field, pool hall, and other small-scale enterprises also exist. The only industry in the municipality is a large sugar cane processing mill which operates for five to six months a year and is located a few kilometers west of town.

Asunción's physical layout displays traces of its earlier division into separate Indian and Ladino communities. A town map is shown in Figure 3.1. There are two plazas, each with a park and colonial church. One is located in the upper or northern section in the neighborhood (barrio) Dolores. The other lies a few blocks to the south in the barrio Asunción. These upper and lower sections are further set apart by the names given to the principal north-south and east-west thoroughfares. From the highway to the church of Asunción, the main street is called Avenida Atlacotl after the Indian leader who mounted local resistance to the Spanish in the sixteenth century. From here on it becomes Avenida Morazán in honor of the last president of the Federal Republic of Central America and a leading figure in early nineteenth century liberal politics. In a similar fashion, the main east-west street displays two names: Calle Union and Calle Libertad.



Figure 3.1.—Map of Asunción, 1979.

The original church in the barrio Asunción was destroyed by an earthquake in the eighteenth century but was rebuilt in 1815. A small tower situated near the church houses the bell given to the community by Charles V of Spain in the sixteenth century. The present church of Dolores also dates from the nineteenth century. In 1979, one priest served both churches. Government offices are located around the two plazas, with the mayor's office (alcaldía) and the health center located in the barrio Asunción and the national guard post, local military post, and telephone office in the barrio Dolores.

In addition to Dolores and Asunción, the town has seven other barrios: Santa Teresa, La Otra Banda, Santa Lucia, San Sebastian, Santa Cruz, Cruz Galana, and San Juan. The newest neighborhoods, Lourdes and San José, are called colonies (colonias). In contrast to the barrios, these are planned subdivisions. In 1979, the owner of this tract of urban property was partitioning housing lots for sale or for rent. More will be said regarding these neighborhoods in the section on housing characteristics at the end of this chapter and in the discussion on ethnicity in the next chapter.

The Community Census

National census data on Asunción dated from 1971 and did not provide the detailed information necessary for this research. Housing records available from the local sanitation inspector at the health center also proved outdated. With the help of two research assistants from Asunción, I conducted a census in November and December 1978 to gather general demographic and socioeconomic information. This

information was used for descriptive purposes and also served as the basis for selection of a stratified sample of families who later participated in an illness episode survey.

Census interviews were conducted with every fourth household. The following information was gathered: age, sex, occupation, level of education, religion, and civil status of the household head and spouse; relationship to the household head, age, sex, occupation, and level of education of all residents; number of children born to the household head and spouse; and number of children living. Questions were asked regarding house ownership and characteristics of the dwelling; possession of radios, televisions, and motor vehicles; and ownership of urban and rural properties. The question on property ownership was meant to discriminate between those owning or renting small plots under 3 hectares, those owning between 3 and 20 hectares, and those owning more than 20 hectares. No information was collected on income or ethnic identity. It was unlikely that accurate information on income could be gained on a brief visit to the household. De Guevara's experiences interviewing in similar types of communities and discussions with the research assistants suggested that direct questions regarding ethnic identity could elicit hostility or suspicion (De Guevara 1975).

A total of 525 households was interviewed.² In 363 (69.1%) of the cases, the household head or spouse was the respondent. In the remaining instances older sons, daughters, or other adult family members answered the questions.

The census, information gathered from participant observation, and secondary source material provide the basis for examining Asunción's demographic and socioeconomic features.

Population Characteristics

Demographic profiles, particularly the population's age and sex distribution, reflect the effects of social and economic processes. A review of these distributions serves as a departure point for a consideration of the town's socioeconomic composition.

Table 3.3 presents information on the number of residents. The figures are from the four national censuses conducted since 1930 and the 1978 community census. Between 1930 and 1950, the number of urban residents declined by 752 (11.2%). The deaths associated with the 1932 uprising may have played a role in this decline.³ Out-migration of Indian families owing to increased discrimination during the revolt's aftermath also may have been a factor. By 1961, however, the population had surpassed its 1930 level, and by 1971 it reached 8,404. In December 1978, the census of one-quarter (525) of the dwellings revealed that the average household size was 5.38 persons. This yields a total population estimate of 11,298. Between 1971 and the end of 1978, then, the inhabitants increased by 2,894 (34.4%), producing an average growth rate of 3.7% per year.

Differences in the census methodologies used in 1971 and 1978 may explain part of this increase. There may well have been underenumeration in the 1971 national census. For example, because dwellings at the outskirts of town do not front directly on streets but rather are

scattered throughout blocks, they can be easily overlooked by census enumerators. Also, different definitions of town boundaries may have been employed. In 1978, members of households on the outer perimeters of Asunción were counted as residents if they considered themselves as such. It is not known what procedure was followed in 1971. Finally, because the 1978 census was conducted during the coffee harvest season when some temporary workers and their families had moved into local apartments (mesones), the population estimate may have been somewhat greater than the actual number of year-round residents. Nonetheless, it is unlikely that these considerations fully account for Asunción's population growth.

Table 3.3.--Population of the municipality, 1930-1978.

Year	Rural	Urban
1930	13,161	6,718
1950	16,289	5,966
1961	21,879	7,201
1971	27,556	8,404
1978		11,298

Source: De Guevara 1975: 202 and the 1978 town census.

An examination of the age and sex distribution provides insights into the town's composition and permits speculation regarding the causes for its growth. The figures are drawn from the 519 households providing complete information on the age and sex of residents. Figure 3.2 shows the age-sex pyramid. Of the 2,790 people included, 1,077

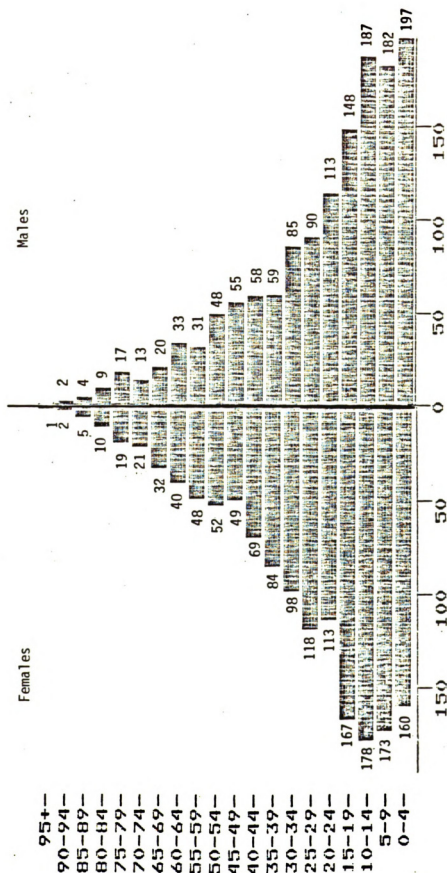


Figure 3.2.--Population pyramid for Asunción, 1978. (Source: 1978 town census.)

(38.6%) were under 15 years of age. In 1976, the urban population of the department was 102,730, and of these 43,078 (41.9%) were under the age of 15. Thus, in comparison with other urban areas, Asunción's population may be slightly older. The average age of males and females in the sample was 23.7 and 26.4 years, respectively.

An examination of the 0-15 age category suggests a relatively recent decline in the number of children born, coupled with declines in infant and childhood mortality. Age-sex pyramids in areas of high fertility and high infant and childhood mortality show a step progression whereby the 0-4 age cohort is the largest, followed by the 5-9 and 10-14 age cohorts. In Asunción, there was relatively little difference in the number of children in the three age groups under 15 years. In fact, there were slightly more children between the ages of 10-14 than between the ages of 0-4 and 5-9. Because there were no known epidemics or large population movements during the last five years that would account for the small number of children in the 0-4 age group, it is reasonable to assume that recent declines in fertility and infant and child mortality may partially explain this distribution.

Two other considerations deserve mention. First, as noted previously, the average age of females in the sample was relatively high, which may result in fewer births. A second point is related to family composition. While this will receive more elaboration in subsequent chapters, many households had taken in grandchildren, nephews, and nieces whose parents did not reside in the town. These children may have slightly swelled the ranks of the 0-4 and 5-9 age groups. The

preponderance of males in all age categories under 15 may be due in part to a tendency to leave or return more males than females to the care of relatives.⁴ Thus, a portion of Asunción's growth is explained by the combined effects of relatively high, although declining birth rates, decreases in infant and child mortality, and the practice of leaving children with relatives in the town.

The effects of migration on the growth rate and the age-sex distribution are also important factors although they are difficult to document fully with the available information. While the sex ratio is .90 for the 0-14 age group, in the population 15 years and over it is 1.18. An examination of the age-sex pyramid suggests that considerable male out-migration occurs after the age of 15 and is either greater than that of females or is accompanied by an in-migration of females. This latter factor indeed may play a role. Although no information was gathered on the number of people who had moved to the town between 1971 and 1978, migration of campesinos to urban centers is common in El Salvador. White (1973: 146) reports that over a 10-year span, approximately 6% of the rural population move to cities; 4% of these remain there permanently and 2% eventually leave. Because single women have few employment opportunities in rural areas, many move to cities where they can engage in small-scale vending or work as domestic servants. These factors suggest that in-migration of rural dwellers, especially women, may play a role in the population increase between 1971 and 1978.

Asunción also has gained residents from other urban areas. Its physical amenities, somewhat lower cost of living in comparison with neighboring Sonsonante, and its location on the highway attract families whose wage earners work in other nearby urban centers. With the expansion of the public education system in the last decade, many teachers moved to the town. According to the director of one of the local schools, there were over 140 resident school teachers in 1978. Many worked in Sonsonante or in the surrounding rural cantons but preferred to live in Asunción.

Finally, the age-sex pyramid reveals that 155 (5.5%) of the census population was over 65 years of age. Longevity of females is greater than that of males. Ninety (6.3%) of the females were over 65, whereas only 65 (4.8%) of the males were this age or older.

Overall, it appears that the rate of natural increase is declining and that in-migration plays an important role in the population growth experienced between 1971 and 1978. Asunción is attracting residents from rural areas and from surrounding urban centers. In part, its location on a highway and its proximity to the department capital explain its attraction. These same factors, however, are leading to Asunción's gradual incorporation as a suburb to Sonsonante. Buses running between the two cities every 20 minutes, the tranquility of small town life, and the lower cost of living all account for Asunción's popularity as a place of residence at the same time that they undermine its independence. The demographic profile suggests that the

town is taking on the trappings of an older, middle-class bedroom community whose youth move away in search of work.

Economic Organization

Since the sixteenth century, Asunción's economy has undergone a continuous process of change and adaptation conditioned by its integration into, first, the Spanish empire and, later, the independent Salvadoran state. In 1978, the most crucial national-level factors influencing the local socioeconomic structure were progressive land concentration linked to increased export crop production and an industrialization process that depended on foreign technology and capital and that generated few jobs. In this section, these trends' effects on the local economy are examined. The town and its inhabitants are viewed as active participants in the processes that shape the local economic structure. Information is presented on the occupations of the household heads interviewed during the census. Next, the strategies households use to deal with their economic circumstances are reviewed.

Occupations of the Household Heads

Five occupational sectors were identified in analyzing the census information: I. The small-scale agricultural and day-laboring sector, II. The artisan and trades sector, III. The white-collar and semi-professional sector, IV. The professional and large landowning sector, and V. Those not in the labor force and unemployed. Using this framework, Table 3.4 shows the occupations of the 525 household heads.

Table 3.4.--Occupations of household heads.

Sector ^a	Occupational Group	No. Male	No. Female	Total	% Sample	% Econ. Active	% Econ. Active by Sector
I	Agricultural day laborers	76	6	82	15.6	19.3	
	Ag. day laborers who own/ rent land	16		16	3.0	3.8	38.3
	Laborers	36	4	40	7.6	9.4	
	Sm./med. agriculturalists	25		25	4.8	5.9	
II	Artisans	102	8	110	20.9	25.8	
	Vendors	24	15	39	7.4	9.2	40.6
	Owners small shops	2	7	9	1.7	2.1	
	Owners med./lg. shops	2	13	15	2.9	3.5	
III	White-collar employees	37		37	7.1	8.7	17.4
	Semi-profess. employees	34	3	37	7.1	8.7	
IV	Professionals/owners large estates	16		16	3.0	3.7	3.7
V	Housewives		66	66	12.6		
	Retired	23	5	28	5.3		
	Unemployed	5		5	1.0		
Total		398	127	525	100.0	100.0	100.0

Source: 1978 town census.

^aI--Small-scale agricultural and day-laboring sector, II--Artisan and trades sector, III--White-collar and semi-professional sector, IV--Professional and large landowning sector, V--Not in the labor force and unemployed.

Before discussing characteristics of the occupational sectors, two general points merit consideration. First, nearly one-fifth (18.9%) of the sample were not in the labor force. Most of these household heads were retired or were housewives. Only a small number (5) were unemployed at the time of the interview. This low level of unemployment reflected the expanded job opportunities afforded by the coffee harvest and was not characteristic of the situation at other times of the year. Second, one-fourth (24.2%) of the households were headed by women. The high percentage of female-headed households will receive attention in Chapter V.

Sector I: Small-scale agriculturalists and day laborers. Of the 426 economically active household heads interviewed, nearly two-fifths (163 or 38.3%) earned their living as agricultural day laborers (jornaleros), laborers, or small property owners or renters.

Nearly half (82) of the 163 people in Sector I were entirely dependent on work as jornaleros. Sixteen others also relied on agricultural wage labor for the majority of their income although they owned or rented small plots of land (under three hectares). Few (6) female household heads reported that they worked in agriculture, and all of these women were temporarily employed picking coffee.

Another one-fourth (40 or 24.5%) of the household heads in Sector I were laborers on construction projects, fincas, or at the sugar cane processing mill. A small number were machine or truck operators. With the exception of these more skilled workers, little distinguished the laborers from the jornaleros. In fact, when unable to find work in

construction, laborers frequently sought jobs as jornaleros and vice-versa. The four women in the laboring group were domestic servants.

In summary, nearly one-third (138 or 32.5%) of the economically active household heads in the census were dependent on wage labor for all or a major portion of their livelihood.

While many household heads were either landless or had access to plots that were too small to meet their subsistence needs, there remained a group of agriculturalists owning small to medium-size plots (3 to 20 hectares) that were of sufficient size so that they did not have to engage in permanent wage labor during the year. These household heads constituted only a small percentage (25 or 5.9%) of those in the labor force.

The heavy reliance on wage labor contrasts with the situation before the abolition of community-held lands at the turn of this century. At that time, such dependence was reported to be rare (Anderson 1971, Browning 1971). In general, it appears that the holdings of those who managed to gain title to land when the communal properties were divided were subsequently lost or were not sufficient to support the needs of subsequent generations.

Although there was variation by employer and by season, the average wage of jornaleros was approximately C3.00 (\$1.20) per day and work opportunities were irregular. Considerable underemployment and unemployment occurred outside of peak planting and harvesting periods. The minimum daily wage of C4.50 (\$1.80) was rarely complied with because, as one large landowner stated, both harvests and prices were

undependable. In such situations, risks and uncertainties were passed on to those least able to bear their consequences.

Sector II: Artisans and tradespeople. The single largest occupational sector comprised artisans and tradespeople. Two-fifths (173 or 40.6%) of the economically active household heads were employed in these occupations.

Nearly two-thirds (110 or 63.6%) of those in Sector II were artisans. The five largest groupings were carpenters, masons, tailors, sawyers, and seamstresses. Many artisans were self-employed, but some, especially those in the building trades, worked for others. The large number of carpenters, masons, and sawyers suggests that Asunción was a center for the local construction industry. In addition to work in town, many found employment in surrounding communities and rural cantons. The services of tailors, seamstresses, shoemakers, and carpenters were frequently sought by those who could not afford to purchase the more prestigious and expensive industrially manufactured goods.

The few remaining townspeople engaged in traditional handicraft activities were included in the artisan category. One carpenter's shop produced finely carved wood furniture and home accessories that were sold locally or made their way into the tourist trade in San Salvador. One woman made rough pottery items. Hand-woven cloth, by contrast, was no longer made in Asunción. Its manufacture had all but disappeared by the early 1950s (Adams 1976). The few Indian women who wore indigenous apparel in 1978 bought their materials from vendors from Guatemala or

from Nahuizalco, a nearby community where the Peace Corps had undertaken to revive the Indian weaving industry. Some older indigenous women still wore the traditional sash (refaja), but these also were no longer made in town.

The number of household heads employed as musicians, another occupation once of significance, has declined in recent years. Musicians used to play an important role in religious festivities and social gatherings, but they have increasingly lost out in popularity to stereos and tape decks. In the sample, there were four musicians and one man whose job it was to set off fireworks.

The remaining one-third (63 or 36.4%) of Sector II comprised vendors and shopowners. While there were more women than men in these occupations, real differences existed in the nature of their occupations. Three-fifths (24) of those in the vendors group were males. The majority worked as comerciantes, or middlemen, in the distribution process. That is, they purchased agricultural produce or industrially manufactured goods from large stores or markets in Sonsonante or San Salvador for resale to small-scale vendors and shopowners. Five owned trucks for this purpose. The earnings of comerciantes varied widely but could be substantial.

In contrast to many of the male vendors who worked as comerciantes, female vendors were concentrated at the end of the distribution system selling directly to the public on streets or in markets. In general, they earned less than comerciantes. Some street vendors grew or purchased local fruits and vegetables, then traveled by bus to

Sonsonante, Acajutla, or Santa Ana to sell them. At times, this required spending a number of days a week away from home. Babies and young children either accompanied their mothers or were left in the care of older children or relatives. Vendors with friends or family in these cities could obtain lodging, but many others slept on sidewalks or in parks. Because a sales permit was legally required and because few could afford to obtain one, many vendors were harassed by local authorities.

Other vendors sold produce or goods in local markets. Market stalls in Asunción and Sonsonante were in great demand. Those who had connections which facilitated obtaining a stall and who could afford to pay the rental fees could establish a regular clientele and, hence, had more assured and higher incomes than did most street vendors.⁵

While more men than women worked as vendors, females owned or ran almost all the commercial establishments in Asunción. As the data in Table 3.4 indicate, 20 of the 24 shops were owned by women. Of the four males who owned commercial enterprises, two operated small, state-licensed liquor stores (cantinas), one sold watches and clocks, and one ran a large store with the aid of his wife.

Except in the case of a few large establishments, businesses were located in the front room of homes. There was considerable variation in earnings generated through store ownership. The large shops, pharmacies, and "supers" were among the most successful businesses in town. These store owners often purchased merchandise from traveling sales representatives of large stores or distributorships in Sonsonante

and San Salvador. They frequently were offered credit and discounts on the merchandise. Small shop owners, in contrast, tended to rely on transient vendors in stocking their establishments. Neither credit nor discounts were usually obtainable. These stores had small inventories, and prices were sometimes higher than those in the larger stores. Income generated from these small businesses was meager.

As the political struggle against the Romero government intensified during 1979, many tradespeople's and artisans' earnings fell sharply. This was especially the case for those who relied on buses and other means of transportation. During April and May, the destruction of buses by the opposition was intensified, and hijackings of trucks and cars became more frequent. Normal deliveries to stores were interrupted, and many people were unable or afraid to travel. At one point, the town was left without bus service for almost a week, severely disrupting economic and social activities.

A number of points can be made regarding the artisan and trades sector. First, improvements in the country's transportation network and industrialization brought about by the Central American Common Market has increased the availability of manufactured goods. In Asunción and elsewhere, this has resulted in the disappearance of certain occupations such as those of weavers and potters. In other cases, both the amount and nature of the work have changed. For instance, many tailors, seamstresses, and carpenters are increasingly called on to repair rather than produce finished items. At the same time, opportunities for other jobs have expanded. Some occupations,

like radio and television repair work, require formal training which places them beyond the reach of many people. While other new jobs do not require such skills, they have been accompanied by shifts in workforce composition. The change in preference from tortillas to french bread among the middle class has reduced opportunities for those individuals, mostly female, who make and sell tortillas. In contrast, the business of bakers, who are predominantly male, has expanded. Overall, it appeared that while artisans were usually able to find some work, many were underemployed and their earnings were low due to competition from others and from industrially manufactured goods.

Second, the heavy dependence on work in the trades sector may result from an interaction between more generalized economic trends and circumstances specific to the local context. The availability of manufactured goods and the lack of productive employment opportunities in industry and agriculture have led to a proliferation of vendors and middlemen. As will be discussed below, the town's location on a major highway near the departmental capital has facilitated this trend.

Another result of recent economic processes is the growth in small businesses, many owned by women. A conjunction of socioeconomic and cultural factors may explain the concentration of females in these occupations. First, given the large number of males in search of secure and remunerative employment, job opportunities for all but the most well-educated women are limited. Second, cultural norms dictate that a woman's primary responsibilities are to home and family. Middle- and upper-class women who pursue careers meet this expectation because they

employ domestic servants to fulfill many household and child care obligations. Poor women who work outside the home and must leave many of these tasks unattended are stigmatized. Therefore, when possible, women prefer to combine earning a living with the fulfillment of domestic responsibilities. Small stores and vending operations located in the home provide one such opportunity. Other popular options are taking in sewing, hair styling, or giving injections. The least preferred option is to turn to street vending.

Finally, a contrast exists between the economic effects of the number of household heads employed as agricultural day laborers, laborers, and artisans and those who earn their living in trades occupations. The large number of those seeking work as laborers and artisans depresses wage levels and helps keep earnings low. The large number of traders, on the other hand, may keep food and merchandise prices high. In part, this is a function of the source of supply of merchandise. Owners of small- to medium-sized stores and many vendors purchase goods from middlemen whose sale price includes their profits. The high price paid for goods combined with a low trade volume means that most vendors and owners of small and medium enterprises cannot afford to engage in price cutting to attract customers (White 1973: 148). This option is available only to owners of large stores who purchase in bulk from distributorships.

Section III: White-collar and semi-professional workers. Those engaged in white-collar and semi-professional occupations accounted for

less than one-fifth (74 or 17.4%) of the economically active household heads in the census.

Half (37) of the household heads in this sector earned their living as white-collar workers (empleados). All were males. Because only the largest businesses in Asunción hired workers, most of these men commuted to Sonsonante, Acajutla, Santa Ana, or San Salvador to work in government offices, banks, or private enterprises. Compared with those in the occupations discussed previously, white-collar workers had the advantage of regular employment and income, although salaries frequently were low. For example, store clerks in Asunción earned less than C125.00 (\$50.00) per month.

In addition to the 37 white-collar workers, there were 37 household heads in Sector III with semi-professional occupations. Twenty-five were school teachers. The others were accountants, nurses, or officers in the military and security forces. Again, many of these individuals worked elsewhere. Only three of these 37 household heads were women: two school teachers and one nurse. Those in semi-professional jobs who worked in the public sector (i.e., health center, public schools) reportedly experienced frequent delays in receiving their pay. Nevertheless, by community standards many of those in semi-professional occupations had large salaries, ranging between C200.00 (\$80.00) and C450.00 (\$180.00) per month.

The teachers deserve special comment because of the large number of them in town, the high regard in which they were held, and their role in the political struggle. On the national level, teachers were

organized into either a government sponsored union or into the National Association of Salvadoran Educators (Asociación Nacional de Educadores Salvadoreños, ANDES) which was allied with the Popular Revolutionary Block. To avoid trouble, many teachers were nominal members of the government union, but there was a small number of active ANDES members in Asunción. During 1979, a campaign of terrorism was launched against these teachers and other suspected left-wing sympathizers. Between April and June, many houses were searched by masked and armed men. Five teachers were shot and one was killed. Many others fled town, and the schools were closed. While it is not possible to say with certainty who was behind these actions, it was widely believed that the right-wing terrorist organization White Hand (Mano Blanca) or the National Guard was responsible.⁶

Sector IV: Professionals and owners of large estates. Finally, as the information in Table 3.4 indicates, there was a small number (16 or 3.7%) of professionals and owners of large estates among the economically active in the census. These included two lawyers, one physician, physician/pharmacy owner, one deputy in the national legislature, a Protestant missionary from New Zealand, and 11 hacienda or finca owners. Three of the five professionals owned extensive land holdings in addition to their other sources of income.

An undetermined number of other estate owners and professionals also maintained homes in Asunción but resided in San Salvador and returned only for holidays. In a brief ethnographic survey in 1975, De Guevara noted that many owners of the largest agricultural

properties did not live in town. Unfortunately, no detailed information could be gathered regarding the number of absentee landowners, the size of their holdings, or of the holdings of the resident upper class. Indirect information from townspeople concurred with De Guevara's findings and the data presented earlier on the department as a whole. It appears that a relatively small group of families own large estates devoted to coffee, sugar cane, dairy, and cattle production.

The families of most of the professionals and owners of large agricultural properties had affluent lifestyles. Since San Salvador could be reached in an hour by car, trips for business, shopping, visiting, and health care were frequent. Children attended private high schools in the capital and U.S. and European universities. Vacations abroad were common. These families were members of what Adams (1956: 889-90) terms the cosmopolitan upper class of Middle American communities. A considerable gap in education and wealth separated them from the local upper class composed of the owners of the most successful commercial enterprises and some medium to large properties.

Because there are no recent detailed ethnographic descriptions of Salvadoran towns, it is difficult to determine the degree to which Asunción's occupational structure approximates that of other communities its size. The information presented above indicates that the local economy was influenced by, and could not be considered apart from, the departmental and national contexts. In particular, the

large proportion of household heads (21.0% of the economically active) engaged in white-collar, semi-professional, and professional occupations may be attributed to Asunción's location. Because of its proximity to Sonsonante and its situation on a major highway, the town has retained and/or attracted more people in these occupational categories than would be the case in a more geographically isolated community.

This same factor helps explain the large number of household heads (40.6% of the economically active) who earned their living as artisans and tradespeople. Of equal importance here, though, is the lack of other job opportunities. Assessing the national situation in the early 1970s, White drew attention to the number of workers who, due to limited employment opportunities in industry and lack of access to land, had no option but to work as jornaleros or to establish small buying and selling operations. For example, White (1973: 135) estimated that more than 40% of the agricultural labor force was superfluous in the sense that production would not decline if they were removed. Excluded from access to land and with little industrial employment available locally, the most viable alternative for many in Asunción was to engage in small commercial and artisan ventures. It is reasonable to assume that in a more geographically isolated town where the opportunities for commerce in nearby urban centers were not available, fewer people would be dependent on artisan and trades jobs and more would be working as agricultural wage laborers. While artisans and tradespeople might be expected to earn more than jornaleros, this was not always the case.

Underemployment, unemployment, and low wages were characteristic of both sectors.

In summary, the construction of the road linking Sonsonante to San Salvador in the 1930s, subsequent improvements in the transportation system, and changes in the national economy have resulted in a shift in Asunción's economy. The number of household heads dependent on agricultural work has declined, while those in the artisans and trades sector have increased. This shift has not necessarily been accompanied by an improvement in the economic circumstances of the families involved.

Occupations of Other Family Members

Households coped with difficult economic circumstances in two ways. As noted earlier, many young people moved away in search of work. In some cases, men left families behind but returned on a regular basis and continued to contribute to their support. In other cases, as the large number of female-headed households suggests, marital unions dissolved.

In addition to the temporary or permanent migration of household members, families often adopted a second strategy, termed occupational multiplicity (Dieter Evers, et al. 1984), to deal with lack of resources. In more than half (295 or 56.2%) of the households in the sample, there were two or more people in the labor force. Most frequently, this was the spouse. Of the 525 household heads interviewed, 364 were married or accompanied (living in common-law union), and

two-fifths (144 or 39.6%) of the spouses worked. The majority were engaged in small-scale trades and vending activities.⁷

First-hand observation suggested that many of the 220 women whose occupations were given as housewife (oficios domésticos) also were engaged in vending activities, selling fruit, vegetables, firewood, or soft drinks from their homes. After residing in the town for a number of months, it was my impression that most women were involved at least occasionally in some form of remunerative activity. While this was an economic necessity for the majority, wives or companions of household heads in white-collar, semi-professional, and professional jobs also sold goods. Because casual visiting among these women was considered improper, selling from homes represented one of the few culturally sanctioned means for social interaction, permitting neighbors and friends to come and go, often simply on the pretext of making a purchase. Failure to report such activities during the census may reflect the insignificance of the earnings or the interaction's largely social function, but it is also indicative of the cultural ideal that women's primary responsibilities are in the domestic sphere.

Table 3.5 provides information on the employment status and occupation of household members (other than the household head and spouse) 15 years of age and older. These include children, grandchildren, nephews, nieces, and other relatives living in the dwelling. In many cases, they were engaged in the same occupational sector as the household head. In homes where the head worked in the

Table 3.5.--Occupations of household members 15 years and older by household heads occupational sector.^a

Occupational Sector ^b of Household Head	Occupational Sector of Household Members					No. Working	% Working	No. Work Other Sectors	% Work Other Sectors	% Work Same Sector
	I	II	III	IV	V					
I	59 50.4%	43 36.8%	15 12.8%		135	252	46.4	58	49.6	50.4
II	25 23.4%	65 60.7%	16 15.0%	1 .9%	133	240	44.6	42	39.3	60.7
III	3 8.6%	15 42.8%	17 48.6%		77	112	31.3	18	51.4	48.6
IV		1 10.7%	4 66.6%	1 16.7%	17	23	26.1	5	83.3	16.7
V	46 50.5%	30 33.0%	15 16.5%		101	192	47.4	91	47.4	52.6
Total	133 16.2%	154 18.8%	67 8.2%	2 .3%	463 56.5%	819	43.5	356		

Source: 1978 town census.

^aNot including the household head or spouse.^bI--Small-scale agricultural and day-laboring sector, II--Artisan and trades sector, III--White-collar and semi-professional sector, IV--Professional and large landowning sector, V--Not in the labor force and unemployed.

small-scale agricultural and day-laboring sector (Sector I), half (59 or 50.4%) of those in the labor force had similar occupations. This pattern holds for the artisan and trades sector (Sector II) and the white-collar and semi-professional sectors (Sector III), as well, where three-fifths (65 or 60.7%) and half (17 or 48.6%) had jobs similar to that of the household head. The small percentage (1 or 16.7%) of family members in the professional and large landowning sector (Sector IV) who had occupations similar to the household head's was due to the fact that many children were only beginning careers and/or had not yet inherited property. In addition, many others were attending school or working elsewhere.

While family members frequently worked in the same occupational sector as the household head, diversification also existed. This was most notable in cases where the head was in Sectors I and III. Roughly half (49.6% and 51.4%, respectively) of these household members had jobs in other sectors. For households in Sector I, this reflected an effort to hedge against periods of unemployment and low wages characteristic of agricultural work. Alternative sources of employment helped assure that at least some income was available on a regular basis during the year. The tendency for household members of heads in Sector III to be engaged in other occupations was most likely due to the lack of clerical and administrative jobs in Asunción. In Sector II, the relatively small percentage (39.3%) of family members with jobs in other sectors may be attributed to the tendency for artisans'

children (and other relatives) to be apprenticed in the same occupations as the household head or for them to help with the business.

Finally, as the data in Table 3.5 indicate, the percentage of household members in the labor force declines steadily from nearly half (91 or 47.4%) in Sector V, where the household head was not working, to one-fourth (6 or 26.1%) in Sector IV, where the head was a professional or large landowner. The higher percentage of household members in the labor force in Sectors I, II, and V reflects the marginal earnings and periods of unemployment or underemployment experienced by household heads in these sectors and the need for others to contribute to the support of the domestic unit.⁸ A more in-depth study could well indicate that this type of occupational multiplicity played an essential role in permitting employers to pay less than the amount necessary for the reproduction of the labor force (Friedman 1984: 44).

In summary, this review of the occupational structure suggests that since the turn of the century, but especially since 1932, in line with developments in the wider economy and society, many alterations have occurred in the local context. Increased land concentration has reduced the number of small- and medium-sized agricultural holdings and increased dependence on wage work. Improvements in transportation networks, coupled with Asunción's proximity to Sonsonante, enlarged the proportion of the population earning livings from small-scale artisan and commercial ventures. As other investigators have suggested, the large number of jornaleros, laborers, artisans, and tradespeople results from the lack of alternative employment

opportunities more so than it does from the needs of the local or national economy. Reflecting the marginal earnings generated by most of these jobs, households in these sectors tend to have more members employed than do those in other sectors. Asuncion's proximity to Sonsonante has allowed it to attract and retain more white-collar and semi-professional employees than would be the case in more isolated towns. While disparities between the rich and poor were great, they were somewhat attenuated by the presence of this sizable middle class.

Educational Characteristics

In recent years, formal education has taken on increased importance in the minds of many townspeople. Middle- and upper-income families see high levels of educational attainment as a necessary means for their children's advancement. Among poor households, at least some schooling is regarded as an essential way of defending oneself (defenderse). In addition, the large number of resident teachers has undoubtedly increased the population's perception of the importance of education.

Besides seeming to provide access to better-paying jobs, formal education carries with it values of a preeminently social nature. Verbal and written adeptness, proper modes of address, and good manners are viewed as signs of individual merit and are stressed in the classroom. Formal education, along with other criteria such as occupation, income, and family status, is another important dimension in the local stratification system.

Since the late 1960s, the national government has extended the public education system and upgraded its quality. New schools were built in rural cantons and small towns, and higher grades were added to the curriculum in many other schools.⁹ U.S.A.I.D. and government funds underwrote improvements in teacher training and instructional materials. Nevertheless, the system has not kept pace with the growing number of school-age children. Classes remain large, and the attrition rate is high. In 1968, only 20% of the children who began first grade were expected to complete sixth grade (White 1973: 231).

The educational system is divided into four levels. Grades 1 through 3 constitute the first cycle (primer curso), 4 through 6 the second cycle (segundo curso), 7 through 9 the basic plan (plan básico), and 10 through 12 the baccalaureate (bachillerato). Ten years ago, completion of the sixth grade was sufficient educational qualification for many low-level, white-collar jobs. Recent government efforts to integrate the plan básico with the primer and segundo cursos as a nine-year program mean that employers increasingly require a ninth-grade diploma of prospective employees.

Alongside the public schools are private educational facilities, the majority Catholic. These are thought to provide better quality education and are more prestigious than the public facilities. The costs of tuition, books, and uniforms place private schools beyond the means of most families. In some instances, financial barriers are reinforced by social ones. Some Catholic schools require proof of the parents' marriage as a prerequisite for a child's admission. In a

country where common-law unions are frequent among the lower and middle classes, such policies restrict access to all but children from the upper social stratum.

The public schools in Asunción serve the needs of most children from town and nearby rural areas. Classes are offered through the ninth grade. The plan básico is a recent addition to the curriculum, having been added only in the early 1970s. There is also an adult education program offering evening classes and one small Catholic school run by the priest. Children who continue their education beyond the ninth grade generally commute to schools in Sonsonante. However, some children from well-off families are sent to private schools after the completion of the sixth grade.

An examination of the census data on educational attainment provides further insights into the demographic and economic processes discussed previously and suggests some future trends. As expected, those in the lowest occupational groups had the lowest level of formal education. Table 3.6 shows the completed years of schooling of household heads by occupational sector. The white-collar workers, semi-professionals, professionals, and large landowners were grouped together as one sector.

Of the 521 household heads on whom complete information was available, one-fourth (131 or 25.1%) had never attended school. The majority (104 or 79.4%) were agricultural day laborers, laborers, small to medium property owners, or were not in the labor force. Another one-fourth (126 or 24.2%) had between a first and third grade

Table 3.6.--Household Heads level of education by occupational sector.

Occupational Sector ^a	No School		1st-3rd Grade		4th-6th Grade		7th-9th Grade		10-Bach. or Teach. Cert.		Bach. +		University Degree		Total
	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	
I	58	44.3	52	41.3	47	27.5	3	8.1	2	4.0					162
II	26	19.8	35	27.8	83	48.5	21	56.8	7	14.0					172
III & IV	1	.8	11	8.7	20	11.7	12	32.4	39	78.0	2	100.0	4	100.0	89
V	46	35.1	28	22.2	21	12.3	1	2.7	2	4.0					98
Total	131 (25.1%)	100.0	126 (24.2%)	100.0	171 (32.8%)	100.0	37 (7.1%)	100.0	50 (9.6%)	100.0	2 (.4%)	100.0	4 (.8%)	100.0	521 (100%)

Source: 1978 town census.

^aI--Small-scale agricultural and day-laboring sector, II--Artisan and trades sector, III and IV--White-collar, semi-professional, professional, and large landowning sectors, V--Not in labor force and unemployed.

education. Again, many (80 or 63.5%) were in the same two occupational sectors. Most of those with a third grade education or less could not read or write or had such difficulties that they were functionally illiterate. Altogether, these household heads accounted for half (257 or 49.3%) of the sample.

At the other end of the scale, one-tenth (56 or 10.8%) of the household heads held teaching certificates or had a twelfth grade education or more.¹⁰ A small number (6) had attended the university or held university degrees. The majority (80.4%) of those with a twelfth grade education or better were white-collar workers, semi-professionals, professionals, or owners of large estates.

Finally, it should be pointed out that less than one-fifth (93 or 17.9%) of the household heads in the census had attended classes beyond the sixth grade, which is due, in part, to the recent addition of grades 7 through 9 to the local curriculum.

The relationship between age and number of years of school is also important. Educational levels in the community have risen steadily in recent decades, reflecting the increased availability of schools and the greater importance attached to education as a means of advancement. Figure 3.3 shows the average number of years of school completed, by household-head age category. While the mean number for those 75 years and older was only 1.59, it was 4.75 for those between 35 and 44 years of age and 7.00 for those between 15 and 24. For the sample as a whole, the average number of years of schooling completed was 4.11.

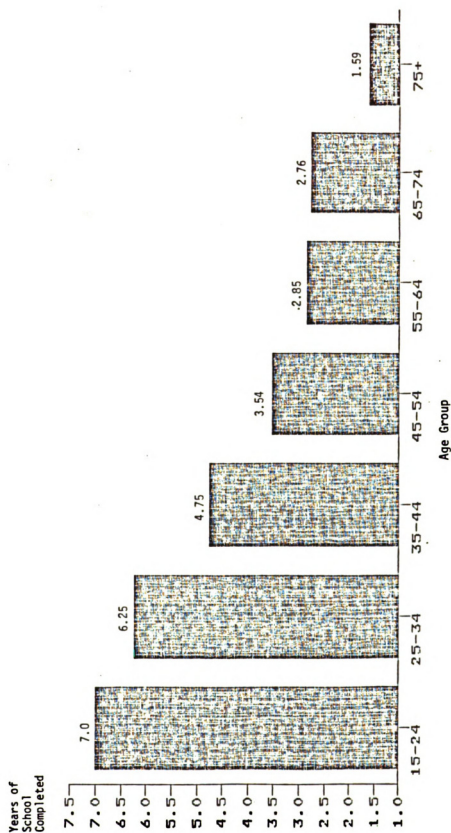


Figure 3.3.--Average number of completed years of education by household heads' age group.
(Source: 1978 town census.)

The trend toward higher levels of education is also reflected in the school attendance and dropout rates of children between the ages of 8 and 15. Because the census was taken during the summer vacation period, information was gathered on the number of children who had attended school on a regular basis the previous academic year. This age range was selected for two reasons. First, by their eighth year most children who were going to attend school should have completed at least the first grade. A small percentage of children begin their education at the age of five, but most enter the first grade when they are six or seven years old. Second, as the age-sex pyramid indicated, out-migration becomes significant in the 15- through 19-year-old age group. Any consideration of school attendance and dropout rates beyond this point is distorted by the absence of these individuals, most of whom have left to work or attend school elsewhere.

There were 563 children between the ages of 8 and 15 in the sample, and, of these, more than four-fifths (484 or 86.0%) had attended classes the previous year.¹¹ Less than one-tenth (35 or 6.2%) had never gone to school. In addition, a small number (18 or 3.2%) had dropped out before the fourth grade and another small number (26 or 4.6%) between the fourth and twelfth grades. If those quitting school before the fourth grade and those who had never enrolled are considered together, it suggests that only a small percentage of the upcoming generation (53 children or 9.4%) stands a good chance of remaining illiterate or barely literate. This is an overly optimistic assumption because some of those in the first through third grades

will drop out, and some who attend the fourth grade or beyond may not be, or may not remain, literate. Even so, if compared to the 49.3% of household heads who had received three years of schooling or less and were functionally illiterate, this suggests a considerable increase in literacy.

Regardless of the greater availability of schools and the increased overall attendance, socioeconomic circumstances continued to influence school attendance and dropout rates. Table 3.7 presents this information for the 8- through 15-year-old age group from homes of agricultural day laborers (the poorest economic group), artisans (a middle group), and white-collar, semi-professional, professional, and large landowning families (the most well-off). While almost all of the children from the highest socioeconomic grouping and from the middle category (97.1% and 86.5%, respectively) had attended school the previous year, less than three-fourths (72.7%) of the children of jornaleros had done so.

Three general remarks can be made regarding this information that support the findings on demographic and economic characteristics and suggest future trends. First, and perhaps most significant, is the rise in educational attainment in recent decades. While the average number of completed years of school for household heads was still relatively low (4.1), the information on the educational attainment of household heads in the 15- through 24-year-old age group and that on the dropout rate of children suggests that school attendance is increasing rapidly. This should not be confused,

however, with the situation in rural areas or the country as a whole. Even compared to towns of similar size, Asunción may be atypical. The large number of middle-class families, plus the ease with which high schools in Sonsonante can be reached, make it likely that educational levels are higher in Asunción than in other communities.

Table 3.7.—School attendance of children 8-15 years of age by occupational group.

Occupational Group	Number of Children	Number in School	Percent in School
Agricultural day laborers	121	88	72.7
Artisans	111	96	86.5
White-collar workers, semi-professionals, professionals, and large landowners	105	102	97.1
Totals	337	286	84.9

Source: 1978 town census.

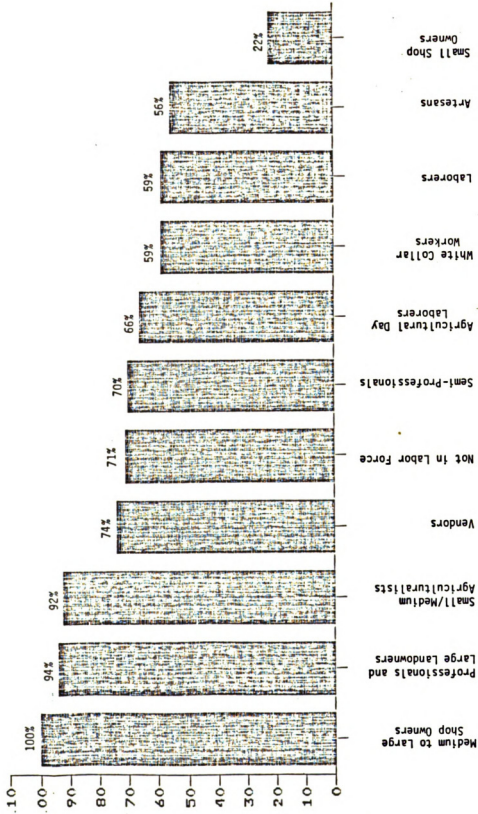
Second, as the discussion on the economic structure indicated, the town offers relatively few employment opportunities. As levels of education increase, it appears likely that so will the number of young people who leave in search of work. In other words, barring a significant transformation in the economy, out-migration of the young may be expected to grow, resulting in possible declining birth rates and an aging population structure. These trends are already in evidence.

Further, many of those who do remain in Asunción will have to seek work in other large urban centers. Out-migration of the youth and an aging population structure have implications for social organization, a topic explored in the following chapters.¹²

Third, the inability of the local and national economy to provide jobs may be a factor in rising levels of education. Because work is hard to find, children who otherwise would have begun contributing to their families, or would have established their own households, remain in school. For example, of the 325 young adults between the ages of 16 and 21 in the census, over one-third (129 or 39.7%) were still attending classes. In many instances, individuals older than these were reported to be in school because they were unable to find work. In such an economic climate, rising levels of education may signal growing discontent and dissatisfaction as many individuals will have no choice but eventually to assume work that is not commensurate with their expectations and qualifications.

Housing Characteristics and Ownership of Consumer Goods

Two-thirds (352 or 67.0%) of the 525 families lived in dwellings owned by the household head, wife or companion, or one of their relatives. Figure 3.4 displays the percentage of households in each occupational group whose homes were owned by a resident family member or kinsperson.¹³ Three groups are distinguishable. The first is composed of small to medium agriculturalists, professionals, large landowners, and medium to large shop owners. In 92% to 100% of these



Based on 524 cases on which complete information was obtainable.

Figure 3.4.--House ownership by occupational group. (Source: 1978 town census.)

cases, the dwelling belonged to a resident or a kinsperson (usually the household head's or spouse's mother or father). As owners of rural property, it is not surprising that most agriculturalists owned their residences. Owners of medium and large shops also were likely to own their homes because they used them as their place of business and because most of these enterprises were quite profitable.

A second group comprises artisans, laborers, white-collar employees, agricultural day laborers, semi-professionals, vendors, and those not in the labor force. Home ownership ranged from 56% to 74%. The finding that agricultural day laborers were more likely to own their dwellings than were some of the other better-off groups is not a reflection of their economic well-being but rather of the fact that the house and the land surrounding it (solar) are all that remain to them. In the past, many had access to, or owned, rural properties in addition to homes in town.

Also of note is the finding that home ownership among white-collar workers and semi-professionals is lower than their economic circumstances would suggest. Some of these families were newcomers, having chosen to live in Asunción rather than Sonsonante, Acajutla, or the rural cantons where they worked. Because they may not settle permanently in the community, they often rent rather than buy homes. Finally, only 22% of household heads with small shops owned their dwellings. In part, this may be due to the small sample size (only nine families), but it also reflects the marginal economic circumstances of these predominantly female-headed households.

Over one-fourth (27.0%) of the homes in the sample were owned by female household heads, wives, or companions. Many other families lived in houses belonging to female relatives or landlords. These urban properties are often inherited by daughters. In a context where job opportunities for women are scarce and many marital unions are unstable, possession of a dwelling that can be used as a residence, business, or for rental purposes provides one of the few margins of security that can be left to daughters.

There were approximately a dozen multiple-family housing units (mesones) in town. A small number (25 or 4.8%) of the sample lived in these. Some were workers who had come for the coffee harvest and may not remain permanently. Others were long-time residents who could not afford better accommodations. These were often older, single women or single women with children. Rooms in the mesones were small and usually lacked ventilation. Toilet, bathing facilities, and water supply, where available, were shared and not well maintained.

Overall, two points can be made regarding these patterns. First, while economic circumstance plays a role in home ownership, this by itself does not explain the distributional patterns presented in Figure 3.4. Other factors such as length of residence, inheritance, and type of economic activity are also important. Second, if home ownership is taken as an index, the high percentage of those owning dwellings suggests that many have long-standing ties in the community or view it as more than a temporary place of residence. Nonetheless,

one-third of the sample were renters, and, according to townspeople, their numbers have grown during the last decade.

Although home ownership was not directly related to economic position, characteristics of the dwelling were more closely associated with the household head's sector of economic activity. Based on materials used in construction, three housing categories were identified. Apart from the mesones, dwellings of straw (ranchos) and/or scraps of wood and other materials with hard-packed dirt floors were the poorest accommodations. Houses constructed of mud and pole walls (bahareque), adobe, or concrete blocks with earthen floors represented an intermediate category. Those of adobe or concrete block but with tiled or concrete floors in one or more rooms were the better accommodations. These categories largely corresponded to community members' evaluations of the merits of the different kinds of housing.

