

*Salud Colectiva*

**The Role of Public Health Campaigns in Building a Modern Mexican Nation, 1940s-1960s**

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THESIS

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For their unconditional love and encouragement, I dedicate this dissertation to:

My parents, Tom and Carla Baker

My husband and best friend, Luke Opperman

Mis amigas, Christine Bolles, Veronica Johnston, Catherine Siebel and  
Nicole Stoller

## TABLE OF CONTENTS

<u>CHAPTER</u>	<u>PAGE</u>
1. INTRODUCTION .....	1
1.1 Background .....	1
1.2 The Role of Modernization in Public Health .....	5
1.3 Public Health in Latin America: A Historiography .....	8
1.4 Case Studies .....	17
2. PANORAMA OF PUBLIC HEALTH PROGRAMS IN MEXICO, 1940-1960 .....	20
2.1 Introduction .....	20
2.2 Global Moment (1940s to 1960s) .....	21
2.3 Global Public Health (1940s to 1960s) .....	26
2.4 Indigenismo .....	36
2.5 Overview of Three Case Studies .....	41
2.5.1 Veracruz .....	44
2.5.2 Michoacán .....	46
2.5.3 Oaxaca .....	49
2.6 Conclusion .....	54
3. THE COMISIÓN DE TEPALCATEPEC AND PROYECTO MEX-MED 4 .....	56
3.1 Introduction .....	58
3.2 Geography and Population .....	61
3.3 Comisión de Tepalcatepec .....	64
3.4 Proyecto MEX-MED 4: Goals and Objectives .....	72
3.4.1 Proyecto MEX-MED 4: The Project in Action .....	74
3.5 Conclusion .....	89
4. BIENESTAR SOCIAL RURAL .....	92
4.1 Introduction .....	95
4.2 Creating the Bienestar Social Rural Program .....	99
4.2.1 Philosophy of Community Development .....	101
4.2.2 Goals and Objectives: The Program Outline .....	105
4.3 Lessons from the Pilot Centers .....	111
4.4 Implementing the Program on a Large Scale .....	120
4.5 Conclusion .....	131
5. THE INI COORDINATING CENTER: MIXTECA .....	134
5.1 Introduction .....	137
5.2 Problems in the Mixteca .....	145
5.3 Coordinating Center: Mixteca .....	150
5.4 Situation in 2000 .....	165
5.5 Conclusion .....	168

6.	CONCLUSION.....	171
	CITED LITERATURE .....	182
	VITA.....	193

## **LIST OF ABBREVIATIONS**

DCISP	Dirección de Cooperación Interamericana de Salubridad Pública (Directorate of Interamerican Cooperation on Public Health)
DSP	Departamento de Salubridad Pública (Department of Public Health)
IMSS	Instituto Mexicano del Seguro Social (Mexican Social Security)
INI	Instituto Nacional Indigenista (National Indigenous Institute)
SEP	Secretaría de Educación Pública (Ministry of Public Education)
SRH	Secretaría de Recursos Hidráulicos (Ministry of Water Resources)
SSA	Secretaría de Salubridad y Asistencia (Ministry of Public Health and Welfare)
UN	United Nations
UNESCO	United Nations Educational, Scientific, and Cultural Organization
WHO	World Health Organization

## SUMMARY

This dissertation argues that health campaigns in Mexico during the 1940s-1960s became more effective through the mediation of health promoters working in rural indigenous communities. By carefully balancing state-sponsored health initiatives with on-the-ground implementation, health promoters in this period perpetuated community-focused national health programs while further integrating rural populations into the modern nation. This dissertation innovatively combines social history with the history of health to reveal the lived reality of health providers working with Mexico's indigenous populations.

In a broad sense, the findings show a major shift away from previous national health programs that attempted to administer uniform healthcare regardless of culture or environment. Beginning the 1940s, healthcare providers worked to establish a dialectic relationship with rural populations to achieve short-term social and economic improvements. The three regional case studies that serve as the core of this dissertation each required a different organizational structure, set of agency collaborations, level of community participation, and range of provider mediations between officials and locals. Together, the three cases show the crosshatching of bureaucratic goals with international pressures, indigenous activism, and local participation as health providers put institutional policies into practice.

# 1. INTRODUCTION

## 1.1 **Background**

In his 1955 presentation to the World Health Assembly, Gonzalo Aguirre Beltrán offered a reinterpretation of Mexico's health programs from a cross-cultural perspective. Beltrán, one of the nation's most prominent anthropologists and a member of the Instituto Nacional Indigenista (INI) leadership, stated:

A program which is planned in accordance with the inflexible standards of Western technique and backed by a large budget and by personnel of high professional caliber may be ideal for the most urbanized section of one of our cities in the process of industrialization, but it is completely unworkable in a cross-cultural situation such as is to be found in Indian zones throughout the country. (32)

Beltrán stressed that health care providers needed to overcome their misconception that all people living in rural regions shared a common ethnicity and cultural belief system. He argued that, while early twentieth-century health officials approached rural communities with a standardized disease treatment program, future healthcare providers needed to tailor their methods to the specific needs of each community they encountered.

Beltrán's work drew attention to the fact that social disparities, not just disease prevention, must be taken into account in order for health programs to be successful. His study showed that rural mestizos lived in the regional nucleus and constituted the majority of the population. Their cultural practices were similar to those in urban areas, and many had access to scientific professionals for medical care. In contrast, indigenous families lived in separate communities along the regional center's periphery. Their cultural practices were considerably different from their urban and rural mestizo counterparts, he maintained, and they relied on local healers and mystical concepts for their health care. Mestizos often had access to drinking water and sewage drainage whereas indigenous groups did not. Mestizos lived in ventilated brick

houses and wore Western clothing, while indigenous groups lived in reed houses with little light or air, and wore one outfit for long periods of time. Lastly, mestizos had access to hospitals, medical institutions, and maternity clinics established in town while indigenous families were dependent on close, inexpensive domestic care. Based on these social differences, Beltrán concluded that the only reason mestizos became healthier than indigenous families was by access to sewage disposal and potable water. He argued that knowledge of cross-ethnic exchanges between mestizos and indigenous groups in a given area, including economic dependence, social tensions, and cultural differences, would greatly assist healthcare professionals in determining appropriate public health programs for both communities.

Beltrán's speech epitomizes the larger reevaluation of health policies taking place in post-war international circles. Global social and political changes created an unprecedented environment for collaboration between national policymakers and rural populations. Mid-twentieth century international relations spotlighted for the first time the scale of global inequality and the common fear for the political and economic stability of developing nations. Humanitarian efforts spanned from international economic recovery and public health campaigns to local community development projects. The rapid growth of scientific achievement inspired renewed attempts to modernize global societies. The establishment of the World Health Organization (WHO) in 1948 gave increased importance to public health policies. International policymakers and humanitarian organization leaders touted the universal right of all individuals to be healthy. They associated health and well being with political stability and economic progress.

Within this global setting, Mexican politicians worked to culturally unify the nation and solidify their political authority over remote rural populations. Intellectuals experimented with



new approaches to assimilate indigenous communities into the modern nation while economists looked for ways to tap into rural natural and human resources. Although these challenges represent long-standing issues for Mexican policymakers, new collaborations between indigenous populations and federal representatives in the 1940s changed the dynamic under which both groups operated.

Mortality rates among rural populations, which encompassed the majority of society, reached alarming heights that drove policymakers to reformulate their public health campaigns. Previous health programs largely centered on disease eradication and urban sanitation efforts. Traveling medical brigades and schoolteachers administered vaccination and first aid, but rural communities relied on local healers as their permanent form of medical care. As the World Health Organization and other philanthropic organization leaders asserted, health was fundamental to the growth and strength of a society. Consequently, by the late 1940s, Mexican policymakers significantly expanded state-sponsored social services into remote regions of the nation.

In order to adequately serve indigenous communities, Mexican public health officials focused on establishing new collaborations with these populations. There were several reasons for this. First, they hoped to improve relations with groups of people who had grown to mistrust government officials. Medical care had previously been utilized as a form of social control, but healthcare providers in this period strove to move beyond this power-based method to offer services they hoped would be useful to their targeted populations. Second, health officials wanted to understand local languages and customs in order to communicate more effectively with community members. This led, in some cases, to improved programs that incorporated culturally sensitive approaches into their implementation. Third, given the lack of available state

resources for health initiatives, healthcare providers needed collaborations with local groups to offset their limited personnel and budget. Rural volunteers, community participation, and local financial contributions therefore became crucial aspects to carrying out new public health programs.

For their part, rural populations largely cooperated with state public health campaigns. Malaria, smallpox, whooping cough, and dysentery plagued many communities. Lack of potable water and sanitation services undoubtedly contributed to the spread of disease, and once installed, quickly produced health improvements. By working with public health officials in promoting health programs, building latrines and drainage systems, and contributing financial resources, rural populations felt they could directly support their community's well being. Finally, the fact that healthcare providers learned local languages significantly improved communication between the two groups.