Initially, efforts were made to gather information on the number of rooms in houses, but because partitions were often used as dividers, this proved unfeasible. There was little consensus on what constituted a room, and rooms were often used for a multitude of purposes. Generally speaking, dwellings made of straw and other such materials consisted of a single room. Cooking was done outside, weather permitting. In more substantially constructed homes, cooking was done outside under a portion of the roof or in a separate room set aside for this purpose. Furnishings were sparse in all but the houses of the most well-off. They consisted of a few wooden chairs or

stools, a table, and one or two beds. Children in the poorest families shared a cot or hammock, or slept on floor mats.

Table 3.8 presents information on the distribution of house types by occupational sector. In nearly three-fourths (119 or 73.0%) of the cases where the household head worked as a jornalero, a laborer, or was a small- to medium-sized property owner, the family lived in a low or intermediate quality dwelling lacking tiled or concrete floors. Half (49 or 48.5%) the families whose heads were not in the labor force and somewhat under half (75 or 43.4%) of artisans' and tradespeople's families lived in similar homes. By way of contrast, less than one-fifth (17 or 18.9%) of those in the white-collar, semi-professional, professional, and large landowning groups lived in low to intermediate quality dwellings. Most of these were renters who were unlikely to institute improvements in houses they did not own.

The largest and most well-maintained homes were located in the northern part of town in the barrios Dolores and Asunción, and in adjacent portions of surrounding barrios. These houses fronted directly on streets and were usually built around enclosed patios. Streets were cobbled or paved, and most homes and businesses were connected to the public water, sewage, and electrical power systems.

Table 3.8.--House type by occupational sector.

Occupational Sector ^b	House Type ^a						Total
	Low	Medium	Total	%	High	%	
I	51	68	119	73.0	44	27.0	163
II	24	51	75	43.4	98	56.6	173
III & IV	2	15	17	18.9	73	81.1	90
V	14	34	48	48.5	51	51.5	99
Total	91	168	259	49.3	266	50.7	525

Source: 1978 town census.

^aLow-quality dwelling--made of straw and/or scraps of wood and other material with hard-packed earthen floors; medium-quality dwelling--made of mud and pole walls, adobe, or concrete blocks with earthen floors; high-quality dwelling--adobe or concrete block walls and tiled or concrete floors in one or more rooms.

^bI--Small-scale agricultural and day-laboring sector, II--Artisan and trades sector, III and IV--White-collar and semi-professional sector, professional and large landowning sector, V--Not in the labor force and unemployed.

Toward the periphery of town, streets became rough and housing conditions deteriorated. Dwellings were scattered throughout the blocks, and access could be gained only by walking across yards. Some houses had electricity, but most were not connected to the water or sewage systems. In contrast to homes in the center where living space was private, in these areas daily activities took place outside in full view of the neighbors. Living conditions were poor and presented risks to health. Not only were water and sewage facilities lacking, but dwellings were usually overcrowded. Typically, they consisted of a single room shared by an average of five to six people. Children

slept, ate, and spent their time playing on the earthen floors or in the yards--spaces shared with chickens, ducks, pigs, and other domestic animals. As will be discussed more fully in Chapter VI, residents reported a high prevalence of illness.

Information was also collected on radio, television, and motor vehicle ownership. Radios and televisions were selected because they indicated the degree to which the population was exposed to commercial advertising of medications and other merchandise. In addition, because no information could be gathered on income, these items, together with motor vehicles, served as a rough index of wealth. Table 3.9 shows ownership of these goods by occupational sector. Only one-tenth (56 or 10.8%) of the households did not own any of these items, and the majority (34 or 60.8%) of these were in Sectors I and II. Nine-tenths (463 or 89.2%) of the households owned radios, and of these nearly half (220 or 42.4%) also owned televisions. Television ownership was not confined to the highest occupational sectors. One-fifth (31 or 20.0%) of households in Sector I and over two-thirds (80 or 69.9%) of those in Sector II had televisions. Finally, one-tenth (56 or 10.8%) of the households in the sample owned motor vehicles in addition to radios and televisions. In almost all cases, the household head was a professional, large landowner, vendor, or owner of a large shop. Car or truck ownership was essential for vendors' and large shop owners' businesses. The most successful business owners and almost all the owners of large estates and professionals had additional vehicles for family use.

Table 3.9.--Radio, television, and motor vehicle ownership by occupational sector.

Occupational Sector ^a	Items Owned					
	None		Radio		Radio, TV	
	No.	%	No.	%	No.	%
I	24	42.9	106	43.6	30	18.2
					1	1.8
II	10	17.9	80	32.9	62	37.8
					18	32.1
III & IV	3	5.3	15	6.2	36	22.0
					35	62.5
V	19	33.9	42	17.3	36	22.0
					2	3.6
Total	56 (10.8%)	100.0	243 (46.8%)	100.0	164 (31.6%)	100.0
					56 (10.8%)	519 (100%)

Source: 1978 town census.

^a I--Small-scale agricultural and day-laboring sector, II--Artisan and trades sector, III and IV--White-collar, semi-professional, professional, and large landowning sector, V--Not in the labor force and unemployed.

Given that so many households owned televisions, their possession was a better index of the degree of commercial penetration than it was of the households' economic circumstances. Some families who could not adequately feed or clothe their children or institute home improvements nonetheless had purchased televisions. Popular programs included U.S. series, such as Bonanza and the Six Million Dollar Man, translated into Spanish. Special events in the U.S. such as the Miss America Contest, the World Series, and the Superbowl Game were often broadcast live and drew large audiences. There were also Mexican and South American soap operas (novelas) plus some local programming. Advertisements for products typical of middle-class lifestyles that were alien to the circumstances of most of the local audience were interspersed. The overall effect of the programming and advertisements may well be to create needs and expectations, especially among children, that are beyond most families' reach and beyond the means of the political and economic system to deliver as it is currently organized.

Conclusion

The paucity of recent studies of Asunción or of other Salvadoran communities hampers generalizations about Asunción over time or in comparison with other communities. Nevertheless, two points regarding Asunción's socioeconomic and demographic characteristics merit highlighting because they suggest the extent to which findings of this investigation may be applicable to other Salvadoran contexts.

First, the information presented here indicates that Asunción may have more in common with larger urban centers than it does with towns of a similar size that are more geographically isolated. Its proximity to Sonsonante and the ease with which other major urban centers can be reached have influenced its composition and growth. These factors have permitted Asunción to retain and attract more white-collar and semi-professional employees than would otherwise be the case. It seems likely that this factor, combined with the effects of recent national-level socioeconomic trends, has permitted those displaced from agriculture to find work in the artisan and trades sector. In other words, although part of the population continues to depend on agriculture, the occupational structure suggests that Asunción is a predominantly urban setting that may well be taking on the status of a suburb vis-à-vis its larger neighbor, Sonsonante.

Second, and related to the above, although many families have long-standing ties in town, the population appears to be increasingly mobile. Rising levels of education and scarcity of jobs result in considerable out-migration of young people. This loss is partially offset by in-migration from surrounding rural areas and other urban centers. Regardless of their place of origin, however, many residents and their children commute to work or school on a daily basis. These changes in occupational structure and in population dynamics have implications for social organization and use of medical resources, topics to be explored in the following chapters.

CHAPTER IV

ETHNICITY AND CLASS

The overview of demographic and economic trends presented in the preceding chapters drew attention to Asunción's articulation with the regional and national structures. These relationships affect not only households' material circumstances but also social organizational features. This chapter explores two of the most significant of these social organizational features--class and ethnicity--and examines their interrelationship. The information presented here suggests that increasing social differentiation set in motion by many of the recent socioeconomic and political processes has continued to modify the structure of the indigenous community and the meaning of Indianness in Asunción. The chapter is divided into two sections. In the first section, changes are examined in the Indian community and ethnic relations brought about by many of the trends outlined in the previous chapters. In the second section, the methodology used to delineate the social classes is outlined, and the relationship between class and ethnicity is explored.

The Indigenous Community

Asunción is frequently cited as one of the few remaining indigenous communities in El Salvador. This reputation stems from

its early history as a center of Pipil civilization, from the part played by the Indian cacique (headman) and population in the 1932 revolt, and from traits considered indigenous by many Salvadorans. These include certain forms of social and political organization and beliefs in witchcraft.

Works by anthropologists and historians lend support to this view of the town as Indian. One of the best known English language sources of information on Asunción is Richard Adams's (1976) community survey included in Cultural Surveys of Panama, Nicaragua, Guatemala, El Salvador, Honduras, originally published in 1956 and based on fieldwork in the early 1950s. Adams characterized Asunción as Modified Indian, noting that it was one of the few remaining centers of a distinctly indigenous culture in El Salvador. Browning (1971), White (1973), and Anderson (1971), relying in part on Adams's work, also contend that Asunción is an Indian town. In assessing these characterizations, it is necessary to clarify what is meant by the term Indian in Middle American ethnography and to examine Adams's community survey in some detail.

Indians in Anthropological Perspective

From an anthropological perspective, Middle American Indians participate in a set of lifeways and social institutional arrangements that differ from those of the dominant Ladino culture and often from those of indigenous peoples in other communities. Indians cannot usually be distinguished from the wider population on the basis of overt physical characteristics. In this sense, being Indian is a

socioeconomic rather than a biological or racial trait. Also, being Indian is context specific. Although anthropologists speak of the Indians of El Salvador, Mexico, or Guatemala, the term has meaning only within the confines of a community or a limited group of communities. Individuals or groups who permanently sever their community ties cease being Indian. Finally, from a wider-society perspective, Indians are a subordinate group who often occupy the lowest rung on the social scale. States such as Mexico that bolster a sense of national identity by drawing on Indian culture usually do not turn to contemporary groups but instead draw on the pre-Colombian heritage (Friedlander 1976).

The best known and one of the earliest typologies of Middle American indigenous communities was developed by Richard Adams (1956: 895-97). This typology is based on the degree to which Indian populations have abandoned their distinctive cultures, an acculturation process referred to as ladinoization. Drawing largely on fieldwork in Guatemala, Adams identified three types of Indian communities along a continuum from Traditional to Ladinoized. Indians in Traditional Communities retained a distinctive costume and a high degree of Indian monolingualism. The culture was structured around the religious and age hierarchy system and a syncretic religion composed of Catholic and Mayan elements. In general, these communities were culturally insulated. In Modified Indian Communities, women retained distinctive costume, and bilingualism predominated. Social organizational forms distinct from those of the Spanish American

cultural tradition also were found. In comparison to the Traditional Indian Communities, the degree of insulation from the wider society was reduced. Finally, Adams regarded Ladinoized Indian communities as the next-to-last step along the road to assimilation with Spanish American culture. Only a few distinctive elements of a separate tradition remained. These populations usually regarded themselves as Indian, and some forms of indigenous social organization persisted, although these were greatly modified as to recruitment, participation, and functions. Use of the Indian language and costume had been abandoned.

Underlying this typology is a model of change implying that increasing integration into the wider society is accompanied by the progressive disintegration of Indian culture, a process that Adams sees as culminating in the New Ladino type. New Ladinos are viewed as a deculturated group: "that is, they have given up most of their Indian traits but they have moved into the lower class of the Ladino population which does not share in much of the traditional upper class Spanish American heritage" (Adams 1976: 490).

Many changes in thinking concerning the process of development and national integration have taken place in Meso-American studies since this typology and the deculturation-integration model underlying it were proposed. It has become increasingly clear that, although some aspects of indigenous culture in Asunción and in other Meso-American communities date from pre-conquest times, most of what currently is regarded as Indian is of recent origin. In this light,

Wolf (1982) persuasively argues that "most of the societies studied by anthropologists are an outgrowth of the expansion of Europe and not the pristine precipitates of past evolutionary stages" (1982: 76). Thus, the maintenance of ethnic distinctions in Asunción and the relationship between these and class divisions must be explained by an interaction between historical factors specific to the town and wider socioeconomic and political processes.

Asunción in the 1950s: Adams's Survey

Adams's description of Asunción in the early 1950s merits detailed attention because many other researchers have used it as a basis for labeling Asunción an Indian town. Adams's survey of the town was part of his larger study on the cultural characteristics of Central American countries. Because of the broad scope, relatively little time could be spent in the communities chosen for study. Adams was in Asunción only one day and relied on interviews with selected informants for his data. These informants estimated that 20% to 30% of the municipal population of 22,255 and 75% of the town population of 5,966 was Indian in 1950. Informants also verified the existence of the seven cultural traits Adams used to distinguish Indians from Ladinos. These were the use of the traditional harness (mecapal) for carrying purposes, cooking fires on the floor, distinct forms of attire for Indian women, use of the indigenous language, religious activities different from Ladino customs, survival of a distinct political organization, and retention of an indigenous hand industry.

On the basis of the 75% population estimate, plus the persistence of these traits, Adams characterized Asunción as Modified Indian (1976: 489).

Methodological and historical considerations suggest that the information Adams relied on may not have been accurate. In particular, it is likely that his informants over-estimated the percentage of the population that was Indian in 1950. It appears that two separate sets of informants were used. One group within Asunción verified the persistence of the seven traits, and another group of undetermined origin provided the population estimate. In this latter case, the criteria used to identify the indigenous population were determined by the informants themselves and may have differed from those employed by Adams. In presenting information on the number of Indian residents in Asunción and other Salvadoran communities, Adams states that: "We go on the assumption that when a population group is called Indian there is some set of characteristics which distinguish them from the population which is called Ladino" (1976: 486). Thus, it appears that the informants who provided the population estimate employed their own criteria to identify the Indian population and to judge its size.

The risks involved in this procedure are numerous. In El Salvador, supposed racial characteristics, traits associated with poverty, or deviations from accepted middle-class ideals are frequently identified as Indian. For example, in a recent monograph by a Salvadoran sociologist, common-law unions, child neglect, and

unstable family relations were said to be indigenous characteristics in Asunción and elsewhere in western El Salvador (De Guevara 1975: 242). In an earlier monograph on Panchimalco, an indigenous community on the outskirts of San Salvador, housing characteristics such as inadequate ventilation and sanitary facilities, one-room dwellings, and overcrowding were considered Indian traits (Marroquín 1974: 43). These conditions are widespread in El Salvador. Their existence among Indian populations suggests only that Indians share much in common with others in the lowest social class. Without more precise information on the criteria Adams's informants used to identify the indigenous population, it is difficult to determine what they were measuring when they estimated that 75% of Asunción's population was Indian in the early 1950s.

Perhaps of greater weight, historical accounts also suggest that this estimate was too high. In the late nineteenth century, Indians were juridically and culturally more identifiable than they were in the 1950s and 1970s. The indigenous language and dress were in use, Indian and Ladino birth and death records were kept separately, and communal properties existed. Reports from this era indicate that slightly over half of Asunción's population was indigenous. For example, Barberena noted that 4,845 of the 9,129 residents were Indian in 1895 (cited in De Guevara 1975: 205). The massacre of the Indian population that took place after the 1932 peasant uprising, along with subsequent declines in this population suggesting high out-migration, undoubtedly reduced the number of Indians to below the 50% mark.

To summarize, although the persistence of indigenous traits suggests the existence of an Indian community, on the basis of population alone Asunción could not be considered an Indian town in the early 1950s. At that time, Indians constituted under half of the residents. In other words, Asunción was a predominantly Ladino town that, nonetheless, retained a sizable indigenous population.

Adams's use of the label Modified Indian for Asunción may also have caused some confusion among other researchers, contributing to the perception of the town as more Indian than Adams intended. Adams's best known typology of indigenous communities is the one, described above, that he developed for Guatemala. Modified Indian communities in Guatemala were characterized by bilingualism and retention of distinctive costume on the part of Indian women. As Adams makes clear, in El Salvador by the 1950s there were no remaining monolingual speakers of indigenous languages, and bilingualism was found primarily among the elderly. Only older Indian women retained distinctive modes of dress. In other words, Adams used the term Modified Indian in the Salvadoran context to refer to communities that were considerably more acculturated than their counterparts in Guatemala. Failure to note the different ways in which the term Modified Indian was used in El Salvador and Guatemala may well have contributed to subsequent characterizations of the town as more Indian than Adams intended.

Although Asunción was not predominantly indigenous in the early 1950s and although its Indian community retained fewer traits than

those associated with Modified Indian communities in Guatemala, it was, nonetheless, one of the few locales in El Salvador where vestiges of indigenous culture persisted. In the 25 years since Adams's survey, the Indian community has undergone considerable change. Although a detailed investigation of this population is beyond the scope of the present study, general trends which have modified the structure and functioning of Indian organizations and culture are identified, and the impact of these trends is examined. Asunción's folk Catholic celebrations, many of which embody outward manifestations of indigenous religious and political organization, are examined first. This is followed by a consideration of methodological issues in identifying Indian households and a description of Indian residential characteristics.

Folk Catholic or Popular Celebrations

In a town of Asunción's size and socioeconomic diversity, few events elicit widespread support and community participation. Among the most significant at the time of this research were the celebrations (fiestas) in honor of the two patron saints and Holy Week (Semana Santa) observances.¹ While these were rooted in Catholicism, none was under the direction of the priest or other officials of the Catholic Church. The patron saints' day celebrations, the Feast of the Virgin of the Assumption (La Virgen de Asunción) in mid-August, and the Feast of the Immaculate Conception (Purísima Concepción) in early December were organized by committees of leading citizens appointed by the mayor and by one type of

religious brotherhood, the cofradías. Holy week celebrations were under the direction of the cofradías and a second form of brotherhood, the hermandades. In the words of Asuncion's priest, these celebrations belonged to the people and the street, not the Church. Thus, they were aspects of folk or popular culture.

Although similar events take place in other communities, Asunción has a rich heritage in this regard in part because of the indigenous culture. These celebrations, and particularly the brotherhoods that are responsible for them, are integral components of the indigenous religious and political structure. In this section, the effects of the socioeconomic and demographic trends outlined earlier on these celebrations and on the organizations that sponsor them are considered.

When the towns of Asunción and Dolores were formally unified in 1869, the indigenous community retained some autonomy through its control over the communal lands (tierras comunes). This autonomy was expressed in a separate, although juridically subordinate, religious and political structure. The religious portion of the indigenous organization consisted of over two dozen cofradías that varied in size and importance. Each celebrated a saint's day or other ritual occasion in the Catholic calendar. These cofradías consisted of a majordomo (mayordomo), one or two assistants (in the case of the large organizations), the wives of these officials (mayoras), and the general membership (De Guevara 1975: 213). Images of the saints, many dating from early colonial times, were kept in the majordomos' homes

or in shrines especially constructed for this purpose. There was a system of ranking among the cofradías, and men rose in the hierarchy as they grew older.

This religious structure formed the basis of, and was interwoven with, the political organization. The majordomos of the cofradías served as members of a council from which a mayor of the commons (alcalde del común) and two or more councilmen (regidores) were chosen. The assumption of offices took place in December of alternate years. When the tierras del común were in existence, these officials' most important function was to administer this communal land, parts of which were irrigated by a system of aqueducts. After these holdings were abolished, the Indian mayor and councilmen were limited to acting as spokespeople for the indigenous community to the Ladino municipal and church authorities and to supervising the activities of the cofradías (De Guevara 1975: 243). Elders (principales) who had served in the system gave advice and assistance to the Indian council and authorities.

In the 1920s and early 1930s, the largest and most prestigious cofradía was the Espíritu Santo. Patricio Shupan, and later his son-in-law Jose Feliciano Ama, were majordomos of this organization. These men, by virtue of their strong characters, their positions, and the political climate of the time, functioned as ex-officio headmen (caciques) for the indigenous community vis-à-vis the national government. Adams (1976) and Anderson (1971) reported that the cacique position was independent from the religious structure and

constituted the sole manifestation of the political organization. Adams hypothesizes that it may have been separated as a result of events in 1932. Describing the situation in the early 1950s, he states:

The position of cacique is not part of a hierarchy or extensive political system such as is found in Traditional Guatemalan Indian towns. It stands quite alone, and is related neither to other political posts nor to the system of religious cofradías. Also, the man holding the position of cacique does so sheerly on the basis of strength of personality and the fact that outsiders, specifically Ladino politicians, turn to him over issues of the political activity of the [Asunción] Indian population (1957: 494).

Discussions with the priest, who was born and raised in Asunción, and with older townspeople, however, suggest that the cacique position was not the sole manifestation of an Indian political structure.

Reportedly, the alcalde del común and the regidores continued as actors in the Indian political organization after the 1932 revolt. In contrast to the cacique, their functions were largely confined to the community level. In essence, an integrated political and religious structure does appear to have existed within the indigenous community. As Adams suggests, the cacique position was not institutionalized within this framework, but grew out of circumstances specific to the times.

In 1979, this structure remained intact although it had been reduced in size and function. The number of Indian cofradías had declined to 15. Figure 4.1 presents the 1978 cofradía calendar. A reduction in the scope of the celebrations has accompanied the cofradías' decline in number. De Guevara (1975) and Herrera Vega

Date	<u>Cofradía</u> Celebration
January 6	<u>Cofradía</u> of the Boy Pepe or Boy of the Turtles
January 20	<u>Cofradía</u> of Saint Sebastian
March 11	<u>Cofradía</u> of Saint Gregory
March or April (date varies)	<u>Cofradía</u> of Jesus of Nazareth
May or June (date varies)	<u>Cofradía</u> of the Eternal Father
August 10-15	<u>Cofradía</u> of the Virgin of the Assumption
August 30	<u>Cofradía</u> of Saint Rosa of Lima
September 9	<u>Cofradía</u> of Saint Nicolas
September 12	<u>Cofradía</u> of the Virgin of Dolores
September 29	<u>Cofradía</u> of Saint Michael Archangel
October 14-15	<u>Cofradía</u> of Saint Teresa
November 12	<u>Cofradía</u> of Saint Diego
December 6-8	<u>Cofradía</u> of the Virgin of the Immaculate Conception
December 13	<u>Cofradía</u> of Saint Lucia
December 14	<u>Cofradía</u> of the Virgin of Remedies
December 24	<u>Cofradía</u> of the Boy Pepe or the Boy of the Turtles (Ladino)

Source: 1978 Festejos Dicembrinos en Honor a la Inmaculada Concepción.
Tip. y Enc. San José, Sonsonante, author's translation.

Figure 4.1.--Annual cofradía calendar.

(1935) document the disappearance of many of the ritual dances, songs, and other events sponsored by these organizations. With the exception of the Cofradía of the Virgin of Remedies, to be discussed below, most cofradía celebrations consisted only of a small procession and mass on the saint's day.

Funds for these events were raised in a variety of ways. Some organizations had small parcels of land (tierras del santo) where they grew crops for sale and use during the fiesta. In large measure, however, cofradías depended on contributions from the majordomos and from welcomings (entradas) of the saints. These took place on the days preceding the saint's mass and procession. Cofradía members, their relatives, and friends took contributions of money or items such as candles, firewood, and food to the majordomo's home for use in the upcoming celebration. Large cofradías usually sponsored several entradas before the saint's day. Some were major events in their own right, accompanied by singing, dancing, and refreshments.

Although the number of cofradías and the elaborateness of their festivities has declined, at least one organization, the Cofradía of the Virgin of Remedies (Cofradfa de la Virgen de los Remedios), has prospered. The image of the Virgin of Remedies is thought to possess miraculous powers in administering to the sick and distressed. Largely through donations, the cofradfa purchased land along the highway in the southern part of town and built a shrine to house the Virgin. In 1979, this was an important local pilgrimage site, with visitors arriving especially in December for the feast day celebration.

In recent years, a second kind of brotherhood, the hermandad, has come to overshadow the cofradías in size and importance. The largest hermandad was the predominantly indigenous Hermandad of Jesus of Nazareth (Hermandad de Jesús Nazareno) which had eclipsed in importance the cofradía of the same name. This hermandad and the predominantly Ladino Hermandad of the Holy Burial (Hermandad del Santo Entierro) were responsible for many of the Easter Week observances. These included masses, devotions, stations of the cross, and two large processions. The Hermandad of Jesus of Nazareth sponsored a procession that began wending its way through town in the mid-afternoon on Holy Thursday and terminated at dawn the following day. This event was preceded by the smaller Procession of the Christs (Procesión de los Cristos) composed of the majordomos of the indigenous cofradías bearing the cofradía images. Late in the afternoon on Holy Friday, a second large procession sponsored by the Hermandad of the Holy Burial began. Following a circuitous route through the main streets, it ended at dawn on Saturday. Easter Week events culminated in a re-enactment of the crucifixion on Holy Saturday and on Easter Sunday mass attended by the mayor, other prominent officials, and the citizenry.

The organizational structure of the hermandades differed from that of the cofradías. The hermandades consisted of a general membership, board of directors, and president. In 1979, the Hermandad of Jesus of Nazareth had approximately 145 members. This organization had built a large chapel in the barrio San Sebastian to house its images, to hold

meetings, and to carry out other official functions. The board of directors was composed of Indian men, but Indian women and Ladinos of both sexes were admitted to the general membership. In 1979, a heated debate took place over the inclusion of Indian women on the board, and although the motion was defeated, it gained considerable support from the membership. Those wishing to join the hermandad submitted a petition which the board reviewed. Dues were C15.00 (\$6.00) for men and C6.00 (\$2.40) for women. The board and the president of the organization were elected annually.

The Hermandad of the Holy Burial was slightly smaller than the Hermandad of Jesus of Nazareth, having approximately 100 members in 1979. Although the board of directors and most of the membership were Ladinos, some Indians reportedly belonged to the organization. The organization's meetings were held in the Church of Dolores rectory.

As the descriptions of the hermandades and cofradías indicate, neither type of organization was under the direct tutelage of the Catholic priest. In fact, the events sponsored by the brotherhoods during Holy Week were a source of consternation to Asunción's priest, who regarded them as irreverent. Townspeople reported that each year he fell ill during this period. In 1979, for example, he was invited to bless the litters (andas) used to carry the images of the saints in the processions but was taken ill with a migraine headache which prevented his participation. In most cases, members of the hermandades were orthodox Catholics. Cofradía members included orthodox

Catholics and followers of the local customs (costumbres) related to folk Catholicism.²

The president of the Brotherhood of Jesus of Nazareth and the majordomos of the indigenous cofradías continued to form a council from whose ranks an alcalde del común was selected. The alcalde oversaw the operations of the indigenous brotherhoods and acted as a liaison to the municipal and Church authorities in staging the fiestas.³

Although some community members reported that a descendant of Feliciano Ama was recognized as cacique, this position as mediator between the community and the national government was not of great importance at the time.

The factors underlying the persistence of this indigenous political-religious structure and a more in-depth examination of its functioning are subjects for a more detailed investigation. It is only possible here to draw attention to some of the general interactions between micro-level, or community-centered, and macro-level, or extra-community, forces that have permitted the continued operation of the structure.

Although the number of religious brotherhoods has declined, at least two of them, the Cofradía of the Virgin of Remedies and the Hermandad of Jesus of Nazareth, have grown in size and importance. Nevertheless, the growth of these organizations should not be interpreted as an indication of the strength or vitality of indigenous associations or of the indigenous community. Both organizations generated a following and funds from the general population and, in the

case of the Hermandad of Jesus of Nazareth at least, there were many Ladino members. In fact, these organizations' success was partly due to their ability to garner support from all sectors of society.

In a more general sense, this is also the case with regard to other aspects of Indian culture. Events significant to the indigenous population, such as the election of the Mayor of the Commons and the Procession of the Christs, occupied a prominent position in community-wide celebrations. For example, the program and advertising pamphlet, December Festivities (Festejos Dicembrinos), publicized the election of the Mayor of the Commons as capping off the December 1977 celebrations in honor of the Virgin of the Immaculate Conception, although no relationship had previously existed between the originally Ladino patron saint's day celebration and the indigenous election. This election and events like the Procession of the Christs were considered folkloric, adding a touch of local color to community-wide events. To the extent that Indian customs, if not the Indians themselves, contributed to the success of popular culture festivities, they received support from Ladino municipal authorities and townspeople.

There were social and economic motives underlying the preservation of indigenous traditions. At a time when the town was increasingly subsumed under the wing of its larger neighbor, Sonsonante, the celebrations in honor of the patron saints and Holy Week provided a visible manifestation of its individuality and vitality. Asunción's Holy Week events, many of which were under the direction of the Hermandad of Jesus of Nazareth, compared favorably with similar celebrations in

Sonsonante although Sonsonante's were larger. Asunción's positive reputation aided in attracting visitors. During 1979, for example, the large Holy Week processions drew crowds numbering in the thousands throughout their entire course. Campeños from the surrounding cantons and visitors from other communities attended. In addition, many individuals who were born and raised in Asunción but had moved away returned for the events.

These crowds were a stimulus to the local economy. As the information presented in the previous chapter indicated, much of the population was dependent on artisan and trades occupations. These people, together with vendors from other towns and from Guatemala, set up booths in the parks and along the main streets to sell food, drink, and other items. Business also was brisk at restaurants and stores. Commercial activities were most pronounced during the 10-day celebration in August in honor of the Virgin of the Assumption and the two-week celebration of the Immaculate Conception in December. On these occasions, the Festival Committees appointed by the mayor engaged bands and amusement rides and sponsored dances and sporting events.⁴ The municipal government charged admission fees and levied taxes on vending stalls and other sales activities. These popular culture celebrations provided townspeople and municipal authorities with the opportunity to generate revenue.

To summarize, the Ladino townspeople's and government officials' support for indigenous organizations and culture is explained, at least in part, by the role these play in the success of wider community

celebrations contributing to Asunción's social prestige and economic well-being. In essence, as the boundaries between Asunción and Sonsonante have become blurred, so too has the distinction between Indian and Ladino. Elements of indigenous culture are being drawn upon to serve interests wider than those of the Indian community alone. At least in regard to public-sphere activities, the older antagonism between Indians and Ladinos is being replaced by recognition that those born and raised in the town are naturales, or natives of the place, who share more in common with one another than they do with many of the newcomers. Thus, as Asunción is gradually incorporated as a suburb to Sonsonante, it is turning increasingly to its indigenous heritage as a means of maintaining an identity.

This study did not directly examine the Indian political and religious organizations' internal functioning. Such an investigation is necessary to fully understand changes in the indigenous community. Nevertheless, the research did identify two general processes at work which influence the Indian political and religious structure. First, while a degree of differentiation in the cofradías' size and rank has existed since at least the 1920s, it is likely that this differentiation has increased in recent years. The information presented here suggests that those indigenous organizations whose activities are either integral to or occur at the same time as the Holy Week observances or the patron saints' festivities have endured and prospered, while those organizations whose events do not so coincide have declined in number and size.

Second, a reduction in the importance of ethnic divisions has accompanied this process of consolidation around events of significance to the entire town. Although organizations such as the Herman-dad of Jesus of Nazareth and the Hermandad of the Holy Burial may have originated in the Indian and Ladino communities, their memberships are now drawn from both segments of the population. In this regard, individual-centered criteria such as vows and promises made to saints are of greater significance to participation than are ethnic distinctions per se.⁵

A separate study is required to determine the effects of these changes on the internal functioning of the indigenous political and religious organizations. Brintnall (1979), however, has provided an illustration of the complex set of factors at work to bring about changes in community structure in an indigenous municipality in Guatemala. Focusing on Aguacatan municipality in the Department of Huehuetenango, he examined interactions between the material basis of production and the social and ideological superstructure that have taken place over the last 50 years. These interactions resulted in the evolution of a new political, economic, and sociocultural order in the municipality. Brintnall provides a detailed account of the collapse of the civil religious hierarchy, highlighting how strains between young and old, rich and poor, Indians and Ladinos were implicated and drawing attention to the roles of cash cropping and the influence of the Catholic and Protestant missionaries. The study documents the breakdown of older inter-ethnic and inter-racial forms of

association and domination and their replacement by more contemporary forms--class distinctions and new kinds of formal associations. If more information were available on Asuncion's indigenous community, this work would serve as a useful point of comparison.

Along these same lines, it should be noted that although class differentiations have modified and largely subsumed ethnic divisions in Asunción, there remains a viable indigenous nucleus which, in combination with extra-local forces, could serve as a basis for ethnic resurgence. For example, at the time of this research, there was a small indigenous organization, the National Association of Salvadoran Indians (ANIS), with headquarters in Sonsonante.⁶ In 1978, ANIS purchased an abandoned hacienda at Las Hojas near Sonsonante and turned it into an agricultural cooperative. On February 22, 1983, troops from the Sonsonante garrison invaded the hacienda and killed an estimated 74 people suspected of being subversives. The leader of ANIS, Andrian Esquino, attempted to have those responsible for the massacre brought to justice, but he had little success. As a consequence, he and other ANIS members have become increasingly disenchanted with the Christian Democrats and President Duarte, whom they supported in the 1984 elections. Esquino and his organization have ties with the largest labor coalition, the Popular Democratic Union (UPR), and with the AFL-CIO, which has provided funds to expand the ANIS headquarters. These kinds of extra-local linkages may have implications for future developments in ANIS and for the Indian

population in the area, giving it a power base and source of legitimacy outside the local context (NACLA May-June 1985: 10).

While general information on the indigenous organizations was readily available, gathering data on the indigenous households presented certain difficulties. These difficulties and the spatial distribution of the indigenous population in Asunción will be reviewed before turning to a consideration of the relationship between class and ethnicity.

Indian Households: Methodological Issues and Residential Characteristics

No questions were asked during the census regarding ethnic affiliation because information from townspeople and from researchers at the National University suggested that this could elicit fear or hostility among indigenous families.⁷ This concern was borne out by experiences gained during the census taking. In at least two instances, I encountered Indian families who were unwilling to participate in the census because of past experiences associated with cooperating with perceived authorities.

In analyzing the census data, therefore, surnames were used to distinguish between Indian and Ladino families. Households in which the head or spouse had an indigenous surname were considered Indian. For the most part, these surnames are readily distinguishable from their Spanish counterparts. Examples include Chent, Chue, Culi, Chamel, Chito, Mismit, Musum, Munto, Pasin, Pinti, Quele, Quijo, Shupan, Sunque, Shunico, Tespan, Texin, Tule, and Turish. Discussions

with the priest and others born and raised in Asunción suggested that most of these families would consider themselves Indian or would be regarded as such by others. In essence, the names impose an identity that is difficult to escape within the confines of the town. Reliance on surnames, however, is an inexact measure of ethnic identification since some families in which the head and spouse have Spanish surnames consider themselves and are considered by others as Indian. Nonetheless, use of indigenous surnames as a means of identification was the best available option.

Of the 525 households interviewed during the census, over one-fourth (144 or 27.4%) were indigenous. The spatial distribution of the Indian population reflects both Asunción's past and the Indian population's present low socioeconomic status. Traditionally, most Ladinos resided in the central and northern parts of Asunción in what was earlier the separate community of Dolores. The indigenous population lived on the outskirts of Dolores, principally to the northeast and southwest, and in the adjoining community of Asunción directly to the south of Dolores. When the towns were unified, Dolores became and has remained the commercial center and residence of the more affluent and usually Ladino families.

The residential pattern persisted in 1979. Table 4.1 shows the ethnic composition of the barrios. Only one-fourth (35 or 24.3%) of the Indian households in the census lived in the central and northern barrios of Dolores, Santa Lucia, Santa Teresa, and La Otra Banda. Half (75 or 52.1%) of the Indian families lived in the southern barrios

Table 4.1.--Ethnic group by barrio.

<u>Barrio</u>	Ladino		Indian		Total	Rank ^a
	No.	%	No.	%		
Cruz Galana	25	43.1	33	56.9	58	1
Santa Cruz	19	54.3	16	45.7	35	2
San Juan	21	61.8	13	38.2	34	3
San Sebastian	36	66.7	18	33.3	54	4
Asunción	61	70.9	25	29.1	86	5
Colonia Lourdes & San José	15	78.9	4	21.1	19	6
Santa Lucia	46	80.7	11	19.3	57	7
Santa Teresa	39	81.3	9	18.7	48	8
Dolores	96	88.1	13	11.9	109	9
La Otra Banda	23	92.0	2	8.0	25	10
Total	381		144		525	

Source: 1978 town census.

^aBarrios are ranked from 1 to 10, with 1 having the highest percentage of Indian families.

of Cruz Galana, San Juan, Asunción, Colonia Lourdes and San José; and one-fourth (34 or 23.6%) lived in the northeastern and northwestern barrios of Santa Cruz and San Sebastian. Those barrios with the highest number of indigenous surnamed households were Cruz Galana, where 56.9% of those interviewed were Indian, Santa Cruz with 45.7%, San Juan with 38.2%, San Sebastian with 33.3%, and Asunción with 29.1% Indian. Figure 3.1, showing the location of these barrios was presented in Chapter III.

Other aspects of indigenous family organization also reflect the interaction between micro-level and historical factors and macro-level processes of social and economic change. In discussing the Indian population, however, there is a risk of reifying ethnic divisions. As noted above, by 1979 use of the indigenous language and distinctive modes of dress had all but vanished. Only very elderly Indians were able to speak Náhuatl, and only a few older women retained Indian attire. For the most part, Indians were indistinguishable from the Ladino population, suggesting that the community was highly ladinoized. In this context, ethnic differences must be placed within a class framework to be fully appreciated. The following section identifies the social class divisions in Asunción and explores the relationship between class and ethnicity.

Social Class Divisions

Class differentiation has received little systematic study in the anthropological literature on Middle America. While seemingly

committed to holism, anthropologists' usual choice of study has been small, relatively homogeneous communities or segments of more complex communities. The study of the relationship between groups or classes within these contexts has occupied less attention than the study of the groups themselves. Underlying this focus is the assumption that the units of analysis, for example the Ladino and the Indian population within a community, are more or less discrete entities that can be understood in relative isolation from one another, the most important relationships between groups being mediated by brokerage and patron-client ties. Adams's (1956) early work on population segments was one of the few investigations that took into account, in a descriptive, if not analytical, fashion the full range of strata within Middle American communities.

Beginning in the 1960s, dependency school scholars (Frank 1967, dos Santos 1973) began drawing attention to the relationship between the development of some regions and the underdevelopment of others. Marxist researchers and modes of production analysts (Amin 1976, Mandel 1970, Laclau 1971) have critiqued the geographic, metropolitan-satellite focus implicit in these early investigations and have called attention to the primacy of class divisions.

A weakness in the class analysis model, however, is the lack of study of the relationship between ethnicity and class. Barrera (1979) provides an overview of theories of racial or ethnic inequality, calling attention to the failure of most political economy investigations to adequately treat gender and ethnicity in their analysis. In

his work on the Chicano population, Barrera (1978, 1979) identifies two kinds of intra-class divisions in the capitalist political economy. Divisions within classes stemming from the structure of occupations are labeled structural segments, while those based on characteristics of the workers are called ascriptive segments. Specifically, an ascriptive class segment:

. . . is a portion of a class which is set off from the rest of the class by some readily identifiable and relatively stable characteristic of the persons assigned to that segment, such as race, ethnicity, or sex, where the relationship of the members to the means and processes of production is affected by that demarcation (Barrera 1978: 169-70).

To examine the usefulness of these concepts for understanding the relationship between Asunción's Indian households and the general population, it is first necessary to clarify the social stratification procedure used in the investigation.

Stavenhagen (1975) provides one of the few detailed discussions of inter-ethnic and class relationships in Meso-American communities. His uses of the terms stratification and social stratum are followed in this study.

Stratification means that certain characteristics or variables are unequally distributed among individuals. The combination of some of these characteristics and the value attributed to them by members of society account for the existence of a scale or continuum on which individuals occupy higher or lower positions with respect to one another. If a set of individuals have in common a set of these characteristics which distinguish them from other groupings, and if this is recognized as such by society, we may then speak of a stratum. (1975: 195). 194 + 195

Stavenhagen notes that the most significant criteria in Meso-American stratification systems are ethnicity and socioeconomic indicators such as wealth, education, and access to property. The

relative importance attached to these criteria varies by community and over time. In the past, ethnicity was treated as the most powerful indicator of social position and overrode other considerations. Both intra- and inter-ethnic systems of stratification existed. For example, in the early 1950s when Tumin wrote Caste in a Peasant Society (1952), the inter-ethnic dimensions predominated, leading him to characterize Indian-Ladino relationships in Guatemala in caste terms. More recently, the importance of ethnic divisions has diminished. As noted above, Brintnall (1979) provides a description of the intra- and inter-ethnic stratification system in the Guatemalan municipality, Aguacatan, and the changes it has undergone as a result of alterations in the wider political economy. He reports that relationships between ethnic groups which had previously assumed the form of racial segregation have gradually given way to a more universally shared system of stratification. Information presented above suggests that a similar process is underway in Asunción. To further investigate this process, the stratification procedure used in this investigation is now reviewed.

Methodological Considerations

Up to this point occupational sectors have provided the framework for discussing socioeconomic and demographic characteristics. These occupational categories, while important in delineating the social strata and class structure, do not adequately represent them. To identify the class structure, a procedure was developed for

stratifying the census sample. Following Stavenhagen, it combines the use of objective criteria such as occupation and education, with subjective evaluations of these criteria. A stratum, as used here, is composed of a group of households having certain material characteristics in common and who are recognized, and usually recognize themselves, as sharing a similar social status.

This usage draws on the concept of class as a group of people having a similar relationship to the means and process of production. It relies on this criterion as evidenced by occupation and by other variables such as education and wealth that previously were demonstrated to be closely tied to economic position. The three variables used to stratify the population were those identified by Stavenhagen and used by many other social scientists. Two refer to the household head--occupation and level of education.⁸ The third is an index of the household's economic standing. This index included information on house type and on ownership of radios, televisions, and vehicles. These were used as a surrogate for income because, as discussed previously, reliable data on earnings could not be obtained during a brief interview.

Local standards were considered in designing the scores for the three variables. The educational scores reflected the organization of the school system and the importance attached to degrees and diplomas. Items in the economic index were weighted to give more importance to possessions than to housing characteristics in order to take into account renters who had little control over the conditions of their

dwellings. Finally, a panel of five community members (a shopkeeper, a housewife, a secretary, an artisan, and an agricultural day laborer) were asked to rank the occupations given in the census interview into categories from least to most prestigious. (Appendix A shows the scoring for the three variables.)

This last procedure provided valuable information concerning the local social structure. Considerable overlap existed between the panel members' ranking of the occupations and the occupational categories employed in discussions up to this point. From the panel's perspective, the least prestigious jobs were those of agricultural day laborers, gardeners, cart drivers, domestic servants, and cantina (liquor store) managers. The inclusion of the relatively affluent cantina managers in the lowest category reflected the commonly held belief that they contributed to the social problem resulting from high rates of drunkenness in the town. The second category included laborers, owners and renters of small agricultural properties, and a variety of artisans and tradespeople. Also included in this category were housewives. With the exception of the owners of the small stores and some of the vendors, these occupations all involved manual labor.

The third category identified by the panel was made up of store clerks, clerical employees, those working in low-level health-related occupations (nurses, sanitary inspectors, dental assistants), owners of medium-size agricultural properties, the police, National Guard, and the more highly skilled artisans (radio and television technicians). These jobs provided steady year-round income and, for the most part,

required literacy. The inclusion of the military and the police in this category reflected their secure incomes and the power they exercised, as agents of the state, over others' lives.⁹ Finally, the fourth category included those with the most prestigious occupations--teachers, owners of large stores, large landowners, and professionals (doctors, lawyers, the mayor, and the pharmacist).

In assigning scores to rank the census households, the educational, economic, and occupational variables were each given eight points. The scores of the three variables were added, yielding an index of socioeconomic status for each of the 525 households. Scores ranged from 3 to 24 points, with a median of 11 and a mode of 8. (See Appendix A.) Four clusters, or strata, were identified. The lowest consisted of the 98 households with scores that ranged from 3 through 6 points. The second stratum was made up of 241 households with scores that ranged from 7 through 12 points. The third stratum included the 126 households with scores from 13 through 18 points, and the fourth was composed of 60 households with scores from 19 to 24 points. The general characteristics and ethnic composition of these strata will briefly be reviewed.

Stratum I. The 98 families in stratum I represented the town's destitute. They comprised nearly one-fifth (18.7%) of the census sample. Almost half (47 or 48.0%) of the households in this stratum were indigenous. They constituted one-third (32.6%) of all indigenous households in the census. The other one-half (51 or 52.0%) of stratum

I was composed of Ladinos, and they constituted only slightly over one-tenth (13.4%) of the total Ladino households.

As the data in Table 4.2 indicate, nearly three-fourths (70 or 71.4%) of those in stratum I were agricultural day laborers, some of whom rented small plots of land. The remainder were housewives (13 or 13.3%), artisans (8 or 8.2%), laborers (6 or 6.1%), and vendors (1 or 1.0%). Nearly three-fourths (35 or 74.4%) of indigenous household heads, as compared to two-thirds (35 or 68.6%) of Ladino heads, were agricultural day laborers or agricultural day laborers with small plots.

The educational attainment in stratum I was low, as the information in Table 4.3 demonstrates. Two-thirds (66 or 67.3%) of the household heads had never attended school. Nearly one-third (31 or 31.7%) had between one and three years of schooling, and only one (1.0%) had gone beyond the third grade. School attendance of the Indian household heads was lower than that of the Ladinos. Three-fourths (36 or 76.6%) of the indigenous population had never gone to school, as compared to three-fifths (30 or 58.8%) of the Ladinos.

Housing conditions among those in stratum I also were poor (see Table 4.4). Almost all of the families lived in dwellings with hard-packed earthen floors. Those who had cement or tiled floors were living in rented meson rooms, which represent some of the worst housing conditions in Asunción. More Indians (33 or 70.2%) than Ladinos (30 or 58.8%) lived in dwellings made out of bahareque, straw and scraps of lumber and tin.

Table 4.2.--Occupational composition of strata I and II (the lower class).

Occupational Sector ^a	Stratum I			Stratum II			Total		
	Lad.	Ind.	Total	Lad.	Ind.	Total	Lad.	Ind.	Total
<u>Sector I</u>									
Ag. day laborer (%)	35	31	66	16	12	28	51	43	94
	68.6	65.9	67.3	9.8	15.6	11.6			
Ag. day laborer small plot (%)		4	4	3	9	12	3	13	16
		8.5	4.1	1.8	11.7	5.0			
Laborer (%)	3	3	6	19	7	26	22	10	32
	5.9	6.4	6.1	11.6	9.1	10.8			
Small/medium agric. (%)				9	4	13	9	4	13
				5.5	5.2	5.4			
<u>Sector II</u>									
Artisan (%)	6	2	8	47	24	71	53	26	79
	11.8	4.3	8.2	28.6	31.1	29.5			
Vendor (%)		1	1	11	11	22	11	12	23
		2.1	1.0	6.7	14.3	9.1			
Small shop owner (%)				8	1	9	8	1	9
				4.9	1.3	3.7			
Medium/large shop owner (%)				1		1	1		1
				.6		.4			

Table 4.2.--Continued.

Occupational Sector ^a	Stratum I			Stratum II			Total		
	Lad.	Ind.	Total	Lad.	Ind.	Total	Lad.	Ind.	Total
<u>Sector III</u>									
White-collar worker (%)				11	2	13	11	2	13
Semi-professional (%)				6.7	2.6	5.4			
<u>Sector IV</u>									
Prof./large landowners (%)									
<u>Sector V^b</u>									
Housewives (%)	7	6	13	39	7	46	46	13	59
	13.7	12.8	13.3	23.8	9.1	19.1			
Total (%)	51	47	98	164	77	241	215	124	339
	13.4	32.6		43.0	53.5				

Source: 1978 town census.

^a I--Small-scale agricultural and day-laboring sector, II--Artisan and trades sector, III and IV--White-collar, semi-professional, professional, and large landowning sector, IV--Not in labor force and unemployed.

^b Retired and unemployed household heads were included in the occupational category in which they last worked.

Table 4.3.--Educational characteristics of strata I and II (the lower class).

Level of Education	Stratum I			Stratum II			Total		
	Lad.	Ind.	Total	Lad.	Ind.	Total	Lad.	Ind.	Total
None (%)	30 58.8	36 76.6	66 67.3	43 26.2	20 25.9	63 26.2	73	56	129
1st-3rd grade (%)	20 39.2	11 23.4	31 31.7	57 34.8	26 33.8	83 34.4	77	37	114
4th-6th grade (%)	1 2.0	1	1.0	62 37.8	31 40.3	93 38.6	63	31	94
7th-9th grade (%)				1 .6	1	.4	1	1	1
10th grade + (%)				1 .6	1	.4	1	1	1
Total	51	47	98	164	77	241	215	124	339

Source: 1978 town census.

Table 4.4.--Housing characteristics of strata I and II (the lower class).

House Type ^a	Stratum I			Stratum II			Total		
	Lad.	Ind.	Total	Lad.	Ind.	Total	Lad.	Ind.	Total
Low (%)	30	33	63	17	11	28	47	44	91
	58.8	70.2	64.3	10.4	14.3	11.6			
Medium (%)	18	9	27	76	45	121	94	54	148
	35.3	19.2	27.5	46.3	58.4	50.2			
High (%)	3	5	8	71	21	92	74	26	100
	5.9	10.6	8.2	43.3	27.3	38.2			
Total	51	47	98	164	77	241	215	124	339

Source: 1978 town census.

Note: Meson dwellers were counted as low.

^aLow-quality dwelling--made of straw and/or scraps of wood and other material with hard-packed earthen floors; medium-quality dwelling--made of mud and pole walls, adobe or concrete blocks with earthen floors; high-quality dwelling--adobe or concrete block walls and tiled or concrete floors in one or more rooms.

Information on possessions, presented in Table 4.5, indicates that nearly one-third (32 or 32.7%) of the households in stratum I did not own a radio, television, or motor vehicle. Two-thirds (65 or 66.3%) owned radios, and only one (1.0%) owned a television. More indigenous than Ladino households had radios.

Overall, this brief sketch indicates that the indigenous population was over-represented in stratum I and that, in general, households in this stratum had few resources upon which to draw. These descriptive indicators, however, do little to convey the poverty experienced by families in stratum I. Many household members were unemployed or underemployed for a large part of the year. For the most part, these families were landless and often lacked the funds to purchase food and other necessities for their children. This situation often resulted in painful compromises. The cases of the Texin and Mateo families illustrate the plight of many stratum I households.

The Texins were an indigenous family who lived in the southern part of Asunción along the right-of-way for the highway. Because their house was located on public lands, the family faced eviction at any time. Their one room dwelling opened directly onto the highway. Lacking land on either side or at the back of the house, Mrs. Texin cooked inside or right by the front door, a situation that resulted in the one room home being filled with smoke for most of the day. Guadalupe Texin, a woman in her early fifties, was born and raised in Asunción. Juan Texin, in his late fifties, came from a nearby canton. Although the couple had lived in a common-law arrangement for many

Table 4.5.--Radio, television, and motor vehicle ownership in strata I and II (the lower class).

Possessions ^a	Stratum I			Stratum II			Total		
	Lad.	Ind.	Total	Lad.	Ind.	Total	Lad.	Ind.	Total
None (%)	19 37.3	13 27.7	32 32.7	19 11.6	8 10.4	27 11.2	38	21	59
Radio (%)	31 60.8	34 72.3	65 66.3	106 64.6	57 74.0	163 67.7	137	91	228
Radio, TV (%)	1 1.9	1	1.0	38 23.2	11 14.3	49 20.3	39	11	50
Radio, TV, motor vehicle (%)				1 .6	1 1.3	2 .8	1	1	2
Total	51	47	98	164	77	241	215	124	339

Source: 1978 town census.

^aThe six households lacking information were given the average for their occupational category.

years, when Guadalupe converted to the Evangelical denomination she insisted they marry. Juan worked sporadically as an agricultural day laborer. He had a drinking problem and frequently disappeared for long stretches of time. Guadalupe and her 16-year-old son did what they could to support the two other children and three grandchildren who lived with them. She sold coconuts along the roadside, and her son worked as a jornalero.

The Texins were active in the right-wing paramilitary organization, ORDEN. (This organization was established in the 1960s to quell a potential repetition of a campesino uprising similar to that in which so many of Asunción's indigenous population were murdered in 1932.) The family's participation in ORDEN may have explained why authorities tolerated their squatting on the public right-of-way. ORDEN also provided them with access to a medical clinic in Sonsonante. Even with access to free medical care, however, the three young grandchildren were chronically ill with parasite infestations, malnutrition, and upper-respiratory infections. In Guadalupe's words, the children were persistently sick with parasites and colds ("perenge de parásitos y catarros"). Two of the 10 children she had given birth to had died in infancy. Having no source of steady employment nor access to land, this family was barely able to survive.

Maria Elena Mateo was a Ladina born and raised in a nearby canton. She was 40 years old. Maria had had a number of relationships which had resulted in the birth of eight children. At the time of this study, she was involved with a married man by the name of Salvador

Hernandez, who worked as a carpenter, owned a small plot of land, and had recently built a small meson. Maria lived in one of the meson rooms and acted as the unpaid overseer for the other tenants. She had recently had a daughter by Salvador. Two of her other children also lived with her.

In Maria's eyes, she was fortunate. Her living circumstances were among the best she had experienced. She had a roof over her head and someone to contribute to the support of her family. Nonetheless, her situation was precarious. As Salvador was a married man, she had little hope of establishing any kind of socially legitimate relationship with him.

Stratum II. Stratum II was the largest grouping, representing 241 households or nearly one-half (45.9%) of the census population. Indigenous households constituted one-third (77 or 32.0%) of the stratum and more than one-half (53.5%) of the indigenous population in the census sample. Ladinos represented two-thirds (164 or 68.0%) of the stratum and two-fifths (43.0%) of the Ladino population in the census sample.

The earnings of the household heads in stratum II were derived from a wide range of occupations (Table 4.2). The three largest were artisans (71 or 29.5%), agricultural day laborers and those with small plots (40 or 16.6%), and laborers (26 or 10.8%). Housewives constituted nearly one-fourth (46 or 19.1%) of the stratum. The remaining individuals (58 or 24.0%) were vendors, store owners, small to medium agriculturalists, and white-collar workers. One-third (25 or 32.5%) of

the indigenous household heads worked in the agricultural sector, one-third (24 or 31.1%) were artisans, and one-third (28 or 36.4%) were laborers, vendors, owners of small shops, housewives, and white-collar workers.

One-fourth (63 or 26.2%) of the household heads in this stratum had never attended school, one-third (83 or 34.4%) had between one and three years of schooling, and two-fifths (93 or 38.6%) had attended school for four to six years (Table 4.3). Almost no one (2 or .8%) in this stratum had gone beyond the sixth grade, and little difference existed between the educational attainment of Indians and Ladinos.

In regard to housing characteristics, as Table 4.4 indicates, two-fifths (92 or 38.2%) of the families lived in good quality dwellings with adobe, concrete, or brick walls, and tiled or concrete floors. One-half (121 or 50.2%) lived in intermediate-quality homes, and only slightly over one-tenth (28 or 11.6%) lived in the poorest houses constructed from bahareque, straw or scraps of lumber and tin. Nearly three-fourths of the Indian (56 or 72.7%) as compared to close to three-fifths (93 or 56.7%) of the Ladino households lived in low to intermediate quality homes. Only one-tenth (27 or 11.2%) of those in stratum II had no possessions. Two-thirds (163 or 67.7%) owned radios, one-fifth (49 or 20.3%) owned radios and televisions, and there were two (.8%) households that owned trucks used to transport merchandise. More Ladinos (39 or 23.8%) than Indians (12 or 15.6%) owned televisions (Table 4.5).

To summarize, nearly two-thirds of the household heads in stratum II were illiterate or semi-literate, having received a third-grade education or less. While housing conditions were somewhat better in stratum II than in stratum I, nearly two-thirds of the families in stratum II lived in dwellings with hard-packed earthen floors. Most owned radios and a small percentage owned televisions. Earnings were derived from a great variety of sources. Overall, indigenous families tended to live in poorer quality dwellings and were less likely to own televisions than Ladinos. Indigenous household heads were concentrated in the agricultural, artisan, and trades sectors. Little difference was found in educational attainment between Indians and Ladinos.

While better off than those in stratum I, families in stratum II were nonetheless poor. The family of Paula Mendoza and Juan Musum and that of Verónica Gomez and José Rodríguez provide examples.

Paula Mendoza and Juan Musum were indigenous and were born and had grown up in Asunción. They lived in common-law union. Paula was 38, and Juan was 35. He had dropped out of school after the first grade, and she had never attended classes. They owned a large lot (solar) in the barrio Cruz Galana. Only 6 of the 13 children born to Paula were living. Eight children lived with them in the house: two were his by another relationship, three were theirs, and three were grandchildren. Juan worked as a barber and also cut and sold coconuts in season. He owned a small plot of land. Paula sold fruits and vegetables. Juan's oldest son also contributed to the family's support by working as a jornalero. Their house consisted of a large room divided into

sleeping and living areas. On days that it rained, Juan used the living area as his barber shop. Although the house had electricity, it had no running water. The family's living conditions were cramped, but ownership of land meant that it had some security.

Verónica Gomez and José Rodríguez were Ladinos who lived on the outskirts of the barrio Cruz Galana. Neither José nor Verónica was from Asunción, although she had been brought up on a nearby hacienda. José, 47 years old, was seldom home. He was employed as a ticket collector on buses in San Salvador and had previously worked on construction jobs. He had completed the second grade. Verónica, aged 37, sold pupusas (tortillas filled with beans, meat, or cheese) and yuca (cassava) in Atecosol Park. She had never attended school. Although José and Verónica were not legally married, their common-law relationship was stable. Five of the seven children born to them were still living and resided with them. Verónica's five-month-old nephew, whom her sister, a domestic servant in San Salvador, was unable to care for, also lived with them. The rented house was tiny, consisting of a small room constructed out of bahareque and pieces of lumber. Their steady salaries were what distinguished them from poorer households.

Stratum III. Stratum III was composed of 126 households representing one-fourth (126 or 24.0%) of the census sample. A small proportion (18 or 14.3%) of the households were indigenous, and they represented only slightly over one-tenth (12.5%) of the Indian households in the sample. Most (108 or 85.7%) households in the

stratum were Ladino, and they constituted over a quarter (28.4%) of the Ladinos in the census sample.

A diversity of occupations was represented in stratum III, as Table 4.6 indicates. The most successful artisans (38 or 30.2%), vendors (20 or 15.9%), owners of small to medium agricultural properties (12 or 9.5%), and skilled laborers (9 or 7.1%) belonged to this stratum. Owners of medium to large stores (12 or 9.5%), white-collar workers (22 or 17.5%), and semi-professionals and some professionals (6 or 4.8%) were also members. Included here were nurses, the sanitary inspector, and some owners of large, but not very productive, agricultural estates. Only a small proportion (7 or 5.5%) of household heads were housewives. Of the 18 Indian household heads in the stratum, nearly one-half (8 or 44.4%) were artisans, one-fifth (4 or 22.2%) were white-collar workers, and the remainder (6 or 33.4%) were agriculturalists, vendors, and shop owners.

Educational attainment was higher in this stratum than in stratum II, although it was still relatively low (Table 4.7). Four-fifths (76 or 60.3%) of the household heads had between four and six years of schooling, and over a fourth (34 or 27.0%) had gone beyond the sixth grade. Three (2.4%) had completed high school. Only about one-tenth (12.7%) had a third grade education or less. Perhaps reflecting the greater efforts they had to make to achieve the same status as Ladinos, Indian household heads in stratum III were better educated than their Ladino counterparts. More than two-fifths (8 or 44.5%) had

Table 4.6.--Occupational composition of strata III and IV (the middle and upper classes).

Occupational Sector ^a	Stratum III			Stratum IV			Total		
	Lad.	Ind.	Total	Lad.	Ind.	Total	Lad.	Ind.	Total
<u>Sector I</u>									
Ag. day laborer (%)									
Ag. day laborer small plot (%)									
Laborer (%)	9		9				9		9
	8.3		7.1						
Small/medium agric. (%)	10	2	12				10	2	12
	9.2	11.1	9.5						
<u>Sector II</u>									
Artisan (%)	30	8	38	2		2	32	8	40
	27.8	44.4	30.2	3.5		3.3			
Vendor (%)	18	2	20	1		1	19	2	21
	16.7	11.1	15.9	1.7		1.7			
Small shop owner (%)									
Medium/large shop owner (%)	11	1	12	3	3	3	14	1	15
	10.2	5.6	9.5	5.2		5.0			

Table 4.6.--Continued.

Occupational Sector ^a	Stratum III			Stratum IV			Total		
	Lad.	Ind.	Total	Lad.	Ind.	Total	Lad.	Ind.	Total
<u>Sector III</u>									
White-collar worker (%)	18 16.7	4 22.2	22 17.5	5 8.6	5 8.3		23	4	27
Semi-professional (%)	2 1.8	2 1.6	2 1.6	34 58.6	2 100.0	36 60.0	36	2	38
<u>Sector IV</u>									
Prof./large landowners (%)	3 2.8	1 5.6	4 3.2	13 22.4	13 21.7		16	1	17
<u>Sector V^b</u>									
Housewives (%)	7 6.5	7 5.5					7		7
Total (%)	108 28.4	18 12.5	126	58 15.2	2 1.4	60	166	20	186

Source: 1978 town census.

^a I--Small-scale agricultural and day-laboring sector, II--Artisan and trades sector, III and IV--White-collar, semi-professional, professional, and large landowning sector, IV--Not in labor force and unemployed.

^b Retired and unemployed household heads were included under the occupational category in which they were last employed.

Table 4.7.--Educational characteristics of strata III and IV (the middle and upper classes).

Level of Education	Stratum III			Stratum IV			Total	
	Lad.	Ind.	Total	Lad.	Ind.	Total	Lad.	Ind.
	Total			Total			Total	
None (%)	3		3				3	3
	2.8		2.4					
1st-3rd grade (%)	11	2	13				11	2
	10.2	11.1	10.3					13
4th-6th grade (%)	68	8	76	2		2	70	8
	62.9	44.4	60.3	3.4		3.3		78
7th-9th grade (%)	22	7	29	8		8	30	7
	20.4	38.9	23.0	13.8		13.3		37
10th grade + (%)	4	1	5	48	2	50	52	3
	3.7	5.6	4.0	82.8	100.0	83.4		55
Total	108	18	126	58	2	60	166	20
							186	

185

Source: 1978 town census.

gone beyond the sixth grade, as compared to one-fourth (26 or 24.1%) of the Ladinos.

None of the households in this stratum lived in the poorest quality dwellings, and under one-fifth (19 or 15.1%) lived in intermediate quality homes (Table 4.8). The majority (107 or 84.9%) lived in homes constructed out of adobe or brick with concrete or tiled floors. As was the case with stratum II families, Indian households were more likely to live in poorer quality homes than Ladinos. Over one-fourth (5 or 27.8%) of the indigenous families, as compared to only over one-tenth (14 or 13.0%) of the Ladino families, lived in intermediate quality homes.

Less than one-fifth (20 or 15.9%) of the households in stratum III owned radios, televisions, and motor vehicles, but more than two-thirds (88 or 69.8%) owned radios and televisions (Table 4.9). Only a small percentage (18 or 14.3%) owned none of these consumer goods or only had radios. As was the case in stratum II, a smaller percentage of Indian (12 or 66.7%) as compared to Ladino households (96 or 88.9%) owned televisions.

Overall, families in stratum III were relatively well-off by community standards. Almost all household heads were literate and had successful businesses, landholdings, or secure and steady incomes. The Vega and Quilizapa families serve as illustrations.

José and Reina Vega were born and raised in Asunción. They were married in both civil and religious ceremonies. José was 43 and Reina was 39 years old. They were living in a well-constructed two-bedroom

Table 4.8.--Housing characteristics of strata III and IV (the middle and upper classes).

House Type ^a	Stratum III			Stratum IV			Total	
	Lad.	Ind.	Total	Lad.	Ind.	Total	Lad.	Ind.
Low (%)								
Medium (%)	14	5	19	1	1	1.7	15	5
	13.0	27.8	15.1	1.7				20
High (%)	94	13	107	57	2	59	151	15
	87.0	72.2	84.9	98.3	100.0	98.3		166
Total	108	18	126	58	2	60	166	20
							186	

Source: 1978 town census.

Note: Meson dwellers were counted as low.

^aLow-quality dwelling--made of straw and/or scraps of wood and other material with hard-packed earthen floors; medium-quality dwelling--made of mud and pole walls, adobe or concrete blocks with earthen floors; high-quality dwelling--adobe or concrete block walls and tiled or concrete floors in one or more rooms.

Table 4.9.--Radio, television, and motor vehicle ownership in strata III and IV (the middle and upper classes).

Possessions ^a	Stratum III			Stratum IV			Total		
	Lad.	Ind.	Total	Lad.	Ind.	Total	Lad.	Ind.	Total
None (%)	1		1				1		1
	.9		.8						
Radio (%)	11	6	17				11	6	17
	10.2	33.3	13.5						
Radio, TV (%)	78	10	88	24	2	26	102	12	114
	72.2	55.6	69.8	41.4	100.0	43.3			
Radio, TV, motor vehicle (%)	18	2	20	34		34	52	2	54
	16.7	11.1	15.9	58.6		56.7			
Total	108	18	126	58	2	60	166	20	186

Source: 1978 town census.

^aThe six households lacking information were given the average for their occupational category.

house that Reina had inherited from her family. It was connected to the public sewer and electricity systems. The Vegas had four children, all of whom were living. José had gone through the ninth grade. He worked as a truck driver and merchandiser for a large store in Sonsonante. Reina did not work outside the home, but she did own a refrigerator, which allowed her to sell cold drinks to neighbors. This family was able to afford private medical care for their children and intended to send the children to private high schools in Sonsonante.

Consuelo and Ricardo Quilizapa were born in Asunción. They were living in a rented home in the barrio San Juan at the time of this study. Although Ricardo's family was indigenous, they did not actively participate in any indigenous associations. There was little apparent difference in culture between the Quilizapas and the Vegas. Ricardo had a sixth-grade education and worked as a carpenter. He was 28 years old. Consuelo was 32 years old and also had completed the sixth grade. She had a small store in the front room of their home and also worked as a seamstress. The couple was legally married but had no children. Consuelo was deeply disturbed by their failure to have children. She suffered chronically from nervios (nerves), a condition that had resulted in repeated episodes of paralysis and temporary blindness. Their rented two-bedroom house was connected to the public sewer and electricity systems. By community standards, this family was comfortable, but their lack of offspring was regarded as a misfortune.

Stratum IV. The fourth and highest stratum was composed of 60 households representing slightly over one-tenth (11.4%) of the census sample. There were only two indigenous households in this grouping. They made up a very small proportion of the stratum (3.3%) and of the indigenous population (1.4%) in the census. Ladinos represented the vast majority (58 or 96.7%) of those in stratum IV and comprised one-sixth (15.2%) of all Ladino households in the census.

Stratum IV was composed primarily (49 or 81.7%) of household heads earning their living in semi-professional and professional occupations and as owners of large agricultural estates (Table 4.6). The remainder (11 or 18.3%) were white-collar workers, owners of large stores, vendors, and artisans. The artisans owned large shops that employed other workers. The two indigenous household heads were school teachers.

Educational attainment of the household heads in stratum IV was high by local standards. More than four-fifths (50 or 83.4%) of the household heads had a tenth grade education or beyond (Table 4.7). Of the remainder (10 or 16.6%), most had between a seventh and ninth grade education. The indigenous household heads held teaching certificates. All except one family in stratum IV lived in the highest quality dwelling (Table 4.8). All owned televisions and radios, and more than half (34 or 56.7%) owned motor vehicles (Table 4.9).

Stratum IV represented the upper class in Asunción. The family of Dora and Benjamín Linares provides an example of the

long-established local upper class, while that of Salvador Shupan and Elidia Ortiz represents the newer, semi-professional households.

Benjamín and Dora Linares were born and raised in Asunción as were their parents and grandparents. Benjamín was 51 and Dora was 52 years old. He had a high school degree, and she had completed the ninth grade. They lived in a large house, located in the barrio Dolores, that Dora had inherited from her parents. The front room was used as a store. This was one of the largest commercial establishments in town, and it was managed by Dora. Benjamín also engaged in commerce as a wholesaler supplying smaller stores in Asunción and Sonsonante with a variety of merchandise. Dora and Benjamín had five children, three of whom were attending the National University in San Salvador. Another child attended a private high school in Sonsonante. The oldest son had graduated from high school and worked in an office in Sonsonante. He and his wife and two children lived with Dora and Benjamín. Although the family did not have rural holdings, they did own urban rental properties. Their house was large by any standard, having six bedrooms and three baths. They owned a car in addition to a truck used for business purposes. The family relied on private doctors in Sonsonante and in San Salvador in cases of serious illness. For less threatening conditions, they used one of the pharmacies in Asunción. Dora was related to the owner of this establishment. She and Benjamín were, in fact, related to many of the other upper-class families in town.

Salvador Shupan was one of the two indigenous school teachers in the sample and is representative of semi-professionals in stratum IV. Like many other teachers in the community, Salvador came from a poor family whose members had sacrificed to keep him in school. For many years, he worked at a primary school in a nearby canton, but he recently was hired by one of the primary schools in Asunción. Salvador was 39 years old. His companion, Elidia Ortiz, was 24 years old. She was from a Ladino family who owned land in the canton where Salvador had previously worked. The couple had three children. They lived in a rented house in the barrio La Otra Banda. Although Salvador had what he referred to as a drinking problem, he reported that he had quit drinking and was trying to save money to buy a house. Elidia was not working outside the home. The couple's three children were well cared for. Salvador's relatively high and steady income permitted this family to live comfortably.

To summarize, using a combination of variables, four strata were identified. The lowest stratum, composed of the destitute, represented approximately one-fifth (18.7%) of the sample. The second stratum comprised almost one-half (45.9%) of those interviewed. These households were poor by community standards. Households in the third stratum were better off. They represented nearly one-fourth (24.4%) of the sample. The highest stratum consisted of approximately one-tenth (11.4%) of those interviewed and was composed of the wealthier households. Figure 4.2 displays the percentage of Ladino and Indian households heads, by stratum. This figure shows that, in 1979, indigenous

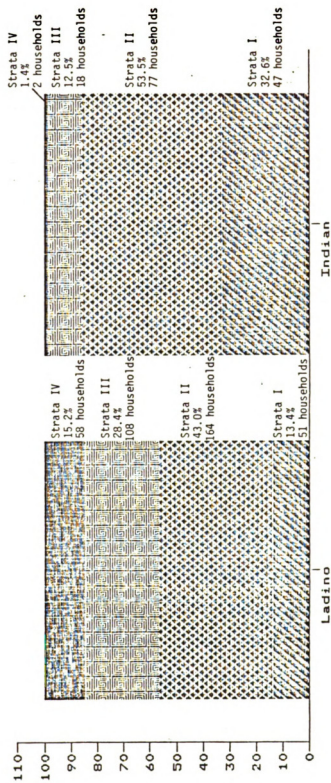


Figure 4.2.--Percentage of Ladino and Indian households by stratum.

households were disproportionately represented in the lower strata. In fact, the vast majority (86.1%) of the Indian families interviewed were members of strata I and II. Not only were Indians more likely to be located in the lower strata, but also, as the discussion above indicates, within especially the lowest stratum they occupied a disadvantaged position with regard to employment and education relative to their Ladino counterparts. These findings suggest that Barrera's (1978) concept of ascriptive class segments may be applicable in the analysis of the relationship between class and ethnicity in Asunción.

Barrera (1978: 170) identifies five factors which help account for and perpetuate the existence of ascriptive class segments. Working with historical materials on Chicanos drawn from the early part of this century, he found that first, Chicanos represented a captive labor force. Their abilities to change jobs in response to fluctuations in the labor market were limited by their position as an ethnic minority. Second, they were subject to a dual wage structure. Third, considerable occupational stratification existed in the labor market, with Chicanos and other minorities concentrated in certain subordinate occupations. Fourth, Chicanos represented a reserve labor force that could be used by employers as leverage in bargaining with their workers. Finally, they functioned as buffers in times of economic dislocation, being laid off at a disproportionately higher rate than Anglos at times of rising unemployment.

Many of these same factors characterized Asunción's indigenous population. For example, the preceding chapters detailed how Indians

were subordinated first to the Spanish Colonial authorities and merchants and, after El Salvador's independence, to the Ladino owners of coffee estates and to producers of other export crops. More recently, as the information presented in Chapter III indicated, occupational diversification has become salient. Within the occupational structure, Indian household heads were concentrated in the lowest paying and least secure jobs as agricultural day laborers. There also were indications that Indians experienced greater difficulty in finding employment than Ladinos. Further, some landowners stated that Indian agricultural day laborers were paid less than their Ladino counterparts. If a more detailed study of the indigenous community were undertaken, it is possible that it would reveal other forms of Indian labor exploitation. Even in the absence of such an investigation, however, the findings presented above indicate that Barrera's concept of an ascriptive class segment adequately characterizes Asuncion's Indian population. Indian families were concentrated in the lowest two strata and within especially stratum I had poorer jobs and lower levels of education than Ladinos.

The relationship between the strata and the social class divisions recognized by townspeople will now be examined.

Social Class: A Perspective From the Community

Asunción's size and social complexity meant that there was no single system of ranking with which everyone agreed. People in different social and economic circumstances had somewhat different

views of the town's class composition. The following sketch depicts social class divisions from the perspective of a member of the local upper class. Mrs. Herrera was a woman in her sixties whose family had lived in Asunción for generations. Her perspective was shared by others in the local upper class and represented the dominant ideology.

In her conversations, Mrs. Herrera referred to two major social groups. The lowest consisted of people of humble birth (gente humilde or los humildes). It was made up of Ladino and Indian families with little or no formal education and low incomes usually derived from manual labor. Indians sometimes were called by the older term natural.¹⁰ Among the humildes, Mrs. Herrera drew a distinction between the hard-working and deserving poor whose circumstances reflected divine will and those who, through lack of initiative or other personal shortcomings, were responsible for their poverty. The highest social group included people of quality (gente de categoría or simply gente). It was composed of Ladinos whose families had resided in Asunción for generations and who generally were well-off financially, although not necessarily wealthy. These people owned urban and rural properties and did not engage in manual labor.

Poor working class people who had recently moved to town were usually considered humildes. More affluent newcomers, such as teachers and some of the white-collar workers, however, could not be easily accommodated in this scheme. Although those whose comportment was deemed proper (formal) were accorded high status, they were not considered gente because little could be known with assurance about their

family background. Those from old, established Asunción families regarded them as outsiders. Nonetheless, this category of newcomers was growing in numbers.

Two points can be made regarding this class framework and the ideology it embodies. First, as noted above, it is class-specific in the sense that the criteria considered significant in distinguishing among the social groups were not shared by all townspeople. For example, from the perspective of the upper class, one of the most important issues in determining standing was family history. This consideration usually overrode other more immediate indicators of status, such as income and property ownership. Hence, for example, the mayor was regarded as humilde although he owned sizable urban and rural landholdings and his wife ran a successful store. In part, this was because his father was an illiterate small-scale landholder and the mayor himself had received little formal education. In addition to family history, another contributing factor in the mayor's case, however, was that his wealth was rumored to have come from his political post. In many people's eyes, the mayor was not formal. In contrast to this situation, the mayor's neighbor, whose wealth and property were squandered by a philandering and alcoholic husband, was regarded as gente. Her parents had owned one of the most successful commercial establishments and were highly respected. Her personal misfortune did not diminish her standing in the eyes of neighbors.

Other important criteria used in identifying the classes and in making distinctions were directly related to the upper-class members'

position as principal owners of the means of production. For example, among the humildes the most important division was not based on ethnicity but rather on perceived willingness to work. Mrs. Herrera's distinction between the deserving (hard-working and reliable) and not so deserving poor reflected her class's reliance on the humildes as a source of docile and inexpensive labor.

Second, as the above discussion indicates, recent changes have placed stress on this framework. Newcomers, especially white-collar workers, semi-professionals, and professionals, could not be easily accommodated in the scheme because little was known regarding their origins. In this sense, this class framework better reflected the era before the improvements in the transportation network when the population was less mobile than it did the late 1970s.

Although these social class divisions did not accord in their entirety with the present-day realities and although the criteria they were based on were not shared by all townspeople, as noted above, this perspective represented the dominant ideology. Mrs. Herrera and her compatriots were the most powerful group in town. They owned most of the property, employed many of the laborers, and made most of the important political and economic decisions. Further, their lifestyles and opinions were emulated by many less fortunate people.

The social divisions recognized by the upper class overlapped in a general fashion with the four social strata identified above. From this perspective, almost all households in strata I and II were considered humildes. Many, but not all, households in strata III and

IV were gente. (Also included in these strata, but not in the gente category, were the better-off newcomers and families whose histories were thought to be disreputable.) In their analysis of social class divisions, then, upper-class townspeople relied on some of the same criteria—educational attainment, occupation, and signs of wealth—used in stratifying the sample. In addition, however, their perspective was influenced by their dominant position in the productive process (especially their reliance on a cheap and docile labor force). They also drew on qualitative factors, such as length of residence and reputation, that were not taken into account in identifying the strata. Although there is not complete agreement between the two stratification systems, for the purposes of this study, strata I and II will comprise the lower class, stratum III will comprise the middle class, and stratum IV the upper class.

Conclusion

The alterations in Asunción's economic base since 1932, resulting from the interaction between micro- and macro-level processes outlined in previous chapters, have resulted in the present class and ethnic structure.

The first section of this chapter explored changes in the Indian community. In the early 1950s, Adams (1976) proposed an explanation for the high retention of indigenous traits in Asunción. He suggested that the Indian population had maintained its economic integrity and had not been converted into a day-laboring group. By 1979, however,

as the information presented here indicates, the situation had changed. The vast majority of Indian households were dependent on wage labor in the agricultural and artisan sectors. There were very few (6 or 4.2%) household heads in the sample who earned their livings primarily from small- to medium-sized agricultural properties.

This alteration in the economic base was accompanied by the disappearance of the majority of the individual-centered cultural traits Adams employed to identify the indigenous population in the 1950s. These include loss of indigenous modes of dress and language and disappearance of the mecapal and of indigenous hand-weaving industries. The most significant remaining institutions are those in the religious and political spheres which, as discussed above, are bolstered by wider-society interests.

As overt signs of Indian culture have disappeared, Indians increasingly have become identified or defined by their poverty. More affluent Ladinos regard characteristics such as living in ranchos, dependence on agricultural wage labor, low educational achievement, and unemployment as evidence of Indian culture and personality, even though these characteristics are found among non-Indians. In this sense, poverty itself has taken on ethnic connotations and serves to reinforce cultural stereotypes as well.

The second section of the chapter delineated the major social class divisions in Asunción and examined, in a more formal way, the relationship between class and ethnicity. A stratification procedure was developed that resulted in the identification of three social

classes. The lower class (strata I and II) represented nearly two-thirds (64.6%) of the population and was composed of households that had access to few resources and were unemployed or marginally employed for most of the year. Upper-class townspeople who relied on their labor usually referred to them as gente-humilde. The middle class consisted of many of the successful artisans, tradespeople, and many of the new arrivals who earned their livings as teachers and white-collar workers. It represented almost one-fourth (24.0%) of the population and contained within its ranks many families with long histories in Asunción whom the upper class identified as gente de categoría. The upper class comprised slightly over one-tenth (11.4%) of the population and consisted of successful shopowners, semi-professionals, professionals, and owners of large estates. Many of these families had resided in Asunción for generations and were considered gente by their peers.

Analysis of the census data indicated that indigenous households were disproportionately represented in the lower class, and within this class they experienced worse circumstances than their Ladino counterparts. Barrera's model of ascriptive class segments was proposed as a useful means to conceptualize the Indian population's position within the class framework.

This class and ethnic structure provides the basis for the subsequent examination of domestic organization, a crucial nexus point between the wider political economy, health status, and the local medical system.

CHAPTER V

DOMESTIC ORGANIZATION

This chapter explores the impact of many of the macro-level socioeconomic and political trends outlined in previous chapters on domestic organization and functioning in Asunción. The information presented here serves as a bridge between the analysis of the broad processes of development and the class structure discussed up to this point and an analysis of health status and the use of medical resources pursued in Part II. The intent is to examine differences in religious affiliation, marital status, and household composition by class and ethnic group membership. In the following chapters, the implications of these class variations in domestic organization for health status and the use of medical resources are considered.

Religious Affiliation

In Asunción, as elsewhere in El Salvador and in Central America, a religious revitalization has occurred in the last few decades. Protestant denominations, many of them fundamentalist, have won a growing number of converts, and the Catholic Church has undergone a major reorientation as a result of Vatican II.

While both Protestant and Catholic missionary efforts place emphasis on grass-roots or community-level organizing, the orientation

of these movements differs. In the late 1970s, under the direction of Archbishop Oscar Arnulfo Romero, the catechist, or Christian base community movement, drew attention to social inequalities and injustices throughout El Salvador. Many priests became actively involved in community organizing, and were persecuted and murdered because of their actions (Montgomery 1983). Protestant denominations and missionary efforts, on the other hand, tended to be politically conservative, placing emphasis on the formation of a small community of believers whose personal behavior and lifestyles accorded with the tenets of their faith. In Asunción, where the religious brotherhoods (cofradías) played an important role in the 1932 revolt, the Christian base community movement was closely monitored and suppressed. Early in 1979, the priest was ordered to cancel the catechist classes, and in May he fled the town after he and other citizens received threats from a right-wing death squad.¹ Given the inward-directed focus of the Protestant denominations, however, few if any constraints were placed in the way of their meetings and services.

Information on religious affiliation was gathered from 499 of the 525 households interviewed during the census.² As the data in Table 5.1 demonstrate, a large majority of the household heads (428 or 85.8%) was Catholic, but there was a small number of Protestants and Spiritists (39 or 7.8%). Most (27 or 69.2%) of the Protestants belonged to the Evangelical denomination. The remainder were Seventh Day Adventists (4 or 10.3%) or Jehovah's Witnesses, Baptists, Church of God members, and Spiritists (8 or 20.5%).³ Finally, a small number of

Table 5.1.--Religious and ethnic affiliation of household heads by class.

Social Class	Catholic			Protestant			None			Total		
	Lad.	Ind.	Total	Lad.	Ind.	Total	Lad.	Ind.	Total	Lad.	Ind.	Total
Lower class (%)	164 80.8	94 80.3	258 80.6	23 11.3	9 7.7	32 10.0	16 7.9	14 12.0	30 9.4	203	117	320
Middle & upper (%) class	153 95.6	17 89.5	170 95.0	5 3.1	2 10.5	7 3.9	2 1.3		2 1.1	160	19	179
Total (%)	317 87.3	111 81.6	428 85.8	28 7.7	11 8.1	39 7.8	18 5.0	14 10.3	32 6.4	363	136	499

Source: 1978 town census.

household heads (32 or 6.4%) did not identify with any church, stating that they had no religious affiliation. This response has been reported in other Meso-American communities (Smith 1977: 52, Warren 1978). Some may have participated in the brotherhoods and, hence, could be considered folk Catholics.

Although no information is available that would permit a comparison of the number of Protestants and nonaffiliated people in 1979 with the situation 20 years earlier, townspeople stated that the number of Protestants had increased in recent years. Most of the Protestant churches in Asunción were established in the 1970s. The appeal of Protestant denominations was reflected in the large crowds that attended the revival meetings in Sonsonante, San Salvador, and other large urban centers and in the popularity of programs such as the Praise the Lord (PTL) Club broadcast on television. Even though the Protestant denominations had made some inroads in the community, there was little, if any, discord among members of the various churches. In fact, many Catholics lauded the Protestants' stress on family life and their prohibition against alcohol, noting that conversion to one or another of these denominations had helped troubled friends and family members.

An examination of class differences in religious affiliation revealed that adherence to Catholicism was greatest among the middle and upper classes. Nearly all household heads (153 or 95.6%) in these classes were Catholic as compared to four-fifths (164 or 80.8%) of those in the lower class. While very few (7 or 3.9%) household heads

in the middle and upper classes were Protestant, even fewer (2 or 1.1%) had no religious affiliation. In the lower class, one-tenth (32 or 10.0%) were Protestants and nearly one-tenth (39 or 9.4%) had no religious affiliation.

Two characteristics of the Protestant denominations in Asunción merit comment because they may help explain why Protestantism was attractive to some members of the lower class. As noted above, many of these churches placed stress on the personal comportment of their members. Living in accord with the tenets of the faith was viewed as a means of spiritual and material advancement. For the poor especially, this philosophy offered what seemed a tangible means of overcoming difficult life circumstances through individual-centered actions. Most of these churches provided a supportive context in which to effect changes in lifestyle. They also monitored the behavior of their congregations. The majority of these denominations were small communities of believers who met once or twice a week at one another's homes for religious services and who provided moral and material assistance in times of crisis.

The Catholic Church's counterpart to these organizations--the base communities--while supportive of members, emphasized the structural rather than the personal roots of poverty and advocated social rather than purely psychological or spiritual reform. As noted previously, the one organization of this type in Asunción was disbanded. Nevertheless, the more traditional supportive services offered by the Catholic Church continued to operate. For example, the Ladies

Auxiliary ran a Charity Home (Casa de Caridad). These activities, provided by members of the middle and upper classes to the poor, were of a qualitatively different order than those offered by the Protestant denominations.

Their extra-community ties were a second factor that helped explain the growing popularity of many Protestant congregations. In contrast to the religious brotherhoods which were town-centered, Protestant churches in Asunción maintained close relationships with congregations in other nearby communities and were linked into national church networks. In an economic context characterized by increased proletarianization, organizations with these linkages may prove advantageous in finding employment. In essence, for the poor especially, the Protestant churches with their small, tightly knit congregations and their ties to counterparts in other communities appeared to represent a more viable alternative in coping with living conditions than participation in either folk or orthodox Catholicism as they functioned in Asunción.

The only notable difference in religious affiliation by ethnicity was that slightly more of the Indian (14 or 10.3%) than the Ladino household heads (18 or 5.0%) stated that they participated in no formal religion, and a slightly larger proportion of the Ladino (317 or 87.3%) than Indian household heads (111 or 81.6%) were Catholic. Almost the same proportion of the two populations (28 or 7.7% of the Ladinos and 11 or 8.1% of the Indians) were Protestant. An in-depth study might well reveal that many of the Indian household heads who

reported that they had no formal religious affiliation were folk Catholics who participated in the religious brotherhoods.

In summary, while the majority of the population was Catholic, there were also a growing number of Protestants and a small number of household heads who were not affiliated with any organized church. Slightly more Indian households belonged to this latter category. More household heads in the lower class than in the upper two classes were Protestant or had no formal religious affiliation. The popularity of the Protestant denominations among members of the lower class may be due to a combination of factors related to the churches themselves and to the broader socioeconomic context. The improvements in the transportation network and the inability of the local economy to provide jobs have resulted in an increasingly mobile population. Older forms of association, like the cofradías, were dependent on a stable population base and reflected a time when regional and ethnic variations were more marked. Increasingly, more complex administrative and voluntary associations exemplified by the hermandades (brotherhoods) have replaced the cofradías. Even the hermandades, however, retain a community focus. In this context, the small Protestant denominations with their emphasis on righteous living as a means of personal advancement, their tightly knit local congregations, and their links to congregations in other communities may present an attractive alternative in coping with difficult living conditions.

Civil Status and Household Organization

Many researchers have drawn attention to the fragility and instability of the family in El Salvador. This is reflected in a high percentage of consensual, or common-law, unions and the instability of these unions resulting in a high frequency of female-headed households. Using 1950 census data, Adams (1976: 456) reported that marriages and common-law unions occurred with equal frequency and that one-third of the households in urban areas and one-fifth of the households in rural areas were female-headed. He noted that the most significant relationships were those among women and their children, particularly their daughters. Domestic units frequently consisted of a woman, her daughter, and her daughter's children with no resident adult males. Because residence at time of marriage or beginning to live together was usually neolocal, Adams (1976: 461) termed this matrilocality by default. White (1973: 246) estimated that in the early 1970s there was essentially the same percentage of common-law and formal unions and that female-headed households were common, especially in urban areas.

Although this situation has existed for some time, there are few detailed investigations of Salvadoran marriage patterns and household organization. What information is available is usually drawn from national census material. These data reveal that there are important variations in the percentage of common-law unions and formal marriages by region. In departments where land holdings are not concentrated and where a sizable peasant proprietor class exists, as for example in

Chalatenango, Cabanas, and Cuscatlán, formal marriages outnumber consensual unions. White (1973: 246) reports that the magnitude is in the order of four to one. In the western portion of the country, where Asunción is located, common-law unions are more frequent than formal marriages. Here there is less small-scale land ownership and a greater dependence on wage labor than elsewhere. Where property ownership is high, White (1973: 246) suggests that inheritance considerations make marriage a contractual relationship, give parents greater control over their children, and provide an incentive for families to stay together.

In addition, occupation appears to influence marital arrangements. White (1973: 246), for example, found that within San Salvador there were virtually no common-law unions among those with professional occupations. In contrast, approximately 30% of white-collar workers, 40% of sales employees, 60% of skilled workers, and 70% of unskilled workers lived in common-law unions. Finally, another factor that is used to explain marriage patterns is ethnicity. De Guevara (1975) and Marroquín (1974) suggest that the prevalence of common-law unions in departments such as Sonsonante reflects Indian customs.

In summary, degree of access to property, type of employment, and ethnic differences are all reported to influence marriage patterns in El Salvador. Nevertheless, the interrelationship between these factors within a community context has received no direct investigation.

Information on household organization is similarly lacking. The studies that are available suggest that household organization, especially in the poor urban areas of El Salvador, shares much in common with patterns of domestic organization found among New World Black populations in the Caribbean and the U.S. While the ideal Salvadoran household consists of a male head, spouse, and children, in many cases this unit is broken or denuded. Often the husband is absent and the household core consists of a woman, her children, and possibly other relatives. In other instances, the male may be present but the household contains other relatives, especially nephews, nieces, or grandchildren whose parents reside elsewhere.

There is debate in the anthropological literature regarding whether units like these constitute families. Smith (in Solien 1971: 405), who has studied family organization in the Caribbean, refers to residential groups or households as families regardless of their composition. Solien (1971), on the other hand, argues that a conjugal relationship and patrification are essential characteristics of units identified as families. Solien (1971: 408) is reluctant to consider households lacking a conjugal pair as families and, instead, contends that they represent a lower level of organization. She distinguishes between households and families, suggesting that the term family be applied only to "a group of people bound together through that complex set of relationships known as kinship ties, between at least two of whom there exists a conjugal relationship"

(1971: 409). Families can be either nuclear or extended. In contrast to families,

. . . households imply common residence, economic cooperation and socialization of children. Although members of a household may be bound together by kinship relationships, no particular type of tie is necessarily characteristic (Solien 1971: 409).

According to Solien, then, families are kin groupings based on the existence of a conjugal relationship while households are residential groupings, the members of which may or may not constitute a family.

Nieves (1979), studying household arrangements among shantytown dwellers in San Salvador, further elaborates on and refines Solien's definition of a household. She found that the group of people who provide economic support, child care, and food preparation may not be confined to a household. That is, essential reproductive roles may be performed by people who do not live together. Her example calls attention to the complexities involved in dealing with Salvadoran materials. Many households do not contain conjugal pairs and, hence, may not constitute families. Further, in some cases, reproductive roles may be performed by people other than household members.

Working in urban areas in Central America, Nieves (1979), Roberts (1970), and Solien (1971) report that while the nuclear family household is the most prevalent, consanguineal, especially female-headed, households are also common. Nieves found that one-fifth of the sample of shantytown families in San Salvador were composed of individuals related through blood ties. These were kinship groupings in which no male was regularly present in the husband-father role or in which the male was economically inactive and did not contribute to

household income (1979: 137). Most often, the core of these households consisted of mothers and children.

Investigators suggest that consanguineally related households represent coping mechanisms in dealing with marginality. For example, Whitten and Szwed (1970) noted that in many New World Black communities where economic opportunities are restricted, definable, bounded groups are maladaptive and their survival value is limited. Nieves (1979) makes this point with regard to consanguineal households in San Salvador. She suggests that among poor urban mestizo populations, consanguineal groups may be more adaptive than other varieties of household composition precisely because they are unmarked and unbounded (1979: 135).

The census material and other information from Asunción present a unique opportunity to examine this thesis. Specifically, does household composition differ by class? Are consanguineally related households more common among the lower than the middle and upper classes, and what role, if any, does ethnicity play in this regard? Do consanguineally related households offer their members greater benefits than other forms of household organization? These issues will now be explored.

Civil Status

In Asunción, very few young people establish households before marriage. Most remain with their parents or other relatives until

they enter into a common-law or legal marriage arrangement. Residence after marriage is usually neolocal.

Townpeople recognized six named categories of civil status: married, separated, divorced, accompanied, single, and widowed. The term married (casados) was used to refer to those relationships recognized in civil and, in most cases, religious ceremonies. Separated (separados) included individuals who no longer lived with their spouse but whose relationship was legally recognized and whose spouse was still living. Divorced (divorciados) was employed for people who had had a civil ceremony and had obtained a legal divorce. (Formal divorce was not common in Asunción, and most married couples whose relationship failed simply separated. There was only one household head in the sample who had obtained a divorce.) Accompanied (acompañados) included those living with spouses in a common-law relationship. Single (soltero/a) referred to two categories of people: those who had not yet entered into a conjugal relationship and those whose common-law relationship had terminated, frequently leaving them with children to raise. Widowed (viudo/a) referred to individuals whose legally recognized or common-law spouse had passed away. In some cases, however, a widower or widow from a common-law relationship was referred to as single.

For all practical purposes, common-law relationships were regarded as marriages and should not be confused with affairs or extra-marital relationships, which occurred with some frequency in Asunción. Even though common-law unions were a form of marriage,

many of these relationships were unstable. Many men and women entered into a series of these unions during their lives. The full degree of instability is difficult to measure and cannot be fully captured in the absence of detailed life histories. In the analysis that follows, the singles category is separated into those with and without children as one means of gauging the degree of marital instability.

The complicated nature and the significance of conjugal bonds are reflected in the record-keeping system for births in Asunción. The mayor's office kept three registry books: one for recording the birth of children whose parents were legally married (hijos legítimos), a second for births resulting from common-law relationships (hijos naturales), and a third for children born out of wedlock (hijos ilegítimos). This record-keeping system replaced an earlier one used until the turn of the century, in which births were registered by ethnic group. The change in registry procedures reflects alterations in property relations. When communal properties were in existence, ethnic affiliation was of paramount importance in gaining access to land. After the abolition of communal landholdings in the late nineteenth century, however, the nature of the individual's relationship to the property owner became most crucial.