A fundamental but previously unrecognized transformation in healthcare provision during these years was the shift in public health programs from individual to collective care. Mexican health officials, influenced by WHO policies, repositioned their focus from the needs of individuals to the needs of Mexican society as a whole. While previous attempts to treat disease centered on vaccinations, programs in the 1940s and 1950s included community public works initiatives to improve local living conditions and increase the number of healthy workers available to carry out national development projects. State officials' definition of health also changed from disease prevention to the population's well being. This new approach, also influenced by WHO policies, guided healthcare providers in their efforts to engage with rural community members. Health workers effectively appealed to community leaders by seeking regional participation in health programs, and encouraging community mobilization to aid the

state in rural health improvement. Collective health care gave community members a new role in the nation's modernization program, as rural individuals joined forces with government agencies to improve the standard of living for the larger Mexican society.

This dissertation examines three different rural case studies in the Central Mexican states of Michoacán, Veracruz, and Oaxaca to explore how interactions between healthcare providers and their publics changed the nature of health programs. While other contributing factors, most notably the lack of state financial resources to sustain the programs over time, are also considered, I argue that the ability of healthcare providers to adjust, and readjust, their programs in an effort to improve health in rural areas played a significant role in their effectiveness. Policymakers assisted in this process by expanding their focus from disease treatment to prevention, and added considerable public works projects, organized community activities, and improved health education classes to their larger modernization agenda. They also utilized local volunteers and community promoters to help transition communities into regional hubs of state activities. Many community leaders cooperated in new health campaigns and incorporated Western medicine and hygienic practices into local cultural norms. The result was a short-term improvement in the health and well-being of rural Mexicans before limited financial resources and politicians' economic expansion goals undercut these gains in the 1960s.

## **1.2 The Role of Modernization in Public Health**

Mexican bureaucrats first linked health with "order and progress" in the late 1800s, and this model continued to serve as a benchmark of modernization throughout the 1900s. During the Porfiriato (1870-1910), government officials viewed the lower classes as potential disease vectors and worked to push them to the periphery of Mexican society. Policymakers designed large-scale sanitation, hygiene and burial programs in Mexico City to make the capital attractive

to urban businessmen and international investors. By the 1920s and 1930s, healthcare providers and anthropologists worked to extend public health programs into rural Mexico. They hoped to rebuild areas destroyed by the Mexican Revolution (1910-1920) and to work with local politicians in establishing national political and cultural uniformity. (3)

After the World Health Organization's foundation in the late 1940s, countries with high mortality rates, poor living conditions, and uncontrollable disease outbreaks received international attention. Wanting desperately to avoid being classified as an underdeveloped country, and therefore losing potential international authority and foreign investment, Mexican policymakers made public health campaigns a national priority in the 1940s and 1950s. They also realized the economic advantages of adding public health into their modernization agenda. Schoolteachers and health officials, who had been instructing indigenous populations on their right to health care as guaranteed in the 1917 Constitution since its ratification, now gained the additional responsibility of linking the right to be healthy with the obligation to contribute to the national economy. Industrialization and commercial agricultural efforts in Mexico required a strong, healthy work force. Official attempts to raise rural standards of living, education, life expectancy, and overall well-being were instrumental to overall economic growth because they often produced a healthier, happier workforce. Additionally, by offering these services to communities as a step toward fulfilling the promises of the Mexican Revolution, bureaucrats increased the likelihood that indigenous community members would feel obligated to reciprocate by agreeing to work for state-sponsored development projects. (93)

While politicians supported universal healthcare as part of their larger goal to increase economic productivity, indigenous community activists advocated for care that incorporated local cultures. Indigenous groups recognized assimilationist undertones in national health

policies that sought to transform native health beliefs and practices. Community advocates attempted to counter these threats to their cultural survival by emphasizing their own health needs and understandings. They utilized increased local awareness of healthcare rights to proactively demand better services for their communities. The foundation of the *Instituto Nacional Indigenista* (INI) in 1948 added an additional layer to the conflict as Institute officials worked to ease indigenous communities into the modern nation by simultaneously respecting local languages and traditions while also promoting national cultural and economic conformity. While INI representatives appeared to appreciate the cultural uniqueness of indigenous communities, their ultimate goal of assimilation complicated their relationship with community leaders.

Healthcare providers working in rural communities during this period recognized the mounting resistance of community leaders against assimilationist, and ultimately ethnocidal, state health policies. Their on the ground experiences taught them that community leaders did want to receive modern health services but were reluctant to accept care that jeopardized their native cultures. Furthermore, healthcare providers discovered that different peoples understood health in different ways. Just as the Western definition of health shifted from individual to collective care in international circles, local definitions similarly transitioned from supernatural beliefs into a medical pluralism that incorporated helpful practices from many different cultures. Consequently, rather than encouraging state-designed assimilationist health projects, healthcare providers worked with community members to introduce modern medical practices in culturally relevant ways. They mediated official and local conflicts to provide short-term health campaigns that satisfied the needs of both groups. By the mid 1950s, state officials applauded the level of

local cooperation health providers established in rural areas, and community leaders largely accepted and participated in modern health programs.

### **1.3 Public Health in Latin America: A Historiography**

This dissertation utilizes public health as a tool for understanding state building in Mexico and popular support or resistance to these efforts through the mediation of healthcare providers. In the three case studies that serve as the core of my dissertation—the *Comisión de Tepalcatepec* in 1940s Michoacán, the *Bienestar Social Rural* program in 1950s Veracruz, and the INI Coordinating Center in 1960s Oaxaca—I analyze how Mexican health officials transformed national public health campaigns into local programs that emphasized community participation. Additionally, I evaluate the political, economic, and social motivations of state officials for developing rural Mexico as well as indigenous responses to these initiatives. My work is influenced by Diego Armus, one of the most prominent Latin American historians of public health. Armus contends that the study of health is central to any society's history because it “addresses the powerful interplay among culture, history, medicine and society.” (19) Rather than concentrating on individuals, Armus argues, public health allows societal perspective to evolving political trends, economic climate, technological innovation, scientific discovery, and cultural norms. Following this concept, I utilize the role of healthcare providers as a new lens for exploring political and social relations in Mexico during the 1940s and 1950s. The complex mediation of health professionals between national policies and local norms improved rural healthcare and redefined interactions between state representatives and indigenous groups in this period.

Historians in the last decade have begun evaluating the links between public health campaigns and modernization efforts in Mexico. Claudia Agostoni explores the Porfirian

government's efforts to equate health and hygiene in the late nineteenth and early twentieth centuries with "patriotic and essential services to the nation." (4) Linking order and progress to cleanliness, Agostoni maintains that health policies in Mexico and throughout Latin America coincided with policing efforts to sanitize big cities, enforce moral order, and ultimately attract foreign capital and immigrants. (3) Policymakers believed that it was the duty of all Mexicans to maintain clean home and work environments, in addition to a standard of personal sanitation. They rationalized that the nation needed to work together toward establishing higher standards of living in order for Mexico to be considered a modern nation by international businessmen and visitors. Consequently, all residents were obligated to either help urban centers look like their cosmopolitan European and United States counterparts or, if families were unable to live up to these new standards, to remain out of sight in rural peripheries. I argue that the concept of patriotic responsibility to be healthy became even more prominent in the 1940s as a result of renewed government efforts to push for civic participation. Officials in my study hoped that reframing health from an individual concern to a collective responsibility would harness greater validation for their position and support for their programs in rural areas.<sup>1</sup> While Agostoni examines the early stages of modernization efforts, my work carries the discussion forward by analyzing how politicians attempted to deal with the marginalized groups that had been pushed to or left in the periphery in the post-revolutionary period.

This dissertation suggests that Mexican officials understood modernization not only as political subjugation but also social cohesion based on Western culture. Politically, officials wanted each social class to embrace their role in contributing to national stability. This meant not

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<sup>1</sup> Michel Foucault's *Birth of the Clinic* notes this phenomenon occurring throughout the world during the 1940s and 1950s. He wrote that the gradual ideological extension of individual well-being to the health of the nation gave social scientists and medical professionals the leverage they needed to spark community participation. Not only were they offering individuals the opportunity to improve their own health, but they also gave them a stake in the health of the local and nation community.

only participating in the market economy, either by selling or manufacturing goods, but also by acknowledging the authority of the federal government through civic participation. Policymakers attempted to consolidate the national government and unite the fractured society of post-revolutionary Mexico by establishing public welfare programs targeted at rural communities. A primary goal of these initiatives was to offer community members health services in exchange for their support. With a new spirit of cooperation in place, policymakers hoped to then regulate the moral and social activities of citizens as a way to transition previous cultural distinctions among indigenous groups into a new unified culture. This theory is based, in part, on Heather McCrea's scholarship concerning nineteenth-century Yucatán. McCrea suggests that policymakers utilized turn-of-the-century Western scientific advancements in immunization and disease eradication as a means to having greater influence over the private lives of rural and urban populations. (109) Examining her case studies together with my work draws attention to the fact that Mexican officials and healthcare providers grappled with ways of "subjecting the population to the norms of a modern Mexico-in-progress" from the 1840s until at least the 1940s by attempting to control both disease and personal behavior. (36)

The political climate of 1940's Mexico created an unprecedented opportunity for Mexican officials to merge their economic development and social cohesion goals. Anne-Emanuelle Birn maintains that President Lázaro Cárdenas' (1934-1940) "belief in modernization and industrialization necessitated healthy and productive workers who accepted the legitimacy of the government." (33) My work also shows that the modernization efforts established under Cárdenas linked health to political consolidation. However, my research challenges Birn's conclusion that this causal relationship ended with the presidential election of Manuel Ávila Camacho (1940-1946). She contends that along with the end of the *ejidal*, or communal, model



in 1940, “federal public health programs replaced integrated consideration of health and community issues such as employment, housing, transportation, and education with measures directed at individual body parts.” (33) In contrast, my work shows that during the 1940s and 1950s government agencies sent healthcare providers into rural areas with the specific purpose of developing these communities. The multi-tiered public health campaigns described in this dissertation not only incorporated sanitation, access to water resources, and hygiene behavior education into larger state modernization goals, but also included industrialization and infrastructure components. National leaders linked this “integrated consideration” of health and community to the national economy even more after Cárdenas than before. This finding is significant because it points to the continuation of community-focused development programs well into what is commonly considered to be a conservative turn in Mexican history. Political ideals in the 1940s suggested both individual responsibility and the common good. Exploring how Mexican healthcare providers reconciled these two seemingly opposite goals helps to contextualize the complex relationship between rural peasants and national policymakers.

In his study of the 1950s *Comisión Nacional de Erradicación del Paludismo* (National Commission for the Eradication of Malaria) Marcos Cueto posits, “For the Mexican government the campaign provided a means to obtain funds from abroad, to reinforce its strong centralized administrative system, to create rural health services in poorly served areas, and to demonstrate that it was fulfilling the social promise of the 1910 Mexican Revolution for better health.” (56) My work complicates these ideas by showing that full-fledged economic development programs including specialized health treatments were already well underway in the 1950s. The arms of the public health department, coupled with the departments of education, water resources, agriculture, and the *Instituto Nacional Indigenista*, spread to establish contact and provide care to

millions of rural Mexicans in the 1940s. I also show that while government officials continued using the rhetoric of the Revolution, rural Mexican communities were already informed of their rights as citizens and were taking active steps to ensure those rights were protected. Cueto's explanation of state goals more closely matches those of the Cárdenas era than the time of Avila Camacho. Again, I suggest that the extension of periodization is important because the international influences, national modernization agenda, and *indigenismo* movement that defined this period combined to create a unique set of pressures for Mexican officials. The political struggle to balance these tensions helped to produce a distinct environment for promoting rural collective care.

Petitioning for welfare services increased dramatically among indigenous groups during my period of study. Anne-Emanuelle Birn examines the intersection of postrevolutionary politicians' ambitions for industrialization based on scientific progress and peasant demands for government officials to carry out their revolutionary promise to improve living and working conditions in the late 1930s. (33) Ana María Kapelusz-Poppi also highlights peasants' demands for their own local clinics as part of their accepted constitutional right to healthcare during the Cárdenas administration. (92) While I agree with both authors' assessments of peasant attitudes in the 1930s, my case studies move the scholarship forward by showcasing petitions in the 1940s for health centers by communities previously hesitant to accept government assistance. Additionally, indigenous groups gained more specialized services in this period as a result of improved cooperation with healthcare providers. By learning local languages and customs, as well as offering opportunities for direct involvement in program implementation, health workers established a more collaborative relationship with indigenous groups. All health programs, Gonzalo Aguirre Beltrán suggested, required active community participation in order to be

successful. He believed this would not only promote cooperation between healthcare workers and indigenous groups, but would also help offset inadequate state resources by encouraging economic support from community members. The result, as my research shows, could be an more specialized health programs based on the healthcare providers' perceived needs of the community rather than the mandates of state policymakers.

Guillermo Bonfil Batalla presented a counterargument to these ideas in the 1970s by asserting that Indian self-determination was essential for the survival of indigenous culture. Rather than cooperating with state officials, whom Bonfil criticized for increasing the inequality of native populations rather than protecting their interests, he maintained that indigenous groups should reject all forms of government assistance. He also argued that social service programs were designed to force indigenous groups to abandon their traditions and integrate into the unified culture supported by national politicians. (25) Charles Briggs and Clara Mantini-Briggs' work on the 1990s cholera epidemic in Venezuela utilized the idea of "medical profiling" to explain state officials' differentiation between "sanitary citizens" and "unsanitary subjects." (40) While policymakers considered urban non-indigenous people to be capable of understanding and implementing modern Western medicine, they regarded poor, marginalized communities as unable to help themselves or accept medical care. The authors argue that, by directing health education campaigns directly at indigenous groups in their local language and within cultural context, policymakers indirectly implied that non-indigenous groups did not need instruction.

The arguments presented in both cases stress that the intentions of government agents included not only health improvements but also the assimilation and eventual ethnocide of indigenous communities. My work complicates these discussions by suggesting that healthcare providers offered a new middle ground between state policies and indigenous traditions. While

health workers brought with them the assimilationist agenda they learned in their state-sponsored training programs, their experience in the field also taught them to respect local definitions of health. They recognized the willingness of community members to integrate valuable contributions of modern medicine into their folk medical concepts, and used this opening as a way to discuss broader cooperation in health programs. Marcos Cueto noted a medical pluralism during the malaria eradication campaign in the 1950s as indigenous groups incorporated Western science into their traditional beliefs about the body. (56) Steven Palmer's study of medical populism in Costa Rica shows a similar medical pluralism "between popular and conventional practitioners...characterized by coexistence, complementarity, and dialogue more than outright rivalry and ideological warfare." (119) Along these lines, healthcare providers in the 1940s and 1950s worked with community members in Mexico to establish a fluid definition of health that evolved, like the national health policies themselves, through trial and error. Ultimately, providers used their position as middlemen to develop programs that were sensitive to rural beliefs, and therefore more attractive to community members, while also continuing to work toward the long-term assimilationist plans of state officials.

In Mexico, health intermediaries took on many different shapes. Ana María Kapelusz-Poppi found that *ejidal* clinics functioned as the middle ground between the agricultural development goals of national policymakers and the health needs of local communities. These clinics, financed by the local communities themselves, provided reasonably priced modern medical treatment to rural areas and amplified state discourse on improving national public health. (92) Gonzalo Aguirre Beltrán's idea of an intercultural relationship required local cultural promoters selected from within the community to represent Western medical ideas to the native population through a culturally contextualized filter. (28) Heather McCrea draws attention to the

role of state “socialist brigades” as intermediaries in turn-of-the-century Yucatan. (109) In my research, I found that the healthcare providers themselves gradually took on the role of intermediaries between policymakers in the capital and native populations living in rural communities. Their on-the-ground experience helped them learn the local culture and adapt national programs to serve the health needs of the community. Indigenous groups in this period often accepted their role in Mexican politician’s larger development agenda, as well as the degraded social status that came with it, in exchange for health services. (70) The result, I argue, was a dialectic relationship that ultimately gained cooperation from both sides in an unprecedented collaboration for improved living and working conditions.

The key to this collaboration was the cultural context gained by healthcare providers working in rural communities. Gonzalo Aguirre Beltrán wrote in the 1950s that, despite progress in prevention and care activities, “the government’s unilateral model of treatment limited the ability of healthcare professionals to heal the sick and prevent the onset of disease by implementing programs without taking into account the social determinants of a region’s health.” (28) He argued that, while professionals trained in Western medicine focused on an individual, rational approach to healthcare, indigenous groups based their medical beliefs on community values and mystical experiences. In other words, cultural context, including the shared beliefs, values, and morals of a community, directly influenced how native peoples understood the concepts of sickness, cleanliness, pollution, the body, and the role of medical professionals. Since the 1970s, Mexican intellectuals have been even more vocal in encouraging the addition of cultural context to health promotion campaigns. In 1974, Luis Cañedo wrote an article for national and international audiences that challenged Mexican health educators and administrators to reexamine their rural health campaign efforts. (45) He surmised that the current system

created widespread healthcare inefficiency without local or regional coordination, including urban-only training facilities, disregard for local *curanderos* and their contributions to health improvement, technical language in dissemination materials and a lack of resources for rural medical facilities. Similarly, Rafael Alvarez-Alva argued that preventive medical education prior to the 1970s neglected to include cultural and socioeconomic influences on health in rural communities. (8) He stated that students were trained to focus on curative medical procedures for diseases but were given little, if any, training in developing health programs that incorporated local traditions and non-Western medical procedures. While Beltrán highlighted a model for bridging Western and traditional medical cultures, Cañedo and Alvarez-Alva both point to the failure of national health programs to adequately address the cultural challenges to healthcare in rural Mexico by the mid 1970s.