Adams (1976), in the 1950s, and White (1973), in the early 1970s, reported that common-law unions outnumbered legal marriages in the Department of Sonsonante. In Asunción in 1979, the number of legal and common-law marriages was roughly equal. Table 5.2 presents information on the household heads' civil status and ethnic group, by

Table 5.2.--Civil status and ethnic group of household heads by class.

Social Class	Single Without Children			Single With Children			Accompanied			Married			Separated/ Divorced			Widowed			Total		
	Lad.	Ind.	Total	Lad.	Ind.	Total	Lad.	Ind.	Total	Lad.	Ind.	Total	Lad.	Ind.	Total	Lad.	Ind.	Total	Lad.	Ind.	Total
Lower	13	5	18	43	11	54	77	67	144	46	29	75	4	1	5	32	11	43	215	124	339
class (%)	6.0	4.0	5.3	20.0	8.9	15.9	35.8	54.0	42.5	21.4	23.4	22.1	1.9	.8	1.5	14.9	8.9	12.7			
Middle &	9	2	11	6		6	39	7	46	90	10	100	9		9	13	1	14	166	20	186
upper &	5.4	10.0	5.9	3.6		3.2	23.5	35.0	24.7	54.2	50.0	53.8	5.4		4.9	7.9	5.0	7.5			
class																					
Total	22	7	29	49	11	60	116	74	190	136	39	175	13	1	14	45	12	57	381	144	525
(%)	5.8	4.9	5.5	12.9	7.6	11.4	30.4	51.4	36.2	35.7	27.1	33.3	3.4	.7	2.7	11.8	8.3	10.9			

Source: 1978 town census.

social class. Overall, somewhat over one-third of the sample (190 or 36.2%) were accompanied and one-third (175 or 33.3%) were legally married. One-tenth (57 or 10.9%) were widowed and only a small proportion (14 or 2.7%) were separated or divorced. Few household heads (29 or 5.5%) were single without children, but over one-tenth of the sample (60 or 11.4%) were single with children.

There were differences in civil status by social class, especially with regard to marriage patterns. Among the 339 household heads in the lower class, more than two-fifths (144 or 42.5%) were accompanied and only one-fifth (75 or 22.1%) were married. In contrast, only one-fourth (46 or 24.7%) of the 186 middle- and upper-class household heads were accompanied, whereas over one-half (100 or 53.8%) were married. Similar proportions of household heads in the lower class (18 or 5.3%) and the middle and upper classes (11 or 5.9%) were single without children, but considerably more household heads in the lower class (54 or 15.9%) than in the middle and upper classes (6 or 3.2%) were single with children. Further, a larger proportion of the household heads in the middle and upper classes than in the lower class (9 or 4.9% as compared to 5 or 1.5%) were separated or divorced. Finally, slightly more household heads in the lower class than in the two upper ones were widowed (43 or 12.7% as compared to 14 or 7.5%).

Taken as a whole, this information suggests that very real differences existed between the lower class and the middle classes with regard to civil status. Household heads in the lower class were more likely to live in common-law relationships than were their

middle- and upper-class counterparts. Further, household heads in the lower class appeared to experience a greater degree of instability in their marital relationships. Almost one-fifth (59 or 17.4%) of those in the lower class were either separated or divorced or were single with children, whereas less than one-tenth (15 or 8.1%) of those in the middle and upper classes found themselves in this situation.

Because there may be a tendency to formalize marital relationships with increasing age, these findings could be an artifact of age differences between household heads in the two class groupings. The data in Table 5.3 show that, while some difference in the age distribution does exist, it is not great. Nearly four-fifths (271 or 79.9%) of the household heads in the lower class were 35 years of age or older, whereas slightly over two-thirds (130 or 70.3%) of the middle- and upper-class household heads were in this age category. The number of common-law and legally married household heads in the three age groups is presented in Table 5.4. The information in this table suggests that those in the lower class may have a greater tendency to formalize their relationships as they grow older than do their counterparts in the middle and upper classes. Overall, however, differences in proportion of those accompanied and married persist between the two class groupings regardless of the age of the household heads.

De Guevara has reported that the majority of indigenous families in Asuncion live in common-law arrangements. The picture she presents of these households is one of laxness and irresponsibility:

Table 5.3.--Age and ethnic group of household heads by class.

Social Class	18-34 Years			35-54 Years			55 Years +			Total		
	Lad.	Ind.	Total	Lad.	Ind.	Total	Lad.	Ind.	Total	Lad.	Ind.	Total
Lower class (%)	38	30	68 20.1	100	50	150 44.2	77	44	121 35.7	215	124	339 100
Middle & upper (%) class	45	10	55 29.7	71	6	77 41.6	49	4	53 28.7	165	20	185 100
Total (%)	83	40	123 23.5	171	56	227 43.3	126	48	174 33.2	380	144	524 ^a 100

Source: 1978 town census.

^aTotal does not equal 525 because information on the age of one upper-class Ladino male is missing.

Table 5.4.--Marital status of household heads by age and class.

Age Group	Social Class	Accompanied		Married		Total	
		No.	%	No.	%	No.	%
18-34 years	Lower class	43	76.8	13	23.2	56	100.0
	Middle & upper class	18	37.5	30	62.5	48	100.0
35-54 years	Lower class	63	62.4	38	37.6	101	100.0
	Middle & upper class	16	24.2	50	75.8	66	100.0
55 years +	Lower class	38	61.3	24	38.7	62	100.0
	Middle & upper class	12	38.7	19	61.3	31	100.0
Total		190	52.2	174	47.8	364 ^a	100.0

Source: 1978 town census.

^aTotal does not equal 365 because information on the age of one married upper-class Ladino male is missing.

The children grow up independently and with little care taken of them. From an early age, they confront the problems of life, learn to take care of themselves and cooperate economically with the family such that by the age of fourteen years a youngster can leave his home and go elsewhere in search of work.

In addition, frequently when couples reach maturity, the woman and the man may decide to separate in order to establish a new relationship and neither pays much attention to the problem of the children. It is also common for the man to have relationships with various women at the same time and to have children by them (1975: 242).

De Guevara does not indicate how these conclusions were reached.

The information presented in Table 5.2 indicates that a greater number of Ladino than Indian household heads were legally married. Of the 381 Ladino household heads, slightly over one-third (136 or 35.7%) were married, and slightly less than one-third (116 or 30.4%) were accompanied. Among the 144 Indian household heads, over half (74 or 51.4%) were accompanied, and slightly over one-fourth (39 or 27.1%) were married. If common-law relationships are viewed as a variant of marriage, however, a somewhat larger proportion of Indian than Ladino household heads had conjugal relationships. Nearly four-fifths (113 or 78.5%) of the Indian as compared to two-thirds (252 or 66.1%) of the Ladino household heads were accompanied or married at the time of the interview. Perhaps more tellingly, fewer Indian than Ladino household heads (12 or 8.3% as compared to 62 or 16.3%) were single with children, separated, or divorced.

These same patterns emerge within the social classes (Table 5.2). For example, over three-fourths (96 or 77.4%) of the Indian household heads in the lower class were accompanied or married, compared to less than three-fifths (123 or 57.2%) of the Ladinos. Again, fewer Indians

(12 or 9.7%) than Ladinos (47 or 21.9%) in the lower class were single with children, separated, or divorced.

In summary, while the available information does not permit a determination of the degree of stability of Indian as opposed to Ladino marriages, indigenous household heads were more likely to be living in some form of marriage relationship than were the Ladinos. Overall, Ladinos were more likely to have legalized their relationships. In other words, it appears that the form that the marriage takes differs by ethnic group, with Ladinos tending to have civil ceremonies and Indians more likely to be involved in common-law relationships. Much of this difference, however, is a function of class. Indian and Ladino household heads in the middle and upper classes were much more likely to be legally married than their lower-class counterparts.

The household heads' religious affiliation also appears to influence the kind of conjugal bond they established. As noted above, adherence to Protestantism was greatest among those in the lower class (Table 5.1). A much greater proportion of Protestants (24 or 82.8%) as compared to Catholics (140 or 45.6%) were formally married, as the data in Table 5.5 indicate. Those with no religious affiliation were the least likely to have legalized their unions (7 or 31.8%).

Researchers working in El Salvador have used the number of female-headed households as a measure of familial instability. In Asuncion, nearly one-fourth (127 or 24.2%) of the 525 household heads in the census were women. An examination of the census material

Table 5.5.--Religious affiliation and ethnic group of household heads by marital status.

Marital Status	Catholic			Protestant			None			Total					
	Lad.	Ind.	Total	%	Lad.	Ind.	Total	%	Lad.	Ind.	Total	%	Lad.	Ind.	Total
Accompanied	105	62	167	54.4	4	1	5	17.2	6	9	15	68.2	115	72	187
Married	114	26	140	45.6	16	8	24	82.8	4	3	7	31.8	134	37	171
Total	219	88	307	100.0	20	9	29	100.0	10	12	22	100.0	249	109	358

Source: 1978 town census.

indicates, however, that many of these women were widows. This is a qualitatively different form of female headship than that resulting from dissolution of marital bonds. Table 5.6 presents information on the civil status and ethnic group of the female household heads by social class. Over one-third (49 or 38.6%) of the female heads of households were widowed. A small number (9 or 7.1%) of the women were accompanied. They had recently established a relationship with a man who had moved into their house, but due to the newness and tenuous nature of the relationship, they stated that they were the household heads. All of these newly accompanied women had borne children by previous relationships. Over one-third (46 or 36.2%) of the female heads of households in the sample were single with children, and nearly one-tenth (10 or 7.9%) were separated or divorced. Another one-tenth (13 or 10.2%) were single without children. In other words, only half (65 or 51.2%) of the female household heads were single with children, recently accompanied, separated, or divorced and, hence, gave evidence of having experienced a separation.

As might be expected, female-headed households were more common in the lower class. Slightly over three-fourths (97 or 76.4%) of the female heads of households belonged to this class, and only one-fourth (30 or 23.6%) were members of the middle and upper classes.

A number of interesting patterns emerge when the civil status of the female household heads within the two class groupings is considered. Roughly the same proportion of those in the lower class (38 or 39.2%) and those in the middle and upper classes (11 or 36.7%) were

Table 5.6.--Civil status and ethnic group of female household heads by class.

Social Class	Single Without Children		Single With Children		Accompanied		Separated/Divorced		Widowed		Total	
	Lad.	Ind.	Lad.	Ind.	Lad.	Ind.	Lad.	Ind.	Lad.	Ind.	Lad.	Ind.
Lower class (%)	5	2	7	32	1	7	3	28	10	38	69	28
			7.2	41		8		3				97
Middle & upper (%)	6	6	5	5	1	1	7	11	11	38	30	30
			20.0	16.7		3.3		23.3		36.7		100
Total (%)	11	2	13	37	2	7	10	39	10	49	99	28
				46		9		10				127
	11.1	7.1	10.2	37.4	2.0	25.0	10.1	39.4	35.7	38.6	77.9	22.1
				36.2		7.1		7.9				100

Source: 1978 town census.

widowed. A greater proportion of women in the middle and upper classes (6 or 20.0%) than the lower class (7 or 7.2%) were single without children. While middle- and upper-class women had the resources necessary to maintain their own households, women in the lower classes were more likely to have experienced a series of relationships with men who contributed to the household on a temporary or sporadic basis. The data in Table 5.6 show that when household heads in the accompanied, single with children, separated, and divorced categories are considered together, over one-half (52 or 53.6%) of the women in the lower class as opposed to slightly over two-fifths (13 or 43.3%) of those in the middle and upper classes gave evidence of having had a previous relationship which terminated. The form this break-up took reflected the different types of marriage characteristic of the two class groupings. Couples in the middle and upper classes, as noted above, were more likely to have legalized their marriage relationships and, consequently, when these ended they became separated or divorced rather than single. Reflecting the greater number of common-law marriages among the lower class, the majority of women in this class who experienced a broken relationship reverted to calling themselves single.

The information in Table 5.6 also shows that, in Asunción, female-headed households are primarily a Ladino phenomenon. Over three-fourths (99 or 77.9%) of the female heads of households were Ladinas, and less than one-fourth (28 or 22.1%) were Indian. Overall, over one-fourth (26.0%) of the Ladino households in the census were

headed by women, as compared to under one-fifth (19.4%) of the Indian households. All of the indigenous women were members of the lower class. Approximately the same proportion of the two population groups were widowed (39 or 39.4% of Ladinas as compared to 10 or 35.7% of Indians), but more female Indian household heads showed evidence of broken relationships. Close to three-fifths (16 or 57.2%) of the indigenous women were single with children, recently accompanied, separated, or divorced as compared to only one-half (49 or 49.5%) of the Ladinas. Interestingly, however, all except two of the women in the recently accompanied category were Indian. This finding coupled with the finding that fewer female Indian (2 or 7.1%) than Ladino household heads (11 or 11.1%) were single without children suggests that Indian women were less likely to form or be able to maintain households on their own.

Taken as a whole, the above information indicates that female-headed households are more characteristic of the lower than the middle and upper classes and that they are more characteristic of Ladinos than Indians. The finding that Indians were more likely to be involved in some form of marital relationship than were their Ladino counterparts may be attributed to differences in the two populations' socioeconomic situations. The information presented in previous chapters demonstrated that Indian household heads had less education and fewer skills than Ladinos. Indians were less able to compete and, hence, represented a less mobile and more stable community than the Ladinos. The greater tendency to be involved in some form of marital

relationship (accompanied or married) may well have been an outgrowth of these circumstances at the same time that it represented one means to cope with them. The combining of resources by spouses and other household members constitutes a way of dealing with restricted economic opportunities (Smith 1984, Dieter Evers, Clauss, and Wong, 1984). The greater tendency for the indigenous population to be involved in conjugal relationships, then, may result from the combined effects of a relatively stable community and greater economic marginality.

Household Organization

Relatively little information on household organization exists for Ladino or mestizo populations in Middle America. Nutini, for example, states that most sources:

. . . are fragmentary (that is, they do not contain information in all the major traditional categories of analysis in marriage and the family) and not infrequently superficial and impressionistic. Statistical and census data are conspicuously absent. In a few cases we are presented with only samples (and one may wonder what prevented the investigator from getting complete censuses, say, of the population or households, especially since they were sometimes dealing with small populations of less than 1,000 individuals and 150 to 200 households); while in the majority of cases there is no quantitative information at all (1967: 384).

Although Kendall (1978) notes that some of these gaps have been addressed since the publication of Nutini's article, he nonetheless concurs with the findings. Sources of general information on domestic organization in El Salvador include Marroquín (1974), White (1969, 1973), Durham (1979), and Nieves (1979). Kendall (1978) has studied a Ladino village in the Municipality of Esquipulas in eastern Guatemala,

which, because it is located in the same general region as Asunción, serves as another source of comparison.

Two clarifications are necessary before reviewing the information on household composition in the town. First, following Solien (1971), Nieves (1979), and others, a distinction is drawn between the household and the family. The unit of analysis under consideration here is the household, or group of co-resident individuals who share responsibilities for domestic maintenance. Second, an often neglected issue concerns the locus or distribution of authority within households. Households with the same kin composition can be classified differently depending on where authority rests. For example, a unit composed of a male head, spouse, children, and the household head's father could be considered extended if the locus of authority rested with the elder parent. It also could be considered as a variety of a nuclear family, however, if decision-making powers had passed to the son. The procedure adopted in this study was to use the household head, as defined by the residents themselves, as the reference point in discussing household organization.

In analyzing the census data, five household types were identified: single person households; households that consisted of a head and a relative (other than a child of the household head) of the collateral, ascending, or descending generation; nuclear family households consisting of three basic subtypes--a head and children (plus an additional relative if any other than a spouse), a head and spouse (plus an additional relative if any other than children) and a

head, spouse and children (plus another relative, if any); extended family households composed of two or more nuclear families or fragments thereof related lineally or collaterally or in a composite fashion; and a group of nonrelated people. Appendix B contains a list of kin included in these household types, together with their frequency of occurrence.

This classificatory framework was more appropriate for the context than other existing ones. The classificatory system developed by Hammel and Laslett (1974), and relied on in part by Kendall (1978), groups all nuclear family households with other resident kin into the extended and multiple family categories. In Asunción, and in other Salvadoran contexts, although the nuclear family household is the preferred type, household composition is fluid and many nuclear families take in additional kinsfolk on a temporary or permanent basis. The presence of an elderly grandmother, nephew, or aunt in these households, however, does not alter their fundamentally nuclear character. Further, as Kendall (1978) has pointed out, Hammel and Laslett's typology overlooks the significance and hides the existence of female-headed households.

Table 5.7 shows the distribution of household types by social class and ethnic group for the 520 cases for which complete information was available. Only three (.6%) households consisted of unrelated people. In addition, there were very few single person households (23 or 4.4%) or households composed of a single person plus another kinsperson (27 or 5.2%). Over two-thirds (361 or 69.4%) of

Table 5.7.--Household composition and ethnic group by class.

Social Class	Single-Person Household			Household Head & Adjunct Relative			Nuclear Family			Extended Family			Group of Nonrelated People			Total		
	Lad.	Ind.	Total	Lad.	Ind.	Total	Lad.	Ind.	Total	Lad.	Ind.	Total	Lad.	Ind.	Total	Lad.	Ind.	Total
Lower class	10	7	17	19	19		136	87	223	47	29	76	1	1	2	213	124	337 ^a
% total			5.0			5.6			66.2			22.6			.6			100
% Lad. & Ind.	4.7	5.6		8.9			63.8	70.2		22.1	23.4		.5	.8		100	100	
Middle & upper class	6	6		7	1	8	124	14	138	26	4	30		1	1	163	20	183 ^b
% total			3.3			4.4			75.4			16.4			.5			100
% Lad. & Ind.	3.7			4.3	5.0		76.0	70.0		16.0	20.0			5.0		100	100	
Total	16	7	23	26	1	27	260	101	361	73	33	106	1	2	3	376	144	520
% total			4.4			5.2			69.4			20.4			.6			100
% Lad. & Ind.	4.3	4.9		6.9	.7		69.1	70.1		19.4	22.9		.3	1.4		100	100	

Source: 1978 town census.

^aTotal does not equal 339 because information on two Ladino households is missing.^bTotal does not equal 186 because information on three Ladino households is missing.

the households were nuclear and one-fifth (106 or 20.4%) were extended.

Within the nuclear category, as the data in Table 5.8 show, over half (192 or 53.2%) of the households consisted of a head, spouse, and children. An additional one-fifth (65 or 18.0%) were of the same basic composition but had additional relatives present. In other words, simple nuclear families with and without other kin represented well over two-thirds of the households in the nuclear category and half (257 or 49.4%) of all households in the census sample. A small proportion of the nuclear households were made up of conjugal pairs (18 or 5.0%) and conjugal pairs plus additional kinspeople (23 or 6.4%). Another small proportion consisted of a head plus his or her children (47 or 13.0%) or a head, children, and additional relatives (16 or 4.4%). Hence, in nearly one-fifth (63 or 17.4%) of the nuclear family households one spouse was missing.

When class variations were considered, it was found that middle- and upper-class households were more likely to be nuclear in composition than were households in the lower class (Table 5.7). Among the 337 households in the lower class, two-thirds (223 or 66.2%) lived in some form of nuclear family as compared to three-fourths (138 or 75.4%) of households in the middle and upper classes. While roughly the same proportion of the nuclear families in the lower class (64 or 28.7%) and in the middle and upper classes (40 or 28.9%) had other relatives living with them, more nuclear families in the lower class were missing a spouse. One-fifth (48 or 21.5%) of those in the

Table 5.8.--Nuclear family types by ethnic group and class.

Social Class	Conjugal Pair (A)		Conjugal Pair & Children (B)		Incomplete Nuclear Family (C)			Total					
	a	%	A/1	%	B	%	B/1		%	C	%	C/1	%
<u>Lower class</u>													
Ladino	4		8		69		17		25		13		136
Indian	7		5		46		19		8		2		87
Total	11	4.9	13	5.8	115	51.6	36	16.2	33	14.8	15	6.7	223
<u>Middle & upper class</u>													
Ladino	6		9		68		26		14		1		124
Indian	1		1		9		3						14
Total	7	5.1	10	7.2	77	55.8	29	21.0	14	10.2	1	.7	138
<u>Total</u>													
Total	18	5.0	23	6.4	192	53.2	65	18.0	47	13.0	16	4.4	361
Total category	41 (11.4%)				257 (71.2%)				63 (17.4%)				361

Source: 1978 town census.

^aA--Household head and spouse; A/1--Household head, spouse, and other relative(s); B--Household head, spouse, and children; B/1--Household head, spouse, children, and other relative(s); C--Household head and children; C/1--Household head, children, and other relatives.

lower class and only one-tenth (15 or 10.9%) of those in the middle and upper classes were composed of a household head and children or a household head, children, and another relative.

Of the remaining households in the lower class, over one-fifth (76 or 22.6%) were extended and over one-tenth (38 or 11.2%) consisted of a single person or a head plus a relative. In the middle and upper classes, a smaller proportion of the households was extended (30 or 16.4%) or was made up of a single individual or a head plus a relative (15 or 8.2%).

To summarize, nuclear families predominated in both class groupings representing over two-thirds of the households in the lower class and three-fourths of those in the middle and upper classes. There were more extended-family households and more households missing spouses in the lower class.

Ethnicity does not appear to be an important variable in household composition. As the information in Table 5.7 indicates, roughly the same proportion of Indians and Ladinos lived in nuclear and extended family households. Slightly over two-thirds of the Indian households (101 or 70.1%) were nuclear as were over two-thirds of the Ladino households (260 or 69.1%). Approximately one-fifth of the Ladino (73 or 19.4%) and of the Indian households (33 or 22.9%) were extended. Within the nuclear family category, however, Ladino households were most likely to be missing a spouse. One-fifth (53 or 20.4%) of the 260 Ladino nuclear families were missing a spouse,

compared to only one-tenth (10 or 9.9%) of the Indian nuclear families.

Few ethnic differences were noted within the two social class groupings. The same proportion of Indian and Ladino families in the lower class lived in nuclear and extended households, while in the middle and upper classes more Ladinos than Indians lived in nuclear families and a slightly greater proportion of Indians lived in extended families. Extended family households were reported to once have been the norm among the Indian population (De Guevara 1975). The finding that the same proportion of Indians and Ladinos in the lower class lived in nuclear families may be an indication of the fragmenting effects of the social and economic trends outlined in previous chapters on the Indian community. It is also possible, however, that the manner in which the census was taken (visits to every fourth household) obscured the number of family compounds and, hence, resulted in an under-enumeration of Indian extended households.

This overview of marital status and household composition permits discussion of the adaptive value of the various kinds of household organization found in Asunción. Nieves (1979) has suggested that among urban shantytown dwellers in San Salvador, certain forms of household composition contribute more than others to their members' well-being. Using the type of bond relating household members as the basis for classification, she identified two major household types: affinal households whose members were related through marriage and consanguineal households whose members were related by descent.

Nuclear and extended family households with males present are examples of the affinal type, while those composed of a group of sisters and their children or a mother, her daughters, and grandchildren represent the consanguineal type. In Nieves's analysis, the key element in defining a consanguineal household is the absence of a male in the husband-father role. In essence, then, she uses this term to refer to female-headed or -centered households.⁴

Nieves argues that these households are more adaptive in their structure and can change their composition more easily than can affinally based ones:

A household group whose members are recruited on the basis of kinship has a greater capacity for internal modification than a household group formed around the ties of affinity of one or more couples, at least in societies which do not practice polygamy. Kinship ties can be filled with any number of individuals in different capacities, while ties of affinity can be filled only with one individual at a time. When the household group is organized around father, mother and unwed children it is difficult, although not impossible, to add new members to the group. The modifications of the consanguineal household group are more viable and less complicated. The consanguineal household group has the capacity, for example, to absorb immigrant relatives, since its limits are less bound and its composition loosely defined (1979: 140).

Hence, she claims that consanguineal households are well-suited to the needs and lifestyles of the poor, especially poor women:

Cross-cultural information seems to indicate that consanguineal household groups enable socially and economically marginal people to adapt to an urban environment. In great measure, the adaptability of these groups derives from the fact that their women can fulfill their roles of mothers, housewives, and providers simultaneously. The consanguineal household allows them the flexibility, mobility and freedom to participate in the urban labor force and so contribute to the maintenance of the household group itself without neglecting their maternal responsibilities (1979: 142).

Nieves conducted a study of 197 mestizo households in San Salvador to examine these propositions. The investigation revealed that one-fifth (41 or 20.8%) of the study households were consanguineal and four-fifths (156 or 79.2%) were affinal. She identified four varieties of consanguineal household: single women with children (12 or 29.3% of the consanguineal households), those composed of two or more consanguineally related women with children (11 or 26.8%), households consisting of two or more consanguineally related women with children and an elder couple (6 or 14.7%), and those with two or more consanguineally related women with children and adult men consanguineally related to the adult women (12 or 29.3%) (1979: 138).

Two points can be made regarding this study. First, because the sample was drawn exclusively from the lower class, it was not possible to determine if consanguineal households were indeed more prevalent among the lower than the middle or upper classes. Second, given Nieves's argument in favor of the advantages of consanguineal households, the finding that only a small proportion of the sample lived in such arrangements is somewhat surprising. As she acknowledges, other forms of household organization also must present advantages.

Nieves suggests that consanguineal households free women to become economically active and, hence, enhance the well-being of their members. Kendall advances a somewhat similar argument. He suggests that female-headed households are more flexible, showing a greater diversity of domestic organization than male-headed households. This flexibility is a result both of the kinds of options available to

women in household formation and of the need for support entailed by female headship. Kendall provides information on female-headed household types in San Isidro, a small Ladino village in eastern Guatemala. Somewhat under one-fifth (16 or 16.2%) of the 99 households in the village were headed by women. Employing Hammel and Laslett's typology, but taking gender into account, he reported that these households were distributed over five basic household types and that they formed the major portion of three types: the single person, no family, and multiple family categories. Male-headed households, in contrast, were found in only four of the five categories and were concentrated especially in the single family type (Table 5.9). Kendall concluded that in order to be economically viable, female-headed households pursued more varied strategies of domestic organization and that the differences among female-headed households, therefore, were greater than among male-headed households (1978: 139).

The Asunción data provide an opportunity to examine Nieves's and Kendall's arguments concerning the adaptive character of these households in a context in which both class and ethnicity can be taken into account. If consanguineal households are defined as those where there is no regularly present male in the husband/father role, they constituted approximately one-fourth (127 or 24.2%) of the households in the sample. The first point of interest, as noted previously, is that the female household heads were concentrated in the lower class and that the majority were Ladinas (Table 5.6).

Table 5.9.--San Isidro, Guatemala, female-headed households by type and percentage of category.

Type	Female Headed Households			Male-Headed Households		
	No.	% of Total Female-Headed Households	% of Total Category	No.	% of Total Male-Headed Households	% of Total Category
Solitaires	2	12.5	100.0			
No family	2	12.5	66.0	1	1.2	33.3
Single family households	6	37.5	8.3	66	79.5	91.7
Extended family households	4	25.0	23.5	13	15.7	76.5
Multiple family households	2	12.5	40.0	3	3.6	60.0
Total	16	100.0		83	100.0	

Source: Adapted from Kendall (1978: 136, 138).

Information on the composition of 125 of these households was obtained and is presented in Tables 5.10 and 5.11. Relatively few women lived alone (12 or 9.6%) or with only one other relative (15 or 12.0%). Most lived in a nuclear or extended family arrangement. Nuclear households were the most prevalent (57 or 45.6%), followed by extended households (41 or 32.8%). The data in Tables 5.10 and 5.11 also show that, similar to Kendall's finding, female-headed households were not distributed evenly over the five household types. Rather, they constituted over half of both the single person households (12 or 52.2%) and those composed of a head plus another kinsperson (15 or 55.6%). They also made up over one-third (41 or 38.7%) of the extended family households.

Some differences by class and ethnicity existed (Table 5.11). While the same proportion of the female-headed households in the two class groupings was nuclear (44 or 45.8% in the lower class as compared to 13 or 44.8% in the middle and upper classes), households in the lower class were more likely to be extended than were those in the middle and upper classes. Middle- and upper-class women, on the other hand, were more likely to live with another kinsperson. Only one-tenth (9 or 9.4%) of lower-class female household heads lived in this type of arrangement as compared to one-fifth (6 or 20.7%) of the middle- and upper-class women.

All female-headed Indian households were situated in the lower class. These women were more likely to live in extended family arrangements than were their Ladina counterparts. Overall, very few

Table 5.10.--Asunción, El Salvador, female-headed households by type and percentage of category.

Type	Female-Headed Households			Male-Headed Households		
	No.	% of Total Female-Headed Households	% of Total Category	No.	% of Total Male-Headed Households	% of Total Category
Single person household	12	9.6	52.2	11	2.8	47.8
Household head & other kin	15	12.0	55.6	12	3.0	44.4
Nuclear family household	57	45.6	15.8	304	77.0	84.2
Extended family household	41	32.8	38.7	65	16.5	61.3
Group unrelated people				3	.7	100.0
Total	125	100.0		395	100.0	

Source: 1978 town census.

Table 5.11.--Household composition and ethnic group of female household heads by class.

Social Class	Single Person			Household Head & Other Relative(s)			Nuclear Family			Extended Family			Total		
	Lad.	Ind.	Total	Lad.	Ind.	Total	Lad.	Ind.	Total	Lad.	Ind.	Total	Lad.	Ind.	Total
Lower class (%)	7	2	9	9	9	9	30	14	44	22	12	34	68	28	96
			9.4			9.4			45.8			35.4			
Middle & upper (%)	3	3	10.4	6	6	12	13	13	26	7	7	14	29	29	29
class			10.4			20.7			44.8			24.1			
Total (%)	10	2	12	15	15	30	43	14	57	29	12	41	97	28	125 ^a
	10.3	7.1	9.6	15.5	15.5	12.0	44.3	50.0	45.6	29.9	42.9	32.8	100	100	100

Source: 1978 town census.

^aTotal does not equal 126 because information on one Ladina and one Indian female household head is missing.

Indian women lived alone or with another relative. Most, in fact, lived in nuclear or extended families. More than nine-tenths (26 or 92.9%) of the Indian women lived in these arrangements as compared to three-fourths (72 or 74.2%) of the Ladinás.

This pattern of lower-class women, especially lower-class indigenous women, living in nuclear and extended family arrangements is in accord with the information presented earlier concerning their marginal economic circumstances. Women in the two class groupings had access to very different resource bases. To manage, lower-class households headed by women needed to draw on, or combine, resources from a variety of sources. These included the income and household labor of their grown children, grandchildren, and other relatives. Middle- and upper-class women, on the other hand, could afford to maintain their own homes on an independent basis. They frequently resided with another relative, often a brother or sister, grandchild, or mother. When grown, the children of these middle- and upper-class women usually married and maintained separate households and, hence, these women were much less likely than those in the lower class to have single daughters and their children living with them.⁵

This information indicates that consanguineal or female-headed households are found in all social classes, but the composition of these households varies by class, with those in the lower class more likely to be nuclear or extended and those in the middle and upper classes more likely to consist of women living alone or with a kinsperson other than their children.

Although households headed by women are found among both class groupings, the Asunción data do confirm that they are a predominantly lower-class phenomenon. Adopting a functionalist perspective, Nieves argues that this household structure best contributes to the members' well-being. The information presented here, however, suggests otherwise. Although consanguineal households may represent a survival strategy allowing women in the lower class to combine work and domestic responsibilities, they are not a means to take advantage of economic opportunity so much as an outgrowth of the lack of opportunity.

This argument is buttressed by the finding that consanguineal households are, in fact, only one among a range of household types characteristic of the lower class. Affinally based households (nuclear and extended households where there is a husband/father present) are much more common, representing almost two-thirds (221 or 65.6%) of the lower-class sample. Perhaps more important, male-headed nuclear households did not appear to have the difficulty Nieves suggests in adding members. Over a fourth (88 or 28.9%) of the 304 male-headed nuclear families had other kin residing with them. Forty-nine of these were members of the lower class, and 39 were in the middle and upper classes. Finally, over one-tenth (42 or 12.5%) of the households in the lower class were affinally based, extended families that also incorporated other kin.

Taken as a whole, this suggests that Nieves's thesis regarding the well-being and greater benefits conferred by consanguineal

households in lower-class urban settings needs tempering. As the Asunción findings indicate, there is considerable diversity in the domestic organization of female-headed households, with both class and ethnicity playing a role in this variation. Further, female-headed households are only one among a range of household organizational forms that the lower class employ to survive. Although female-headed households are more common among the lower than the middle and upper classes, here, as was the case in the shantytowns in San Salvador, affinally related households were the major type. The Asunción data indicate that nuclear or extended, male-headed households, are not as inflexible as Nieves suggests. A high percentage of them contained additional kinspeople. In addition, the information on the most marginal segment of the population in Asunción, the lower-class, indigenous population, indicated that they were not as likely as their Ladino counterparts to live in consanguineal households. There was a smaller proportion of households headed by women in this ethnic group than among the Ladinos. Lower-class Indian women appeared, instead, to practice a form of serial monogamy that assured the presence of a male as a contributor to the household.

Conclusion

The information presented in this chapter indicates that very real differences exist between the two class groupings with regard to civil status and household composition. A higher proportion of the household heads in the middle and upper than in the lower class were legally married, and more of them lived in nuclear households.

Although female headship did occur in the middle and upper classes, it was not as prevalent as in the lower class and was associated with a different kind of household composition. Unmarried middle- and upper-class women were financially more capable and more likely than women in the lower class to live in their own homes with perhaps an additional kinsperson to keep them company.

The situation confronting those in the lower class was very different. A greater proportion of household heads in this class lived in common-law marriages. (The exception here were the Protestant household heads, a majority of whom were legally married.) As the high number of female-headed households indicates, those in the lower class were also more likely to have experienced a break-up of their marriages. The most prevalent form of family organization was nuclear, although there were more extended households and households where a spouse was missing than was the case in the middle and upper classes.

The findings on the relationship between ethnicity, civil status, and household organization are in keeping with the information presented in previous chapters. The majority of the Indians in the sample were members of the lower class, and their most prevalent kinds of marital relationships and household composition corresponded with their marginal position, as an ascriptive class segment, within this class. Overall, a greater proportion of them than of the Ladinos were married at the time of the interview. These marriages tended to be common-law unions. Although there were fewer female-headed households

among the Indian population, a greater proportion of them than the Ladinos showed evidence of having experienced marriages that had terminated. Thus, the greater tendency toward unstable marriages among the Indians reflected their more marginal social and economic positions compared to their Ladino counterparts. At the same time, however, this increased marginality resulted in a need to combine resources and, overall, led to a greater involvement in marital relationships. Hence, economic parameters were reinforced by and helped perpetuate sociocultural ones.

This information on the resource base and types of household composition by class and ethnic group sets the stage for a consideration of health status and the use of medical resources in the chapters that follow.

MICHIGAN STATE UNIV. LIBRARIES



31293000837223

10-1-92

v.2





RETURNING MATERIALS:

Place in book drop to
remove this checkout from
your record. FINES will
be charged if book is
returned after the date
stamped below.

~~Feb - 1970~~
Feb - 1970

PART II

CHAPTER VI

HEALTH STATUS AND THE USE OF MEDICAL RESOURCES

In Part I, attention focused on the class structure and forms of domestic organization in Asunción resulting from an interaction between forces emanating from the wider political economy and from the town itself. Part II extends this analysis of macro/micro relationships to the health field. It begins with a critique of the ideational paradigm frequently employed in medical anthropological investigations to explain health-related behavior. Information on the health status of Asunción's population is then presented. Records from the government health center and from the death registry as well as the results of an illness episode survey are reviewed. This is followed by an examination of the organization of the medical sector and the use of medical resources by the social classes.

Throughout these discussions, particular attention is paid to the implications of class and ethnic differences in household organization for health status and health-seeking behavior. Thus, households are viewed as nexus points where social, economic, and cultural influences are translated into actions that directly impinge on the health status of the members.

Medical Anthropological Paradigms

Young's (1981) monograph on medical decision making in Pichataro, Mexico, serves as an example of the theoretical orientation and the concerns that characterize much of the medical anthropological research on Meso- and Middle America. He begins by providing an overview of recent health-care utilization studies, identifying two dominant orientations, or paradigms, in this literature. The first is the ideational paradigm in which culture, defined as a system of knowledge, provides the primary explanation for beliefs and practices. Representative works in this tradition are numerous, some recent examples being those by Janzen (1978b) and by Young himself (1981). The second orientation in the literature is the correlational paradigm. Here single variables, or classes of them, are posited to explain aggregate data on treatment choices. Two major variants of this tradition exist: One emphasizes the characteristics of the illnesses taken to treatment resources (Erasmus 1952, Foster 1958, Simmons 1955); the second focuses on the characteristics of the people using each alternative (K. DeWalt 1977, Press 1969, Woods and Graves 1973).

Young claims that the correlational paradigm fails to provide a truly cultural explanation of medical choice. In his study of Pichátaro, he examined the effects of shared beliefs on health-care actions and provided a decision-making model that accounted for differential use of medical resources. Pichátaro is presented as a relatively homogeneous community where, although there are differences

in access to resources and in standards of living, villagers share beliefs, values, and understandings regarding illness. The concept of marginality is used to explain this homogeneity of culture. The community is characterized as occupying a peripheral position in relation to the concentration of wealth and decision making in Mexico. In Young's view, it is not differential access to resources within the community as much as the community's marginal position vis-à-vis the centers of power that explains health-related behaviors and beliefs. Thus, similar to the work of the early dependency school researchers discussed in Chapter I, Young relies on a geographical rather than a class analysis.

Relatively isolated and homogeneous communities that have a uniform culture are increasingly uncommon in Mexico and Central America. More frequently, the development process has resulted in growing stratification which undermines the cultural homogeneity Young describes. Part I of this study has outlined elements of this process in Asunción. Since the turn of this century, and especially since 1932, the town has undergone a steady process of change that cannot be grasped through the concept of an increase or decrease in the marginality of the town as a whole. Instead, households within Asunción have been differentially affected by changes in the larger political economy. As the analysis in this chapter will demonstrate, this process of change has implications for health status, health beliefs, and actions.

Health Status: Methodological Considerations

Information on health status was gathered from two sources. The first was a review of town records: the 1978 municipal registry of deaths and the January and May 1979 morbidity records from the government health center. The second was an illness episode survey conducted with a stratified sample of households.

While the health center and municipal records do provide an overview of the population's health status, each set of records has certain limitations. The death registry included the names of those who died in Asunción itself and in the surrounding rural cantons. As is often the case in developing countries, many infants' deaths were not reported, especially if they died before being baptized. Further, when confronted by serious illness, wealthy townspeople sought care in Sonsonante or San Salvador. Their deaths, when they occurred, were usually recorded in these locations.

The reported cause of death was another area of concern. Very few deaths in the municipality were attended by a physician. For example, in only one-tenth (24 or 11%) of the 220 deaths in 1978 was the deceased under the care of a doctor. In most cases, the cause of death listed in the registry represented the family's own interpretation. The recording process, which took place at the mayor's office and included one or more relatives of the deceased and the municipal secretary, often involved negotiation. The family presented their interpretation of the cause, usually listing symptoms. The secretary then provided what he regarded as an acceptable illness label.¹

The health center morbidity records presented another set of problems. As noted in Chapter II, the Ministry of Public Health and Social Assistance operates medical facilities throughout the country which provide care free of charge for those who cannot afford to pay. The health posts (puestos de salud) are located in villages and rural areas. Usually, these are open only once or twice a week, although some are staffed on a regular basis by a nurse. The larger outreach facilities run by the Ministry are the health centers (centros de salud). These may be staffed by a medical student completing the required year of social service, nurses, and sometimes a dental assistant or student. Health centers frequently are open a number of hours every day except Sundays and holidays. The Asunción facility followed this pattern. It included a medical student, a local physician who worked on a half-time basis, three nurses, a dental assistant, a public health inspector, and secretaries.

Although the health centers had larger staffs and were open on a more regular basis than the health posts, both were usually understaffed and lacked the necessary equipment and medications to function effectively. The health center in Asunción, for example, had long lines of patients, frequently ran short of medications, and had no laboratory or x-ray facilities.

Perhaps more important, however, treatment was not available to everyone who visited the clinics. The doctors had a quota of patients to see on a daily basis, and priority was given to children and women

of child-bearing age. Table 6.1 presents information on the age and sex of patients seen at the Asunción health center during the months of January and May 1979. These months were selected for recording because it was anticipated that the prevalence of disease would vary. January is the dry season and the period when more cash is available as a consequence of wages earned in the coffee harvest. May, at the beginning of the rainy season, presents fewer opportunities for wage labor, and the living standards of many households are lower than in January. At the clinic during these two months, children under the age of five accounted for over half (877 or 53.0%) of the clients, and women between the ages of 15 and 44 years represented another one-fourth (390 or 26.8%) of the clients. In fact, of the 443 people between the ages of 15 and 44 seen at the center, nearly nine-tenths (390 or 88.0%) were women.

In other words, clinic priorities were directed to family planning and well-baby efforts. Older children and men received attention only if clinic time allowed. As the doctors' quotas were usually exhausted in treating the priority patients, many were turned away. Although a study of donor agencies' contributions to the public health-care sector in El Salvador was not undertaken, certain agencies such as U.S.A.I.D. placed emphasis on well-baby and family planning programs, and it is likely that they influenced the health-care priorities of the Salvadoran Ministry of Health. This policy of giving priority to women of child-bearing age and to young children may better account for men's low use rates than do culturalological

explanations concerning males' presumed hardiness or their tendency to ignore illness.

Table 6.1.--Age and sex of patients at the Asunción health center, January and May 1979.

Age of Patient	Males	Females	%	Cumulative %	Total
0-11 months	227	190	25.2	25.2	417
1-4 years	212	248	27.8	53.0	460
5-9 years	54	61	6.9	59.9	115
10-14 years	29	51	4.8	64.7	80
15-24 years	31	130	9.7	74.4	161
25-34 years	13	157	10.3	84.7	170
35-44 years	9	103	6.8	91.5	112
45-54 years	17	45	3.8	95.3	62
55-64 years	18	22	2.4	97.7	40
65-74 years	13	11	1.4	99.1	24
75 years +	3	12	.9	100.0	15
Total	626 37.8%	1,030 62.2%	100.0		1,656 100.0%

Source: Asunción health center records.

The overall effect of this structure was that only the very poorest segments of the population used the health center and then only certain categories of these clients, women and children, were likely to receive treatment. Observations at the Asunción health center and a review of the records indicated that very few townspeople used the facility. Most users were from rural areas. For example, of the 1,656 consultations made during January and May 1979, three-fifths

(1,002 or 61%) were campesinos (rural dwellers) from the surrounding cantons, and only two-fifths (654 or 39%) were urbanites.²

In summary, Asunción's health center records and death registry did not cover all social classes, but instead provided information primarily on the poor rural population in the municipality.

To gain a better overview of health status in the town, an illness episode survey was conducted over a four-month period between January and May 1979.³ A stratified sample of 84 households was selected randomly from the three social classes identified in the census and asked to participate in the survey. Twelve either refused to participate or had moved and could not be located. A total of 72 households took part in the survey: 38 from the lower class and 34 from the middle and upper classes. The wife or companion of the household head or, in cases where the household head was a single male or female, the household head, was interviewed initially once every two weeks and then once a month. They were questioned concerning the illnesses experienced by household members and sources of care used during the two weeks preceding the visit.

The information on health status gathered from the municipal death registry, clinic records, and the illness episode survey will now be reviewed.

Health Status: An Overview

The registry of deaths provided information on the deceased's place of residence, age, and cause of death. For the purposes of

analysis, the causes of death were grouped into nine categories: gastro-intestinal disorders, respiratory disorders, deaths due to fevers and other infectious processes, old age, cardio-vascular problems, trauma, childbirth and neonatal tetanus, other causes, and unknown processes.

Most deaths resulted from the diseases of poverty, infectious processes that could be prevented with an improvement in living standards and access to medical care. The data in Table 6.2 indicate that the three leading causes of death in 1978 were gastro-intestinal disorders, upper respiratory disorders, fevers, and other infectious processes. These accounted for half (110 or 50%) of the deaths in the municipality, and nearly three-fourths (81 or 73.6%) of those who died were children under the age of five. The percentages of deaths in these categories considerably exceeded the national averages presented in Table 2.1 and indicate that health standards and living conditions in this municipality were very poor.

Information from the health center confirms this finding. The January and May 1979 records were examined to determine the leading causes of consultation. Table 6.3 shows the distribution of illnesses during these months.⁴ The three leading reasons for consultation were upper respiratory disorders representing two-fifths (665 or 40.2%) of the cases, gastro-intestinal disorders comprising one-fifth (363 or 21.9%) of the cases, and uro-genital disorders representing over one-tenth (245 or 14.8%) of the consultations. In all, over three-fourths (1,273 or 76.9%) of the patients were treated for these conditions.

Table 6.2.--Causes of death in Asunción, January-December 1978.

Cause of Death	0-11 Months	1-4 Years	5-9 Years	10-14 Years	15-24 Years	25-34 Years	35-44 Years	45-54 Years	55-64 Years	65-74 Years	75+ Years	Total	
												No.	%
Gastro-intestinal disorders	26	8	1		1	2			1	3	6	48	21.8
Upper respiratory disorders	20	6			1	1	1				2	31	14.1
Fevers and other infectious processes	8	13	2		1				4	1	2	31	14.1
Old age								1	1	4	24	30	13.6
Cardio-vascular disorders							4	7	2	7	9	29	13.2
Trauma		1		1	6	7	3	4			1	23	10.4
Childbirth and neo-natal tetanus	9				1		2					12	5.5
Other causes	1					1	2	1	1	3	3	12	5.5
Unknown causes	1	1							1	1		4	1.8
Total	65	29	3	1	7	11	14	14	10	19	47	220	100.0
%	29.5	13.2	1.3	.5	3.2	5.0	6.4	6.4	4.5	8.6	21.4	100	

Source: Asunción municipal records.

Table 6.3.--Reasons for consultation at the Asunción health center,
January and May 1979.

Diagnosis	January		May		Total	
	No.	%	No.	%	No.	%
Upper respiratory infections	320	38.8	345	41.5	665	40.2
Gastro-intestinal infections	188	22.8	175	21.1	363	21.9
Uro-genital infections	124	15.0	121	14.6	245	14.8
Malnutrition	51	6.2	44	5.3	95	5.7
Dermatological disorders	39	4.7	39	4.7	78	4.7
Trauma	31	3.8	27	3.2	58	3.5
Chronic conditions & congenital defects	25	3.0	22	2.6	47	2.8
Other infectious processes	22	2.7	33	4.0	55	3.3
Psychological disturbances	14	1.7	7	.8	21	1.3
Cardio-vascular & neurological disorders	6	.7	9	1.1	15	.9
Other conditions	5	.6	9	1.1	14	.9
Total	825	100.0	831	100.0	1,656	100.0

Source: Asunción health center records.

The remainder were diagnosed as suffering from malnutrition, dermatological disorders, trauma, chronic and congenital conditions, other infectious processes, psychological disturbances, cardio-vascular disease, and other conditions.