The case studies I examine attempt to fill in the missing pieces of these arguments by offering examples of healthcare practitioners mediating between national health policies and indigenous realities. The case studies I examine suggest that sensitivity to local needs was not just the product of 1970s intellectuals offering a new theoretical appreciation for indigenous culture, but in fact was a decades-long process of reconsiderations about how to provide healthcare. Providers working on behalf of the Ministry of Public Health and Welfare and the *Instituto Nacional Indigenista* put considerable energy into developing initiatives that would appeal to indigenous communities. They grappled to reconcile local expectations, needs, and understandings of health with the developmentalist and *indigenista* state agenda that sought rural assimilation. Moreover, they achieved several short-term successes in treating rural patients and showcasing the value of their services. Finally, I conclude that the difficulty healthcare providers faced in establishing long-term programs was not a lack of cultural understanding as much as a

lack of resources combined with a gradual shift in national policymakers' interest away from health and toward economic expansion in the late 1960s.

#### **1.4 Case Studies**

My research centers on three case studies that serve as representative examples of the different agency collaborations, stated objectives, cultural approaches and community responses to healthcare programs in rural Central Mexico. All three cases targeted indigenous communities in areas that had abundant natural resources, close proximity to the capital city, and large populations that could transition into a healthy workforce for the state. Chapter Two will provide an overview of the international and national influences that helped to shape each program. Over time, and through the attentive dialogue and hands-on experience between healthcare providers and community members, each case transformed how national institutional objectives were put into practice and achieved short-term health improvements in rural areas.

The first case study evaluates the *Cuenca de Tepalcatepec* development program in 1940s Michoacán. This program was among the first multi-agency collaborations in Mexico to balance indigenous and non-indigenous health issues with national economic programs. Politicians hoped to integrate this resource-rich area into their industrialization initiatives while also establishing physical and cultural bridges between the urban capital and the rural periphery. Health officials from the Ministry of Public Health and Welfare (*Secretaría de Salubridad y Asistencia*) joined forces with agricultural specialists, industrial developers, water resource managers, rural schoolteachers, anthropologists, and sanitary engineers to coordinate a cohesive plan for improving the standard of living and the economic potential of the region. Appealing to their rights as citizens, healthcare providers worked with residents to improve social and economic conditions. Native groups cooperated with health officials and government

representatives to bring about significant health improvements and development projects among populations situated along economically viable river basins.

The *Bienestar Social Rural* (Rural Social Well-Being) program in the 1950s initiated health promotion campaigns in rural areas by sponsoring community-led health projects. Beginning with pilot centers including Villa Cardel, Veracruz, this program extended health treatment and disease prevention practices to also include the psychological and social well being of the inhabitants. *Bienestar Social Rural* centers were established throughout Mexico and hosted social activities, agricultural instruction, nutritional classes, employment enhancement opportunities, and village infrastructure improvements in addition to medical clinics. Rather than dictating the terms of healthcare, the program was designed to allow health officials to work with communities in determining their needs and providing them with the resources to operate their own health centers. Although the centers never fully developed into the community-operated cultural and medical hub that the program leaders envisioned, the legacy of the *Bienestar Social Rural* program was the ability of healthcare providers to engage indigenous people in pursuing the health benefits offered by the state. The project helped to spark a national shift from individual to collective health that hinged on community participation.

The *Instituto Nacional Indigenista's* Coordinating Center in Jamiltepec, Oaxaca aligned public health officials with indigenous groups in the 1960s to address regional health priorities in a culturally sensitive way. The anthropological approach of *Instituto* delegates built on the social welfare and indigenous activism projects of preceding rural health campaigns by training local volunteers to act as mediators. Healthcare providers working in Jamiltepec found themselves in the difficult situation of mediating between local demands for social services and *Instituto* officials' misunderstanding that native acceptance of healthcare initiatives also meant their



support for broader national development and social unification plans. Providers also realized that culturally sensitive approaches to healthcare were less important to Jamiltepec natives than lasting health improvement services. Healthcare workers provided short-term health treatment to the area, but continue today to experiment with balancing local health needs and state assimilationist goals.

These three cases demonstrate several important themes that, together, brought rural health improvements to central Mexico in the 1950s and 1960s. New agency collaborations provided unprecedented comprehensive healthcare services to indigenous communities. Program leaders gained indigenous cooperation in rural development by improving living and working environments and introducing disease treatment and prevention programs. Indigenous groups worked with healthcare providers to determine their level of participation and methods of care. Healthcare providers also served as valuable intermediaries between policymakers and local leaders by developing culturally relevant programs that attracted indigenous participation. The evolving national political climate led health officials to encourage community involvement in society as part of larger modernization efforts. They also hoped collaboration with rural groups would lead to greater national cultural cohesion. By reading them against each other, the three cases shed new light on how healthcare providers brought conservative politicians and remote indigenous communities together with the shared goal of improved health and well being in mid-twentieth century Mexico.

## **2. PANORAMA OF PUBLIC HEALTH PROGRAMS IN MEXICO, 1940-1960**

### **2.1 Introduction**

The nature of healthcare provision in mid-twentieth century Mexico changed as a result of the interaction between healthcare providers and their publics. The three case studies analyzed in this dissertation highlight the formation and utilization of a dialectic relationship between health officials and indigenous communities during the 1940s and 1950s. They also offer examples of negotiation and resistance by rural leaders and point to the social complexities of establishing inter-cultural rural health campaigns. Before examining the specific events and exchanges that shaped these collaborations, this chapter offers an overview of the national and international trends that influenced public health programs in Mexico during this period.

Post World War II sparked an international movement of cooperation. Nations joined forces in new humanitarian efforts that reached across borders and appealed to the universal rights of all. Sustained industrialization became increasingly linked to a nation's geopolitical status. The World Health Organization's constitution included health and well-being as determinants of a functioning society. In this environment, Mexican politicians prioritized their modernization goals of economic prosperity, political stability, and social cohesion. Policymakers utilized advancements in science and technology, as well as anthropological studies of indigenous communities, to reformulate rural public health campaigns into more cooperative endeavors. They encouraged health workers to establish relationships with rural community members in an attempt to provide more adequate healthcare. Policymakers' motives for improved public health were not just humanitarian acts but also to consolidate their political authority and assimilate indigenous groups into a unified national culture.

After exploring the themes listed above in greater detail, this chapter concludes with a detailed overview of three rural case studies. It provides a summary of major public health initiatives in Michoacán, Veracruz, and Oaxaca prior to the 1940s and sets the stage for a thorough analysis of each program in the chapters that follow. The three programs helped to improve rural life expectancy rates and decrease mortality rates in the 1940s and 1950s. This dissertation argues that the public health programs established in this period made unprecedented contributions to rural standards of living and suggests that these advances abruptly ceased when economic development surpassed health improvement priorities in the 1960s.

## **2.2 Global Moment (1940s to 1960s)**

The conclusion of World War II brought about a significant reconfiguration of global political and economic relationships. International security, containment or support of communism, and assistance with economic recovery determined new international alliances. In an effort to curb communist influences in the West, United States diplomats established hemispheric alliances with Latin America. The Organization of American States, an inter-American political association founded in the late 1940s, merged the political goals of United States policymakers with the industrialization and social objectives of their Latin American counterparts. (66) While U.S. officials utilized the organization to push their anti-communist agenda, many Latin American representatives drew on the organization for support in elevating the standard of living for their populations. International financial institutions such as the International Monetary Fund and the World Bank granted development loans to Latin American administrations for industrialization, irrigation projects, and electrical power. (64) Given that the United States was the largest shareholder in both institutions, it is probable that loans were prioritized for political leaders who complied with the tenets of capitalism, democracy, and

Western Hemispheric solidarity. Consequently, Latin American politicians found themselves negotiating international political pressure with national economic strain during this period. Closer international connections meant both new economic possibilities and increased global awareness of diplomatic relations.

Post-war global economic circles categorized nations based on their political affiliation and level of industrialization. While First and Second World nations referred to democratic and communist industrialized countries respectively, the Third World represented the remaining non-industrialized states with populations suffering from underdevelopment and poverty. This demarcation drew the first definitive line between modernized nations and their seemingly backward counterparts. As anthropologist Arturo Escobar noted, “Many in the Third World began to think of themselves as inferior, underdeveloped, and ignorant, and to doubt the value of their own culture, deciding instead to pledge their allegiance to the banners of reason and progress.” (66) Consequently, political leaders hoping to elevate their nation from Third to First World status used Western economic standards established by the United States as their benchmark for development.

The Cold War played a crucial role in the development process. Whereas previous United States diplomatic relations with Latin America largely focused on economic protection and border security, by the 1950s United States politicians believed it was their duty and right to contain communist influences in the Western hemisphere. They directly intervened in the political struggles of nations that appeared too weak to thwart popular unrest on their own. In the case of Latin America, the United States military and Central Intelligence Agency became heavily involved in backdoor politics in Guatemala, Cuba, and the Dominican Republic. United States politicians linked political ideology extremism, including totalitarianism, communism, and

fascism, to economic instability. They believed the key to establishing democratic institutions was economic development, and worked with international aid organizations like the World Bank, United Nations, and Rockefeller Foundation to introduce new industrial and agricultural models to Latin American nations. Latin American policymakers, aware of the United States-sponsored Marshall Plan to rebuild the European economy and regain political stability after the war, hoped they would also receive financial assistance toward development. (96) In reality, the aid they were offered arrived in small parcels for specific projects, including infrastructure, agricultural expansion, and disease eradication. These programs provided genuine benefits to the national economies but also served United States policymakers interests in creating greater access to raw materials and improved conditions for investment. In other words, development assistance gave Latin American nations just enough aid to keep them allied with United States politics but not enough to raise them out of Third World status and economic dependence.