Malnutrition was a more serious problem than the information in Table 6.3 suggests. Most cases were not brought to the attention of medical authorities unless the child became ill from another condition. In addition, the two physicians at the health center employed different diagnostic criteria. The medical student listed malnutrition as a primary diagnosis only if he could find nothing else wrong with the child. The physician, in contrast, frequently cited this as a primary diagnosis. When both primary and secondary diagnoses were considered, over one-third (301 or 34.3%) of the 877 children under five years of age were found to be suffering from some level of malnutrition (Table 6.4).⁵

Almost no differences were discovered in the prevalence or distribution of illnesses during January and May, although there was a slight increase in upper respiratory complaints in May (Table 6.3). In both months, the three leading causes of consultation were upper respiratory conditions, gastro-intestinal disorders, and uro-genital complaints. The lack of difference between the dry and wet seasons may be attributed, at least in part, to factors outlined above concerning clinic priorities in treating patients. Nevertheless, as the information from the illness episode survey suggests, upper

Table 6.4.--Cases of malnutrition in children 0-4 years of age, January and May 1979.

Grade of Malnutrition	January 1979			May 1979			Total	
	Prim.	Sec.	Total % All Children (411)	Prim.	Sec.	Total % All Children (466)	No. Children (877)	% All Children (877)
Grade I	34	60	94	25	78	103	197	22.5
Grade II	10	15	25	12	45	57	82	9.4
Grade III	7	4	11	7	4	11	22	2.5
Total	51	79	130	44	127	171	301	34.3

Source: Asunción health center records.

respiratory complaints were a major cause of illness in the town regardless of the season.

A total of 209 illnesses were reported in the course of the illness episode survey. When these are grouped into categories, the overall distribution, as indicated in Table 6.5, is similar to that found at the health center. In both cases, the two leading complaints were upper respiratory and gastro-intestinal disorders. Upper respiratory disorders by themselves accounted for nearly one-half (102 or 48.8%) of the illnesses reported in the survey. The second and third most frequent illness categories were gastro-intestinal disorders and rheumatic, head, and other body aches, which accounted for one-fourth (52 or 24.8%) of the cases. Following these in descending order were other infectious processes, psychological complaints, dermatological and eye irritations, trauma, uro-genital disorders, cardio-vascular disorders, and other illnesses.

In contrast to the clinic records, the illness episode survey results can be disaggregated by class and ethnic group. A number of differences in the prevalence of illnesses were found between the lower class and the middle and upper classes. As the data in Table 6.5 indicate, the percentage of upper respiratory infections was the same in the two groups. Nearly half the illnesses in the lower class (61 or 48.8%) and in the middle and upper classes (41 or 48.8%) fell into this category. A wide range of illness terms and symptoms were used to describe these conditions. The most frequent were chest and

Table 6.5.--Class differences in reported illnesses.

Illness Categories	Lower Class		Middle & Upper Classes		Total Illnesses Reported	
	No.	%	No.	%	No.	%
Upper respiratory disorders ^a	61	48.8	41	48.8	102	48.8
Gastro-intestinal disorders	23	18.4	8	9.5	31	14.8
Rheumatic, head, and other body aches	13	10.4	8	9.5	21	10.0
Other infectious processes	9	7.2	2	2.4	11	5.3
Psychological complaints	3	2.4	8	9.5	11	5.3
Dermatological and eye irritations	4	3.2	5	5.9	9	4.3
Trauma	2	1.6	4	4.8	6	2.9
Uro-genital disorders	3	2.4	1	1.2	4	1.9
Cardio-vascular disorders	2	1.6	2	2.4	4	1.9
Nutritional disorders	2	1.6	1	1.2	3	1.4
Others ^b	3	2.4	4	4.8	7	3.4
Total	125	100.0	84	100.0	209	100.0

Source: Illness episode survey.

^aEleven people, three Ladinos and five Indians in the lower class and three Ladinos in the middle and upper classes, reported a combination of upper respiratory and gastro-intestinal disorders. These were tabulated under the major complaint headings.

^bIncluded here were appendicitis, exhaustion, toothaches, and nosebleeds.

head colds. (Appendix C contains a list of the terminology used in reporting conditions.)

Gastro-intestinal disorders were the second leading cause of illness in the lower class and in the middle and upper classes, although these conditions were much more common among lower-class households than among the middle- and upper-class ones. They represented nearly one-fifth (23 or 18.4%) of the conditions in the lower grouping but only one-tenth (8 or 9.5%) of those in the middle and upper classes. Most commonly reported were stomach aches and diarrhea.

Rheumatic, head, and other body aches represented the third major complaint in the lower class. These occurred with almost equal frequency in the middle and upper classes. One-tenth (5 or 10.4%) of the illnesses in the lower class and one-tenth (8 or 9.5%) of those in the middle and upper classes fell into this category. A wide range of body aches were found, many of them associated with the aging process.

Psychological complaints, commonly referred to as nerves (nervios), occurred with the same frequency (8 or 9.5% cases) as body aches among individuals in the middle and upper classes. The only cases of nervios reported were among women. The principal cause of this illness was the tension induced by the political and social struggle underway in the country. The effect of the violence varied by class. Many of the nervios cases among middle- and upper-class women involved stress brought on by the right-wing death squads and the murders in the town and Sonsonante. These women were more likely

to be related to, or friends with, the teachers and others who were killed than were women in the lower class.

Nervios occurred less commonly in the lower class than in the middle and upper classes. Here the condition resulted from anxiety states brought on by poverty. The economic disruptions, especially the burning of buses, resulting from the political violence made providing for families an even more difficult affair than normally. This was especially the case for market or street vendors, who depended on the transportation system to reach their places of work.

Although the three leading causes of illness among the lower-class and the middle- and upper-class households were the same, when all infectious processes (upper respiratory complaints, gastro-intestinal disorders, other infectious processes, dermatological and eye irritations, and uro-genital disorders) were grouped together, some important variations emerged. Infectious processes accounted for four-fifths (100 or 80.0%) of the conditions in the lower class and only two-thirds (57 or 67.8%) of those in the middle and upper classes. The greater prevalence of illnesses such as colds, flu, and diarrhea among the poor reflects their crowded and unhygienic living conditions and, in many cases, their lack of adequate nutrition.

Rates of illness per person and per household also were greater in the lower class than in the middle and upper classes. Among the 72 households in the survey, 38 (213 people) were in the lower class and 34 (181 people) were in the middle and upper classes. As the data in Table 6.6 show, among the lower class there were .59 illnesses per

Table 6.6.--Illness rates by class.

Classes	Total Illnesses Reported	Total People in Class	Incidence of Illness Per Person	Total Households in Class	Incidence of Illness Per Household
Lower class	125	213	.59	38	3.3
Middle & upper classes	84	181	.46	34	2.5
Total	209	394	5.3	72	2.9

Source: Illness episode survey.

person or 3.3 per household during the observation period. In the middle and upper classes, by contrast, there were .46 illnesses per person or 2.5 illnesses per household. Taken as a whole, this information indicates that members of the lower class were more likely to experience an illness, especially an infectious one, than were their counterparts in the middle and upper classes.

In addition, there were class differences in birth and child death rates.⁶ The average number of children born to women 45 years and over in the lower class was 6.2, and close to one-fifth (19%) of these children died before their fifth birthday. The average number of children born to those in the middle and upper classes, on the other hand, was 3.7, and only one-twentieth (5.1%) died before the age of five (Table 6.7). This finding further confirms the existence of differences in reported health status between the two class groupings.

Some ethnic differences also were found. Only three middle- and upper-class indigenous families were included in the illness episode survey. Consequently, the number of conditions reported was small (only eight), and comparison with the Ladinos in these classes was difficult. In the lower class, however, 16 families were interviewed, and sufficient illnesses (52) were reported for meaningful comparisons to be made. Table 6.8 displays this information. Upper respiratory disorders were the leading illness category reported in both ethnic groups, followed by gastro-intestinal disorders. Indian households, however, had fewer upper respiratory infections and more gastro-intestinal disorders than did Ladinos. Indians also reported

Table 6.7.--Natality and child mortality rates by class.^a

Classes	Total Born	Total Died Before Age Five	% Died Before Age Five	Total Households	Average No. of Children per Household
Lower class	105	20	19.0	17	6.2
Middle & upper classes	59	3	5.1	15	3.7
Total	164	23	14.0	32	5.1

Source: Illness episode survey.

^aIncluded were female household heads and wives of male household heads in the illness episode survey.

Table 6.8.--Ethnic differences in illnesses among lower-class households.

Illness Categories	Ladinos		Indians		Total Illnesses Reported	
	No.	%	No.	%	No.	%
Upper respiratory disorders	40	54.8	21	40.4	61	48.8
Gastro-intestinal disorders	11	15.1	12	23.1	23	18.4
Rheumatic, head, and other body aches	8	11.0	5	9.6	13	10.4
Other infectious processes	2	2.7	7	13.5	9	7.2
Psychological complaints	2	2.7	1	1.9	3	2.4
Dermatological and eye irritations			4	7.7	4	3.2
Trauma	1	1.4	1	1.9	2	1.6
Uro-genital disorders	3	4.2			3	2.4
Cardio-vascular disorders	2	2.7			2	1.6
Nutritional disorders	2	2.7			2	1.6
Others	2	2.7	1	1.9	3	2.4
Total	73	100.0	52	100.0	125	100.0

Source: Illness episode survey.

significantly more illnesses in the other infectious processes and dermatological and eye irritations categories than did Ladinos. The rate of illness per household among the indigenous families was 3.25, whereas it was 3.01 among the lower-class Ladino families. This suggests that, similar to their living and working conditions, educational attainment, and other characteristics, the health status of lower-class Indian families was poorer than that of lower-class Ladino families.

During the course of the interviewing, there were indications that even more marked differences in health status than those reported actually existed between the lower- and the middle- and upper-class households. There are two primary reasons why the illness episode survey did not reveal these differences. The first concerns variations by class in work patterns and household organization, and the second has to do with class differences in the use of medical resources. More will be said concerning these factors after considering use of medical resources.

Class Differences in Use of Health-Care Resources

Home Treatment

In Asunción, many of the illnesses reported during the survey were self-limiting conditions that never reached the attention of formal health-care practitioners.⁷ In fact, as the data in Table 6.9 indicate, of the 209 illnesses reported, nearly three-fifths (120 or 57.4%) did not involve consultation with medical practitioners. In a

Table 6.9.--Class differences in home treatment.

Classes	No Treatment Administered		Home Treatment		Total		Total Illnesses in Survey	% Receiving No or Home Treatment
	No.	%	No.	%	No.	%		
Lower class	6	7.9	70	92.1	76	100.0	125	60.8
Middle & upper classes	4	9.1	40	90.0	44	100.0	84	52.4
Total	10	8.3	110	91.7	120	100.0	209	57.4

Source: Illness episode survey.

small number (10 or 8.3%) of cases, nothing at all was done to treat the condition. Usually, however, illnesses were treated by a combination of alterations in diet, changes in behavior patterns, and the administration of medications.

Changes in diet often involved the elimination of foods, while changes in behavior consisted of the temporary cessation of certain daily routines. For example, those suffering from colds and other upper respiratory infections almost always stopped consuming foods and drinks regarded as cold (helado). These included items whose temperature was cold (popsicles, cold beverages) and foods classified as cold, such as melons and other fruits. Changes in behavior involved eliminating bathing, washing clothes, and opening the refrigerator and, for men, shaving.

The kinds of medicines administered at home fell into three categories: prepackaged pharmaceutical products purchased at pharmacies, in stores, from street vendors, or in the market; products made within the pharmacy; and traditional remedies concocted at home and usually referred to as home remedies (remedios caseros or monte).

Many of the prepacked pharmaceutical products employed in home treatment had been used, or prescribed by physicians, for previous cases of the same illness. Others were recommended by friends or family. Prescription drugs, especially antibiotics, were widely employed in home-treatment regimes and were sometimes taken as preventive measures. For example, two women reported that they gave a teaspoon of Pantomicina (tetracycline) to their children on a daily

basis to prevent colds. For curative purposes, antibiotics usually were taken only as long as the symptoms persisted.

Pharmacy-made remedies also were used, especially by the campesino population. One pharmacy in Asunción specialized in making these products and, in the 1940s and 1950s, had been well-known in the region for its waters (aguas), pommades (pomadas), essences (esencias), and spirits (espíritus). The other three pharmacies carried a limited line of these medicines but were considering discontinuing them because the cost of ingredients had risen substantially while their market appeal had diminished. The wife of one of the pharmacy owners reported that the ingredients used in making the medicines in her shop were routinely diluted. In fact, some products consisted only of food coloring and cooking oil or water. She explained these practices by noting that what cures is the faith the customer has in the medicine, not its contents.

Finally, there were many homemade remedies used in Asunción. Most of these were teas concocted from local flora, but baths and pommades were also reported. For example, colds were commonly treated with various kinds of teas (aguitas) made from plants and herbs such as izote and licorice (orozuz).

Home treatment was usually the first line of defense in cases of illness, and only if symptoms did not abate were other sources of care sought. Consultation with practitioners, however, did not necessarily signal the cessation of home treatment. Many home remedies were used concomitantly or intermittently with other medical resources. This

was especially the case with regard to alterations in diet or behavior, which tended to be adhered to throughout the illness regardless of the practitioner employed.⁸

Reliance on home treatment varied by ethnicity and class. Table 6.10 shows class and ethnic differences in home treatment. Overall, more illnesses in the lower class (76 or 60.8%) received no treatment or were cared for at home than were illnesses in the middle and upper classes (44 or 52.4%). As will be pursued in greater detail below, middle- and upper-class households were generally quick to consult other practitioners, while lower-class families gave home remedies a longer time to be effective before seeking other sources of care.

More illnesses in indigenous households received no treatment or were treated at home than those in Ladino households. Slightly over one-half (80 or 53.7%) of the conditions experienced by Ladinos fell into this category as compared with two-thirds (40 or 66.7%) of those experienced by Indians. This was also the case within the lower class (Table 6.10). Here a larger proportion (36 or 69.2%) of Indian illnesses were cared for at home than were illnesses among the Ladinos (40 or 54.8%). This finding is in line with others reported throughout the study, which indicate that indigenous households were differentiated from their Ladino counterparts within the classes and, hence, could be considered ascriptive class segments (Barrera 1979).

Table 6.10.--Ethnic and class differences in home treatment.

Classes	Ladinos			Indians		
	Total Illnesses Reported	# No Treatment or Home Care	% No Treatment or Home Care	Total Illnesses Reported	# No Treatment or Home Care	% of Treatment or Home Care
Lower class	73	40	54.8	52	36	69.2
Middle & upper classes	76	40	52.6	8	4	50.0
Total	149	80		60	40	

Source: Illness episode survey.

Use of Medical Practitioners

In addition to home treatment, many kinds of practitioners were used by the households in the survey. The government health center in Asunción was open on a half-time basis six days a week. The student physician and the other physician working at the center also maintained private practices. In addition, there were four pharmacies, two pharmacy clerks (idóneos) who ran private medical practices, nurses, at least half a dozen mediums or witches (curanderos or brujos) at spiritualist centers (centros), a few traditional curing specialists such as bone setters (sobadores), and midwives (parteras or nodrizes). There was also an array of churches where healing sometimes took place. Vendors of prepackaged medicines or traditional remedies and amulets frequently sold their wares on the streets and in the market.

Many other healing resources were available in nearby Sonsonante. A public hospital, another government health center, some private clinics (one run by ORDEN), and numerous physicians were located in this city, along with many pharmacies, centros, and other sources of care. Asunción's location on the highway also facilitated use of medical resources in other large cities, particularly San Salvador.

Two points concerning these resources merit comment. The first concerns pharmacies. While these establishments sold over-the-counter medicines and filled physicians' prescriptions, much as they do in the U.S., they also served as important sources of medical care in their own right. In very few instances, however, was a licensed pharmacist

or pharmacist's apprentice (idóneo) available for consultation. As will be described in greater detail in the following chapter, illnesses usually were treated by clerks and others with limited or no formal training in medicine. In essence, then, although they relied on medications developed by western biomedicine, pharmacy personnel were lay practitioners.

The second point concerns Asunción's alternative curers. Two types were distinguishable: a small group that relied principally on locally made remedies and another group that, while retaining many alternative beliefs concerning etiology and treatment, nonetheless employed prepackaged pharmaceutical products as part of their treatment strategies. Some practitioners such as the idóneos, nurses, and many of the medicine vendors depended almost exclusively on these products. Others, such as the mediums at the centros, relied on them in combination with other treatments. Many curers sent their clients to the pharmacy with prescriptions.

These two considerations suggested the need for an addition to the usual traditional-modern framework used in most anthropological analyses of health-care resources. Thus, the sources of care were organized into three categories: the western biomedical sector, the popular sector, and the traditional sector. The biomedical sector consisted of physicians, nurses, and other formally trained medical practitioners in private practice or at health centers, hospitals, and other institutions where cosmopolitan medicine was practiced. The major representatives of the popular sector were the pharmacy

personnel, medicine vendors, and idóneos whose philosophies of disease causation and cure represented popular variants of western and alternative or lay medical traditions and who relied on prepackaged pharmaceutical products as an important healing strategy. Mediums practicing at centros were also included in this category because of their heavy reliance on western medicines. The traditional sector consisted of those who still practiced the old arts of massage, bone setting, and curing with herbs, and midwives who had not attended programs to improve their skills.⁹

Western biomedical practitioners were the most frequently used source of care reported in the illness episode survey. The data in Table 6.11 show that in over one-half (48 or 54.0%) of the 89 illnesses, help was sought from private physicians or physicians at hospitals or health centers. All but one of the remaining illnesses (40 or 44.9%) were treated by popular-sector practitioners, especially pharmacy personnel. Only one (1.1%) illness was taken to a traditional curer. Although stories of reliance on brujos were recounted, these practitioners reportedly were used by people from out of town.¹⁰ The only traditional healer used by the families in the sample was a bone setter (sobador).

The decline in use of traditional resources such as the sobadores merits a detailed study in its own right. It is closely related to the social disruptions that have characterized Salvadoran life during this century and to the process of modernization that has taken place. In the following chapter the effects of the penetration of western

Table 6.11.--Types of medical resources used by class.

	Western Biomedical Sector				Popular Sector			Traditional Sector	Total
	Phys.	Hosp.	Health Center		Pharm.	Idóneo	Vendor	Sobador	
<u>Lower class</u>	9	6	4		23	1	4	1	49
% resource	18.4	12.3	8.2		46.9	2.0	8.2	2.0	100
% sector		38.9				59.0		2.0	100
<u>Middle & upper class</u>	21	5	3		10	1			40
% resource	52.5	12.5	7.5		25.0	2.5			100
% sector		72.5				27.5			100
<u>Total</u>	30	11	7		33	2	4	1	89
% resource	33.7	12.4	7.9		37.1	2.2	4.5	1.1	100
% sector		54.0				44.9		1.1	100

Source: Illness episode survey.

pharmaceutical products on these practitioners and on the organization of the medical sector in general will be explored. Here a brief description is presented of the disappearance of one local healing resource that took place during the research period.

In Asunción, the illness of fright took two forms. A severe condition known as espanto occurred when a person was accosted by a brujo, usually taking the form of a monkey or pig, who intended to cause grave harm. A lesser form of the illness, known as susto, resulted when neighbors or family members of the victim also saw the pig or monkey. It was commonly believed that there was little hope for victims of espanto but that those suffering from susto could be cured if they attended a religious service known as the Evangelicals (los evangélicos). This service had been held by the priest every Thursday in the Asunción Church for as long as people could remember. Victims of susto would select a godmother (preferably named Juana) and attend the service three consecutive Thursdays. The current priest was under pressure from his supervisors to discontinue his participation in this curing rite as it was considered undignified and irreligious behavior. In August 1978, he capitulated and refused to celebrate the evangélicos any more, saying that susto was a problem for psychologists, not priests, to treat. This over-night cancellation of the cure for susto left many people bewildered and worried.¹¹

A growing reliance on popular-sector practitioners who combine alternative or lay beliefs with aspects of the state-sponsored cosmopolitan medical system has accompanied the disappearance of these

local healing resources. There were class differences in reliance on popular-sector practitioners in Asunción. As the information in Table 6.11 demonstrates, lower-class households relied more heavily on them as sources of primary care than did those in the middle and upper classes. Nearly three-fifths (29 or 59.1%) of the illnesses reported in the lower class were brought to the attention of popular-sector practitioners. Most of these conditions were treated in pharmacies, but idóneos, medicine vendors, and centros were also used. Close to two-fifths (19 or 38.9%) of the illnesses reported by the lower class were treated by physicians and other biomedical resources, and the remainder (1 or 2.0%) were brought to the attention of traditional healers. In the middle and upper classes, in contrast, almost three-fourths (29 or 72.5%) of the illnesses were cared for by physicians in private practice or working at hospitals and clinics, while only one-fourth (11 or 27.5%) were brought to popular-sector practitioners. No traditional healers were used.

Although middle- and upper-class families did not seek medical treatment from pharmacy personnel as frequently as did lower-class families, they did rely heavily on pharmacies as an important source of medicines for self-treatment. As noted above, in many instances, these products previously had been prescribed by physicians. Thus, pharmacies played a pivotal role in the delivery of health care, serving as sources of treatment in their own right, as sources of products used in home care, and as sources of medicines used by

alternative practitioners. The role of pharmacies is further explored in Chapter VII.

Relatively few ethnic differences in utilization patterns were found in the course of the survey. As the information in Table 6.12 shows, in the lower class slightly more of the illnesses reported by indigenous households (10 or 62.4%) than Ladino households (19 or 57.6%) were cared for by popular-sector practitioners.

Class Differences in Work Patterns and Household Organization:
Implications for Perception and Treatment of Illness

The organization and functioning of domestic units are of special significance in considerations of health and illness. Both material conditions, such as access to sufficient and nutritious food sources, potable water, and adequate sanitary facilities, and socioeconomic factors, such as patterns of participation in the work force and the allocation of income and of responsibilities for child care, have immediate implications for well-being. In essence, domestic units are nexus points where social, economic, and cultural influences are translated into actions that affect the health status of the members. In Part I, information on participation in the work force and on class and ethnic variations in household organization was presented. In this section, some of the health ramifications of these variations are explored. Particular attention is paid to how class standing affects the perception and reporting of illness.

Perceptions of illness were heavily influenced by economic considerations mediated by household composition and organization. In

Table 6.12.--Types of medical resources used by lower-class households by ethnic group.

	Western Biomedical Sector			Popular Sector			Traditional Sector	Total
	Phys.	Hosp.	Health Center	Pharm.	Idóneo	Vendor	Centro Sobador	
<u>Ladinos</u>	7	5	1	15		3	1	33
% resource	21.2	15.2	3.0	45.5		9.1	3.0	100
% sector		39.4			57.6		3.0	100
<u>Indians</u>	2	1	3	8	1	1		16
% resource	12.6	6.2	18.8	50.0	6.2	6.2		100
% sector		37.6			62.4			100
<u>Total</u>	9	6	4	23	1	4	1	49
% resource	18.4	12.3	8.2	46.9	2.0	8.2	2.0	100
% sector		38.9			59.1		2.0	100

Source: Illness episode survey.

the lower class, women did not usually report conditions unless they interfered with normal daily routines and responsibilities. For example, a 45-year-old woman from Asunción, Mrs. Tespan, worked as a vendor selling fruits and vegetables on the streets of Ahuachapán. She usually took the bus to Ahuachapán on Sundays and returned to Asunción on Tuesdays or Wednesdays, sleeping on the streets the nights she was away from home. When questioned about her health, she reported suffering from colds, fevers, and headaches caused by sitting for long periods in the hot sun and sleeping outside at night. She was quick to add, however, that these conditions did not constitute real sickness. In her words, "The bad thing is to allow yourself to be overcome by illness; to get sick is to have to stop working" ("Lo malo es dejarse apoderar de la enfermedad; enfermarse es tener que dejar de trabajar").

In a similar vein, children in the poorer households were not reported sick even though they were obviously suffering from runny noses, coughs, and diarrhea at the time of the interview. Further, in cases where their illnesses were recognized, it was often impossible for their mothers to determine where one illness episode ended and another began. Households in the lower class tended to have more of their members in the labor force than those in the middle and upper classes. Hence, infants and young children often were left in the care of slightly older siblings or were left alone while their parents worked. Many of these children were chronically ill.

The family of Ana Maria Gonzalez and Victor Morales serves as an example of this pattern. The couple had four children, aged nine, seven, three, and one year. Victor worked as a tailor in Sonsonante and Ana Maria sold vegetables in Acajutla. They left home in the early morning and seldom returned before 7:30 p.m. During summer vacations, the two older children took care of their younger siblings, but during the school year, the three and the one year old were left alone in the house, with a neighbor occasionally looking in on them. The interviews conducted over the course of four months revealed that the younger children were constantly ill with colds, diarrhea, and fevers, which Ana Maria attributed to the fact that they spent their time playing and eating in the street with little supervision. She reported that the family had never gone as many as 15 days without someone being sick and that illness was the natural state of affairs. In households such as this, it was impossible for anyone concerned to tell when one illness ended and another began. Children were chronically ill with acute conditions.

This situation contrasts markedly with the experience of sickness in middle- and upper-class families. Women in these classes were less likely to be employed outside the home than were women in the lower class and, when they were, they hired domestic servants to perform household and child-care tasks. In addition, as reported in Chapter V, in many cases, the household head's or spouse's mother resided in the home. Here, infants and young children were constantly attended by their mothers, other adult relatives, or servants. Given these

different circumstances, children's illnesses in middle- and upper-class homes were quickly recognized and treated.

The household of Norma and Pedro Perez serves as an illustration. They lived in a large home with Norma's mother. Pedro was a wholesale merchandiser who sold goods in Sonsonante, Acajutla, Santa Ana, and other large urban centers. His 28-year-old wife was trained as a secretary but had given up work when they married. Their child, Carlos Alberto, was one and a half years old and Norma was again pregnant. This family paid close attention to health, in part because their favorable financial situation allowed them to do so, and in part because of Norma's pregnancy.

Over the four-month period, only three illnesses occurred. Norma developed a cold, which she treated by stopping bathing and eliminating the consumption of certain foods. She took no medicines because her doctor had told her these could harm her pregnancy. The child, Carlos Alberto, experienced two illnesses. The first was described by his mother as a stomach infection and the second as a throat infection. Home treatment was commenced the day the symptoms were first noticed. For the throat infection, bathing was stopped and all cold foods were withdrawn. All fats and milk products were removed from the diet for the stomach infection. In both instances, these measures alone were tried for a day and, when they failed to alleviate the symptoms, they were combined with other treatment resources. In the case of the stomach infection, Norma first purchased a remedy that had been prescribed by the family pediatrician

for a previous episode of the same illness. Because this did not halt the diarrhea, on the third day the child was taken to the pediatrician in San Salvador. For the throat infection, Carlos Alberto was taken to the same doctor. Here, then, illnesses received prompt recognition and attention.

As these case studies indicate, class position mediated by household organization and composition exerted a powerful influence on the perception and reporting of illness. Women in poorer households were often away from home for the greater portion of the day and consequently had less opportunity than their middle- and upper-class counterparts to focus on their children's illnesses. They frequently took an instrumental view of their own conditions and those of others in the family. Children in these households tended to be chronically ill, and it was often difficult for all involved to specify when one illness ended and another commenced. This resulted in an under-enumeration of illnesses.

Class differences in reliance on medical resources also had implications for the experience of sickness and for health attitudes and beliefs. The argument proposed here differs from that advanced by Young (1979). He indicated that, in Pichátaro, beliefs and values regarding illness were essentially homogeneous or shared. Economic constraints were seen as limiting poorer community members' abilities to act on their beliefs and, thus, influenced treatment options. What is suggested in the case of the more highly stratified community of Asunción, in contrast, is that by imposing limits on the range of

medical resources that could be used, poverty influenced the experience of illness and ultimately affected attitudes and beliefs, giving rise to, and reinforcing, class variations in these attitudes and beliefs. As this process cannot be fully documented in a synchronic study, the proposition must be regarded as a hypothesis to be tested in future research. Nevertheless, the general parameters of the argument can be sketched.

There were indications that the medical resource used affected the experience of illness. While almost all healers in Asunción relied on western pharmaceutical products and made use of prescription drugs, the way in which these drugs were administered differed significantly. As will be discussed more fully in the following chapter, pharmacy personnel used products in a manner more in keeping with lay notions of illness, a practice that often resulted in the misuse of medicines. For example, many antibiotics were prescribed and purchased in quantities that were too small to be effective and were taken for conditions in which their use was not indicated. The more limited information gathered on physician prescribing suggested that they followed recognized indications for use and dosage requirements but tended to recommend a large number of medicines.

As demonstrated above, middle- and upper-class households in Asunción relied heavily on physicians in treating their illnesses. By using medications such as antibiotics in a more effective manner, physicians may have contributed to their clients' quick recoveries.¹² Illnesses in these two social classes lasted a shorter period of time

and were experienced as more discrete events than were illnesses in lower-class households. Here, in contrast, it often was impossible to determine when one condition ended and another began.

The type of health resource employed also had implications for diagnosis, or labeling of conditions. Recent studies have indicated that in many areas of Meso and Middle America, diagnosis is not an explicit step in the illness process and does not necessarily precede decisions about treatment (Young 1981: 70, Harrison 1983). Illness labels often are used in a tentative fashion until a cure is effected. In this sense, diagnosis is dependent on the outcome of treatment.

This often occurred in Asunción. Illness terminology varied with the treatment resource. In cases where physicians were consulted, labels frequently signaled their use. For example, throat conditions treated at home or by alternative medical practitioners were referred to as sore throats (dolor de garganta or mal de garganta). If a physician was consulted, however, the labels usually applied were throat infection (infección de la garganta), tonsillitis (amigdalitis), bronchitis (bronquitis), or some other technical term. In this way, access to and reliance on different practitioners directly affected the terminology used in reporting illness.

Of perhaps even greater importance, use of medical resources influenced beliefs regarding illness. Popular-sector practitioners tended to provide different explanations of the cause of illness than did physicians and others trained in western biomedicine. For example, in the case of the middle-class family discussed earlier,

when I asked Mrs. Perez what had caused her son's cold, she promptly replied little animals (animalitos), a term her physician had used to explain the germ concept. In lower-class households such as Mrs. Gonzalez's, in contrast, the explanations offered for children's colds shared much in common with beliefs advanced by the pharmacy clerks and popular-sector practitioners. These illnesses were said to result from a carelessness (descuido) on the part of those responsible for the children's care or on the part of the children themselves. Common examples of descuidos resulting in colds included allowing children to eat popsicles or drink cold pop on hot days, or allowing them to play outside at dusk. Thus, popular-sector practitioners tended to reinforce lay beliefs, while western biomedical practitioners frequently introduced new notions although these were not always fully understood.

Conclusion

Taken as a whole, the information presented in this chapter indicates that the most common illnesses in Asunción were the diseases of poverty--upper respiratory infections and gastro-intestinal disorders. While both lower-class and middle- and upper-class families suffered from these complaints, there were indications that they experienced them and other illness processes differently. Women in poor households reported a greater number of illnesses and more deaths among children under five years of age than did middle- and upper-class families. As discussed in previous chapters, many of these homes were overcrowded and lacked access to potable water or adequate

sewage disposal. The need for all adults to contribute to the financial support of the family resulted in children often being left alone or in the care of young siblings. In these situations, many children were chronically ill with acute conditions.

There also were class differences in the use of medical resources. More conditions among the lower class were treated at home or were taken to popular-sector practitioners than were illnesses in the middle and upper classes, where reliance was greatest on physicians. It was suggested that these reliance patterns influenced the experience of illness. Physicians and other western biomedical practitioners may make more effective use of drug products than do popular-sector practitioners and, hence, in some instances, their clients' illnesses may be of shorter duration than those of other healers. Other effects of use of different medical resources included differences in illness terminology and in beliefs concerning the cause of illness.

More generally, the illness episode survey revealed a heavy reliance on western biomedical practitioners and what are here termed popular-sector practitioners, such as pharmacy personnel, medicine vendors, and centros. Few healers using local resources remained in Asunción, and relatively little use was made of them. The following chapter focuses on the role of pharmacies and pharmaceutical products in bringing about these changes in the health system.

CHAPTER VII

THE ROLE OF PHARMACIES IN THE DELIVERY OF HEALTH CARE

The impact of multinational corporations on economic development in the third world has been a focus of attention in a growing number of social science investigations. The multinational pharmaceutical industry, in particular, has received considerable study. The majority of these investigations focus on two issues: the consequences for human health of many of these firms' promotional and sales practices (Hellegers 1973; Heller 1977; Ledogar 1975; Medawar 1979; Medawar and Freese 1982; Melrose 1981, 1982; Mother Jones 1979; Sesser 1971; Silverman 1977, 1979; Silverman et al. 1982; Van der Geest 1981, 1982a, 1982b, 1984a, 1984b) and the effects of the pharmaceutical invasion on pharmaceutical industries and public-sector health budgets in Third World countries (Agarwal 1978; Barnett 1980; Bertero 1972; Evans 1979; Gish and Feller 1979; Lall 1974, 1975, 1977, 1982; Lall and Bibile 1978; Mamdani and Walker 1985; Patel 1983; Segall 1975; World Health Organization 1977, 1979; Yudkin 1980). Nonetheless, little is known about the impact of modern medicines and the agents who dispense them on community-level health systems. This chapter focuses on private-sector policies and practices in El Salvador regarding the distribution and sale of prepackaged pharmaceutical

products. Specifically, it examines the effects of different distributional networks for medicines on health care provided at pharmacies in Asunción. It is, then, a case study of the relationship between micro and macro phenomena and processes, a subject that has received attention throughout this investigation.

While the focus is on pharmacies, the effects of the penetration of pharmaceutical products on other medical resources also are considered. Some initial information on the structure, organization, and impact of the multinational pharmaceutical industry in developing countries is necessary to place the present investigation in context.

The Multinational Pharmaceutical Industry in Developing
Countries: Health and Economic Consequences

The availability of medicines manufactured by large, sophisticated pharmaceutical firms is one of the most salient developments in the health field in recent decades. While precise figures are not available, marketing surveys indicate that developing countries account for approximately 20% of world pharmaceutical consumption. This figure masks important variations in reliance. Drug consumption is higher in Latin America and Asia than it is, for example, in Africa (Gish and Feller 1979: 3). In regard to Latin America, estimates on the consumption of pharmaceuticals vary considerably. At a conference sponsored by the Pan American Health Organization in 1971, it was estimated that the volume of manufactured drugs consumed in Latin America and the Caribbean for that year was \$1,950,000,000 (Pan American Health Organization 1971: 21). Other researchers provide

much higher figures. For example, Ledogar (1975: 7) reports that in 1974 approximately \$900 million worth of modern medicines was sold in Brazil alone. In El Salvador, as noted in Chapter II, imports of pharmaceutical products grew substantially between 1967 and 1975 from \$6,713,000 to \$23,392,000 (Piachaud 1980).

The production of pharmaceuticals is concentrated in a small number of countries. France, the Federal Republic of Germany, Italy, Japan, and the U.S. accounted for roughly 80% of the total output in 1970 and, in 1974, exported approximately 60% of the total value of medications moving in international commerce (Gish and Feller 1979: 4). The concentration of drug production in the hands of a few multinational pharmaceutical firms located in the major producing countries is steadily increasing. In 1976, it was estimated that 25 firms supplied 50% of total world shipments of medicines. By the 1990s, it is expected that world production and marketing will be in the hands of from one to two dozen companies (Gish and Feller 1979: 9).

Some of these firms have established production and research facilities in developing countries. Such countries are attractive because they offer cheaper labor pools and often have less stringent regulations on the testing and licensing of new products than do the developed countries. Regardless of geographic location, companies tend to manufacture medications designed to meet the health needs of populations in Europe and the U.S. (Gish and Feller 1979: 15). In the Third World, many products are promoted in a manner that has adverse

effects on health. Multinational firms have dumped medications found unsafe for use in the home country, exaggerated the indications for use of products, and minimized their contraindications and warnings (Ledogar 1975, Silverman 1979).

While statistics on drug-induced illnesses and deaths are rarely available in developing countries, medical authorities report that such occurrences are not uncommon. The World Health Organization has voiced repeated concern regarding the inappropriate use of medications, especially antibiotics. The misuse of these products leads to the development of drug-resistant strains of infectious disease, and it is conceivable that epidemics comparable to the pre-antibiotic era will occur (World Health Organization 1977, Illich 1976).

Little, in fact, is known about the impact of modern pharmaceuticals on mortality and morbidity rates in developing countries. In Western Europe and the U.S., mortality from infectious diseases had already declined before the discovery of effective medications, due in large part to improvements in nutrition and environmental sanitation (McKeown 1979). The revolution in drug making, which began in the 1930s with the discovery of sulfa drugs, may have exercised a greater impact on declining mortality rates in the Third World than it did in Europe and the U.S. In El Salvador, for instance, it is doubtful that any dramatic improvement in nutritional standards or hygiene measures has occurred which would explain declining mortality rates among the campesino population or among the urban poor in towns such as Asunción. While mortality rates have declined, morbidity rates may be

increasing. Modern pharmaceutical products may keep greater numbers of people alive as the quality of health deteriorates. It is clear, however, that the principal illnesses in Asunción and throughout El Salvador are associated with lack of adequate nutrition and unhygienic living conditions. The elimination of these causes of disease lies beyond the realm of medicine and can only be achieved through governmental commitments to socioeconomic and political reforms.

Researchers have pointed out that treating the diseases of poverty by providing more medical services and modern medicines results in a cycle of disease-treatment-disease that drains away resources without resulting in any long-term health improvements (Gish and Feller 1979: 56, Segall 1975: 5). The proliferation of medications for sale in many Latin American countries represents a drain on scarce financial resources. The World Health Organization Expert Committee on the Selection of Essential Drugs reported that drug expenditures account for more than 40% of the available public-sector health funds in some developing countries (World Health Organization 1977). Some countries have attempted to limit the number of drugs by establishing national formularies which regulate types of medicines that can be imported. Allende of Chile suggested such a policy and also advocated banning all pharmaceutical products from the country until they had been tried on paying clients in North America or Europe for as long as the patent would run (Illich 1976: 68-69). In 1977, the World Health Organization published a list of approximately 200 drugs regarded as sufficient to treat the majority of illnesses in developing countries. In

Brazil, however, there are over 30,000 different products for sale, while in Mexico there are possibly as many as 80,000 (Gish and Feller 1979: 21).

Pharmacies' Role in the Delivery of Health Care

While the literature provides information on the risks to human health and the drain on national economies posed by the pharmaceutical invasion, the institution that makes modern medicines available at the retail level--the pharmacy--has received little study until recently (Kohane 1984, Laurell 1977, Logan 1983, Mitchell 1980, Ven der Geest 1982, Weisberg 1982). In the U.S., the role of the pharmacy in health-care delivery is limited by prescription laws, which require a physician's authorization for the sale of certain categories of drugs. Although pharmacies serve as a source of advice and treatment for mild or self-limiting conditions, their role in the overall medical delivery system is clearly secondary.

This is not the case in El Salvador or throughout Latin America. Prescription laws do exist, but they are seldom enforced. With the exception of certain narcotics, most medications can be purchased over-the-counter. This situation is explained by a conjunction of interests on the part of business and health authorities. Three factors are involved. First, regulatory bodies are generally poorly funded and understaffed and, thus, cannot assume the task of monitoring pharmacies. In some cases, such as in El Salvador, the regulatory body itself is partially composed of pharmacy owners who are unlikely to enforce laws limiting their sales. Second, multinational and

national firms give only token support to enforcing prescription laws, as these would reduce their sales.¹ The few efforts companies with laboratories in the Central American region have made in this regard (such as eliminating package inserts in an attempt to reduce unauthorized use) deny access to valuable information about drugs rather than limit their sales (Silverman 1979). Third, health authorities throughout Latin America recognize that to enforce prescription laws and to limit the sale of medications is, in many cases, to prevent access to any form of western medical care. In Latin America, physicians and hospitals are concentrated in the major urban centers and are often inaccessible to much of the population.

In the case of El Salvador, for example, it was estimated that 90% of doctors were located in the capital and two other major urban centers (Ferrer Denis 1968). El Salvador does have a system of government health clinics and hospitals but, as discussed in previous chapters, these facilities meet only certain segments of the population's needs. Given the maldistribution of physicians and the characteristics of government health facilities, pharmacies function as a source of primary medical care for both urban and rural dwellers.

While these stores play an important role in the provision of health care, they are private businesses run for profit. In El Salvador, certain aspects of these businesses are regulated for the public welfare by the semi-autonomous government agency, the Office of Chemical Substances and Pharmacy (Junta de Química y Farmacia). In stocking their stores, pharmacy owners also are tied into national

drug distribution networks. As these regulatory and business structures provide the parameters within which the store owners conduct their affairs, their most relevant aspects will briefly be reviewed.

National Business and Regulatory Structures

In El Salvador, pharmacy owners have three major sources of supply available for the products they sell: national companies and multinational pharmaceutical firms with production facilities in the country, distributorships of medications manufactured by national and multinational pharmaceutical laboratories which generally have the rights to sell a number of pharmaceutical firms' products, and large wholesale pharmacies which purchase stock from distributorships and pharmaceutical firms and resell to other pharmacies. Pharmaceutical companies and distributorships employ sales representatives to sell products throughout the country. While there is some variation by company or distributorship, visitadores are the representatives who concentrate their sales efforts on doctors' offices, clinics, hospitals, and pharmacies that have extensive inventories. Viajeros or vendedores visit pharmacies. These salespeople are assigned territories to cover on a monthly basis and, as will be discussed below, offer pharmacy owners similar incentives to buy their products.

The other major source of supply, wholesale pharmacies, usually does not employ sales representatives to visit small towns. Pharmacy owners in these areas who purchase from wholesale outlets are

generally responsible for placing their own orders and for arranging to have the products delivered. Wholesale pharmacies do not promote any particular firm's line of products and, therefore, their advertising campaigns and sales offers differ from those of pharmaceutical laboratories and distributorships.

In addition to this business structure, there are national laws that have a bearing on pharmacy ownership and management. Store owners are required to hire the services of either a trained pharmacist or licensed apprentice (idóneo) as their legal representative. Idóneos are clerks who have had years of experience working in pharmacies. Those who have passed a formal examination in drug use given by the National University are licensed by the national regulatory body to serve as the legal representatives for pharmacies in small towns.

Although owners who are not pharmacists or idóneos must hire such people, in many cases the functions of prescribing and dispensing are carried out by the owners themselves, their family members, or hired clerks. Pharmacists or licensed idóneos may appear only to sign the appropriate documents for the renewal for the pharmacy licenses in early January and thereafter simply to pick up their paychecks on a monthly basis. Their time is spent pursuing other business interests. For example, in Asunción some idóneos set up private medical practices in their homes or visited rural areas to treat the campesino population.

Many pharmacy personnel in small towns have received no formal training in the use of the products they sell. Some are skillful, but

it is not uncommon for illiterate or semi-literate clerks or children to prescribe and dispense medications. Of the seven pharmacy clerks employed in the stores in Asunción, for example, four had a sixth-grade education, two had completed the third grade, and one had never been to school. Two were illiterate. In one of the stores, the owner's ten-year-old nephew often prescribed and dispensed products.

In El Salvador, the Junta also regulates retail drug prices. A ceiling is placed on the amount that may be legally charged for medicines. The retail markup over distributor prices varies from product to product. With retail prices, in effect, controlled, the profits a pharmacy owner generates come from three sources. First is volume of sales. The number of customers and the number of purchases they make are important factors in determining profit level. Second is the type of product sold. Generally, prepackaged medications made by pharmaceutical firms carry higher markups than do remedies made on the pharmacy premises. Further, in some cases, products manufactured by multinational companies carry a higher markup than do those made by national companies.² Third, profits are realized from the savings the owner makes in the supply price of the medications purchased. Distributorships and pharmaceutical firms offer better sales terms than do wholesale pharmacies. Because this third point is crucial to a pharmacy owner's success in the other two areas of potential profits, the terms of sale offered by the three supply outlets will be reviewed.

The price of many of the products sold by pharmaceutical firms and distributorships is lower than that offered by wholesale pharmacies. As Figure 7.1 illustrates, wholesale pharmacies are additional middlemen in the overall distributional system. While wholesale pharmacies, pharmaceutical firms, and distributorships give discounts on the purchase of large quantities of medications, pharmaceutical firms and distributorships offer sales incentives that wholesale pharmacies do not make available. These take the form of bonificaciones--a system whereby those who purchase a certain quantity of a product are given another quantity free of charge, and viñetas--money-back box-top offers (money given back to the pharmacy owner in this case, not to the client). Often a bonificación and a viñeta are offered on the same product.

An example will make the savings effected through purchasing from pharmaceutical firms and distributorships clear. The product is Gesterra, employed in the treatment of menstrual irregularities and manufactured by a multinational firm. Figure 7.2 displays two conditions of sale. The Junta set retail price per unit is C6.10. The bonificación is one unit free of charge per every 12 units purchased, and the viñeta is C.25 back for every box-top (12 + 1 + .25 each). Pharmacy owners who take advantage of the bonificación and viñeta make 57% more on the sale of the medication. On other products, the profits made through these special offers are even higher. For example, those who take advantage of the bonificación and viñeta offered on Cobalex, a medicine widely used in the treatment of anemia,

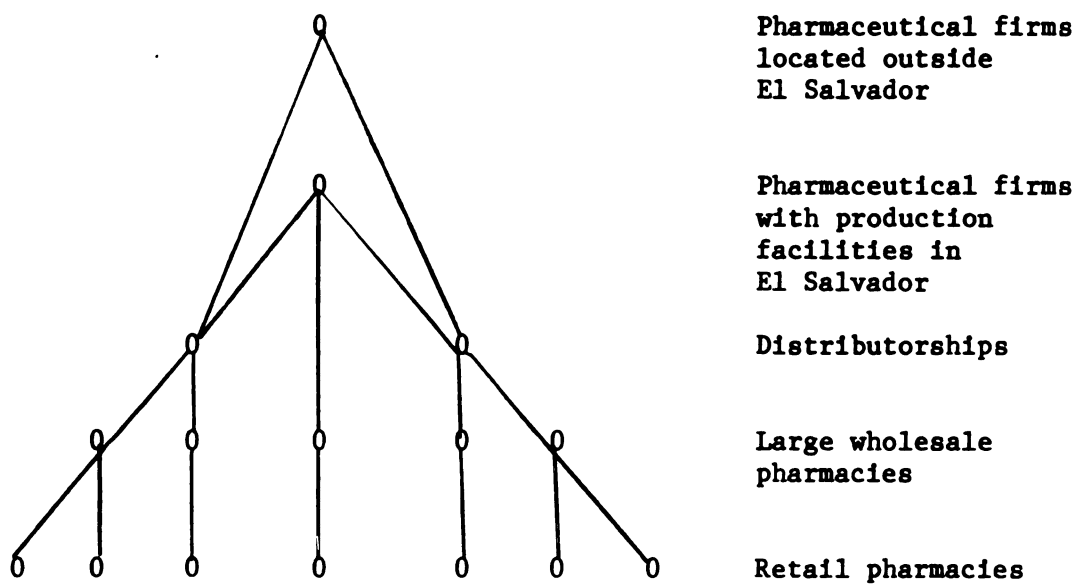


Figure 7.1.--Distributional network for pharmaceutical products

Sales Conditions to Pharmacy	Price to Pharmacy	Pharmacy Price to Public	Pharmacy Profits (%)
No sales offer	12 units at C4.75 each = C57.00 ^a	12 units at C6.10 each = C79.30	C16.20 (28%)
<u>Bonificación</u> and <u>vineta</u> (12+1 plus C.25 on each box top	13 units at C4.14 each = C53.82	13 units at C6.10 each = C79.30	C25.48 (47%)

^aExchange rate in 1979 was C2.50 = \$1.00.