Latin American leaders did not rely exclusively on international aid to improve their economies. They implemented their own domestic development schemes and collaborated with other nations as part of the Economic Commission for Latin America (CEPAL) to decrease economic dependence on industrialized nations. The concept of Import Substitution Industrialization gained momentum during this period as nations reconfigured their economic activity from raw materials to manufactured goods. By the 1950s, economists in Latin America determined that their nation's ability to participate in the global market would significantly increase if they were not dependent on importing goods from other nations. Instead, they strove to establish their own self-sustaining industries and produce high-quality industrialized goods that were competitive in the larger exchange system. (66) As a result, Latin American national

leaders prioritized domestic industrialization in this period and extended their scope beyond urban centers to include rural areas with surplus workers and available land.

In addition to new geopolitical alliances, events in World War II also produced a growing global faith in science and technology. The Truman Doctrine (1949) stressed utilizing scientific advancements to improve the living conditions of underdeveloped nations. United States leaders embraced global achievements in agricultural techniques, industrial technology, medical knowledge, and population control. They encouraged Latin American nations to follow their lead, and given the military, economic, and political successes of the United States, many foreign diplomats eagerly accepted the challenge. They promoted widespread modernization efforts in both urban and rural settings. Campaigns to replace indigenous traditional customs with advanced technology became a central component to economic development initiatives. Many leaders felt that cultural unification, including a shared language, religion, and way of life, would demonstrate order and progress to the global arena. As a result, they devoted considerable time and energy to systematizing education and social welfare programs.

Social sciences, or the collection and analysis of data to gain knowledge on a region's economy, society, geography, and politics, also gained a wide following during this period. Anthropologist Arturo Escobar stated, "Development fostered a way of conceiving of social life as a technical problem." (66) The role of anthropologists, political scientists, and economists gained newfound significance as policymakers looked to these officials for insight on life outside the capital cities. Ethnographers revealed indigenous customs and languages to state officials, who in turn used this information to plan culturally relevant social improvements. Consequently, officials attempted to introduce health, education, irrigation, and sanitation in meaningful ways that might prompt adaptation by indigenous communities.

By the early 1960s, political unrest in Brazil, Argentina, Peru, Panama, Bolivia, and the Dominican Republic compelled United States policymakers to rethink their development approach in Latin America. Rather than piecemeal aid based on their own economic priorities, United States agents petitioned for larger initiatives to gain continued hemispheric support. President John F. Kennedy's administration established the Alliance for Progress in 1961 to offer developmental funding to nations continuing to struggle with economic and political stability. The Alliance, which pledged twenty billion dollars over a ten-year period, never gained widespread acceptance in Latin America. (77) By this point, leftist leaders vocalized their discontent with United States politics and hesitated to accept any form of American economic support. Additionally, several of the more conservative Latin American leaders feared becoming inextricably linked to political and economic policies of the United States. The intervention of the United States military and intelligence agencies in Latin American politics caused many national leaders to be more cautious in their relations with United States officials. While leaders continued to seek help in times of debt relief or currency crisis, by the end of the 1960s they took a more nationalized stance to development.

From the late 1940s to the early 1960s, Latin American leaders balanced domestic and international development goals. The Cold War period provided a new stage for industrialization and modernization efforts. Economic prosperity became an increasingly important component to forming new political alliances. Hemispheric solidarity, enforced by United States military dominance, made it difficult for Latin American political leaders to stray too far from democratic institutions. Those that did faced increased political and economic hardships. External pressures aside, many leaders embraced modern economic and social practices. They developed their own agenda for achieving economic progress and attempted to poise their nations to compete in

international markets. This mindset dictated the economic development initiatives in mid-twentieth century Latin America.

### **2.3 Global Public Health (1940s to 1960s)**

Postwar economic and political alliances also fostered new collaborative social welfare initiatives, especially in regard to public health. International health programs originated in the nineteenth century as increased trading, traveling, and political relationships motivated national authorities to cooperate in public health initiatives beyond their borders. Heightened interactions led to “the age of universal contagion,” where any person living in any part of the world might be exposed to infectious diseases. (24) Beginning in the twentieth century, international organizations such as the Rockefeller Foundation and the League of Nations Health Organization expanded health communications by establishing scientific networks to collectively address disease prevention and eradication. After World War II, the United Nations merged these previous efforts into the new World Health Organization that served as the central institution for international public health campaigns. The social and political objectives underlining these international health efforts offer crucial insight into external pressures for rural health improvement in Mexico during the 1940s and 1950s.

International health organizations first came onto the global scene in the mid nineteenth century. In 1851, scientists and policymakers from eleven European countries attended the first International Sanitary Conference in Paris. Prompted by recent cholera outbreaks in Europe and Asia, the group joined forces in an effort to globally control infectious diseases. (136) Turn-of-the-century scientific discoveries in germ theory and bacteriology propelled stricter border controls. As a result, agencies like the United States Public Health Service started to administer immigrant inspections, vaccinations, and quarantines prior to admittance. In 1902,



representatives from twelve countries attended the Second International Conference of American States in Mexico City and jointly established the International Sanitary Office of the American Republics to oversee sanitation and disease prevention in the Western Hemisphere. (57) This office, the first international agency devoted to public health, transitioned into the Pan American Sanitary Bureau in the 1920s. After World War I, the League of Nations established their own Health Organization to work in Europe, Asia, and South America as a supranational institution that disseminated health expertise and aided governments in gaining domestic support for establishing national health agencies. (35) Beginning in the 1920s, the Rockefeller Foundation, a U.S.-based philanthropic organization, expanded its domestic hookworm, yellow fever, and malaria eradication campaigns into China, Brazil and Mexico. This new International Health Commission also introduced a United States-based model of medical education and public health programs to developing nations in the Caribbean, Latin America, Africa, and Asia. Lastly, the discovery of penicillin, antibiotics, and vaccines in the 1920s and 1930s significantly reduced cases of tuberculosis, cholera, and bubonic plague around the world. (136)

The accomplishments of early international health organizations paved the way for establishing a permanent global health agency in the post- World War II era. The creation of the United Nations (UN) in 1945 led to an increased dialogue among national leaders regarding the protection of rights, welfare, and health of all individuals. Members of the United Nations agreed that a “new specialized health agency” was needed to help address global poor living and working conditions. (41) As historians Alexandra Minna Stern and Howard Markel have noted, “individual and collective health was now considered by representatives of the United Nations to be ‘fundamental to the attainment of peace and security.’” (136) By linking health to larger political and economic motivations, UN officials helped instigate a theoretical shift from the

individual to the collective needs of a society. In other words, healthy communities became the new model for national and international economic rebuilding. In 1948, members from the Pan American Sanitary Bureau, League of Nations Health Organization, *Office International d'Hygiène Publique* in Paris, and other organizations incorporated the new collective approach to health into their design for an UN-based World Health Organization (WHO). The preamble of the WHO constitution emphasized the “value to all” provided by health and the need for “active co-operation” by local populations in order for programs to be effective. It redefined health as not just the treatment of disease but also the general well-being of all persons. It also drew attention to the social aspects to health, including commonalities and shared rights among individuals of all nations. Finally, the document stated very clearly that governments were directly responsible for providing adequate health and social services to their populations. (76)

While nations like the United States, Soviet Union, and China clashed over political ideologies in the Cold War period, one thing that most national leaders agreed on was that introducing modern medical and hygienic practices to underserved populations was central to political and economic development. As historian Marcos Cueto noted, “The value of health precipitated discussions about the need to ensure long-lasting peace and build a better world, using the health and well-being of the world’s population as a principal foundation for achieving this goal.” (57) By fostering communal health, WHO officials maintained that national leaders would contribute to domestic and international stability. Forging collaborations with community members would not only benefit the way of life for local populations, but would give individuals a stake in improving global economic prosperity and social welfare. The links between collective health, economic development, and political stability established in the WHO’s early doctrine

enabled international health officials to create a new model for public health programs that appealed to multiple nations.

The primary objectives of the Organization included collecting data on populations suffering from high mortality rates and training medical professionals, health workers, field researchers, policymakers, and administrators to provide adequate medical care to those in need. WHO leadership also bureaucratized international health by coordinating meetings, overseeing field research, conducting program evaluations, standardizing medical regulations, and hosting global conferences. The Pan American Sanitary Bureau transitioned into the regional WHO office for the Western Hemisphere and the remaining international health institutions merged into the larger Organization. The International Health Division of the Rockefeller Foundation also ended in 1951, leaving the WHO as the primary international health agency. In its first ten years of service, the World Health Organization sponsored large-scale malaria, tuberculosis, and smallpox eradication campaigns. The work of the WHO garnered widespread global support, prompting the organization to rapidly expand from 206 employees with a budget of \$3.8 million in 1948 to 3,178 employees with \$67.6 million in 1967. (35)

WHO officials devoted considerable time to working with national leaders and local health workers in Mexico and around the globe “to generate awareness of the dire need for improved health infrastructure, culturally sensitive public health campaigns, and the availability of primary medical care.” (35) Anthropologists from organizations like the United States’ Institute of Social Anthropology (later the Institute of Inter-American Affairs) assisted in this process by conducting extensive ethnographic studies of indigenous and non-indigenous communities. National anthropologists working for Mexico’s *Instituto Nacional Indigenista*,

most notably Gonzalo Aguirre Beltrán, also spent considerable time evaluating rural communities and disseminating their findings to policymakers.<sup>2</sup>

In Latin America, Institute of Social Anthropology experts found several common themes in folk medical practices and beliefs. Folk medicine centered around the four humors—blood, phlegm, yellow bile, and black bile—introduced to the region by Spanish administrators during the Conquest. Over time, indigenous groups refashioned these concepts into the innate qualities of “hot” and “cold.” For example, diseases and body ailments with “hot” attributes were treated with remedies believed to be “cold.” This dichotomy established the “dos and don’ts for popular medicine.” (69) Furthermore, folk concepts of disease were based on a combination of empirical knowledge, supernatural beliefs, and emotional experiences. All three influenced how community members responded to Western medical ideas. George Foster, Director of the Institute of Social Anthropology, summarized several key distinctions between folk and Western medicine that health workers needed to consider prior to interacting with local populations. He wrote:

1. Health consists in feeling well.
2. Bathing is frowned upon.
3. Ventilation is dangerous at any time.
4. Contagion is recognized as characterizing certain diseases (e.g., measles, smallpox) but not others (e.g., syphilis, tuberculosis).
5. Patients are isolated as a form of treatment for some illnesses, especially in Mexico.
6. Vaccination and injections are characterized by ambivalence. (69)

This list demonstrates the importance community members placed in superstition (e.g., air, water, spirits) and personal experiences. Foster also recorded that remedies for illnesses included massages, herbs, egg rubbings, and dietary changes. Given that local healers administered all of

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<sup>2</sup> For a sample of works by Gonzalo Aguirre Beltrán in this period, see *La población negra de México/Estudio etnohistórico*, (Ediciones Fuente Cultural: México, 1946); *Problemas de la población indígena de la Cuenca del Tepalcatepec* (Instituto Nacional Indigenista (Memorias, vol. III): México, 1952); *Formas de gobierno indígena* (Imprenta Universitaria (Colección Cultura Mexicana, núm. 5): México, 1953); *Programas de salud en la situación intercultural*, (Instituto Indigenista Interamericano: México, 1955); and *El proceso de aculturación*, Universidad Nacional Autónoma de México (Colección Problemas Científicos y Filosóficos núm. 3: México, 1957).

these treatments, he concluded that many communities might hesitate to accept professional medical care.

The information collected by international anthropologists, coupled with the guidelines for public health programs put forth by the World Health Organization, greatly influenced health policies in Mexico and other Latin American nations during the 1940s and 1950s. Mexican officials participated in international health efforts by attending conferences, presenting research, hosting meetings, and sending medical students abroad for specialized training. They incorporated many aspects of global health studies into their own national policies. Miguel Bustamante, a prominent Mexican public health official, played an active role in the activities of the Pan American Sanitary Bureau, which was renamed the Pan American Health Organization in 1958. He hosted meetings, printed summary reports, and published the *Boletín de la Oficina Sanitaria Panamericana* to disseminate the latest medical findings to scientists in Latin America. (57)

As historian Diego Armus noted, however, Latin American policymakers did not merely accept the scientific knowledge and practices being introduced to them by international organizations. Instead, health officials modified and reassembled them:

according to specific cultural, political, and institutional contexts. In this interpretive frame, the practices of medical doctors, hygienists, and scientists from peripheral Latin America were sometimes allied with, sometimes competed against, and sometimes challenged practices originating in scientifically and culturally hegemonic Europe or North America. (19)

The case studies explored in this dissertation evaluate the “interpretive frame” with which health providers in Mexico treated indigenous communities. In addition to international influences, Mexican officials faced domestic challenges to all-inclusive health programs. While culturally-

sensitive approaches were increasingly suggested in international dialogues, their implementation was often a difficult task.

First, public health care in Mexico is a fairly recent phenomenon. During the three hundred years of colonial rule (1521-1821), the Catholic Church provided the only formalized medical care. After independence, enlightened ideals of reason and individual responsibility coupled with liberal efforts to reduce corporate privileges gave state officials the authority to gradually take over the provision of health care. (141) The main state contribution to health was the establishment and maintenance of hospitals in the nation's urban areas. This left many rural communities to fend for themselves. Scientific professionalism and medical training regulation intensified after the 1857 Constitution, which marked the beginning of a Liberal Reform movement in Mexico. (128) Incorporating the global ideals of order and progress in the late nineteenth century, scientists worked alongside government officials to centralize political, economic and social power while regulating societal behavior through hygiene and sanitation initiatives. (1)

The Mexican Government entered the international science community by participating in the First International Conference of American States in 1902. Mexican health officials also helped to organize the Pan American Sanitary Bureau that resulted from the meeting. (57) Under the leadership of President Porfirio Díaz (1880-1910), public works programs flourished in Mexico City as part of his larger modernization effort. (4) The Sanitary Code of 1891, for example, established sanitary regulations along the national borders and ports to prevent the spread of communicable diseases. It also laid out a plan for sanitation efforts in the capital, including vaccinations, hygienic standards for public spaces, new construction of latrines, regulated food production, and health education classes. Many of these ideas were quickly put

into practice, and Díaz hosted several international conferences to show foreign businessmen the city's rapid transformation into a modern, clean, and safe environment for investment. While upper class families and international businessmen benefitted from these changes, lower class families were marginalized along the city's periphery. Historian Claudia Agostoni's research found that Mexican politicians' global promotion of scientific achievements in Mexican public health campaigns "cast a veil over the social contradictions of the Porfirian modernizing project..." (3) The image of a modern city reached international audiences while national leaders debated how to either address or hide existing social inequalities.

Public interest in state-sponsored health improvements escalated after the violent destruction of many villages during the early twentieth-century Mexican Revolution. The 1917 Constitution guaranteed government responsibility for the welfare and well-being of all citizens. The Department of Public Health (DSP) was founded the same year with the goal of providing universal access to healthcare. Officials in the department faced the challenge of reconfiguring previously haphazard state and local health agencies into coordinated, cohesive units under DSP authority that were equipped to extend health programs into more rural areas. Together, the codes, clinics, and mobile health units created in the first decade of DSP operations laid the foundation for greater interaction between doctors and rural patients. They established national goals for prevention and introduced remote areas to formal health services. Finally, they drew increased attention to the need for active community participation in order for future programs to succeed.

In the 1920s and 1930s, national health care developed slowly as politicians consolidated their authority over rural and urban areas. Most health campaigns were quick-fix initiatives designed to control the spread of disease. Beginning with the presidency of Manuel Avila

Camacho (1940-1946), policymakers increasingly linked health care to the national economy. Industrialization gained enormous momentum during this period, repositioning Mexico's economy from export-focused to internal development. Along with this change, manufacturers needed a large supply of healthy workers in both urban and rural areas to complete their increasing workloads. Health care continued to receive a prominent place in political discourse, but the dialogue shifted from public welfare to "the production of qualified manpower." (102) Politicians prioritized the development of highways, electricity, and irrigation to establish a modern national infrastructure equipped to handle the economic reconfigurations to commercial agriculture and large-scale industrial production. The Rockefeller Foundation's Green Revolution project, which attempted to increase food supplies through new land uses, quickly replaced the communal farming method of Cárdenas' *ejidal* system. (56)

State building efforts were forced to contend with a rapidly increasing rural and urban population that had demands of its own, including health care, education, and social services. As workers realized the importance of their role in building the national economy, they also began to utilize their collective efforts to demand better health care coverage. The government responded with the creation of the *Instituto Mexicano del Seguridad Social* (IMSS) in 1943. IMSS provided in-house medical centers, retirement benefits, and sick leave to industrial workers in exchange for accepting state regulation of unions. (63) Also during this period, private health services offered by elite physicians became increasingly popular among wealthy families. To address the remainder of society, including non-union workers, agricultural workers, and the unemployed, Camacho's administration consolidated Mexico's Department of Public Health and Secretary of Public Assistance into the new Ministry of Public Health and Welfare (SSA). (102) The SSA was charged with providing healthcare to two-thirds of the population, as



well as overseeing disease control and eradication programs, nutritional programs, and sanitation efforts. Hygiene education also played an important role, but sometimes duplicated the work of the Ministry of Public Education and IMSS.