Figure 7.2.--Sales offers: The case of Gesterra. (Source: Sales representatives at Asunción pharmacies.)

make 98% greater profit than those who do not have this special sale offer available to them. Large companies such as Bayer usually have a number of products on special at all times. Other companies have permanent bonificaciones on some medications. Often new products are launched with these sales offers to establish them on the market.

The owners of stores obtaining stock from pharmaceutical companies and distributorships frequently offered lower than Junta-set prices on the medications they sold. While this reduced the profits somewhat, the lower prices attracted more customers. Clients who visited the shops because of these savings often sought health-care advice from the establishments. As will be discussed below, the type of health-care advice and service they received differed from that found in stores purchasing from wholesale pharmacy outlets.

This brief summary of the national business and regulatory structures provides the background necessary for an examination of the local context. First, the Asunción pharmacy owners' relationships to the major drug supply networks are discussed. Second, the effects of source of supply on health service offered at the stores are examined, and, finally, a brief account of the impact of the penetration of pharmaceutical products on sources of medical care and on the process of medicalization in the town is provided.

Pharmacy Owners' Relationship to National Drug Distribution Networks

As discussed in the previous chapter, there were four pharmacies in Asunción: the Antigua owned by Don Oscar Delgado, the San Judas

owned by Dr. Francisco Velez, the Santa Teresa owned by Dr. Alvaro Castillo but, due to his poor health, run entirely by his wife Delmy, and the Sagrado Corazon owned by Lorena Gomez. All owners employed idóneos as the legal representatives. Nevertheless, none of these idóneos worked in the establishments, and all medicines and medical treatments were dispensed by the owners, their family members, or hired clerks.

The owners of the San Judas and the Antigua purchased stock from wholesale pharmacies. Don Francisco of the San Judas bought from a large pharmacy located in San Salvador and, on occasion, from two pharmacies located in Sonsonante. Don Oscar generally bought from a large pharmacy in San Salvador. They often waited until they were nearly out of a number of products before placing an order. Due to shortages at the wholesale pharmacy level, they frequently experienced difficulties in obtaining their orders. Consequently, Don Oscar and Don Francisco were often out of many of the most popular drugs and were forced to turn customers away.

Both owners usually purchased only those medications that were widely used in the community. They did not stock many prescription products manufactured by multinational firms--items that, in some cases, generated larger profit margins. Don Oscar, in particular, had a very limited range of medications for sale. His stock was confined almost entirely to over-the-counter products manufactured by Salvadoran firms and to remedies made in the pharmacy itself. While wholesale pharmacies offered clients discounts on the purchase of

large volumes of medications, neither Don Oscar nor Don Francisco ordered in sufficient quantities to take advantage of many of these offers.

As this brief description suggests, there were few financial gains to be made in purchasing from wholesale pharmacies. There were three reasons why these owners relied on this supply source. First, no substantial capital outlays were necessary. Don Francisco and Don Oscar bought medicines in the quantity they desired or could afford and were not under pressure from their wholesale suppliers to purchase more. Second, buying from wholesale pharmacies was not a time-consuming procedure. Medications were ordered from only one or two outlets, and orders were placed as the need presented itself. Third, many drug products have shelf-lives after which they are no longer effective or safe to use. Those who purchase large quantities and are not able to sell the medications before the expiration date printed on the product risk losing their investment or gaining a reputation for selling old medicines. Since Don Francisco and Don Oscar bought small quantities of products they expected would sell quickly, they were not usually confronted with this problem.

In Don Oscar's case, the first of these advantages was the most important in explaining his reliance on wholesale pharmacies. At the time of this investigation, he was in debt and lacked the financial resources to purchase from the distributorships and pharmaceutical firms. Don Francisco, on the other hand, devoted most of his attention to other business ventures and did not want to spend the time

involved in purchasing from the other sources of supply. In both cases, buying from wholesale pharmacies reflected a marginal involvement in the pharmacy business.

Purchasing stock from the pharmaceutical firms and distributorships required a substantially greater commitment of capital and time. The owners of the Sagrado Corazon and the Sta. Teresa, who obtained their stock from this source of supply, had to be in or near their stores on a daily basis to place and receive drug orders from the sales representatives. The Sagrado Corazon was visited by 35 to 40 and the Sta. Teresa by 25 to 30 salespeople per month. While Lorena and Delmy were tied to their shops, purchasing from this supply source offered them greater financial advantages than did buying from wholesale pharmacies. The bonificaciones and viñetas offered by the sales representatives allowed them to buy medications more cheaply than could the owners of the San Judas and Antigua. Some of these savings were passed along to retail customers in the form of slightly lower than Junta-set prices on the medications. This was especially the case at the Sagrado Corazon. These lower prices were an important factor in attracting customers and increased the volume of sales.

Unlike the San Judas and the Antigua, the Sagrado Corazon and Sta. Teresa were seldom out of the most popular medicines and, in fact, sold a great variety of prescription and nonprescription products. The sales representatives brought considerable pressure to bear on Lorena and Delmy to buy a wide range of products and medications in large quantities, in part because their incomes were dependent on

their sales volume. Viajeros and vendedores interviewed during the course of the study reported earning an average monthly salary of only C300.00 (\$120.00). Visitadores, because they usually are better educated and trained, earned on the average C1000.00 (\$400.00) per month. Visitadores stated that they were able to more than double their monthly salaries through their sales commissions, while vendedores and viajeros increased their monthly salaries by six to seven times.

Because they are assigned large territories to cover on a monthly basis, sales representatives visit only those shops whose volume of purchases justifies their efforts. In other words, pharmacy owners who purchase from distributorships and pharmaceutical firms must buy a wide range of medications and large quantities of them or risk losing their sources of supply. Owners who overpurchase, however, run the risk of exceeding the expiration date printed on the medications before selling the products and having their capital tied up in goods that are not selling well. As will be discussed below, to avoid these problems the owners of the Sagrado Corazon and Sta. Teresa engaged in their own forms of "dumping."

In addition to providing financial incentives to buy products, the sales representatives were a major source of information about the use of medications. Visitadores often supplied posters, flyers, and free samples. While viajeros and vendedores carried less printed material and did not usually provide free samples, they explained the advantages of their products to the owners. Interviews conducted with these sales representatives revealed low levels of formal training in

medicine use. Visitadores reported taking part in short courses sponsored by the pharmaceutical laboratories whose products they sold. Nevertheless, they stated that while these classes contained some information on the pharmacological properties and uses of products, the classes stressed sales and promotional considerations. Viajeros and vendedores often received no formal training in the use of medications. This lack of training, coupled with the incentives to sell resulting from the sales commissions, made the information provided by these sales representatives of dubious quality.

Nonetheless, this source of information was increasingly the only one available to pharmacy owners. In 1979, the Para los médicos (PLM), the Central American drug reference guide equivalent to the Physicians' Desk Reference (PDR) in the U.S., which once was dispensed free to pharmacy owners, had to be purchased from the publishers in Mexico. As Silverman (1979) has pointed out in The Drugging of the Americas, the information in this guide is of questionable value. Many pharmaceutical firms exaggerate the indications for use of products and minimize the contraindications and warnings. Further, what information is available is written in biomedical jargon and is difficult, if not impossible, for nonphysicians to understand. Nevertheless, the PLM did provide at least some information on medications. Don Francisco of the San Judas was the only pharmacy owner who purchased this reference book.

Further, in recent years some multinational pharmaceutical firms with production facilities in the Central American region have

eliminated another important source of information, package inserts. Reportedly, this represented an effort to reduce unauthorized medication use and sales (Silverman 1979). The inserts contained the companies' suggested indications for use, contraindications, warning, dosage, and formula. In some cases, dosage and formula plus very general indications for use were printed on the drug carton or package, but in other cases no information at all was included. For example, Pfizer, S.A.'s Terrabron (tetracycline and nystadin) and Terramicina (tetracycline), Abbott's Pantomicina (tetracycline) and Pedralyte (electrolyte solution), McKesson's Diazepam (librium), Searle's Dramamine (dimenhydrinate), and Squibb's Steclin (tetracycline), all popular medications in Asunción, contained no information on contraindications and warnings and only very general information on use. National Salvadoran firms were more likely to include inserts with their products. In most cases, however, these inserts made no effort to alert the purchaser to the risks involved in the product's use and, therefore, must be considered as promotional devices. For example, the insert included with Laboratorio Lopez's Palmicetina (pediatric chloramphenicol) did not indicate that there were any dangers in taking the medicine, although it is widely known to be associated with aplastic anemia, a serious and often fatal condition (Hellegers 1973, Ledogar 1975, Sarasti 1970, Silverman 1977, 1979).

In addition to these policies, many multinational and national pharmaceutical firms packaged prescription products in a way that encouraged their misuse at the retail sales level. Prescription and

over-the-counter medications in pill or tablet form were often packaged to be sold individually. Referred to as the unit-doses form, this packaging technique reportedly reduces medication errors in busy hospital environments (Siler, Sawdey and Meinhoefer 1978: 102). At the pharmacy, however, it permits the sale of medications on a pill-by-pill basis. Prescription products sold in this way rarely contain information about use. The only medicines found to contain adequate indications for use were those with the least risk involved in their administration, the over-the-counter remedies usually packaged by the multinationals.

With the FLM no longer readily available and information on many products either not included or of dubious quality, owners who purchased from pharmaceutical firms and distributorships relied heavily on the information provided by the sales representatives. Those who bought from wholesale pharmacies did not even have access to this source of information.

Partly as a result of this lack of information, prescription and over-the-counter medications have become integrated into lay or folk conceptions regarding illness. In a sense, pharmacy personnel serve as interpreters between different medical traditions, gleaning what they can from the information they receive from salespeople and relying to a large extent on shared cultural understandings of the nature and treatment of illness.

To illustrate how this integration is achieved, the case of chest colds, one of the most common illnesses in Asunción, will briefly be

considered. Pharmacy personnel and many townspeople felt that this condition was caused by the weather (often the north wind, which stirred up dust and produced lower temperatures), usually coupled with a failure of the sufferer to comply with expected role obligations or responsibilities. Women interviewed during the illness episode survey frequently explained their colds by saying me serené, meaning that they had lingered outside their homes at dusk longer than they should have. As noted in the previous chapter, children's colds were often said to have resulted from a descuido, a carelessness on the part of the children or those responsible for their care.

Pharmacy clerks shared these beliefs regarding the nature of chest colds and combined western medications with popular treatment strategies in the advice they offered clients. Clients were reminded to avoid foods or drinks considered cold and not to bathe until their symptoms abated. In addition, they were usually prescribed tetracycline, which was regarded as best for illnesses of the chest and throat. Other broad-spectrum antibiotics such as chloramphenicol were preferred to treat stomach conditions and diarrhea. Again these medications were combined with advice regarding foods or behaviors to be avoided until the patient improved.

To consider the effects of source of supply of medicines on health services provided at the pharmacies, because of the similarities in distribution and sales promotion, the distributorships and pharmaceutical firms will be considered as one supply outlet and wholesale pharmacies as the other major supply network. Also, for the

purposes of analysis, pharmacies relying on the same distributional network will be grouped together in the following discussion. Significant differences were found in purchasing patterns, prescribing practices, and customer services between stores that obtained stock from wholesale pharmacies and those that purchased from distributorships and pharmaceutical firms.

Purchasing Patterns and Prescribing Practices

To supplement information gathered during the illness episode survey concerning pharmacy utilization, periodic observations were made at the Asunción pharmacies over a four month period. This involved recording all transactions that occurred between pharmacy personnel and clients, sales representatives, and others who visited the stores. It also included discussions with the staff concerning the uses of medicines, the treatment of illnesses, and other topics of daily interest in the community. Unlike the information gathered during the illness episode survey, however, class and ethnicity could not be taken into account in the pharmacy interactions. Over the course of these observations, considerable rapport was established with the owners and workers in the Sagrado Corazon and the San Judas.

Because the Sagrado Corazon and the Sta. Teresa sold a wide range of products and because prices on some of the medicines were lower than those at the Antigua and San Judas, they attracted a greater number of customers. On Saturdays and Sundays--market days--business boomed at these establishments. For example, at the Sagrado Corazon

on one Saturday morning, 274 people made purchases in the period of three hours.

Customers shopping at these stores spent more per visit than did those shopping at the Antigua and San Judas. This information is summarized in Table 7.1. The average amount spent per customer at the Antigua and San Judas was only C.83, whereas it was Cl.59 at the Sagrado Corazon and the Sta. Teresa. These differences are based on two categories of customers: those who made purchases without medical consultation at the pharmacy and those who sought advice on the treatment of illness at the store before they bought. As the data in Table 7.1 indicate, the average amount spent by customers who simply purchased medications at the San Judas and the Antigua was only C.78, while at the Sagrado Corazon and the Sta. Teresa it was Cl.27. The larger amount spent by customers shopping at stores obtaining stock from pharmaceutical firms and distributorships reflected the more expensive products these stores offered for sale and the greater number of medications purchased by these customers than at the other establishments.

The effect of source of supply is revealed most clearly by examining the purchases made by customers seeking health advice at the pharmacies. Strong differences emerge between the groups of stores when average amount spent by customers seeking advice is analyzed. As the information in Table 7.1 shows, the average amount spent for treatment at the Sagrado Corazon and Sta. Teresa was C3.92, while at the San Judas and Antigua it was only Cl.41. In other words,

Table 7.1.--Number of customers and average amount spent at pharmacies.

Type of Customer	Pharmacies Purchasing From Pharmaceutical Firms and Distributorships (Sta. Teresa & Sagrado Corazon)	Pharmacies Purchasing From Wholesale Pharmacies (San Judas & Antigua)	Totals
I Making Purchase w/o Seeking Advice			
Total no. customers	806	546	1352
Total spent	C1024.60	C423.75	C1448.35
Average spent	C1.27	C.78	C1.07
II Seeking Advice			
Total no. customers	111	57	168 ^a
Total spent	C435.05	C80.25	C515.30
Average spent	C3.92	C1.41	C3.07
Totals I & II			
Total no. customers	917	603	1520
Total spent	C1459.65	C504.00	C1963.65
Average spent	C1.59	C.83	C1.29
III Not Making Purchases			
Referred to other practitioners	1	2	3
Desired product out	36	77	113
Totals	954	682	1636

Source: Pharmacy observations.

^aA total of 170 people sought treatment from pharmacies. One asked for advice on two illnesses, so the total number of illnesses treated was 171. In three cases, information could not be gathered on the nature of the complaint or the medications recommended. The total number of illnesses for which complete information was available was, therefore, 168.

customers who sought advice and received treatment at stores that obtained stock from the sales representatives paid considerably more than customers who consulted at the establishments that bought from wholesale pharmacies.

A more detailed analysis of purchases made by customers seeking advice at the two groups of pharmacies is necessary to explain these variations. Five potential sources of the differences in average amount spent were examined: variations in types of illnesses brought to the pharmacies and differences in dosage level, in quantity of medicines, in price, and in total number of products prescribed.

To determine if the stores specialized in the treatment of illnesses, the health complaints presented by the customers were examined. During the periods of observation, 170 people sought treatment at the shops. One of these asked for advice on two illnesses so the total number of illnesses treated was 171. In only 168 of these cases could complete information be gathered on the characteristics of the condition and the types of medicines prescribed.

The illnesses were classified into nine categories. Table 7.2 presents this information. There was no strong concentration of complaints either by pharmacy or by groups of pharmacies. Slightly more nutrition-related problems and illnesses classified under the other infectious conditions category were treated at the San Judas and Antigua (12 or 10.5% and 16 or 28.1%) than at the Sta. Teresa and Sagrado Corazon (6 or 5.4% and 20 or 18.0%). All the dermatological

Table 7.2.--Types of illnesses treated at pharmacies.

Illness Categories	Pharmacies Purchasing From Pharmaceutical Firms & Distributorships				Pharmacies Purchasing From Wholesale Pharmacies				Total	
	Sta. Ter.	Sag. Cor.	Total	%	San Jud.	Ant.	Total	%	No.	%
Upper respiratory disorders	17	16	33	29.7	10	4	14	24.6	47	28.0
Other infectious processes	13	7	20	18.0	10	6	16	28.1	36	21.4
Gastro-intestinal disorders	8	8	16	14.5	7	3	10	17.5	26	15.5
Rheumatic, head and body aches	5	9	14	12.6	4	2	6	10.5	20	11.9
Nutritional disorders	3	3	6	5.4	4	2	6	10.5	12	7.1
Uro-genital disorders	3	4	7	6.3	2	1	3	5.3	10	5.9
Trauma	2	5	7	6.3	1	1	2	3.5	9	5.4
Dermatological & eye irritations	4	2	6	5.4					6	3.6
Psychological complaints	2		2	1.8					2	1.2
Totals	57	54	111	100.0	38	19	57	100.0	168	100.0

Source: Pharmacy observations.

and eye irritations were brought to the Sta. Teresa and Sagrado Corazon.

The distribution of illnesses treated at the pharmacies roughly paralleled the leading causes of consultation at the Ministry of Public Health and Social Assistance Medical Facilities in the country as a whole. For example, in 1976 the leading causes for consultation at these facilities were dental work (a service not available at pharmacies), respiratory disorders, enteritis and other diarrheal diseases, and nutritional disorders (Table 2.2). In Asunción itself, there were few differences in illnesses treated at the pharmacies and at the health center, as a comparison between the data presented in Tables 6.3 and 7.2 indicates. Taken as a whole, then, this information suggests that none of the shops specialized in treating specific conditions; rather, they dealt with the range of illnesses most frequently brought to the attention of the public health facilities.

The average amount spent by illness category at the two groups of pharmacies is shown in Table 7.3. In all cases where comparisons could be drawn, the average amount spent by those seeking treatment at the Sagrado Corazon and the Sta. Teresa was higher than that spent by clients at the San Judas and Antigua. For the three leading complaints, upper respiratory disorders, gastro-intestinal disorders, and other infectious processes, the average amount spent was 375%, 283%, and 266% higher. Further, as the information presented in Table 7.3 indicates, these differences were not associated with any one condition but, instead, were found in all illness categories. The data in

Table 7.3.--Total and average amount spent by illness category at pharmacies.

Illness Categories	Pharmacies Purchasing Stock From Pharmaceutical Firms & Distributorships				Pharmacies Purchasing Stock From Wholesale Pharmacies			
	Sta. Teresa & Sagrado Corazon				San Judas & Antigua			
	No. of Customers	Total Spent	Average Spent		No. of Customers	Total Spent	Average Spent	
Upper respiratory disorders	33	C133.55	C4.05		14	C15.15	C1.08	
Other infectious processes	20	C81.30	C4.07		16	C24.45	C1.53	
Gastro-intestinal disorders	16	C62.95	C3.93		10	C13.65	C1.37	
Nutritional disorders	6	C48.25	C8.04		6	C16.05	C2.68	
Rheumatic, head and body ache	14	C29.10	C2.07		6	C6.70	C1.11	
Uro-genital disorders	7	C25.70	C3.67		3	C2.00	C.66	
Trauma	7	C12.85	C1.84		2	C2.25	C1.13	
Dermatological & eye irritations	6	C39.55	C6.59					
Psychological complaints	2	C1.80	C.90					
Totals	111	C435.05	C3.92		57	C80.25	C1.41	

Source: Pharmacy observations.

Tables 7.2 and 7.3 also show that the variations in average amount spent cannot be explained by differences in health complaints brought to the pharmacies.

Differences in dosage levels of medicines constituted another possible source of variation in spending between the two groups of stores. The pharmacies in Asunción stocked only one or two dosages of the various presentations of drugs. For example, tetracycline was available only in 250 mg capsules, ampicillin in 110 and 85 mg capsules, and Ilosone in 250 mg pills. Thus, variations in dosage did not explain the differences in average purchase price between the two groups of stores.

Nor can these differences be explained by factors relating to the quantity of a medicine sold. In all Asunción pharmacies, the quantity of a product received by a customer asking for treatment depended on four interrelated factors: the age of the patient, the perceived seriousness or stubbornness of the complaint, certain factors related to how medicines were packaged, and the customer's ability to pay. These factors represent further illustration of how western medicines were accommodated to the local socioeconomic and cultural context.

In the four stores, babies and small children were usually prescribed injections, syrups, or liquid medicines. These were considered stronger than pills or capsules, and they were easy to administer. Injections were also recommended to adults or older children whose illnesses were considered serious or which had not responded well to previous ministrations. Injections, syrups, and

liquid medications packaged by pharmaceutical companies were not dispensed in small quantities. To obtain them, customers had to purchase the entire bottle. Older children and adults whose conditions were not deemed serious generally were prescribed pills or tablets. As discussed above, these often were packaged in the unit-dosage form and were sold individually. Pills or tablets not packaged in this manner sometimes were sold on a one-by-one basis from the bottles.

There was sufficient information available on 131 of the 171 illnesses treated at the pharmacies to permit classification by the age of the patient and the presentation of the medication. Table 7.4 presents this information. Overall, two-thirds (39 or 67.2%) of those receiving injections or liquid medicines were children under the age of six, whereas nearly nine-tenths (46 or 86.8%) of those prescribed pills, capsules, or tablets were six years or older.³ This pattern was found in pharmacies purchasing from the sales representatives and, to a lesser extent, in those buying from wholesale outlets.

Customers purchasing injections or liquid medicines were seldom advised to buy more than one package.⁴ Those who bought pills and tablets generally purchased no more than four, regardless of the nature of the complaint or the type of medication. Pharmacy owners and some clerks were aware that such small quantities of drugs, particularly antibiotics, were not effective. Nonetheless, because many people could not afford to buy in large amounts, they recommended these small quantities and suggested that customers return to purchase

Table 7.4.--Relationship between age of patient and type of medicine recommended at pharmacies.

Presentation of Medicine	Pharmacies Purchasing From Pharmaceutical Firms & Distributorships				Pharmacies Purchasing From Wholesale Pharmacies				Total						
	Sta. Teresa & Sagrado Corazon				San Judas & Antigua										
	1-5 Yrs.	%	6 + Yrs.	Total	1-5 Yrs.	%	6 + Yrs.	Total							
Injection or liquid	28	65.1	15	34.9	43	11	73.3	4	26.7	15	39	67.2	19	32.8	58
Pill, capsule or tablet	4	12.9	27	87.1	31	3	13.6	19	86.4	22	7	13.2	46	86.8	53
Combination of above	3	30.0	7	70.0	10	4	57.1	3	42.9	7	7	41.2	10	58.8	17
Salves, creams			2	100.0	2			1	100.0	1			3	100.0	3
Totals	35		51	86		18		27		45	53		78		131 ^a

Source: Pharmacy observations.

^aIn 52 of the 171 cases where advice was sought, information on the age of the patient or the presentation of medicine could not be gathered.

more if the patient did not improve. Needless to say, many who experienced no relief after one injection or two to four pills concluded that the product was not effective and returned to buy another small quantity of a different drug.

Because the prescribing patterns described above were shared by personnel in all the town pharmacies, no significant differences were found in the quantity of a medication prescribed. Variations in types of illnesses, in dosage levels of a product, and in quantities of a product, then, did not explain the differences in average amount spent by customers receiving treatment at the two groups of stores.

There were, however, significant differences in types of medications recommended to treat illness. Clerks and owners in the Sagrado Corazon and the Sta. Teresa consistently advised clients to purchase more expensive medicines. The cases of those treated for grippe illustrate this pattern (Table 7.5). The average amount spent by customers treated for grippe at the Sagrado Corazon and Sta. Teresa was Cl.67 (\$.64), whereas at the San Judas and Antigua it was only C.65 (\$.26). This difference resulted, in part, from the fact that two injections, more expensive forms of medicines, were recommended at the Sagrado Corazon and Sta. Teresa. Even when these are eliminated from consideration and only costs of pills are compared, a difference in average amount spent between groups of pharmacies still remained. Those buying pills paid an average of Cl.06 (\$.42) at the Sagrado Corazon and Sta. Teresa and only C.65 (\$.26) at the San Judas and Antigua. There is no reason to believe that the Sagrado Corazon and

Table 7.5.--Price differences by source of supply of medicines: Patients treated for grippe at pharmacies.

Source of Supply	Pharmacy	Patient's Age	Medication Recommended and Purchased	Price of Medicines	Average Spent
Pharmacies purchasing from pharmaceutical firms & distributorships	Sta. Teresa	Teens	Injection of Estrepto-broncal	C1.85	
		Baby	Injection of Terrabron	C3.10	
	Sagrado Corazon	Teens	Four pills of Kolton-Gripal	C.80	
		Children 3 & 5 yrs.	Five pills of Asafan	C1.25	
		Adult	Four pills of Antagon	C1.60	
		Adult	Tónico Calcifer and Cafeaspirinas	C2.50	
		Adult	Three pills of Codoforme G	C.60	
Total spent and average purchase price:				C11.70	C1.67
Pharmacies purchasing from wholesale pharmacies	San Judas	Adult	Four pills of Guinasol	C.80	
		Adult	Pills of Gripe-San	C.85	
	Antigua	Adult	Six pills of Sulfatiasol	C.30	
Total spent and average purchase price:				C1.95	C.65

Source: Pharmacy observations.

Sta. Teresa did not have cheaper products in stock to treat this illness. In fact, both stores had available all three of the medications recommended to the customers at the San Judas and Antigua. Findings of this nature were duplicated for all complaints brought to the two groups of pharmacies. They indicate that clerks and owners in the Sagrado Corazon and Sta. Teresa consistently recommended more expensive medications to their customers wanting medical treatment.

Pharmacy personnel in stores obtaining their stock from pharmaceutical companies and distributorships also recommended that clients buy more medications to treat complaints. Nearly one-third (30%) of the 112 customers seeking advice at the Sagrado Corazon and the Sta. Teresa and one-fifth (19%) of the 58 customers treated at the San Judas and Antigua bought two or more medicines. These percentages are based on the number of purchases actually made. The differences in number of products prescribed between the two groups of stores was greater than these figures suggest. In many cases where pharmacy personnel in the Sagrado Corazon and the Sta. Teresa recommended that clients buy a number of medications, the customers could not afford to do so. These cases are not reflected in the above figures.

Before turning to consider differences in customer services, some brief remarks will be made on the quality of prescribing at the stores. As noted above, certain prescribing patterns were found in all pharmacies in Asunción. The form of administration of the medicine recommended was dependent on the age of the patient and on the perceived seriousness of the complaint. Quantity of a product

depended on factors relating to packaging and the customer's ability to pay. Cultural preferences and beliefs influenced prescribing patterns. The most frequent number of pills or tablets dispensed was four, a number of ritual significance dating from pre-conquest times (Westheim 1965). It also was commonly believed that injections were more powerful than pills or liquid medicines, that once a patient felt better there was no reason to continue treatment, and that if a patient did not respond promptly, the medicine was not effective. Drugs produced by multinational pharmaceutical firms were considered of higher quality than those manufactured by Salvadoran firms. These beliefs were shared by many townspeople and pharmacy personnel. Thus, the prescribing patterns resulting from them and the associated health risks were found in all the stores.

Other prescribing practices clearly reflected the owners' needs to sell medications growing out of the different supply sources. Because the Sagrado Corazon and the Sta. Teresa were under pressure to stock a wide range of expensive medications, their staff recommended more expensive products and more products to customers seeking care than did the staff at the San Judas and Antigua. Thus, personnel in stores buying from the sales representatives engaged in their own form of dumping. They used the opportunity presented by clients wanting treatment to unload products which, in many cases, would not sell quickly on their own because of their high prices, newness, or unpopularity.

While this practice affected both lower-class and middle- and upper-class customers, the implications were more serious for the poor households with very limited incomes. Information presented in Chapter VI indicated that lower-class families relied more heavily on pharmacies for primary health care than did middle- and upper-class families. Of the 49 people in the lower class seeking care from medical practitioners, 23 relied on pharmacies as their first source of health care. Of these, 19 sought care from pharmacies purchasing from the sales representatives, two used stores that relied on wholesale pharmacy outlets, and two visited pharmacies in the nearby town of Sonsonante. In other words, those who were least able to pay relied on the pharmacies that prescribed the most expensive medicines.

At both groups of pharmacies, individuals often received medications that were inappropriate to treat the sufferer's symptoms. For instance, three of the people treated for grippe were prescribed antibiotics or sulfanomides which are not effective for this complaint. In all pharmacies, antibiotics were among the best-selling products, and they were almost always purchased in small quantities.⁵

Customer Services

In addition to differences in the number and price of medicines prescribed, the Sagrado Corazon and the Sta. Teresa offered two services not available at the San Judas and Antigua. First, and most important in attracting customers, the owners of the Sagrado Corazon and Sta. Teresa administered injections.

Delmy of the Sta. Teresa ran her store very much like a small health clinic. Clients wanting advice usually arrived early in the morning and waited on benches in the pharmacy until she appeared. She had a small section set off for the administration of injections. If the patient was a campesino, Delmy employed a sterilized syringe and charged C.50 for the administration of the injection.⁶ More affluent, usually urban, patients were given injections with disposable syringes which they paid for. Lorena, the owner of the Sagrado Corazon, did not have a special section set aside for giving injections and was, in fact, in the process of eliminating this service. As the Sagrado Corazon was the most successful pharmacy, Lorena felt that the risks involved in giving injections now outweighed the advantages. While owners could not be sued for malpractice if a patient had an allergic reaction or died from an injection, they could be investigated and their license suspended. Rather than administering injections in the pharmacy, Lorena increasingly chose to refer the customers to the wife of the shopkeeper located next door to the Sagrado Corazon. This woman earned extra income by giving injections. Because she took no part in prescribing medications, she was not held accountable for the results; the customers themselves assumed all risks.

Neither Don Oscar nor Don Francisco administered injections. Don Oscar stocked very few medications in this form and at 75 years of age no longer wanted to administer them. Don Francisco, like Lorena, felt the risks outweighed the benefits.

The second customer service offered at the Sagrado Corazon and Sta. Teresa to attract customers was interest-free credit. Only middle- and upper-class families with steady incomes were allowed to delay payment. Because these households were most familiar with modern drugs, extending them credit represented an effort to assure that they would purchase at these stores. Even though Delmy and Lorena were selective in extending credit, they reported difficulty in getting some customers to settle their accounts. A few families were nearly a year in arrears. Given the influential position of these households, these situations were very awkward socially. In neither the Sagrado Corazon nor the Sta. Teresa were the poor given credit. They purchased only on a cash-and-carry basis, or if they had no money, they pleaded for medications.

Because Don Francisco and Don Oscar had a more limited range of products available, middle- and upper-class families were less likely to purchase regularly at these establishments. Therefore, granting credit was not an effective means of encouraging patronage. Since there was little potential gain and some potential problem involved in getting clients to settle their accounts, neither Don Oscar nor Don Francisco offered credit.

To summarize, pharmacy personnel in stores obtaining stock from pharmaceutical firms and distributorships recommended greater numbers of medications and more expensive products to customers receiving treatment than did personnel in stores buying from wholesale pharmacies. The Sagrado Corazon and Sta. Teresa also made available two

services not found in the other pharmacies: the administration of injections and credit. These differences reflected the greater pressures exerted by sales representatives on owners to purchase and sell a wide range of medications.

It remains to be explained how the pharmacy owners came to rely on the different distributional networks, especially in light of the finding that purchasing from pharmaceutical firms and distributorships was the most profitable way to run a business. It was a widely held opinion among townspeople that Don Oscar of the Antigua had failed to keep up with the times whereas Don Francisco of the San Judas had little need to do so. While this was an accurate assessment of their situations, an understanding of how it came about can only be achieved through considering the four store owners' personal histories in the context of the introduction of western medical service.

The Introduction of Western Medicine

Asunción obtained its first regular access to western-trained physicians with the establishment of the government-sponsored health center in 1950. Before that time, physicians had resided in the town only briefly. Healing was carried out by local curers. Asunción was a center for traditional healing, and some of its curanderos were famous throughout the country for their skills. These curers relied on plants and herbs to treat patients or referred them to pharmacies with prescriptions for pharmacy-made products. The most successful pharmacy during this era was the Antigua. The father of the present owner and some of his clerks were well known throughout the region for

their pharmacy-made medicines. Don Oscar inherited the store from his father in the 1930s, and it continued to serve the same community needs until the 1950s.

The arrival of the health center in 1950, coupled with improvements in the transportation and communications networks in the country and the rapid growth and development of the multinational pharmaceutical industry, significantly altered this system of reliance on local healers and locally made medicines. The first doctor assigned to the health center, Dr. Alvaro Castillo, a native of Asunción, set up his own pharmacy, the Sta. Teresa. Although it is illegal in El Salvador for physicians to own pharmacies, Don Alvaro was able to circumvent this law. He was trained as a physician in Mexico and, while he practiced medicine in El Salvador for many years, he was never formally licensed to do so. With the establishment of his store, Don Alvaro hired clerks from the Antigua and began selling a line of traditional remedies, in addition to modern pharmaceutical products.

Shortly after the establishment of the health center and the Sta. Teresa another native son returned to the community. Dr. Francisco Velez was the son of a successful shopkeeper. While he inherited only a small plot of land, he had been well educated, having received a degree in pharmacology from the National University. Upon completion of his studies, he returned to town and established the San Judas. As a longstanding friend of Don Alvaro, together they determined the medicinal needs of the health center and stocked their pharmacies

accordingly. Don Francisco also cut into Don Oscar's business by establishing a line of pharmacy-made remedies.

Until the late 1960s, Don Francisco devoted himself to the pharmacy business, purchasing stock from pharmaceutical firms and distributorships. Profits from the shop allowed him to buy extensive rural and urban properties. By 1979, these business interests were very successful, and most of his attention was devoted to them. As he lacked the time necessary to work in his pharmacy or to deal with the sales representatives, Don Francisco now purchased his stock from wholesale pharmacies. This change in source of supply clearly reflects the growing importance of his property holdings and the declining role of the pharmacy in his business ventures. Although Don Francisco was the only owner with formal training in drug use, he was only rarely available for consultation in his store. The pharmacy was staffed by his wife and two hired clerks.

In Don Francisco's case, purchasing from wholesale pharmacies actually reflected the success he had achieved in the pharmacy business. For Don Oscar, however, it reflected the inabilities of his shop to compete with the other pharmacies in Asunción. Don Oscar's failure to adapt to the changing times was an outgrowth of the nature of his competition. As the first regular physician, Don Alvaro was initially in a unique position to create a need for western medicines and to monopolize their sales. Don Francisco's training in pharmacology, coupled with the increasing reliance on and faith in western drugs, allowed him to successfully work with Don Alvaro. In effect,

Don Oscar's business was slowly undermined as the local medical system he had participated in gave way to a nationally oriented health-care structure.

The newest and most successful pharmacy, the Sagrado Corazon, was established in the early 1970s by Lorena Gomez. Like the other pharmacy owners, she was born in Asunción but, as the daughter of an agricultural day laborer, had received little formal education and no inheritance. As a child, Lorena worked as a clerk in the Sta. Teresa and in a successful pharmacy owned by her uncle located in Sonsonante. It was largely because of this family connection that she was able to establish the pharmacy in Asunción. The owners of the other three shops were opposed to the opening of a new pharmacy and tried to block her petition to the Junta for a license to operate. But, since her uncle was serving at the time on the Junta, he threatened a general inspection of the pharmacies in town. The owners backed down; Lorena borrowed the money from her uncle and established the Sagrado Corazon. In the seven years she had been in business, she had purchased exclusively from pharmaceutical firms and distributorships. Her business was successful enough to allow her to purchase a small apartment complex and some rural properties. At the time of this investigation, Lorena was considering the establishment of a second pharmacy in town.

While it is difficult to evaluate the effects of her business on the profit levels of the other pharmacies, there is little reason to believe that their sales declined because of the presence of her

store. The population of Asunción has increased by approximately one-third since 1970. In addition, the per-capita consumption of medications may have increased. This possibility is reflected in a comment made by Don Francisco regarding the effects of Lorena's shop on his business. He stated that sales in his pharmacy had actually increased since she established her store. Because the Sagrado Corazon sold a wide range of pharmaceutical products, he felt that the shop had increased the population's familiarity with and dependence on modern medications.

The impact of the present means of promotion, distribution, and sale of pharmaceutical products extends beyond health care dispensed in pharmacies. In the final section of this chapter, the effects of the ready availability and widespread use of modern medications on the health system and on the process of medicalization in Asunción will briefly be reviewed.

Medicalization and Commerciogenesis

The absence of reliable information on medicines, coupled with their over-the-counter sale, their integration into the healing strategies of popular-sector practitioners, and their use in self-treatment and preventive regimes has altered Asunción's health system. It also has resulted in a form of medicalization that differs from that found in contexts where physicians and other western biomedical practitioners control access to medicines. To explore the process of medicalization, some initial discussion of the concept is necessary.

In his work, Medical Nemesis, Ivan Illich (1976) used medicalization to refer to the growing tendency in western society to define problems of living in medical terms and to seek solutions by consulting licensed medical practitioners. He suggested that the iatrogenic (physician or medical system induced) consequences of this dependence were part of the medical system itself and appeared whenever western biomedicine gained a predominant position. To combat the various forms of iatrogenesis, Illich called for the deprofessionalization and demonopolization of the medical establishment and a return to individual and community autonomy in defining and treating illness.

In Asunción, where the penetration of multinational pharmaceutical firms and their products has fostered the development of popular-sector practitioners (pharmacy clerks, idóneos, injection givers and alternative healers and others discussed in Chapter VI who rely on pharmaceutical products), a type of medicalization has occurred which is only tangentially linked to the presence of physicians, a point Illich does not fully explore in his brief discussion of the pharmaceutical industry. Here and in other similar contexts, monopolization does not exist. No one healer or medical tradition exercises a degree of control over defining what constitutes illness or how it should be treated comparable to that of physicians in the U.S. What has taken place instead is a growing dependence on a particular form of therapy--prepackaged medications usually manufactured by multinational firms--and a reliance on a range of agents and institutions that make them available. Since this dependence is channeled

through practitioners representing a variety of medical traditions and, ultimately, is tied to the business firms that manufacture, promote, and sell the products, it will be called *commerciogenesis*.⁷ This perspective casts doubt on Illich's analysis of the causes and his proposed solutions to the problem of medicalization and lends support to previous critiques of his work by Navarro (1976), Berliner (1977), and Waitzkin (1976).

In Asunción, three forms of *commerciogenesis* resulting from the process of medicalization were identified. These parallel the cultural, social, and clinical forms of *iatrogenesis* discussed by Illich for the western developed countries, but, as this dependence is channeled largely through popular-sector practitioners, they assume a somewhat different form.

Cultural Forms of Commerciogenesis

The penetration of products manufactured by multinational pharmaceutical firms has altered patterns of reliance on less expensive, but in many cases, equally effective remedies made by Salvadoran firms, in pharmacies, or at home which previously existed in town. As indicated in Chapter VI, it has also reduced the use of medical practitioners who continue to depend on locally made products.

In the early part of this century, Asunción was a center for traditional healing, and some of the local curers were well known throughout the country for their skills. The most famous in recent times was Juana Torres, who died approximately 25 years ago. She reportedly was accused by a physician of being a fraud and was called

before the national legislature where she successfully defended her practice on the grounds that doctors could not treat conditions such as hexes or spells (males) since they did not regard them as illnesses. Curers like Juana Torres relied on a variety of techniques to treat patients and often referred them to pharmacies with prescriptions for pharmacy-made products. Few alternative practitioners still rely exclusively on traditional healing strategies. As reported in Chapter VI, the majority now also use prepackaged medicines.

A second example of the ways in which local-level medical resources have been altered by the penetration of the multinational pharmaceutical firms concerns the Antigua. This pharmacy was known in the 1930s and 1940s for its store-made medicines and was an integral component of the community-centered health system. Although it still stocks these remedies, this pharmacy has suffered a steady decline as customers and healers have come to rely on prepackaged products.

In addition to these alterations, new medically related specialties such as injection giving have developed in response to the ready availability and widespread use of western drug products. There were at least five women in Asunción who supplemented their families' incomes by administering injections. One was a nurse who worked at the health center, but the others had received no formal training. Although these women did not routinely diagnose illness or prescribe medication, they provided an important service, administering intramuscular and intravenous injections and sometimes I.V. drips to

clients.⁸ Other sources of health advice were the pharmaceutical company sales representatives and street and market vendors.

The growing dependence on prepackaged, name-brand pharmaceutical products also affects the success of public-sector policies designed to curb the unregulated use of medications. To reduce unauthorized drug use, the government-sponsored health facilities provided medical services and medications free of charge but did not inform the patient of the name or manufacturer of the product dispensed. Townspeople interviewed during the course of the research cited this policy as an important reason for not using the health center. Because patients were not informed of the name of the product they were prescribed, they were unable to purchase additional quantities at the pharmacies for the treatment of subsequent episodes of the same illness. The lack of brand name and manufacturer on the medicines provided at the health center led clients to believe that these products were inferior to medications sold at the pharmacies. It is clear that public-sector policies such as this one have difficulty competing successfully with current private-sector promotional practices and the resultant habits of drug use.

The manner by which access to medicines is mediated has resulted in a popularization of medical traditions, a decline in indigenous healing, and created new medical specialties. In many cases, it appears that these developments have neither necessitated nor produced radical modifications in beliefs regarding etiology and diagnosis. Nor have alternative and lay healing strategies simply

been replaced by western therapies. Instead, western medicines and, sometimes, disease terminology, dress, and other paraphernalia (Woods 1977, Cosminsky and Scrimshaw 1980, Landy 1974) have been integrated into alternative medical traditions and lay concepts of illness. Considerably more work needs to be conducted on how these products are used by alternative curers, a point barely touched on in this study. The information presented here has focused on their integration into pharmacy personnel's and townspeople's conceptualizations regarding illness, a process that often has serious social and clinical repercussions, as detailed in the following sections.

Social Forms of Commerciogenesis

The growing reliance on modern medications often drains away resources without providing any long-term improvements in health status. Dependence on these products, and on the agents and institutions that dispense them, fosters the notion that the solution to illness lies in the consumption of medicines rather than in improvements in living conditions. Radio, television, and newspaper advertisements contribute to this belief. Although prescription drugs were not advertised in the mass media, large companies such as Bayer indirectly promoted their use by suggesting that the quality and efficacy of their products were superior to those of other companies and that a feeling of well-being and health could be obtained by using their products. One of the town's idóneos wrote most of his prescriptions on Bayer prescription forms, thus linking his practice with the company's reputation for quality.

Although vitamins and vermifuges manufactured by pharmaceutical firms may be effective in treating malnutrition and parasitic infections, the prevention of these conditions awaits a more equitable sharing in the country's wealth and a greater commitment on the part of the government to improved water supply, sanitation, and other public health measures. The heavy reliance on medications to treat colds, parasite infections, and malnutrition results here, as elsewhere, in a cycle of disease-treatment-disease that benefits pharmaceutical firms but does not alter the conditions under which people live and that account for their illnesses (Segall 1975, Gish and Feller 1979, Young 1978).

The Musto family illustrates this cycle. Mr. Musto was sporadically employed as a day laborer. His 19-year-old wife worked as a street vendor. The family's average monthly income was about C75 (\$30.00). As Mrs. Musto was frequently away from home, her children, ages nine months and two years, were left in the care of her eight-year-old nephew. The two children were sick with upper respiratory or gastro-intestinal infections on each of the visits made during the illness episode survey.

When Mrs. Musto could afford care, she generally took the children to the Sta. Teresa pharmacy. On one occasion, I was present when she came in for advice and treatment with her younger child and her husband. The baby, who had a cold and fever, was prescribed one injection of Terrabron (tetracycline and nystatin), Bactrim (trimethoprim and sulfamethoxazole) in liquid form, and four Asawin (aspirin

compound) tablets. The parents also asked for advice regarding vitamin tonics because their children were so thin and sickly. They were recommended Optotonico (a Merck product) and Ferrocebrina (a Lilly product whose name suggests strengthening of mental acumen). Mrs. Musto had a sty and was prescribed Stetlin (tetracycline) ointment. The bill for these medications totaled C30.00 (\$12.00), which represented 40% of the family's average monthly earnings. Three weeks later, on a regular visit to the home, the children were again sick.

Although some of the diseases found in Asunción can be treated effectively through curative services and others are responsive to vaccination campaigns (McDermott 1980, Foege 1979), the most frequent causes of illness and death--upper respiratory and gastro-intestinal infections, coupled with malnutrition--can only be solved by alterations in sociopolitical and economic conditions and, hence, are beyond the scope of purely medical interventions (Smith 1979, Dubos 1959, Segall 1975). To suggest, as McDermott (1979, 1980) has, that a major effort be launched by multinational pharmaceutical firms in conjunction with international health agencies, national governments, universities, and national pharmaceutical firms to solve Third World medical problems ignores the kind and amount of investment the multinational companies already have in these areas and their impact on national pharmaceutical industries and on public-sector health budgets. These broad social consequences of the pharmaceutical invasion are detailed in works by Lall (1974, 1977), Bertero (1972), Evans (1979), Katz

(1973), and Gish and Feller (1979), and were alluded to earlier in this chapter.⁹

Clinical Forms of Commerciogenesis

Drug-induced illnesses resulting from misuse of medicines were a fairly common phenomenon in Asunción. Three cases were reported in the illness episode survey. One of these, an allergic reaction to an antibiotic, required hospitalization. A local injection giver told me that clients sometimes experienced a rash after an injection of antibiotics but that this was no cause for alarm. Another case, ending in death, illustrates the possible effects of the integration of modern medicines into lay and alternative medical systems.

The four-month-old daughter of the Martinezes, a middle-class family, had suffered from upper respiratory infections since her birth. She had been treated by a private physician and at the health center for bronchitis. On March 17, the baby had difficulty breathing and was taken to the health center by Mrs. Martínez, her mother, and sister-in-law. After waiting two-and-a-half hours, they left the clinic and, at the urging of the sister-in-law, went to an idóneo. He administered a "strong" injection, prescribed Binotal (ampicillin) and Broncovinotal (cough syrup), and told Mrs. Martínez that the baby should be given only these drugs to avoid a possible clash of medicines (choque de medicinas).

The baby initially responded to the treatment, but early the next morning again was unable to breathe and shortly thereafter she died at home. Although her condition had worsened, no other sources of

care were sought because of the family's faith in the idóneo's advice regarding the strength of the injection and the possible effects if combined with other drugs. Mrs. Martínez's explanation of the death of her daughter combined popularized western notions of illness and medicines with beliefs in witchcraft. She stated that, as the weakest family member, the child had died of bronchitis as a result of a hex sent to her by an undetermined source.

Pharmacy clerks were often confused by the proliferation of identical products with different brand names. They prescribed medicines such as Hostacilina to patients allergic to penicillin, unaware that Hostacilina is penicillin. The use of small doses of antibiotics for conditions such as colds poses another health problem. As noted above, misuse of these products may result in the development of drug resistant strains of infectious disease, a problem reported in many developing countries (National Academy of Sciences 1979).