Given the growing number of inhabitants living in Mexico, post-revolutionary policymakers faced increased pressure from international organizations like the Pan American Sanitary Bureau and Rockefeller Foundation to reduce high mortality rates and provide better healthcare coverage. By comparing mortality trends in Mexico and United States during the 1940s, historian Nathan Whetten highlights the importance of adequate water and sanitation services in this period. The primary causes of death in Mexico between 1938 and 1942 were diarrhea and enteritis, pneumonia, malaria, violence and accidental deaths. While these causes affected 106.6 per 10,000 inhabitants in Mexico, they only affected 15.7 in the United States. In contrast, the leading causes of death in the United States, cancer and heart disease, caused 41.4 deaths per 10,000, while in Mexico the rate for these ailments was 7.7. (139) These numbers show that deaths in Mexico were largely preventable. While tobacco use, obesity, and genetics were the main factors in U.S. diseases, in Mexico most illnesses were attributed to lack of drinking water or sanitary services. Fifty-six percent of all Mexicans in the early 1940s lived in houses with no access to potable water. Sanitation and sewage systems were only available in select urban areas. Bringing these basic services into rural areas had the potential to dramatically reduce mortality. Therefore, this became the primary component of public health programs. Providing universal vaccinations, regular medical exams, and health education classes served as a second tier of health treatment and disease prevention. Together, public health officials believed these two levels of care would reduce the major illnesses faced by Mexicans. The challenges to implementing these new programs included lack of financial resources from the

state and poor relations between state officials and rural communities. Indigenous groups, settled in the valleys and mountainous peripheries of urban centers, struggled to achieve an autonomous coexistence with the central national government. As state officials gradually targeted rural areas for resource extraction, they depleted these groups of their self-sustaining economy. Attempts to introduce a unified national culture similarly undermined traditional customs in rural villages. The results of these experiments had been indigenous resentment and reluctance to accept future public works projects from the state.

## 2.4 **Indigenismo**

Within this global public health landscape, Department of Public Health (DSP) officials found themselves joining larger political debates over the treatment of indigenous communities. Colonial Mexican society had forged sharp social divisions based on racial distinctions. Spanish elites, creole and mestizo mixed populations, and indigenous groups all coexisted but with very different social and economic realities. When Mexico gained its independence from Spain in the early nineteenth century, national policymakers reformulated the conditions under which society would operate. One of their primary concerns, along with other Latin American countries during this period, was how to resolve “the Indian problem.”<sup>3</sup> Indigenous communities represented the largest population sector, yet were marginalized from other groups based on their perceived racial differences. The remoteness of their rural villages, continued practice of traditional customs and religions, poor living conditions, and local dialects made these individuals seem foreign to their urban, Spanish-descendent counterparts. Post-independence policymakers sought to bridge these two groups by developing an extensive integration program. They hoped

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<sup>3</sup> For a discussion on the “Indian Problem,” see Miguel Othón de Mendizábal, “La antropología y el problema indígena” in Miguel Othón de Mendizábal, *Obras Completas, tomo cuarto* (Mexico: Cooperativa de los Talleres Gráficos de la Nación, 1946), 161-172; and José Vasconcelos, “The Race Problem in Latin America,” in José Vasconcelos and Manuel Gamio, *Aspects of Mexican Civilization* (Chicago: University of Chicago Press, 1926), 75-102.

that establishing a more inclusive society would lead to greater economic and political stability for their newly formed nation. (59)

While nineteenth-century Mexican elites intended to create a unified culture that strengthened national solidarity, their vision for achieving this centered on educating indigenous groups to follow their example. Rather than merging European and Indigenous cultures into a new blended society, policymakers enforced their own Western cultural practices onto rural populations. Positivism, or scientific racism, played a large role in this process. Positivists argued that Indians were racially inferior to European-descended populations and were therefore unable to shed their primitive ways without outside assistance. As historian Robert Buffington argues, “Apathetic, alcoholic, backward, resistant (sometimes to the point of violence) and inherently criminal, Indians presented an impossible obstacle to the great desiderata of nineteenth-century Mexican elites: national consolidation and economic progress.” (42) Singled out from the rest of society, the “othering” of indigenous communities became common practice for frustrated policymakers unable to fulfill their nationalist plan. In order to prevent indigenous populations from hindering modernization efforts, positivists rationalized that social scientists needed to study these groups and learn how to introduce new concepts of hygiene, culture, and development to them. Consequently, the role of anthropologists dramatically increased during this period as state officials looked for data and analyses on indigenous ways of life.

The social upheaval resulting from the Mexican Revolution (1910-1920) forced policymakers to reconsider their goals for national consolidation. Twentieth-century intellectuals prompted an *indigenismo* movement that respected indigenous traditions while developing culturally sensitive approaches to help Indians assimilate into modern society. (59) Policymakers focused on the concept of *mestizaje*, or the blending of European and Indigenous ancestry to

create the best of both cultures. The new national goal was to create a society that adopted European ideas of progress and civilization while also valorizing the traditions of Mexico's indigenous past. (101) Many *indigenistas* maintained that educational intervention was key to incorporating indigenous communities into the new national society. Moises Saenz, sub-secretary of the Ministry of Public Education, stated, "Education helps integration by making people like-minded." (127) To carry out widespread rural education programs, social scientists conducted regional studies to learn the languages and customs of local groups. Manuel Gamio, perhaps the most influential anthropologist in early twentieth-century Mexico, contended, "Without knowing the characteristics and needs of [indigenous populations], it is impossible to seek their incorporation into a national culture." (72) Gamio and his followers maintained that assimilation was imperative to the overall development of the nation.

In 1926, Saenz presented his views on "Integrating Mexico through Education" to the University of Chicago's Harris Institute for international relations. He asserted that the goals of Mexican educators were:

To incorporate [Indians] into that type of civilization which constitutes Mexican nationality. To bring them into that community of ideas and emotions which is Mexico. To integrate the Indians without sacrifice. Our Indian has many faults, but he has, likewise, many virtues—a wonderful patience and quietness; miraculous endurance, both physical and mental; artistic temperament, a soul artistic in its very essence (Oh, the music and the dancing and the painting and the weaving of the Indian—his love of form and his instinct for color!) And our Indian has a background of a civilization so high and delicate that at times, visiting their ancient cities or beholding their marvelous ruins, one wonders if after all the coming of the white man to Mexico was not a pity rather than a blessing. (127)

Saenz's comments draw attention to many commonly held beliefs about race and culture in Mexico during the 1920s. First, *indigenistas* saw Mexican culture as a new creation. Second, they acknowledged indigenous traditions for their contributions over time but also advocated for gently placing them aside in favor of more modern practices. Third, *indigenistas* did not see

themselves as the descendants of indigenous ancestry or the “white man” who once colonized the region. Instead, they viewed themselves as a new race of Mexicans that learned from former societies, but also developed their own sense of nationality and civilization. Accordingly, the social development programs that resulted from ethnographic studies conducted in rural communities in the 1920s and 1930s were geared toward reshaping indigenous culture into the new Mexican image. While most intellectuals agreed that the “glorious pre-Conquest Indian [served] as a national symbol,” they also believed that this culture no longer existed in Mexico. (42) The surviving indigenous civilization was, according to Gamio, “anachronistic, inappropriate, and impractical.” (72) In other words, contemporary indigenous culture had nothing to contribute to modern society and would greatly benefit from exposure to social and economic advancements. The responsibilities of anthropologists in this period therefore became “to give rural Indians the skills that they needed to become part of a modernizing Mexico” and “to study and record the indigenous traditions they had come to eradicate.” (70)

Anthropologists in 1930s Mexico continued to work under the assumption that indigenous culture must be changed. As Robert Buffington’s research showed, Gamio and his followers believed, “Indians might have a secondary place in the new Mexico; their culture, which encouraged degeneration and even criminality, did not.” (42) To ease the assimilation process, the Cárdenas administration encouraged rural schoolteachers and anthropologists to train indigenous groups “to demand rights as citizens and act as agents in their own redemption.” (59) Policymakers in this period hoped that empowering indigenous activists would lead to closer ties between state and local leaders. Miguel Othón de Mendizábal, a prominent anthropologist in the 1940s, maintained that the central problem for indigenous communities was their isolation. These populations did not lack the ability to adopt modern economic and social

practices, he wrote, but simply did not have equal access to the tools they needed for improving their standard of living. (112)

The inaugural Interamerican Indigenist Congress in 1940 solidified the need for significant improvement to living conditions and access to care among the indigenous populations. The Congress, which took place in Patzcuaro, Michoacán, concluded that variation in cultures, languages, literacy levels and ability to pay for medical treatments were all barriers to permeating rural areas with health care. (121) Rather than focus on incorporating indigenous groups into the national system, participants agreed that cultural plurality and indigenous self-determination were the best ways to protect traditional customs while bringing this population into the national fold. They argued that indigenous culture could no longer be ignored or replaced, but must find its place within the rapidly evolving Mexican identity. As Mexican health professionals became more familiar with modern medical practices, they attempted to disseminate health information to local communities in a more culturally sensitive way. They collaborated with *curanderos*, midwives, physicians, local and regional leaders, and national policymakers to establish a truly “Mexican” health system. They also initiated health promotion campaigns and exhibits throughout Mexico City to demonstrate the gaining significance of public health programs in the nation.