The lack of package inserts describing indications for use, dosage, contraindications, and warnings also led to product misuse. For example, one of the pharmacy owners was hospitalized as a result of an overdose of a Mexican product, Lisalgil, to treat a headache. There was no information on the medication in the FLM, and the package contained no information regarding dosage, only very general indications for use and a label saying the product should be sold only with a physician's prescription.

These cultural, social, and clinical manifestations of commercialization affected all social classes in town. Although both the

members of the lower class and the middle and upper classes shared a reliance on modern medicines usually manufactured by the multinational firms, this dependence was mediated in somewhat different ways. Among the middle and upper classes, this dependence was usually channeled through physicians, the most frequently used sources of treatment for these households. Nevertheless, to refer to this as iatrogenesis, as Illich does, is misleading. It confuses instrumental personnel--physicians and other western biomedical practitioners--with causal agents--pharmaceutical firms and government policies regarding the pharmaceutical and health sectors. In the case of lower-class families, reliance on modern medicines was largely channeled through popular-sector medical practitioners such as the idóneos and other pharmacy personnel. In both instances, it is clear that medicalization was not dependent on the monopolization of the health sector by any one type of practitioner or medical tradition so much as on the socioeconomic and political structure that facilitated the penetration of the medicines and their use by a variety of practitioners and by townspeople in curative and preventive regimes.

Conclusion

To summarize, both in the area of prescribing practices and in the area of customer services, significant differences were found between pharmacies obtaining stock from pharmaceutical companies and distributorships and those purchasing from wholesale pharmacies. The owners of the Sagrado Corazon and the Sta. Teresa were under pressure

from the sales representatives to buy a wide range of medications. If they failed to do so, the sales representatives, whose incomes were largely dependent on commissions, would no longer visit the stores. These owners also were encouraged to buy large quantities of products to take advantage of the price discounts. These sales offers allowed them to purchase medications more cheaply than the owners of the Antigua and San Judas. The Sagrado Corazon and Sta. Teresa attracted more customers by passing some of these savings along to clients in the form of slightly lower than Junta-set prices on the medications they sold. The owners of the San Judas and the Antigua, in contrast, obtained their stock from wholesale pharmacies which neither offered the same sales benefits nor exerted direct pressures to purchase large quantities or varieties of drugs. While the profits at the San Judas and Antigua were not as great as at the Sagrado Corazon and Sta. Teresa, neither were the pressures to sell.

The demands inherent in these different distributional networks were evidenced in prescribing patterns in the two groups of stores. While all the shops tended to prescribe similar quantities and dosages of a medication, pharmacy personnel in the Sagrado Corazon and Sta. Teresa consistently recommended more expensive medications and more types of medications to customers seeking treatment than did the stores relying on the other distributional network. The average amount spent by those who asked for advice in the Sagrado Corazon and Sta. Teresa was greater than in the other pharmacies across all illness categories. The average amount spent by customers who

purchased without consultation also was greater, reflecting both the wider range of products and the more expensive medications sold in these establishments.

The pressures to sell which grew out of the distributional network the owners of the Sagrado Corazon and Sta. Teresa were tied into also were evident in the area of consumer services. To increase reliance on their stores, the owners of the Sagrado Corazon and Sta. Teresa offered credit to select customers and administered injections to clients who purchased them in the establishments even though there were well-known risks involved in these practices.

The owners purchasing from pharmaceutical firms and distributorships are among the most successful business people in Asunción, reflecting the profits to be made through participation in this supply network and the growing reliance on pharmaceutical products. Further, and perhaps of more importance, the ready availability of pharmaceutical products has altered local-level systems of healing and has resulted in a form of medicalization different from that found in more developed contexts. A dependence has been created on a particular form of therapy, modern brand-name and often prescription medications, and on the agents and institutions that make them available rather than on a particular type of practitioner or medical tradition. In Asunción, this dependence has altered local health-care traditions and means of coping with illness, has drained away resources without providing any long-term improvements in health status, and has caused illness.

CHAPTER VIII

SUMMARY AND CONCLUSIONS

This study has drawn attention to the relationship between social organization, health status and use of medical resources in Asunción, and the broad patterns of change in El Salvador since 1932. In contrast to anthropological investigations that study communities and health systems solely in terms of themselves or in terms of local-level social psychology, this investigation has emphasized the embeddedness of the community and its medical traditions in the socioeconomic and political fabric of the nation and international capitalist system. While the investigation relies on a political economy perspective, it seeks to discover the nexus between political economy and anthropology in its focus on the interrelationship between structures and processes on the micro and macro levels. This concluding chapter briefly summarizes the major findings of the study and considers research and policy implications.

Summary

The investigation began with an introductory chapter which briefly reviewed micro-macro analysis in anthropology, drawing special attention to recent studies which extend this analysis to research on medical systems. Part I, consisting of four chapters, outlined the

major socioeconomic and political trends in El Salvador and their effects on community social organization.

In Chapter II, Asunción's history was presented from its founding in the eleventh century through 1932, and a review was undertaken of national-level socioeconomic and political developments since that time. The town's mode of integration into first the Spanish Empire and later the nation-state of El Salvador allowed modified indigenous political and sociocultural characteristics to persist here longer than elsewhere in El Salvador. The 1932 uprising that took place in Asunción and other southwestern communities influenced the town's and the nation's subsequent political and economic evolution. In Asunción, the massacre after the revolt seriously undermined the indigenous community and led to the abandonment of most of the outward trappings of Indian identity. On the national level, the military assumed control over the presidency and top government posts for nearly 50 years.

The alliance of interests between the military and the elite has resulted in economic development that benefited the small upper class but led to increasing impoverishment for the majority. In the agricultural sector, small farmers lost access to land, food production declined, reliance on wage labor grew, and underemployment, unemployment, and rural outmigration increased as a result of the expansion and diversification of export crop production. In the industrial sector, the movement toward economic integration and the formation of the Central American Common Market led the agrarian elite to diversify

their interests though establishing manufacturing plants linked with foreign and especially U.S. capital. Only a small number of new jobs was created, and the economic well-being of many engaged in small-scale commercial activities and in artisans and trades occupations was undermined. This form of industrialization has resulted in a decline in imports of finished products but created a new and growing dependency on imported technology, raw materials, and semi-elaborated parts.

These political and economic trends are reflected in the health status of the population and in the organization of the official medical system. High levels of malnutrition and infectious and parasitic diseases characterize the lower class and, especially since 1979, government security forces have been responsible for large numbers of people injured or killed. Most government spending is allocated toward curative rather than preventive and public health services, and the poorly funded and understaffed public-sector medical facilities are unable to deal effectively with the burden of recurrent illness that characterizes the population.

Chapter III examined these broad political and economic trends' effects in Asunción. The town's history as an indigenous community and as a seat of the 1932 peasant revolt, its location on a highway, and its proximity to Sonsonante are all factors that influenced its socioeconomic organization and that modified the impact of national-level policies favoring increased export crop production and dependent industrialization. In contrast to other more geographically isolated towns where there are few employment opportunities outside the

agricultural sector, many people in Asunción who were displaced by increasing land concentration have sought employment in the trades and artisans sector. Asunción's location on a highway and its proximity to Sonsonante have facilitated this process. Nonetheless, many individuals in the artisans and trades sector, similar to those earning livings as agricultural day laborers, are only marginally employed.

The information gathered during the community census indicated that household heads in the agricultural and day-laboring sector and many of those in the artisans and trades sector had low levels of education and lived in poor-quality dwellings lacking potable water and adequate sanitary facilities. They also had more family members in the labor force than did household heads in the white-collar, semi-professional, and professional sectors. Asunción's proximity to Sonsonante has permitted it to retain and attract more households in this latter category than would be the case in a more geographically isolated town. These factors have resulted in the town gradually assuming the status of a middle-class suburb vis-à-vis its larger neighbor, Sonsonante. Overall, however, the population appears to be increasingly mobile with considerable out-migration of the youth and a growing commuter population.

Chapter IV explored the implications of this increased mobility, and the macro-level political and economic trends underlying it, for class and ethnic divisions. The town census revealed that approximately one-fourth of households were indigenous. While Adams

suggested that Indian culture persisted in the 1950s in part because the Indian population had not been converted into wage workers, by the time of this study the situation had changed. Few Indian household heads owned sufficient land to support their families, and most worked as agricultural day laborers or artisans.

Other changes in the Indian community included a reduction in the number of indigenous brotherhoods. Those few brotherhoods that have prospered have done so largely because of Ladino participation or because their celebrations correspond with events important to the town as a whole and offer a means of generating income for a wide array of townspeople. In this sense, elements of the indigenous culture are being drawn on to serve interests broader than those of the Indian community alone. In particular, as Asunción is incorporated as a suburb to Sonsonante and as its population becomes increasingly mobile, its indigenous heritage is being used to maintain a separate identity.

Relying on the census information, a stratification procedure was developed that resulted in the delineation of three classes. The lower class, comprising nearly two-thirds of the population, was composed of households that had access to few resources and whose members worked as poorly remunerated wage laborers in the agricultural and day-laboring sector. The middle class represented nearly one-fourth of the population. It consisted of the more successful artisans, tradespeople, and white-collar workers. The upper class comprised slightly over one-tenth of the population and included

successful store owners, semi-professionals, professionals, and owners of large estates.

The indigenous population was disproportionately represented in the lower class. Nearly nine-tenths of the Indian households in the census sample were members of this class. Further, within the classes themselves, indigenous families often had lower levels of education and lived in poorer-quality dwellings than did their Ladino counterparts. Indian households were considered as ascriptive class segments (Barrera 1978, 1979) in that their indigenous identity has influenced their class position and their relationship to the productive process.

Chapter V examined class and ethnic differences in domestic organization. A greater proportion of household heads in the middle and upper classes than in the lower class was legally married, and more of those in the middle and upper classes lived in nuclear family arrangements than did those in the lower class. Nearly one-fourth of the households in the census sample were headed by women, and three-fourths of these women were members of the lower class. Nieves (1979) has proposed that these consanguineal units represent flexible living arrangements that contribute to the members' well-being. The information presented here, however, suggests otherwise. Although consanguineal households may represent a survival strategy allowing women in the lower class to combine work and domestic responsibilities, these units are not means to take advantage of economic opportunity so much as an outgrowth of the lack of opportunity.

With regard to ethnic differences, the census revealed that indigenous household heads were more likely to be living in some form of marital relationship (either legally married or in a common-law arrangement), and fewer of these households were headed by women than among the Ladinos. While more detailed information on the indigenous community is necessary to determine the reasons for these differences, it is likely that the higher proportion of Indian household heads in marital relationships reflects the combined influence of cultural and economic factors.

In Part II of the study, the relationship between class standing and health status and use of medical resources was considered. Chapter VI reviewed mortality and morbidity information gathered from municipal and health center records. The leading causes of illness and death in the municipality were the diseases of poverty--gastro-intestinal and upper respiratory disorders. An illness episode survey was carried out to determine class and ethnic differences in the prevalence of health problems and in use of medical resources. This revealed little difference in the kinds of illnesses reported in the lower class and the middle and upper classes but did indicate that lower-class households had a greater rate of illness than did middle- and upper-class households. Women in the lower class also reported more deaths of children under the age of five than did women in the middle and upper classes. Very few middle- and upper-class indigenous families were included in the survey. In the lower class, however,

indigenous women reported a greater prevalence of illness than did their Ladino counterparts.

The role of work patterns and household composition in explaining class variations in reported illnesses was considered. In the lower class, the need for women and other adults to contribute to the family's financial support resulted in children often being left alone or in the care of young siblings. In these situations, many children were chronically ill with acute conditions, and many women were unable to specify when illnesses among their children began and ended. In the middle and upper classes, in contrast, women were not as likely to work outside the home and, when they did, other family members and domestic servants took care of the children. In these contexts, illnesses generally received prompt attention and were experienced as more bounded or discrete phenomena.

Chapter VI also explored the use of medical resources. Nearly three-fifths of the illnesses reported in the survey never reached the attention of formal health-care practitioners. Most of these were treated at home with herbal or modern medicines and/or alterations in diet and other behavioral changes, but, in a small percentage of cases, nothing at all was done for the condition. More illnesses in the lower class and more of the illnesses reported among Indian households received no treatment or were treated at home than were the illnesses in Ladino households.

The type of dichotomous traditional-modern framework usually employed in studies of health-care utilization in Latin American

countries did not adequately reflect the structure of Asuncion's health sector. The illness episode survey revealed that few townspeople relied on traditional healers. The only one who was used during the survey was a man who practiced the old arts of massage, bone setting, and curing with herbs. Instead, most illnesses were treated by physicians and other representatives of western biomedicine and by what are here termed popular-sector practitioners: pharmacy personnel, medicine vendors, and some alternative curers. These popular-sector practitioners relied on prepackaged pharmaceutical products as an important healing strategy, and their philosophies of disease causation and cure represented popular variants of western and alternative or lay medical traditions. Thus, instead of a traditional-modern dichotomy, a three-part framework consisting of the western biomedical sector, the popular sector, and the traditional sector was employed to examine use of medical practitioners.

The illness episode survey revealed class differences in reliance on health practitioners. Almost three-fourths of the illnesses in middle- and upper-class families were taken to physicians, and one-fourth were treated by popular-sector practitioners. In the lower class, in contrast, almost three-fifths of the illnesses were treated by popular-sector practitioners, two-fifths were seen by physicians and western biomedical practitioners, and the remainder received care

from traditional practitioners. Few ethnic differences were found in utilization patterns.

While many researchers have focused on how health-related beliefs influence choice of practitioner, little attention has been paid to the dialectics involved in the relationship between practitioners and patients and to how use of medical resources influences beliefs. Efforts were made in Chapter VI to examine how class differences in use of medical practitioners influenced the duration of illness, illness terminology, and beliefs regarding the causes of ill health.

Chapter VII explored the role of pharmacies in the delivery of health care and in the development of popular-sector medicine. An overview of the operations of the multinational pharmaceutical industry in developing countries was provided, and the national-level regulatory structure and marketing networks for modern medicines in El Salvador were outlined. Pharmacy owners in Asunción relied on two different private-sector distributional networks in purchasing medicines. The owners of the Sagrado Corazon and Sta. Teresa bought from sales representatives of pharmaceutical companies and distributorships which were directly linked to the multinational firms, while the owners of the San Judas and Antigua purchased from large wholesale pharmacies. The sales representatives of the pharmaceutical firms and distributorships made available a variety of discounts that could not usually be obtained from the wholesale pharmacy supply source. Many of these discounts were only offered on the newer, usually more

expensive, medicines or required that pharmacy owners purchase large quantities of products.

The demands inherent in these two distributional networks were clearly evidenced in prescribing patterns at the two groups of stores. Pharmacy personnel at the Sagrado Corazon and Sta. Teresa consistently recommended more expensive medications and more medications to customers seeking treatment. The average amount spent by customers in these stores was greater across all illness categories than at the San Judas and Antigua.

The pressures to sell which grew out of the distributional networks the Sagrado Corazon and Sta. Teresa were linked to were also evident in the area of customer services. To increase reliance on their stores, the owners of the Sagrado Corazon and Sta. Teresa offered credit to select customers and administered injections to clients who purchased them, even though there were well-known risks involved in these practices. Partly because of these services, and partly because the prices of some medications were less at the Sagrado Corazon and Sta. Teresa than at the San Judas and Antigua, families in the lower class relied more heavily for medical care on the Sagrado Corazon and the Sta. Teresa than they did on the other two stores.

More generally, pharmacies were an important nexus point among medical traditions in Asunción. In addition to serving as sources of treatment in their own right, they were sources of medications used by townspeople in home treatment regimens, by alternative curers, and by physicians and other western biomedical practitioners. The ready

availability of modern pharmaceutical products through pharmacies has fostered pluralism in the medical sector and has altered local systems of healing. New treatment resources have developed (injection givers, pharmaceutical sales representatives), many alternative medical practitioners have integrated these products into their healing strategies, and curers who rely solely on traditional means of treatment have seen their clientele dwindle.

Pharmacies also were an important nexus point between the business and medical sectors of society. As sources of medications in their own right and as sources of products used by a wide array of other medical practitioners, they have fostered the commodization of health. A form of medicalization has resulted that differs from that found in the developed countries. Illich (1976) notes that in the western developed countries, there is a growing tendency to define problems of living in medical terms and to seek solutions to these problems through reliance on the western biomedical establishment. In Asunción, in contrast, a growing dependence exists on a particular form of therapy--modern brand-name and often prescription medications--and on the agents and institutions that make them available rather than on any one type of practitioner or medical tradition. This has resulted in the development of cultural, social, and clinical forms of commerciogenesis, or commerce-induced disease.

Implications and Directions for Future Research

This study has substantive and theoretical implications for Middle American and medical anthropological research. The implications for Middle American studies will be discussed first.

Middle American Community Studies

With the exception of ethnographies on Guatemalan Indian populations, relatively few community studies have been undertaken in the Central American region. At least in part, this results from social scientists' general neglect of the area until the recent civil unrest made it once again of strategic interest to the U.S. Further, since the mid-1970s, the struggle for liberation underway in El Salvador and Guatemala has limited anthropological field work in these countries.

However, factors related to the discipline of anthropology also must be considered in analyzing the causes of the neglect of community studies. Community investigations, once regarded as the domain and area of expertise of anthropologists, have increasingly been abandoned by them in efforts to grapple with broader systems and structures. Thus, studies of national-level political and economic trends and more focused investigations of peasant unionization, land reform, and agroexport industries have replaced holistic studies of local contexts. While these investigations have contributed to our understanding of the region, they do not address the family and community context and structures in which most people live out their lives. Thus, the challenge to examine the relationship between micro and macro processes at the community level has not been adequately met.

Such investigations must be grounded in the study of local-level structures, processes, and history, in addition to the wider political economy, if we are to fully grasp the meanings of transformations underway in Central America. A primary aim of this study was to identify and examine changes in community-level structures that mediate between the micro and macro levels. Attention was focused in particular on the relationship between the broad socioeconomic and political processes in El Salvador and class and ethnic divisions and domestic organization in Asunción. This approach and the information it provides may serve as a basis for more finely tuned studies of community-level change in the future.

Medical Anthropological Investigations

The health implications of the socioeconomic and political changes which have taken place in Asunción were of central concern in this investigation. One of the most important substantive issues raised concerns the function of popular-sector medicine in the broad political economy.

In El Salvador, as in many Latin American countries, the over-the-counter sale of prescription drugs and the prescribing of these products by other than licensed medical practitioners is technically illegal. Nonetheless, the Salvadoran government has opted to permit a two-tier, or parallel delivery system for pharmaceutical products to develop (see Ledogar 1975 for a similar analysis of Brazil). In Asunción, for example, middle- and upper-class families have access

to private physicians and to any medications from pharmacies that they wish to purchase and use. Families in the lower class, on the other hand, cannot afford private physicians on a regular basis nor can the public-sector government clinics, as they are presently structured and operate, meet their health needs. Instead, lower-class families rely heavily on popular-sector practitioners, especially pharmacy clerks, for medical care. Thus, the popular sector represents an alternative personal service system for the delivery of health care. These practitioners provide access to a powerful treatment resource of western biomedicine--prescription medications--without the government having to underwrite the costs of delivery or to improve or extend its public-sector health-care system. The popular sector, then, is part of a complex of phenomena such as semi-proletarianization and the pattern of multiplicity of occupations in households discussed above, that permits the labor force to be reproduced at low cost.

The study also has theoretical implications for medical anthropology, raising the issue of the utility of the conceptual framework most commonly employed in this subdiscipline. Other investigators working in Latin America have noted that pharmacies and alternative healers who rely on pharmaceutical products are important healing resources, in many cases providing a major portion of the health care to the populations under study (Brown 1963, Cosminsky and Scrimshaw 1980, Harrison 1976, Laurell 1977, Ledogar 1975, K. Logan 1983, M. Logan 1973, Mitchell 1980, Murray 1977, Press 1971, Woods 1977). Even though popular-sector practitioners play an important role

in health delivery, many of these investigators continue to rely on a dichotomous traditional-modern framework in which medical practitioners such as pharmacy clerks are viewed as marginal or as representatives of a transitional stage on the way toward modernity and reliance on western biomedicine (see for example Woods 1977, Young 1981).

The assumption that these popular-sector practitioners are a marginal and transitory phenomenon appears unwarranted. The information presented here, in the other studies cited on Latin America, and in research conducted elsewhere in the Third World (Leslie 1976, Taylor 1976, Unschuld 1976, Van der Geest 1982, Weisberg 1982) suggests that the processes leading to the formation of the popular sector and to the type of medicalization described above are found in many other developing market economies subject to the penetration of multinational pharmaceutical firms. Where medical traditions are different or where access to pharmaceutical products is mediated in other ways, it is likely that other configurations of the popular sector and medicalization exist.

The point is, however, that there is little reason to believe that these are transitory formations that will be replaced in the near future by western biomedicine. In fact, this study suggests that the penetration of multinational pharmaceutical firms coupled with the government's deregulation of the sale of prescription medications fosters medical pluralism. In Asunción, for example, these two factors have permitted the development of new alternative medical

specialties, influenced the curing strategies of other healers, and created different habits and expectations of self-treatment among townspeople than those that exist in contexts where the use of prescription medications is more closely regulated and controlled by physicians.

The fact that the western biomedical system is not undergoing simple replication in developing countries, but instead reflects the needs of the socioeconomic and political structures of the societies in question, suggests that additional thought should be given to the conceptual frameworks and models commonly used in medical anthropology. A holistic approach, one that considers health in relationship to broad patterns of development and relates macro and micro phenomena, needs to be developed. In a review of the literature on women and health in Latin America, Browner (1985) notes that there are few studies of the impact of development on women's health. Potential areas for investigation include the health ramifications of the growing number of female-headed households and the effects of women's double work days on their own and their families' well-being. In this investigation, a somewhat different method was used to address the relationship between broad processes of change and health. Class and ethnicity were seen as key variables in examining the differential impact of socioeconomic change on health status and use of medical resources in Asunción.

A number of issues related specifically to pharmaceuticals warrant further research and consideration. First, investigation of

the impact of modern medicines on mortality and morbidity rates in developing countries is needed. In Western Europe and the U.S., mortality from many infectious processes had already declined significantly before the discovery of effective medications, due in large part to improvements in nutrition and public hygiene (McKoewn 1979, Dubos 1959). The revolution in drug-making that began in the 1930s with the discovery of sulfa products brought about further reductions. In countries such as El Salvador, mortality rates have declined apparently without significant improvements in nutritional status, public health measures, or increases in real income for the majority of the population. Although improvements in the transportation system and vaccination campaigns may have played an important role in this process, it is possible that the popular sector, as a personal service system for the delivery of modern medicines especially to the poor, has been a contributing factor. Declines in mortality, however, may also be accompanied by increases in morbidity, much of it unreported in official health statistics as alternative sources of care are used for treatment. In this context, modern pharmaceutical products may keep more people alive as the quality of health deteriorates.

Second, more detailed studies of popular-sector practitioners' use of modern medicines also are necessary. The information presented in this investigation dealt largely with the integration of pharmaceutical products into townspeople's and pharmacy personnel's conceptualizations regarding the nature and treatment of illness.

Considerably more work needs to be carried out on how modern medicines are integrated into the healing strategies of alternative curers, and what the health ramifications of such an integration are.

Policy Implications

Finally, this research has a number of policy implications. With regard to pharmaceuticals, the socioeconomic and political structure at both the macro and micro levels needs to be taken into account in designing programs to rationalize drug acquisition, use, and sale in developing countries. The need to exert control over the pharmaceutical industry and to limit the number of drugs available in public-sector health-care facilities is widely acknowledged in developed and developing countries. To deal with this issue in the Third World, the World Health Organization (WHO) began advocating the essential drug concept in 1977. Essential drugs are those that satisfy the needs of the majority of the population (WHO 1983). In public-sector health programs, different lists of essential medications for primary health-care centers, district health centers, and major referral hospitals may be necessary. A model list of essential drugs was published by WHO in 1977 and revised in 1979, 1983, and 1985. The current list includes approximately 240 medications and incorporates a guide to the selection of drugs useful in primary health care (Mamdani and Walker 1985).

National selection of pharmaceutical products is only one means of reducing medication expenditures and rationalizing the drug procurement system in developing countries. Other measures include use

of generic products and names, domestic or regional production of medications, and bulk purchase of products or ingredients. Those interested in an in-depth review of these and other options should consult Gish and Feller (1979), Patel (1983), and Mamdani and Walker (1985). These authors also discuss the problems encountered by Third World countries in implementing these measures in the public sector.

While some form of public-sector drug regulation is widely regarded as an essential means of controlling health-care costs, relatively few governments have undertaken regulation of pharmaceuticals in the private sector.¹ The findings of this study suggest, however, that programs to rationalize drug acquisition and use in public-sector health facilities may encounter difficulties when carried out in contexts where little effort is made to regulate and rationalize the private-sector production, importation, and distribution of medicines. For example, the Salvadoran government does not effectively regulate the private-sector importation or local manufacture of medicines, preferring to let free enterprise reign. In its public-sector health programs, however, the government has used generic products, dispensing them free of charge to patients. In Asunción, these medications were regarded as inferior to the brand-name products sold at pharmacies and prescribed by private physicians, and townspeople cited the supposed inferior quality of the generic products as an important reason for not using the health center. Thus, the government's stance on regulation of the private sector

undermines use of public-sector facilities where programs to rationalize pharmaceutical use have been implemented.

In planning programs to improve access to pharmaceuticals at the community level, three points deserve consideration. First, as this study has indicated, access to medications may be mediated differently than planners suppose. In many developing countries, physicians do not exert the same degree of control over one of their most powerful healing resources--prescription medications--as they do in developed countries. In Asunción and elsewhere in Latin America, alternative curers obtain and use prescription medicines, and untrained pharmacy clerks, owners of small shops, and vendors often prescribe and sell these products. As this and other investigations have demonstrated, these are primary sources of medical care for the poor. Given the reluctance of most private physicians to practice outside large cities and the low funding level of most public-sector health programs (including primary health-care initiatives), it is likely that alternative sources of care, especially popular-sector practitioners, will continue to provide most of the medical treatment to the poor in both rural and urban areas for years to come. Nevertheless, plans to train pharmacy clerks or to enforce laws requiring that pharmacies be staffed by trained personnel are rare. Outside of courses to upgrade the skills of indigenous midwives, programs to improve alternative healers' skills in use of modern medications are virtually nonexistent. Yet, in the absence of a thoroughgoing reform of the medical sector which would make western-trained primary and other health-care

workers more accessible, these are the individuals who must be reached with information concerning medication use.

A second point to consider in planning programs to rationalize drug use at the community level concerns the relationship between different kinds of practitioners. Programs to train existing community health-care providers--pharmacy personnel, alternative curers, and others--in use of modern medicines are likely to encounter opposition from the official medical establishment. For example, in Asunción tensions existed between doctors and pharmacy owners over the prescribing of medications. Here, the physicians at the health center were opposed to pharmacy owners' and alternative curers' roles in the delivery of medicines and health care, arguing that their lack of training in western biomedicine and their business interests seriously jeopardized the quality of care they dispensed. Similar opposition was reported in 1979 in the Ministry of Health over the initiation of programs to upgrade the skills of indigenous midwives and to train community health volunteers.

Finally, accurate information regarding medicines also needs to be made available to physicians, nurses, primary health-care workers, and others at the community level. Studies have indicated that the care these practitioners dispense is seriously undermined by the poor quality of information regarding drug use provided by multinational and national pharmaceutical companies (Silverman 1979, 1982).

Although measures such as these could improve the quality of care in Asunción, they do not address the roots of illness and, hence, may have little overall impact on well-being. Throughout this investigation, attention has been drawn to the relationship between health and the broader distribution of resources and power in society. In El Salvador, improvement in the health status of the majority of the population awaits thoroughgoing changes in the political and economic structure.

APPENDICES

APPENDIX A

STRATIFICATION PROCEDURE

<u>Score/Occupation</u>		<u>Score/Education</u>	
2	Agricultural Day Laborer	0	None
	Peon	1	1-2 grade
	Gardener	2	3 grade
	Cart Hauler	3	4-5 grade
	Domestic Servant	4	6 grade
	Cantina Owner	5	7-8 grade
4	Artisan	6	9 grade
	Vendor	7	10-11 grade
	Owner of Small Shop	8	12 & university training
	Housewife		
	Small-Scale Agriculturalist		
		<u>Score/Housetype</u>	
6	Clerical/Office Worker	1	Earthen Floors; Straw, Bahareque, Wood Walls
	Administrator		
	Bookkeeper	2	Earthen Floors; Adobe, Concrete, Brick Walls
	Nurse		
	Sanitation Inspector		
	Dental Assistant	3	Tile, Concrete Floors; Adobe, Concrete, Brick Walls
	Radio Technician		
	Police		
	National Guard		
	Owner of Med. Agric. Property		
		<u>Score/Possessions</u>	
8	Owner of Large Agric. Property	0	None
	Agronomist	1	Radio
	Lawyer		
	Doctor	3	Radio, TV
	School Teacher		
	Missionary	5	Radio, TV, Motor Vehicle
	Officer in the Military		
	Mayor		
	Owner of Large Store		

Figure A.1.--Construction of stratification index variables and scoring. (Source: 1978 town census.)

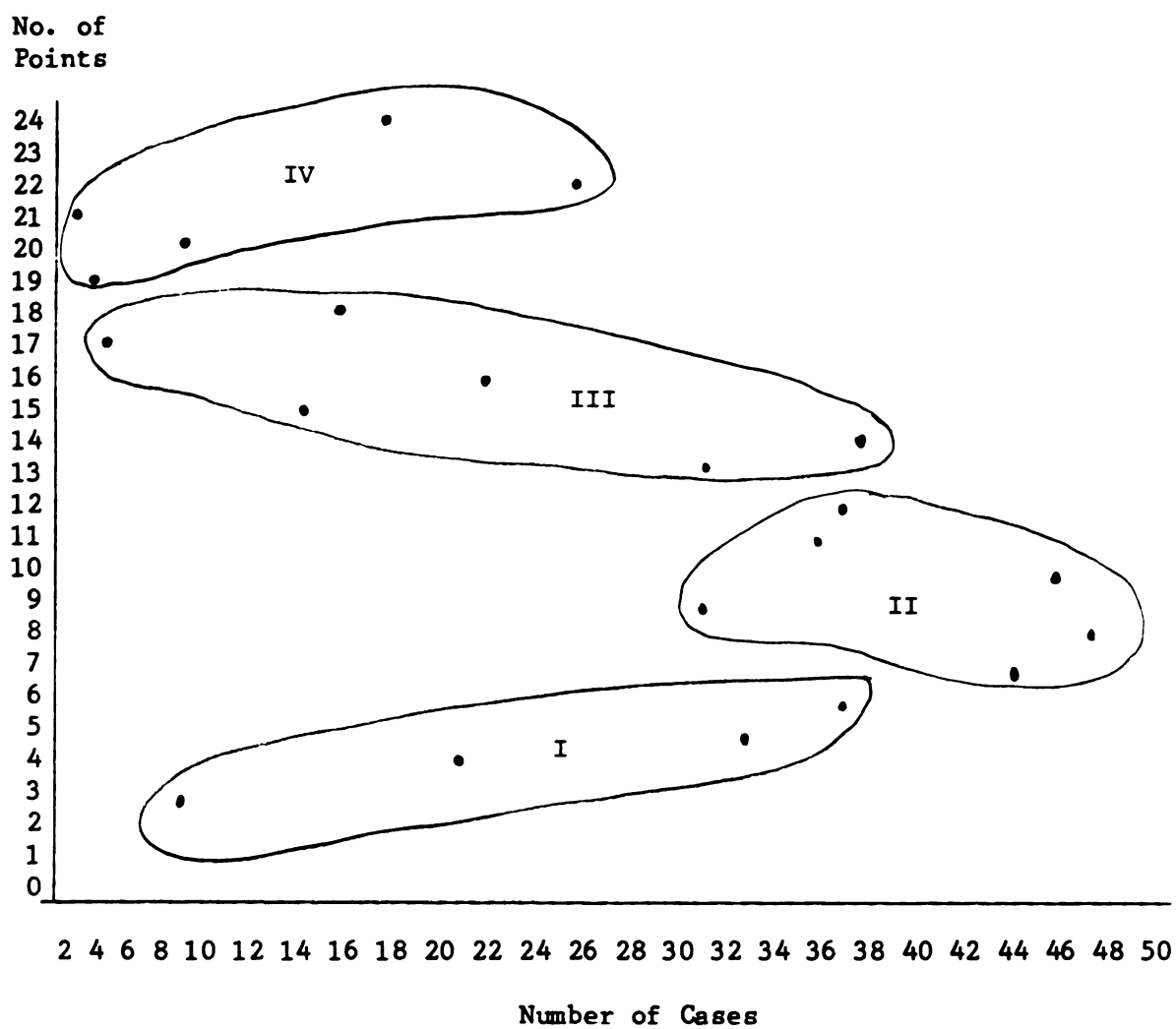


Figure A.2.--Socioeconomic strata by clusters.

APPENDIX B

HOUSEHOLD COMPOSITION

HOUSEHOLD COMPOSITION

- I. Single person household--23 cases, 12 female-headed
- II. Household head & adjunct kinsperson--27 cases, 15 female-headed
 - A. Male-headed households
 - 1. Mother of household head--2 cases
 - 2. Brother/sister--4 cases
 - 3. Nephew/niece--2 cases
 - 4. Grandchildren--none
 - 5. Combinations of the above--4 cases
 - B. Female-headed households
 - 1. Mother--3 cases
 - 2. Brother/sister--5 cases
 - 3. Nephew/niece--0 cases
 - 4. Grandchildren--4 cases
 - 5. Combinations of the above--3 cases
- III. Nuclear family households--361 cases, 57 female-headed. Forty households were composed of the household head and spouse or the household head, spouse plus another kinsperson. Two hundred fifty-nine consisted of the household head, spouse, and children or the household head, spouse, children, and another kinsperson. Sixty-two consisted of a household head and children or a household head, children, and another kinsperson. Overall, then, 103 of the households had adjunct kinspeople. These included the following:
 - 1. Male-headed households--88 cases
 - A. Household head's side of family
 - 1. Mother--10 cases
 - 2. Brother/sister--3 cases
 - 3. Nephew/niece--4 cases
 - 4. Other kin--2 cases
 - 5. Combination of the above--4 cases
 - B. Spouse's side of family
 - 1. Mother--15 cases
 - 2. Father--1 case
 - 3. Brother/sister--9 cases
 - 4. Nephew/niece--7 cases
 - 5. Other kin--0 cases
 - 6. Combination of the above--4 cases
 - C. Grandchildren--20 cases
 - D. Other kin combinations--5 cases
 - E. Non-kin--4 cases
 - 2. Female-headed households--15 cases
 - A. Household head's side of the family
 - 1. Mother--3 cases
 - 2. Brother/sister--1 case
 - 3. Nephew/niece--2 cases

- B. Spouse's side of the family--0 cases
 - C. Grandchildren--8 cases
 - D. Non-kin--1 case
- IV. Extended family households--106 cases, 41 female-headed. Ninety-four of these households were lineal and 12 were collateral.
- 1. Lineal
 - A. Complete lineal three-generational extended family--16 cases, two with adjunct kinspeople.
 - B. Incomplete lineal three-generational extended households
 - 1. Spouse of the household head missing--9 cases
 - 2. Missing married/accompanied children and/or their spouses--38 cases, two with adjunct kin
 - 3. Missing married/accompanied children and the spouse of household head--24 cases
 - C. Incomplete four-generational families--7 cases
 - 2. Collateral Extended Households--12 cases
 - A. Included brother/sister of household head and parts of their family (spouse and/or children)--6 cases
 - B. Included brother/sister of spouse and parts of their family (spouse and/or children)--5 cases
 - C. Included brother/sister of both household head and spouse and part of their family (spouse and/or children)--1 case

Source: 1978 town census.

APPENDIX C

COMPLAINTS INCLUDED IN THE ILLNESS CATEGORIES

COMPLAINTS INCLUDED IN THE ILLNESS CATEGORIES

The following terms were used to describe the sicknesses reported during the illness episode survey.

Upper Respiratory Disorders

asthma (asma)
 bronchio pneumonia (bronco-neumonía)
 bronchitis (bronquitis)
 burning throat (ardor de garganta)
 chest attack (atacado pecho)
 chest cold (catarro de pecho)
 cold (catarro)
 cough (tos)
 gripe (gripe)
 hoarse (ronquera, ronco)
 nasal cold (catarro nasal)
 sickness of the chest (mal del pecho)
 sickness of the throat (mal de la garganta)
 sore throat (dolor de garganta)
 stuffy nose (entapiada)
 swollen throat (hinchazón de la garganta)
 throat cold (catarro de la garganta)
 throat infection (infección de la garganta)
 tonsillitis (amigdalitis, mal de las amígdalas, padece de las amígdalas)

Gastro-Intestinal Disorders

blockage (empacho)
 diarrhea (diarrea)
 dysentery (disentería)
 influenza (influenza)
 parasites (parásitos)
 sickness of May (mal de mayo)
 sickness of the stomach (mal del estomago)
 stomach infection (infección del estomago)
 stomachache (dolor de estomago)
 stools (asientos)
 ulcer (úlceras)
 vomiting (bascas, vomitos)
 worm fever (fiebre de lombrices)

Other Infectious Processes

boils (granos)
 dengue (dengue)
 hepatitis (hepatitis)
 malaria (paludismo)
 measles (sarampión)

Rheumatic, Head and Other Body Aches

air (aire)
 air in the chest (aire en el pecho)
 air in the lower back (aire en la rabadilla)
 arthritis (artritis)
 backache (dolor de espalda)
 body ache (dolor de cuerpo)
 bursitis (bursitis)
 headache (dolor de cabeza)
 leg ache (dolor de pierna)
 liver ache (dolor de hígado)
 lower backache (dolor de rabadilla)
 neck ache (dolor de nuca)
 rheumatism (reumatismo, reuma)
 side ache (dolor de costado)

Psychological Complaints

agitation (intranquilidad)
 desperation (desesperación)
 nerves (nervios)

Trauma

blow to eye (golpe en el ojo)
 broken collar bone (quebradura de clavícula)
 broken hand (quebradura de mano)
 broken scapula (quebradura de escápula)
 burn on foot (quemadura del pie)
 dislocated shoulder (dislocación del hombro)
 foot wound (herida del pie)

Dermatological and Eye Irritations

allergy (alergia)
 body rash (ronchas en el cuerpo)
 burning eyes (ardor de ojos)
 fire-like rash (fuego)
 inflammation (inflamación)
 itching (picazón)
 pimples (granos)
 skin eruptions (erupciones)
 sty (u>pispelo)

Uro-Genital Disorders

bad urine (mal de orin)
 hemorrhage (hemoragía)
 sickness of the kidneys (mal de los riñones, enfermedad de los riñones)
 kidney pain (dolor de los riñones)
 miscarriage (aborto)
 suffers from the kidneys (padece de los riñones)

Nutritional Problems

anemia (anemia)
 lack of appetite (falta de apetito)
 nutritional weakness (debilidad nutricional)
 weak blood (debil de sangre)

Cardio-Vascular Disorders

high blood pressure (alta presión)
 stroke (derrame cerebral)
 suffers from the heart (padece del corazón)
 the heart swelled up (se le agrandó el corazón)

Others

appendicitis (apendicitis)
 nose bleeds (le sangra la nariz)
 old age (viejez)
 tiredness (cansancio)
 toothache (dolor de muela)

Source: Illness episode survey.

ENDNOTES

ENDNOTES

CHAPTER I

¹Asunción is a pseudonym.

²The operation of the Central American Common Market was disrupted by the Soccer War between Honduras and El Salvador in the early 1970s and, more recently, by the political turmoil in the region.

³The dependency and world systems schools have been criticized on a number of accounts. These include the view that the locus of capitalism lies in the sphere of circulation rather than production and the phrasing of the relations between the core and periphery in geographic terms (metropolis/satellite, core/semi-periphery/periphery) rather than in terms of class relations.

⁴No efforts are made here to consider the usefulness of Young's classification of the subfield of medical anthropology. However, he provides virtually no discussion of the works of empiricist-oriented anthropologists, and, in fact, simply dismisses this growing branch of medical anthropology as poor sociology. Nor does his framework accommodate works which look at the interface between biology and culture (Jordan 1983; Rubel, O'Neill, Collado 1984). In 1982, Worsley reviewed works on nonwestern medical systems and, in 1983, Hahn and Kleinman reviewed recent works on biomedical practice, but in neither case was a broad framework for the field as a whole proposed.

CHAPTER II

¹The term Ladino is used to refer to the non-Indian residents of Asunción. Although Ladino was used during the nineteenth century, it is no longer employed. There is no word commonly used today to refer to non-Indians. Indians, on the other hand, are often referred to as natives (naturales).

²Estimates of the number killed during the repression range from 40,000 (Lopez Vallecillos 1964) to Anderson's figure of 10,000.

³In October 1979, President Carlos Humberto Romero was removed from office by a group of military officers promising to institute extensive social reforms. This coup should be seen in the context of the July 1979 Sandanista victory in Nicaragua which led officials in the U.S. and Salvadoran governments to consider that reforms were

needed to avoid a similar occurrence in El Salvador. At the time of Romero's overthrow, the military was divided into a conservative faction led by Col. Jaime Guillermo Garcia and Col. Jaime Abdul Gutierrez and a progressive faction centered around Col. Adolfo Arnoldo Majano. The progressive faction, which initially assumed power, invited prominent civilians such as Guillermo Ungo to join the junta. By the end of the year, however, when it became apparent that the conservative faction was unwilling to relinquish control over the Security Forces, Ungo and other civilian politicians resigned. Later in 1980, Majano was forced into exile. Although the moderate Christian Democrat, José Napoleon Duarte, was installed as President, the conservative military faction remained in power behind the scene. The March 1982 elections gave control of the Legislative Assembly to right-wing parties who have since postponed major reforms. Evidence suggests that the number of people who actually voted in this election was considerably less than the official tabulation (Bonner 1982b). It is impossible to determine if election fraud was confined simply to an inflation in the number of voters.

⁴Although modeled after the PRI, the Salvadoran official party did not function in the same manner. See Baloyra (1982, 1983).

⁵In 1980, these groups coalesced to form the Democratic Revolutionary Front (FDR), the political arm of the revolutionary opposition, and the Farabundo Martí National Liberation Front (FMLN), the military arm of the movement.

⁶In contrast to other Central American coffee producing countries such as Guatemala and Costa Rica which have received financial and technical assistance from the Germans and the British, foreign investment in Salvadoran coffee production has been minimal.

⁷In 1980, under growing pressure from the leftist opposition within the country and from the U.S. government, a new agrarian reform program was announced by the junta. Briefly, it consisted of three phases. Phase I called for the expropriation of estates of 500 hectares or more. This measure potentially affected 376 farms, or 15% of the country's farmland, but was later reduced to 250 farms, or 10% of the land. Properties included in this phase produce about 14% of the coffee, 31% of the cotton, and 24% of the sugar cane (Simon and Stephens 1981). Substantial portions were also used for cattle grazing or were left fallow. Former owners were allowed to retain between 100 and 150 hectares, a ceiling that could be raised by 20% if the owners complied with labor and social security laws and carried out improvements on their properties. Owners were to be compensated for expropriated lands in cash and in agrarian bonds. Under supervision from the Salvadoran Institute for Agrarian Transformation (ISTA), resident workers, renters, and sharecroppers on these properties were to form cooperatives.

Phase II called for the expropriation of holdings from 150 to 500 hectares, or approximately 23% of the farmland in the country. This measure would have affected 30% of the nation's coffee producing lands and would have undermined the economic position of the elite (Simon and Stephens 1981). Again, owners were to receive compensation in cash and agrarian bonds and peasant cooperatives were to be formed.

In April 1980, Decree No. 207, or Phase III, was announced. Called the Land to the Tiller Program, and modeled after U.S. sponsored land reform measures in Viet Nam, it was reportedly imposed on the Salvadoran government by U.S. officials. This decree converted renters and sharecroppers into owners, placing a ceiling of seven hectares on the amount of land each family could so acquire. This phase would have affected 12% of the farmland and benefited an estimated 125,000 tenants. The new owners were to pay for their plots over a 30-year period, during which time sale of the property was prohibited. Previous owners were to receive compensation. The decree also prohibited all future renting of land. Although technically all renters were automatically converted into owners, legal means of gaining title were not made clear until December 1980.

In May 1982, after the right-wing coalition assumed control of the government, support for the agrarian reform program was largely withdrawn (Bonner 1982a). Perhaps the major point that can be made regarding the reform measures as they were originally constituted is that, similar to those enacted in the past, the laws did not provide access to land for the 65% of the rural population who had no access to property and earned their living as day laborers.

The impact of Phase I, which was put into effect in 1980, was reduced because it was carried out in the rainy season when the number of workers on estates is at its lowest and because many campesinos who would have benefited had fled the countryside as refugees from the civil war. The number of beneficiaries of Phase III was also lower than that originally anticipated. In the six months between the time that the decree was announced and the establishment of procedures for gaining title, many potential beneficiaries were forced off their rented plots by owners. Not surprisingly, Phase II was never instituted.

Overall, while calling for a substantial redistribution of property, the aim of the agrarian reform program was primarily political in nature. It would have created a middle level of property owning campesinos who owed allegiance to the government and whose activities in the newly established cooperatives would have been closely monitored by state officials. More detailed evaluations of the reform measures can be found in Simon and Stephens (1981), Wheaton (1980), and the Americas Watch Committee and the American Civil Liberties Union (1982).

⁸The history of the Hacienda Zapotitán in La Libertad Department provides an example of these government land reform efforts. The hacienda was purchased in the late 1930s. It consisted of a few thousand acres, the central portion of which had once been a lake and

which was surrounded by higher lands. Traditionally, the low, humid areas were used for year-round pasture and for corn and coffee cultivation in the dry season. Corn and coffee were produced in the higher elevations. In the late 1940s, the government agency then in charge of the program, Mejoramiento Social, divided part of the estate into parcels of between four and six hectares and distributed them to the resident beneficiaries. Browning (1971: 278-79) notes that whereas before this distribution, the residents had been able to pasture their animals in the lowlands and to collect firewood from the higher portions, after receiving title, they were restricted to their own small holdings. No technical or financial assistance nor public services accompanied the distribution process. Between 1943, when lots were first allocated, and 1966, when a follow-up study was conducted by the Ministry of Agriculture and Livestock, many of the original recipients had lost their properties. These had become consolidated into larger holdings owned, in many cases, by middle-class professionals in the capital.

In 1979, this same style program continued unaltered. In April, the Salvadoran Institute for Agrarian Transformation (ISTA) distributed some of the remaining lands of the Hacienda Zapotitán to 300 campesino families. In the ceremony marking the event, the ISTA Director called attention to the lack of services provided to the recipients but placed the burden for their development on the new owners themselves: "In other words, we want to call your attention to, and try to awaken your interest in, working together in your different communities. On other occasions, we have said that there is much to be done, that work and services are lacking, but for these we need communities that are organized and willing to work" (La Prensa Gráfica, April 22, 1979, author's translation).

⁹ Much of the initiative behind the formation of the Central American Common Market (CACM) came from the United Nations Economic Commission for Latin America. As originally envisioned, the primary purpose of the CACM was to encourage a few designated industries appropriate to the needs of the area through coordinated regional planning. When the U.S. assumed the position of principal supporter of the Common Market, this aim was abandoned in favor of liberalization and expansion of trade for a wider range of industrial products (Browning 1974).

¹⁰ The most detailed analysis of this conflict is provided by Durham (1979).

¹¹ Reagan's Caribbean Basin Initiative (CBI) offers further investment incentives to U.S. corporations willing to establish manufacturing plants in the region. It proposes to eliminate tariffs on some goods entering the U.S. and provides substantial military and economic aid. This plan, if implemented and funded at proposed levels, will increase the region's dependence on the U.S. economy. Particularly, it will encourage the promotion of U.S. controlled consumer

goods industries geared to the U.S. market to a greater extent than has import substitution industrialization. The elimination of tariffs on goods entering the U.S. from the region as a means of increasing trade will have little effect as 87% of Caribbean exports already enter the U.S. duty free, and sugar and textile products would be exempt from the free trade offer (Central American Update, June 1982).

CHAPTER III

¹This information was compiled from the Salvadoran Ministry of Public Health and Social Assistance annual publication Salud Pública en Cifras, 1976. As is the case in most developing countries, there is considerable underreporting of births and deaths. The figures are presented because they are the only means available to make rough comparisons among regions.

²Forty-one households could not be contacted after two visits. Some of these dwellings may have been vacant, their owners no longer residing in Asunción or temporarily absent (for example, picking coffee). These 41 households were replaced by their immediate neighbors. Sixteen households refused to participate in the census. Some of these were indigenous families. They made reference to what cooperation with authorities had cost them in 1932. No substitutes were sought for these 16 households.

³The 1932 Asunción registry of deaths does not record killings resulting from the revolt.

⁴Another factor of importance here may be the indigenous background of many townspeople. Studies of South American Indians indicate that the ABO blood type prevalent among some groups results in a higher percentage of male births than would be the case in the population at large (Millard and Berlin 1983).

⁵Kinship and friendship networks often are important in gaining access to market stalls. In Sonsonante, it was reported that membership in ORDEN also facilitated getting a place in the market.

⁶One man interviewed in the illness episode survey reported seeing National Guardsmen painting the warning symbol of a white hand on the doors of two of those who were later subjected to persecution. At least 30 people were singled out this way, and most fled the community.

⁷Forty-nine spouses or companions owned stores, 1 was a shop clerk, 38 were vendors, and 18 were artisans (usually seamstresses). Twelve of the remaining 38 worked in agriculture, while 26 had semi-professional occupations (most as teachers). Seven of the 12 who

worked in agriculture were males. They were classified as companions because they had only recently established relationships with the women and had moved into the women's homes. In these cases, the women stated that they, and not the men, were the head (jefe) of the household.

⁸Given the brief nature of the interview, it was not possible to gather information on how income generated by members was used in the household. In those cases with which the researcher was most familiar, older sons and daughters retained a portion of their earnings for their use. In the small percentage of joint families (composed of married brothers and/or sisters and their families), arrangements varied depending on cooking and, in some cases, house rental arrangements.

⁹The addition of higher grades to the curriculum has often been carried out by establishing shifts whereby grades one through three are offered in the morning and four through six in the afternoon. In these situations, teachers are paid time-and-a-half for what amounts to twice as much work.

¹⁰The granting of teaching certificates to individuals with less than a twelfth-grade education accompanied the expansion of the public education system. Many townspeople considered these teachers unqualified. When asked about level of education, these and other teachers participating in the census responded by stating that they were professors rather than by giving their grade level. Therefore, it was not possible to distinguish between those who had completed high school and those who had not. Discussions with one of the local school directors suggested that most of those with less than a twelfth-grade education were female elementary teachers.

¹¹Of these children, 269 were female and 294 were male. The dropout rate for females was slightly higher than that of males. Forty-one (15.2%) of the females had left school before the age of 16, whereas only 38 (12.9%) of the males had done so.

¹²This trend may be offset by in-migration of young people and families from the surrounding rural area.

¹³In most cases, those living in homes owned by a nonresident kinsperson, such as a mother or father of the household head or spouse, did not pay rent. Where rent was paid to close kinspeople, it was reported to be minimal, and there was some flexibility in meeting payments.

CHAPTER IV

¹The local soccer teams were another important rallying point for much of the population. Some teams were sponsored by the schools, and others were private clubs. In 1970, one of the teams, Mario Calvo, was having a winning season and was a popular subject of conversation.

²For a detailed discussion of this distinction in a Guatemalan Indian community, see Warren, The Symbolism of Subordination. Indian Identity in a Guatemalan Town. Austin, Texas, University of Texas Press, 1978.

³The State of Siege that was in effect for much of the research period affected the functioning of many brotherhoods. Permits had to be obtained from the town mayor to hold any gathering of more than a small number of people. The Indian mayor and other elders were involved in this process. Cofradía members and participants in the celebrations were stopped on a number of occasions and questioned as to whether proper documentation had been obtained. These interferences caused worry and may well have reduced participation in many events.

⁴In 1979, for example, the committee in charge of the December festivities attracted a rodeo that was traditionally held in Sonsonante. The mayor and the committee were successful in staging this seeming coup in large measure because the mayor of Sonsonante at that time was a native of Asunción. Although the planning committee considered the rodeo a major attraction to the celebrations, many townspeople were angered because the event was to be staged on the soccer field. One of the town's teams, Mario Calvo, had had a very successful year and was scheduled for play-offs on the field the day following the rodeo. Sports enthusiasts felt that the stakes driven into the playing field, and the horse and cow manure, would cause potential injuries and disrupt the play-offs. A large crowd attended the rodeo and the barbecue held in its aftermath. Some townspeople, however, reportedly boycotted the event.

⁵A detailed investigation of membership in cofradías and hermandades could very well reveal class differences in participation.

⁶The number of ANIS members in 1978-79 is not known, but by 1985 it represented 15,000 members nation-wide (NACLA 1985: 10).

⁷Because the census was conducted at the beginning of the research process, I had not had the opportunity to identify other indirect means to determine ethnic identity. Questions concerning participation in the cofradías may well have proven useful.

⁸The 28 retired household heads were classified on the basis of their previous occupations. Housewives, as noted previously, were considered as an independent category. These women were supported by their children, inheritances left by spouses or parents, landholdings, and, in a few cases, by spouses who no longer resided with them but continued to contribute to the family's support. It is also likely that many of these women engaged periodically in vending activities.

⁹Miguel Argueta's novel A Day of Life best captures the relationship between members of the National Guard, many of whom come from peasant backgrounds, and villagers.

¹⁰Although in the eyes of the upper class being poor and being Indian were virtually indistinguishable misfortunes, lower-class Ladinos and Indians were more conscious of ethnic differences and attributed more importance to them.

CHAPTER V

¹Asunción's priest was not a political activist, and his catechist classes focused more on religious issues than on questions of social justice. He was driven out of town because during this period all priests were considered potential radicals.

²In 26 cases, the household members interviewed could not provide information on the religious affiliation of the household head.

³Only one household head was a Spiritist, belonging to the Profesía Church.

⁴Nieves's equation of the term consanguineal households with female-headed households is somewhat confusing. Not all consanguineal households are female-headed. Consanguineal households can be, and in El Salvador sometimes are, composed of brothers or brothers and sisters. While no male in the husband/father role is present, these households are usually considered male-headed and male-centered. Also, her extension of the term consanguineal to include cases where daughters and their children live with their parents is questionable. Both instances speak to the need of having a clearly defined reference point (household head or other figure) in determining household type.

⁵The issue of the role of adult children and other kinspeople in contributing to household maintenance deserves further study. Although some investigators (Smith, Wallerstein, and Dieter Evers 1984) posit that in order to survive and reproduce, poor households in developing countries rely on a pooling of resources supplied by household members, information gathered during the course of research in

Asunción suggests that grown children, wives, and other relatives frequently held back a portion of their earnings.

Further, the Asunción data suggest the need to distinguish between a pooling of resources (which may occur in varying degrees) and a pooling of people. Although lower-class households were more likely to be extended than their middle- and upper-class counterparts, it should be borne in mind that nuclear families were the predominant form in both class groupings and that lower-class families gave evidence of experiencing more marital break-ups than those in the middle and upper classes. Information presented in Chapter III did, however, indicate that those household heads in the lower occupational groupings had more members of their households in the labor force than those with more lucrative occupations. The point here is that the number of able-bodied people in a household may say little concerning their contribution to household maintenance. In Asunción, for example, extended family households did not always confer greater survival benefits. Although their greater size may seem to have created more opportunity to pool resources, this was not always the case. Some of the poorest of these households were composed of older women and their daughters who had either had children out of wedlock or had returned home with their children after their marriages failed. Although there were potentially more wage earners, most of them were unable to find work in either the formal or informal sectors. There were also more dependents in need of support and care. In one household, for example, there were 12 children under the age of 10. In this situation, added members were a burden rather than an economic resource.

CHAPTER VI

¹A review of the death registry records from the early part of this century through the present shows the gradual decline in the use of some folk illness terms and their replacement by popular-sector terminology.

²Not all of these urban clients were from Asunción. People from surrounding small towns and from Sonsonante occasionally used the facility.

³The original plan was to conduct the survey for six months. The number of townspeople killed by right-wing death squads, however, increased steadily during 1979. In June, after a van carrying a group of school teachers was machine-gunned, the interviewing was terminated.

⁴The clinic physicians often provided a primary and secondary diagnosis. The primary diagnosis was used in the tabulations.

⁵Public-sector health facilities in El Salvador rely on the index for malnutrition employed by the Institute of Nutrition for Central America and Panama (INCAP).

⁶These tabulations were based on the number of children born to female household heads and spouses of male household heads in the illness episode survey.

⁷This pattern has been reported by other investigators--Kleinman (1980), Harrison (1983), and Young (1981).

⁸Many practitioners--physicians included--shared these beliefs and, hence, reinforced them among their patients. For example, in treating a case of bronchitis I developed, the physician's advice on the foods and behaviors to avoid was almost identical to the advice offered by my landlady. This included cessation of bathing, opening the refrigerator door, drinking cold liquids, and eating melons.

⁹Townspeople recognized two categories of healers in addition to western biomedical practitioners. Parcheros were those who had learned their trade. Major representatives were the idóneos and the midwives (nodrizes or parteras). Curanderos or brujos (witches) had received a gift (don or dote) from God to either cause or cure misfortune. Many displayed signs of epilepsy and during their attacks a second personality appeared. To fully develop their gift, some studied under the tutelage of other curanderos, learning to convert themselves into monkeys or pigs, or to go into trance-like states to serve as mediums. Brujos practiced at centros which were considered either black (specializing in causing harm) or white (helping people with misfortunes). Brujos were drawn from both ethnic groups and sexes, although there were reportedly more women and fewer Indians than once was the case. Many had integrated western drug products into their practices.

¹⁰It is difficult to measure the extent to which the centros were used by the local population. My informants all stated that townspeople seldom consulted them, and that the centros were used more for marital, financial, or other difficulties than for health problems. Townspeople who did go to centros tended to be secretive about their visits.

¹¹My research assistant commented that no one could possibly take a case of susto to a psychologist--the psychologist would say he or she was crazy.

¹²Another and probably equally important factor contributing to the shorter duration of illnesses in middle- and upper-class families is related to the more regular and nutritious diets, clean sources of drinking water, and more adequate sanitary facilities usually found in these households than in lower-class households.

CHAPTER VII

¹This is the case especially where there is a scarcity of physicians. In large urban areas where doctors tend to be concentrated, more efforts may be made to channel drug sales through them by enforcing prescription laws. I suggest that this results not from a commitment to improve medical services or health but rather from the likelihood, discussed in Chapter VI, that many physicians are heavy prescribers and, hence, boost sales.

²This finding is based on interviews conducted with the sales representatives of pharmacies in Asunción. They were questioned about the sale price to the pharmacy of their best-selling products, and comparisons were drawn between this price and the Junta established retail price of the medications. Because the number of cases is limited, the conclusion is tentative and requires further investigation.

³Of the 19 individuals six years and older who received medications in liquid or injection forms, nearly one-third (6 or 31.6%) were recommended liquids because medicines administered in this form were the only ones available at the time for sale.

⁴The exception here were vitamin products in injection form which were very popular. Customers usually purchased a number of injections.

⁵While the problem of inappropriate prescribing is found in pharmacies, it is not confined to these establishments. It is a widespread occurrence among physicians in developing and developed countries and reflects the problems inherent in the current means of promotion of pharmaceutical products and the education of physicians and other health-care workers (Gish and Feller 1979: 80). Some of the implications of these practices were discussed in Chapter VI.

⁶The Asunción pharmacies offered a limited range of medical services--injections and weighing. Blood pressure was not taken at any of the establishments.

⁷Although both alternative and western biomedical practitioners promote the use of modern medicines, they, in addition to their clients, are often the unwitting victims of the pharmaceutical companies' sales and promotional practices. The origins of the term *commerciogenesis* are uncertain. It was relayed to me in a personal communication from Ms. Dianna Melrose of OXFAM in Oxford, England.

⁸A more thorough study of injection givers would probably reveal that they take an active role in recommending products. In interviews with five injection givers in San Salvador, two reported that women sought their services to induce abortions. Products employed for this were diethylstilbestrol (DES), paramethadione, and piperazine.

⁹The case of this industry is only one aspect of a broader pattern of economic exploitation by international cartels in the Third World that has serious and direct effects on human health (Ledogar 1975, Mother Jones 1979, Castleman 1979), the most well-known being the promotion of infant formulas by large companies such as Nestlé, Abbot, and Bristol Myers.

CHAPTER VIII

¹Cuba is one example of a country where such a program has been successfully implemented. Bangladesh is currently experiencing opposition from multinational pharmaceutical companies in its attempt to regulate both the private and public sectors. See Mamdani and Walker (1985) for a full discussion of these and other cases.

BIBLIOGRAPHY

BIBLIOGRAPHY

- ADAMS, R.
1956 Cultural components of Central America. American Anthropologist 58: 881-907.
- 1976 Cultural surveys of Panama, Nicaragua, Guatemala, El Salvador, Honduras. Detroit, MI., Blaine-Ethridge.
- AGARWAL, A.
1978 Drugs and the Third World. London, Earthscan.
- AMERICAS WATCH COMMITTEE AND THE AMERICAN CIVIL LIBERTIES UNION
1982 Report on human rights in El Salvador. New York, Vintage Books.
- AMIN, S.
1976 Unequal development: An essay on the social formations of peripheral capitalism. New York, Monthly Review Press.
- 1977 Imperialism and unequal development: Essays by Samir Amin. New York, Monthly Review Press.
- ANDERSON, T. P.
1971 Mantanza. El Salvador's communist revolt of 1932. Lincoln, NB., University of Nebraska Press.
- ARMSTRONG, R. AND J. SHENK
1982 El Salvador, the face of revolution. Boston, MA., South End Press.
- BADER, M. B.
1976 Breast feeding: The role of multinational corporations in Latin America. International Journal of Health Services 6(4): 609-26.
- BAER, H. A.
1982 On the political economy of health. Medical Anthropology Newsletter 14(1): 1-2 and 3-17.
- 1985 Towards a critical medical anthropology of health-related issues in socialist-oriented societies. Paper presented at the American Anthropological Association Meetings, Washington, D.C., December 4-8.

- BALOYRA, E. A.
 1982 El Salvador in transition. Chapel Hill, NC, The University of North Carolina Press.
- 1983 Reactionary despotism in El Salvador. An impediment to democratic transition. In *Trouble in Our Backyard*, M. Diskin, ed. New York, Pantheon Books, 101-24.
- BARLETT, P. F.
 1980 Adaptive strategies in peasant agricultural production. *Annual Review of Anthropology* 9: 545-73.
- BARNETT, A. ET AL.
 1980 The economics of pharmaceutical supply in Ghana. *International Journal of Health Services* 10(3): 479-500.
- BARRERA, M.
 1978 Class segmentation and the political economy of the Chicano, 1900-1930. In *New Directions in Chicano Scholarship*, R. Romo and R. Paredes, eds. La Jolla, CA., University of California, San Diego, 167-80.
- 1979 Race and class in the southwest. A theory of racial inequality. South Bend, IN., University of Notre Dame Press.
- BENNETT, J. W.
 1985 The micro-macro nexus: Typology, process and system. In *Micro and Macro Levels of Analysis in Anthropology. Issues in Theory and Research*, B. DeWalt and P. Pelto, eds. Boulder, CO., Westview Press, 23-54.
- BERLINER, H. S.
 1975 A larger perspective on the Flexner Report. *International Journal of Health Services* 5(4): 573-92.
- 1977 Emerging ideologies in medicine. *The Review of Radical Political Economics* 9(1): 116-24.
- BERLINER, H. S. AND J. W. SALMON
 1980 The holistic alternative to scientific medicine: History and analysis. *International Journal of Health Services* 10(1): 133-47.
- BERTERO, C. O.
 1972 Drugs and dependency in Brazil--An empirical study of dependency theory. The case of the pharmaceutical industry. Cornell University, Latin American Studies Program Dissertation Series.

- BONNER, R.
1982 Salvadoran leader denies vote fraud. New York Times CXXXI(45,336) Sunday, June 6: 3.
- BONNER, R.
1982 Salvador evicts peasants from land. New York Times CXXXI(45,329) Sunday, May 30: 3.
- BRINTNALL, D. E.
1976 Revolt against the dead. The modernization of a Mayan community in the highlands of Guatemala. New York, Gordon and Breach.
- BROWN, J.
1963 Some changes in Mexican village curing practices induced by western medicine. America Indigena 13: 93-120.
- BROWNER, C. H.
1985 Women, household and health in Latin America. Paper prepared for the Social Science Research Council Conference, "The Political Economy of Health and Disease in Africa and Latin America," Toluca, Mexico, January 8-12.
- BROWNING, D.
1971 El Salvador. Landscape and society. Oxford, Clarendon Press.
- 1974 The rise and fall of the Central American common market. Journal of Latin American Studies, Cambridge 6(1): 161-68.
- CASTLEMAN, B.
1979 The export of hazardous factories to developing nations. International Journal of Health Services 9(4): 569-606.
- CENTRAL AMERICAN UPDATE
1982 Poisoned carrots and a big stick. III(5) June: 18.
- CHAMBERS, E. J. AND P. D. YOUNG
1979 Mesoamerican community studies: The past decade. Annual Review of Anthropology 8: 45-69.
- COLINDRES, E.
1976 La tenencia de la tierra en El Salvador. Estudios Centroamericanos, 31(335/36): 463-72.
- 1977 Fundamentos económicos de la burguesía Salvadoreña. San Salvador, El Salvador, UCA Editores.

- COSMINSKY, S. AND M. SCRIMSHAW
1979 Medical pluralism on a Guatemalan plantation. *Social Science and Medicine* 14B: 267-78.
- GUENCA, A.
1962 El Salvador, una democracia cafetalera. Mexico, ARR-Centro Editorial.
- DE GUEVARA, C.
1973 Exploración etnográfica en el departamento de Santa Ana. San Salvador, El Salvador, Museo Nacional David J. Guzman, Ministerio de Educación.

1975 Exploración etnográfica. Departamento de Sonsonante. San Salvador, El Salvador, Museo Nacional David J. Guzman, Ministerio de Educación.
- DEWALT, B. R.
1985 Microcosmic and macrocosmic processes of agrarian change in southern Honduras: The cattle are eating the forest. In *Micro and Macro Levels of Analysis in Anthropology. Issues in Theory and Research*, B. DeWalt and P. Pelto, eds. Boulder, CO., Westview Press, 165-86.
- DEWALT, B. R. AND P. J. PELTO
1985 Micro and macro levels of analysis in anthropology. *Issues in theory and research*. Boulder, CO., Westview Press.
- DEWALT, K. M.
1977 The illnesses no longer understand: Changing concepts of health and curing in a rural Mexican community. *Medical Anthropology Newsletter* 8(2): 5-11.
- DIETER EVERS, H., W. CLAUSS AND D. WONG
1984 Subsistence reproduction: A framework for analysis. In *Households and the World-Economy*, J. Smith, I. Wallerstein and H. Dieter Evers, eds. Beverly Hills, CA., Sage Publications, 23-36.
- DISKIN, M.
1983 Trouble in our backyard: Central America and the United States in the eighties. New York, Pantheon Books.
- DOS SANTOS, T.
1973 The crisis of development theory and the problem of dependency in Latin America. In *Underdevelopment and Development*, H. Bernstein, ed. Hammondsouth, Penguin Press, 76-77.

- DOYAL, L.
1979 The political economy of health. Boston, MA., South End.
- DUBOS, R.
1959 Mirage of health. New York, Harper and Row.
- DURHAM, W.
1979 Scarcity and survival in Central America. Ecological origins of the Soccer War. Stanford, CA., Stanford University Press.
- ELAM, R. V.
1968 Appeal to arms: The army and politics in El Salvador, 1931-1964. Albuquerque, University of New Mexico, Ph.D. dissertation.
- ELLING, R. R.
1977 Industrialization and occupational health in under-developed countries. International Journal of Health Services 7: 209-235.
- 1978 Medical systems as changing social systems. Social Science and Medicine 12(2B): 107-115.
- 1981 The capitalist world system and international health. International Journal of Health Services 11: 21-51.
- EL SALVADOR, MINISTERIO DE SALUD PUBLICA Y ASISTENCIA SOCIAL.
DEPARTAMENTO DE ESTADISTICAS DE SALUD
1976 Salud pública en cifras. San Salvador, Ministerio de Salud Pública y Asistencia Social.
- ENGLES, F.
1973 The conditions of the working class in England. Moscow, Progress Publishers.
- ERASMUS, C.
1952 Changing folk beliefs and the relativity of empirical knowledge. Southwestern Journal of Anthropology 8: 411-28.
- EVANS, P.
1979 Dependent development: The alliance of multinational, state and local capital in Brazil. Princeton, NJ., Princeton University Press.
- EVANS-PRITCHARD, E. E.
1937 Witchcraft, oracles and magic among the Azande. Oxford, Clarendon Press.

- FABREGA, H.
1974 Disease and social behavior: An interdisciplinary perspective. Cambridge, MA., MIT Press.
- FAVAR, M. T.
1972 Ecological implications of insect control in Central America: Agriculture, public health and development. St. Louis, MO., Washington University, Ph.D. Dissertation.
- FEDER, E.
1971 The rape of the peasantry: Latin America's landholding system. New York, Anchor Books.
- FERRER DENIS, J.
1968 Estudio de los recursos de personal médico en la República de El Salvador. San Salvador, El Salvador, National University of El Salvador, Faculty of Medicine, Doctoral Thesis.
- FOEGE, W. H.
1979 Accessibility of vaccines. In Pharmaceuticals for Developing Countries. National Academy of Sciences, Division of International Health, Institute of Medicine. Washington, D.C., National Academy of Sciences, 83-94.
- FOSTER, G.
1958 Problems in intercultural health practice. Pamphlet No. 12. New York, Social Science Research Council.
- FRANK, A. G.
1967 Capitalism and underdevelopment in Latin America. New York, Monthly Review Press.
1975 On capitalist underdevelopment. New York, Oxford University Press.
- FRANKENBERG, R.
1974 Functionalism and after? Theory and developments in social science applied to the health field. International Journal of Health Services 4(3): 411-27.
1980 Medical anthropology and development: A theoretical perspective. Social Science and Medicine 14B: 197-207.

- FRANKENBERG, R. AND J. LEESON
 1976 Disease, illness and sickness: Social aspects of the choice of healer in a Lukasa suburb. In *Social Anthropology and Medicine*, J. Loudon, ed. New York, Academic Press, 223-58.
- FRIEDLANDER, J.
 1975 Being Indian in Hueyapan. A study of forced identity in contemporary Mexico. New York, St. Martin's Press.
- FRIEDMAN, K.
 1984 Households as income pooling units. In *Households and the World Economy*, J. Smith, I. Wallerstein and H. Dieter Evers, eds. Beverly Hills, CA, Sage Publications, 37-55.
- GETTLEMAN, M. E., P. LACEFIELD, L. MENASHE, D. MERMELSTEIN AND R. RADOSH
 1981 El Salvador: Central America in the new cold war. New York, Grove Press.
- GISH, O.
 1979 The political economy of health care and "health by the people": An historical exploration. *Social Science and Medicine* 13C: 203-11.
- GISH, O. AND L. L. FELLER
 1979 Planning pharmaceuticals for primary health care: The supply and utilization of drugs in the Third World. Washington, D.C., American Public Health Association, International Health Programs Monograph Series, No. 2.
- GOOD, B. J.
 1977 The heart of what's the matter: The semantics of illness in Iran. *Culture, Medicine and Psychiatry* 1: 25-58.
- GOOD, B. J. AND M. J. GOOD
 1981 The meaning of symptoms: A cultural hermeneutics model for clinical practice. In *The Relevance of Social Science for Medicine*, L. Eisenberg and A. Kleinman, eds. Dordrecht, Holland, Reidel, 165-96.
- GROSS, D. AND B. UNDERWOOD
 1971 Technological change and caloric costs: Sisal agriculture in northeastern Brazil. *American Anthropologist* 73(3): 725-40.

- HAHN, R. AND A. KLEINMAN
1983 Biomedical practice and anthropological theory: Frameworks and directions. *Annual Review of Anthropology* 12: 305-333.
- HAMMEL, E. A. AND P. LASLETT
1974 Comparing household structure over time and between cultures. *Comparative Studies in Society and History* 16: 73-109.
- HANSEN, F. AND V. BREVETTI
1982 How U.S. firms profit from El Salvador war. *Guardian*, August 25: 8.
- HARRISON, P. F.
1976 Contexto socio-cultural de prestaciones de salud en areas rurales de El Salvador. San Salvador: U.S.A.I.D. Contract 519-127.
- 1983 To bear a child: Meanings and strategies in rural El Salvador. Catholic University of America, Ph.D. dissertation.
- HELLEGGERS, J. F.
1973 Chloramphenicol in Japan, let it bleed. *Bulletin of Concerned Asian Scholars* 5: 37-45.
- HELLER, T.
1972 Poor health, rich profits. Multinational drug companies and the third world. Nottingham, Spokesman Books.
- HERRERA VEGA, A.
1935 El indio occidental de El Salvador y su incorporación social por la escuela. Izalco, El Salvador.
- HUIZER, G.
1963 A community development experience in a Central American village. *International Review of Community Development*: 161-86.
- ILLICH, I.
1976 Medical nemesis. The expropriation of health. New York, Pantheon Books.
- INSTITUTE OF NUTRITION OF CENTRAL AMERICA AND PANAMA (INCAP)
1969 Evaluación nutricional de la población de Centroamérica y Panamá. Guatemala City, Guatemala.

- JANZEN, J. M.
 1978(a) The comparative study of medical systems as changing social systems. *Social Science and Medicine* 12B: 121-29.
 1978(b) The quest for therapy in lower Zaire. Berkeley, CA., University of California Press.
- JELLIFFE, D. AND E. F. P. JELLIFFE
 1977 The infant food industry and international child health. *International Journal of Health Services* 7(2): 249-54.
- JORDAN, B.
 1983 Birth in four cultures. A Cross-cultural investigation of childbirth in Yucatan, Holland, Sweden and the U.S. Montreal, Eden Press.
- KATZ, J.
 1973 La industria farmacéutica en Argentina: Estructura y comportamiento. Buenos Aires, Instituto Torcuato di Tella.
- KENDALL, C.
 1978 Female-headed households and domestic organization in San Isidro, Guatemala: A test of Hammel and Laslett's comparative typology. *Journal of Comparative Family Studies* IX(1): 129-41.
- KLEINMAN, A.
 1978 Concepts and a model for the comparison of medical systems. *Social Science and Medicine* 12B: 85-93.
 1980 Patients and healers in the context of culture. An exploration of the borderland between anthropology, medicine and psychiatry. Berkeley, CA., University of California Press.
- KOHANE, J. D.
 1984 The role of the "western pharmacist" in rural Taiwanese medical culture. University of Hawaii, Ph.D. Dissertation.
- LACALU, E.
 1971 Feudalism and capitalism in Latin America. *New Left Review* 67: 19-38.

- LALL, S.
1974 The international pharmaceutical industry and less developed countries, with special reference to India. Oxford Bulletin of Economics and Statistics, August: 143-72.
- 1975 Major issues in the transfer of technology to developing countries: A case study of the pharmaceutical industry. Geneva, UNCTAD.
- 1977 Medicines and multinationals: Problems in the transfer of pharmaceutical technology to the Third World. Monthly Review 28: 19-30.
- 1982 The pharmaceutical industry in India: The economic costs of regulation. Paper presented at the International Federation of Pharmaceutical Manufacturers Association Assembly, Washington, D.C.
- LALL, S. AND S. BIBILE
1978 Political economy of controlling transnationals. Pharmaceutical Industry in Sri Lanka, 1972-76. International Journal of Health Services 8(2): 299-328.
- LANDY, D.
1974 Role adaptation: Traditional curers under the impact of western medicine. American Ethnologist 1(1): 103-28.
- LA PRENSA GRAFICA
1979 300 campesinos reciben tierras en adjudicación. Domingo 22 de Abril.
- LARDE Y LARIN, J.
1957 El Salvador: Historia de sus pueblos, villas y ciudades. San Salvador, El Salvador.
- LAURELL, A.
1981 Mortality and working conditions in agriculture in underdeveloped countries. International Journal of Health Services 11(1): 3-20.
- LAURELL, A., A. BLANDO BLANDO AND A. HEREDIA DUARTE
1977 El desarrollo urbano y los patrones de consumo de productos farmacéuticos. Una encuesta en diferentes grupos sociales de Mexico, D. F. Epoca XIX(3): 397-409.

- LAURELL, A. ET AL.
1977 Disease and rural development: A sociological analysis of morbidity in two Mexican villages. International Journal of Health Services 7(3): 401-23.
- LEDOGAR, R. J.
1975 Hungry for profits. U.S. food and drug multinationals in Latin America. New York, IDOC.
- LESLIE, C.
1976 Asian medical systems. Berkeley, CA., University of California Press.
- LOGAN, K.
1983 The role of pharmacists and over-the-counter medications in the health care system of a Mexican city. Medical Anthropology 7(3): 68-89.
- LOGAN, M.
1973 Humoral medicine in Guatemala and peasant acceptance of modern medicine. Human Organization 32(4): 385-95.
- LOPEZ VALLECILLOS, I.
1964 El periodismo en El Salvador: Bosquejo histórico-documental. San Salvador, El Salvador.
- MACLEOD, M.
1973 Spanish Central America: A socioeconomic history, 1520-1720. Berkeley, CA., University of California Press.
- MAMDANI, M. AND G. WALKER
1985 Essential drugs and developing countries. A review and selected annotated bibliography. London School of Hygiene and Tropical Medicine, EPC.
- MANDEL, E.
1970 The laws of uneven development. New Left Review 59: 19-38.
- MARROQUIN, A. D.
1966 San Pedro Nonualco: Investigación sociológica. San Salvador, El Salvador.

1974 Panchimalco, investigación sociológica. San Salvador, El Salvador, Ministerio de educación.

- MCDERMOTT, W.
 1979 Historical perspective. In *Pharmaceuticals for Developing Countries*. National Academy of Sciences. Division of International Health, Institute of Medicine. Washington, D.C.: National Academy of Sciences, 9-27.
- 1980 *Pharmaceuticals: Their role in developing societies*. Science 209: 240-45.
- MCKOEWN, T.
 1979 *The role of medicine, dream, mirage or nemesis?* Princeton, NJ., Princeton University Press.
- MEDAWAR, C.
 1979 *Insult or injury? An inquiry into the marketing and advertising of British food and drug products in the Third World*. London, Social Audit.
- MEDAWAR, C. AND B. FREESE
 1982 *Drug diplomacy: Decoding the conduct of a multinational pharmaceutical company and the failure of a western remedy for the Third World*. London, Social Audit.
- MELROSE, D.
 1981 *The great health robbery: Baby milk and medicines in Yemen*. Oxford, Oxfam.
- 1982 *Bitter pills: Medicines and the Third World*. Oxford, Oxfam.
- MILLARD, A. AND E. BERLIN
 1983 *ABO blood groups and sex ratios in South American Indians*. Ecology of Food and Nutrition 16: 171-88.
- MITCHELL, M. F.
 1980 *Class, therapeutic role and self-medication in Jamaica*. Ann Arbor, MI., University Microfilms International.
- MONTGOMERY, T. S.
 1982 *Revolution in El Salvador: Origins and evolution*. Boulder, CO., Westview Press.
- 1983 *Liberation and revolution. Christianity as a subversive activity in Central America*. In *Trouble in Our Backyard. Central America and the United States in the Eighties*. Martin Diskin, ed. New York, Pantheon Books, 75-100.
- MORSY, S.
 1978 *Sex roles, power and illness in an Egyptian village*. American Ethnologist 5: 137-50.

- 1979 The missing link in medical anthropology: The political economy of health. *Reviews in Anthropology* 6: 349.
- 1981 Towards a political economy of health: A critical note on the medical anthropology of the Middle East. *Social Science and Medicine* 15B: 159-63.
- MOTHER JONES
1979 The corporate crime of the century. November.
- MURRAY, G.
1977 Traditional and modern strategies of health delivery among peasants of El Salvador. San Salvador, U.S.A.I.D. Contract 1a-c-1186.
- NASH, J.
1981 Ethnographic aspects of the world capitalist system. *Annual Review of Anthropology* 10: 393-423.
- NATIONAL ACADEMY OF SCIENCES, INSTITUTE OF MEDICINE
1979 Pharmaceuticals for developing countries. Washington, D.C., National Academy of Sciences, Division of International Health.
- NAVARRO, V.
1974 The underdevelopment of health or the health of underdevelopment: An analysis of the distribution of human health resources in Latin America. *International Journal of Health Services* 4(1): 5-27.
- 1976(a) The industrialization of fetishism or the fetishism of industrialization. A critique of Ivan Illich. *International Journal of Health Service* 5(3): 351-70.
- 1976(b) Medicine under capitalism. New York, Prodist.
- 1985 U.S. marxist scholarship in the analysis of health and medicine. *International Journal of Health Services* 15(4): 525-46.
- NIEVES, I.
1979 Household arrangements and multiple jobs in San Salvador. *Signs* 5(1): 134-42.
- NORTH AMERICAN CONGRESS ON LATIN AMERICA (NACLA)
1980 Report on the Americas. XIV (January-February).

- NORTH, L.
1981 Bitter grounds: Roots of revolt in El Salvador. Toronto, Between the Lines.
- NUTINI, H. S.
1967 A synoptic comparison of Mesoamerican marriage and family structure. Southwest Journal of Anthropology 23: 383-404.
- ONOGÉ, O.
1975 Capitalism and public health: A neglected theme in the medical anthropology of Africa. In Topias and Utopias in Health, S. Ingman and A. E. Thomas, eds. The Hague, Mouton Publishers, 219-32.
- PAN AMERICAN HEALTH ORGANIZATION
1971 Seminar on drug control in the Americas, Maracay, Venezuela, 15-20 November. Washington, D.C., Pan American Health Organization Scientific Publications Series 225.
- PATEL, S. J.
1983 Pharmaceuticals and health in the Third World. New York, Pergamon Press.
- PELTO, P. J. AND B. R. DEWALT
1985 Methodology in macro-micro studies. In Micro and Macro Levels of Analysis in Anthropology. Issues in Theory and Research, B. DeWalt and P. Pelto, eds. Boulder, CO., Westview Press.
- PIACHAUD, D.
1980 Medicines and the third world. Social Science and Medicine 14C: 183-89.
- PRESS, I.
1969 Urban illness: Physicians, curers and dual use in Bogota. Journal of Health and Social Behavior 10: 209-18.

1971 The urban curandero. American Anthropologist 73: 741-56.
- PROGRAMA REGIONAL DEL EMPLEO PARA AMERICA LATINA Y EL CARIBE,
ORGANIZACION INTERNACIONAL DEL TRABAJO
1977 Situación y perspectiva del empleo en El Salvador, Vol. I. Santiago, Chile, Organización Internacional del Trabajo.

- RAWSON, I. G. AND V. VALVERDE
1976 The etiology of malnutrition among preschool children in rural Costa Rica. *Environmental Child Health* 22: 12-17.
- RAYNOLDS, D. R.
1967 Rapid development in small economies: The example of El Salvador. New York, Praeger.
- RICHTER, E.
1980 Social classes, accumulation, and the crisis of overpopulation in El Salvador. *Latin American Perspectives* VII (2/3): 114-35.
- RIMLINGER, G. V.
1971 Welfare policy and industrialization in Europe, America and Russia. New York, John Wiley and Sons, Inc.
- ROBERTS, B.
1970 The social organization of low income urban families. In *Crucifixion by Power*, R. N. Adams, ed. Austin, TX., University of Texas Press.
- ROEMER, M.
1971 Social security for medical care: Is it justified in developing countries? *International Journal of Health Services* 1(4): 354-61.
- ROSTOW, W. W.
1962 The stages of economic growth. Cambridge, Cambridge University Press.
- RUBEL, A. J., C. O'NEILL AND R. COLLADO ARDON
1984 Susto, a folk illness. Berkeley, CA., University of California Press.
- RUSSELL, P. L.
1984 El Salvador in crisis. Austin, TX., Colorado River Press.
- SARASTI, H.
1970 To the editor. Chloramphenicol in South America. *New England Journal of Medicine* 282(14): 813.
- SATTERTHWAITE, R.
1971 Campesino agriculture and hacienda modernization in coastal El Salvador: 1949-1969. Madison, WI., University of Wisconsin, Ph.D. Dissertation.

SCHEPER-HUGHES, N.

1984 Infant mortality and infant care: Cultural and economic constraints on nurturing in northeast Brazil. Social Science and Medicine 19(5): 535-46.

SEGALL, M.

1975 Pharmaceuticals and health planning in developing countries. Brighton, England, Institute for Development Studies at Sussex, No. 119.

SESSER, S.

1971 Special dispensation. Peddling dangerous drugs abroad. New Republic 164: 16-17.

SHENK, J.

1985 El Salvador. The new and the old war. North American Congress on Latin America (NACLA) XIX(3), May-June: 9-11.

SIECA

1974 El desarrollo integrado de Centro-América en la presente década: Bases y propuestas para el perfeccionamiento y la reestructuración del mercado común Centro-Americano. Programa de desarrollo industrial integrado, Anexo Numero 3, 72/VIII: 6-36.

SILER, W., M. R. SAWDEY AND B. C. MEINHOEFER

1978 Death by prescription. Nashville, TN., Sherbourne Press.

SILVERMAN, M.

1977 The epidemiology of drug promotion. International Journal of Health Services 7(2): 157-66.

1979 The drugging of the Americas. Berkeley, CA., University of California Press.

SILVERMAN, M. ET AL.

1982 Prescription for death: The drugging of the Third World. Berkeley, CA., University of California Press.

SIMMONS, O. G.

1955 Popular and modern medicine in mestizo communities of coastal Peru and Chile. Journal of American Folklore 68: 57-71.

SIMON, L. AND J. STEPHENS, JR.

1981 El Salvador, land reform 1980-81. Boston, MA., Oxfam America.

- SMITH, C. A.
1985 Local history in global context: Social and economic transitions in western Guatemala. In *Micro and Macro Levels of Analysis in Anthropology. Issues in Theory and Research*, B. DeWalt and P. Pelto, eds. Boulder, CO., Westview Press, 82-120.
- SMITH, C. E.
1979 Major disease problems in the developing world. In *Pharmaceuticals for Developing Countries*. National Academy of Sciences, Division of International Health, Institute of Medicine. Washington, D.C., National Academy of Sciences, 30-48.
- SMITH, J.
1984 Nonwage labor and subsistence. In *Households and the World Economy*, J. Smith, I. Wallerstein and H. Dieter Evers, eds. Beverly Hills, CA., Sage Publications, 64-89.
- SMITH, J., I. WALLERSTEIN AND H. DIETER EVERS
1984 *Households and the world economy*. Beverly Hills, CA., Sage Publications.
- SMITH, R.
1984 Anthropology and the concept of social class. *Annual Review of Anthropology* 13: 467-94.
- SMITH, W. R.
1977 *The fiesta system and economic change*. New York, Columbia University Press.
- SOLIEN, N. L.
1971 Household and family in the Caribbean. In *Peoples and Cultures of the Caribbean*, M. Horowitz, ed. Garden City, NY., The Natural History Press, 404-11.
- STAVENHAGEN, R.
1975 *Social classes in agrarian societies*. New York, Anchor Press.
- STOLTZ CHINCHILLA, N.
1980 Class struggle in Central America: Background and overview. *Latin American Perspectives* VII(2/3): 2-23.
- TAUSSIG, M.
1978 Nutrition, development and foreign aid: A case study of U.S.-directed health care in a Colombian plantation zone. *International Journal of Health Services* 8(1): 101-21.

- 1980 Reification and the consciousness of the patient.
Social Science and Medicine 14B: 3-13.
- TAYLOR, C.
1976 The place of indigenous medical practitioners in the
modernization of health services. In Asian Medical
Systems, C. Leslie, ed. Berkeley, CA., University of
California Press, 285-99.
- TORRES-RIVAS, E.
1980 The Central American model of growth: Crisis for whom?
Latin American Perspectives VII(2/3): 24-44.
- TRIMBERGER, K.
1979 World systems analysis: The problem of unequal
development. Theory and Society 8: 101-106.
- 1983 Central America Today. A study in regional dependency.
In Trouble in Our Backyard. Central America and the
United States in the Eighties, M. Diskin, ed. New York,
Pantheon, 1-34.
- TUMIN, M. M.
1952 Caste in a peasant society. Princeton, NJ., Princeton
University Press.
- TURNER, V. W.
1968 The drums of affliction: A study of religious processes
among the Ndembu of Zambia. Oxford, Clarendon Press.
- TURSHEN, M.
1984 The political ecology of disease in Tanzania. New
Brunswick, NJ., Rutgers University Press.
- UNSCHULD, P.
1976 The social organization and ecology of medical practice
in Taiwan. In Asian Medical Systems, C. Leslie, ed.
Berkeley, CA., University of California Press.
- VALVERDE, V., R. MARTORELL, V. MEJIA-PIVARAL, H. DELGADO, A. LECHTIG,
C. TELLER AND R. KLEIN
1977 Relationship between family land availability and
nutritional status. Ecology of Food and Nutrition 6:
1-7.
- VAN DER GEEST, S.
1981 La pathologie de services medicaux: La distribution de
medicaments au sud Cameroon. Amsterdam, Anthropological-
Sociological Center.

- 1982(a) The illegal distribution of western medicines in developing countries: Pharmacists, drug pedlars, injection doctors and others. A bibliographic exploration. *Medical Anthropology* 6(4): 197-219.
- 1982(b) The efficiency of inefficiency: Medicine distribution in south Cameroon. *Social Science and Medicine* 16(24): 2145-53.
- 1984(a) Anthropology and pharmaceuticals in developing countries I. *Medical Anthropology Newsletter* 15(3): 59-62.
- 1984(b) Anthropology and pharmaceuticals in developing countries II. *Medical Anthropology Newsletter* 15(4): 87-90.
- VIRCHOW, R.
1958 Disease, life and man. Translated by L. Rather. Stanford, CA., Stanford University Press.
- WAITZKIN, H.
1974 The micropolitics of medicine: A contextual analysis. *International Journal of Health Services* 14(3): 339-78.
- 1976 Recent work in medical sociology. *Contemporary Sociology* 5(July): 401-406.
- 1979 The Marxist paradigm in medicine. *International Journal of Health Services* 9(4): 683-98.
- WAITZKIN, H. AND B. WATERMAN
1974 The exploitation of illness in capitalist society. Indianapolis, IN., Bobbs Merrill.
- WALLERSTEIN, I.
1974 The rise and future demise of the world capitalist system: Concepts for comparative analysis. *Comparative Studies in Society and History* 16: 387-415.
- 1975 The modern world system. Capitalist agriculture and the origins of the European world economy in the sixteenth century. New York, Academic Press.
- 1980 The modern world system II: Mercantilism and the consolidation of the European world economy. New York, Academic Press.
- WARREN, K. B.
1978 The symbolism of subordination. Indian identity in a Guatemalan town. Austin, TX., University of Texas Press.

- WEISBERG, D. H.
 1982 Drugs--retail and wholesale. The druggist as practitioner and medical middleman in the northern Thai town. Paper presented at the American Anthropological Association Meetings, Washington, D.C., December.
- WESTHEIM, P.
 1965 The art of ancient Mexico. Garden City, NY., Doubleday Anchor.
- WHEATON, P.
 1980 Agrarian reform in El Salvador: A program of rural pacification. Washington, D.C., EPICA Task Force.
- WHITE, A.
 1969 The social structure of the lower classes in San Salvador, Central America, a case study of the social consequences of economic change. University of Cambridge, Ph.D. Dissertation.
- 1973 El Salvador. London & Tonbridge, Ernest Benn, Ltd.
- WHITEFORD, S. AND L. MONTGOMERY
 1985 The political economy of rural transformation. In Micro and Macro Levels of Analysis in Anthropology. Issues in Theory and Research, B. DeWalt and P. Pelto, eds. Boulder, CO., Westview Press, 147-64.
- WHITTEN, N. E. AND J. F. SZWED
 1970 Introduction. In N. Whitten and J. Szwed, Afro-American Anthropology. New York, Free Press, 23-53.
- WILLIAMS, R. G.
 1986 Export agriculture and the crisis in Central America. Chapel Hill, NC.: University of North Carolina Press.
- WILSON, E. A.
 1970 The crisis of national integration in El Salvador, 1919-1935. Stanford, CA., Stanford University, Ph.D. Dissertation.
- WOLF, E.
 1969 Peasant wars of the twentieth century. New York, Harper & Row Publishers.
- 1982 Europe and the people without history. Berkeley, CA.: University of California Press.

- WOODS, C. M.
1977 Alternative curing strategies in a changing medical situation. *Medical Anthropology* 1(3): 25-54.
- WOODS, C. M. AND T. D. GRAVES
1973 The process of medical change in a highland Guatemalan town. Los Angeles, CA., The University of California Latin American Center, Latin American Studies Series, 21.
- WORLD HEALTH ORGANIZATION
1977 The selection of essential drugs. Geneva, WHO Technical Report Series 615.
- 1979 The selection of essential drugs. Geneva, WHO Technical Report Series 641.
- 1983 The use of essential drugs. Geneva, WHO Technical Report Series No. 685.
- 1985 The use of essential drug. Geneva, WHO Technical Report Series No. 722.
- YOUNG, A.
1978 Rethinking the western health enterprise. *Medical Anthropology* 2(2): 1-10.
- 1981 When rational men fall sick: An inquiry into some assumptions made by medical anthropologists. *Culture, Medicine and Psychiatry* 5: 317-35.
- 1982 The anthropologies of illness and sickness. *Annual Review of Anthropology* 11: 257-85.
- YOUNG, J.
1981 Medical choice in a Mexican village. New Brunswick, NJ., Rutgers University Press.
- YUDKIN, J. S.
1980 The economics of pharmaceutical supply in Tanzania. *International Journal of Health Services* 10(3): 455-77.

MICHIGAN STATE UNIV. LIBRARIES



31293000837215