Over the next decade, the links between economic development, political stability, and healthy communities put forth by the UN and WHO impelled Mexican officials to include healthcare as a central component to the integration process. Rural health campaigns brought vaccinations, health education, potable water, and sanitation services to remote villages. They encouraged local volunteers to adopt modern hygienic behaviors and share this knowledge with their communities. They procured indigenous participation in some regions by successfully

eradicating diseases and appealing to community members' right to be healthy. Healthcare providers that learned to collaborate with locals in developing culturally relevant programs garnered even greater support. Indigenous groups also played an active role in accepting, rejecting, or modifying public health programs based on their own health priorities. With this symbiotic relationship in place, rural communities became more open to accepting state-sponsored economic development initiatives. In short, rural health campaigns combated modernization and assimilation obstacles by offering desperately needed social services to areas previously neglected by national programs.

## **2.5 Overview of Three Case Studies**

The global push for economic development, international public health, and domestic cultural programs all shaped Mexican health projects in the 1940s and 1950s. Policymakers looked for ways to incorporate many of the prevailing world concepts of health community, medicine and hygiene, government assistance, and collective well-being into Mexico's unique societal landscape. According to the 1940 census, nearly 65% of Mexicans lived in rural areas and 15% of Mexico's population was indigenous. The census defined indigenous individuals as anyone over the age of five whose primary language was not Spanish. Consequently, the distribution of indigenous groups varied based on proximity to urban centers and access to intercultural relations. For example, the three states analyzed as my case studies—Veracruz, Michoacán, and Oaxaca—each had a unique combination of indigenous and non-indigenous rural populations. The census showed that 18% of Veracruz's population was classified as indigenous. The remaining percentage was comprised of mestizos, or Spanish-speaking individuals sharing European and indigenous ancestry. Mestizo families lived along the coast or in urban areas, and conducted business with international and national investors. In contrast, 54%

of inhabitants living in Oaxaca were classified as indigenous. Most of these individuals lived in remote mountain villages and had little contact with outsiders. Finally, only 6% of Michoacán's population was categorized as indigenous. This low number indicates that the intercultural relationships between mestizos and indigenous communities in the state resulted in many individuals learning Spanish in addition to their native language. Of the monolingual indigenous groups living in Michoacán, the majority were Tarascans living along the central river basins.

(120)

State funding for health programs also varied widely among the three case study areas. In 1938, the total amount of state contributions for national health was 1.3 million pesos. Veracruz, which had productive industries and trading networks, contributed 258,000 pesos toward the health budget. States with less economic development, like Michoacán and Oaxaca, contributed 44,000 and 31,000 respectively. Within each state, the money was unequally distributed to benefit those financially able to contribute. As a result, several poor indigenous communities in Michoacán and Oaxaca had no health services because none of the budget was allotted to them.

(111)

Access to trained medical professionals similarly varied based on the number of developed cities within a state. For example, in the Federal District, eleven municipalities had access to a doctor and only two did not. The ratio represents the priority national health officials placed on treating inhabitants in the nation's capital. In Veracruz, 80 municipalities had access to a doctor while 110 did not. This ratio shows two important facts: Veracruz had the highest national number of municipalities with access to care; conversely, the state also had a large number of outlying areas without any access. Veracruz's urban and rural areas received considerably different care. Michoacán was roughly divided, with 54 municipalities receiving



access to a professional doctor and 44 with no access. The municipalities that had a doctor were located in close proximity to the Federal District, while areas further away from the capital had less access. Finally, in Oaxaca only 30 municipalities had doctors while 560 did not. The Oaxacan periphery had the highest national number of districts without care. This area was located along the mountainous borders outside of Oaxaca City and far from any other regional hub. Put into different terms, the number of inhabitants per doctor in the Federal District was 977 while in Veracruz and Michoacán the numbers were 4,313 and 7,503 respectively. Although the variance between the capital city and the two states appears high, the number for Oaxaca demonstrates a much larger gradient for care. In Oaxaca, the ratio of doctors to inhabitants was 1:18,107. Combined, the statistics listed here demonstrate the large percentage of the population not receiving care or access to medical professionals in Central Mexico during the late 1930s.

(113)

In order to put these numbers into context, and to set the stage for evaluating the health campaigns described in the case study chapters, I will provide a quick overview of public health programs in each state prior to the 1940s. All three states served as testing ground for experimental programs by the Department of Public Health and Rockefeller Foundation during the 1920s and 1930s. Michoacán and Veracruz also benefitted from the Ministry of Public Education's Cultural Missions program. The Cultural Missions trained rural schoolteachers to instruct villages in community development, hygiene, cooking, sanitation, political advocacy, and national cultural programs. (140) While the Cárdenas administration gave prioritized attention to populations in Michoacán, several Oaxacan communities continued to suffer from lack of services as late as the 1950s. Only when the *Instituto Nacional Indigenista* established a

coordinating center in Jamiltepec did Oaxaca's indigenous populations start to receive personalized care.

### **2.5.1 Veracruz**

Given its prominent port city, the state of Veracruz received public health assistance much earlier than other states. Global outbreaks of yellow fever in the eighteenth century prompted Mexican health officials to introduce sanitation efforts in Veracruz to limit the spread of disease via international traders. In the early 1920s, President Álvaro Obregón invited the Rockefeller Foundation's International Health Board to Mexico. In addition to treating and preventing disease epidemics, Obregón's motivations included utilizing international help to develop a national health infrastructure and to help transition the nation from the violence of the Revolution to a more stable political and social administration under his authority. (33) The 1917 Constitution guaranteed universal health care, and post-revolutionary rural populations quickly began to demand the enforcement of their rights. Obregón's administration, established by a shaky collaboration among revolutionary factions, needed to gain popular support for his unsteady government. The Rockefeller Foundation's presence in Mexico signified to the public that Obregón was internationally recognized as the leader of Mexico, played an active role in global affairs, and utilized modern health programs to provide care to the Mexican people.

Rockefeller officials began their work in Veracruz with campaigns against hookworm and yellow fever. Veracruz was selected as the pilot site for these initiatives because of its central location, industrial infrastructure, and political mobilization. United States investors also wanted to protect the area's abundant oil access. While hookworm was not as life-threatening or widespread as other diseases in Mexico during this period, treatment allowed health agents from the Foundation to collaborate with Department of Public Health (DSP) officials on a project that

was easy to administer and had quick, visible results. The success of the hookworm campaign helped to ignite rural Mexican interest in public health and encouraged Mexican officials to collaborate with the Rockefeller Foundation on subsequent local health projects. (33)

In 1927, the Rockefeller Foundation established a pilot cooperative health unit in Minatitlán-Puerto Mexico, Veracruz. Designed as a model for community participatory health, the experimental unit bypassed a formal agreement with Mexico's Department of Public Health and attempted to form a direct relationship between Foundation officials and the community. In 1931, Dr. Miguel Bustamante, an active member in both the Pan American Sanitary Bureau and the Department of Public Health, established a second unit in Veracruz as an alternate example to the Minatitlán-Puerto México model. He hoped to show leaders of the Rockefeller Foundation and local populations that Mexico had the resources and wherewithal to develop programs without international assistance. The Veracruz unit successfully introduced disease control measures, child hygiene instruction, and drainage systems to the local area. (33) The units in Veracruz and Minatitlán-Puerto México not only helped to prevent the spread of smallpox and yellow fever, but also extended hygiene services through epidemiological studies, food and drink inspections, clinical examinations, and health education classes. While Bustamante hoped to replicate this model in other states, the limited federal budget hindered widespread expansion. Ultimately, Bustamante and the DSP joined forces with Rockefeller Foundation officials to form collaborative Rural Hygiene Service units with communities in Mexico. In exchange for committing local resources, personnel, and monetary contributions for rural health units, rural communities received accessible health care. The DSP utilized this model as a way to develop federal financial aid and a cadre of trained personnel. (34) Sanitary service units, established in the 1930s, provided additional programs to Veracruz and helped to significantly reduce the

state's mortality rate over the next decade. By 1940, twenty-six hospitals were established in the state offering modern medical care to both urban and rural inhabitants. (43)

In 1953, the Department of Public Health selected Villa Cardel, Veracruz as a pilot site for the new *Bienestar Social Rural* project. The program fostered community-driven health units that included social welfare and cultural activities. Combining health and well-being efforts, the *Bienestar Social Rural* centers were designed to build on existing healthcare relationships between health providers and local populations. In the Villa Cardel center, health officials negotiated social inequalities and rural/urban distinctions in an effort to adequately serve the village. As argued in my case study chapter, the *Bienestar Social Rural* project succeeded in gaining local support but ultimately failed to produce long-term success due to the lack of state financial resources.

### 2.5.2 Michoacán

Health programs in Michoacán took shape under the leadership of Lázaro Cárdenas. While serving as state governor, Cárdenas helped establish the first *ejidal* clinic in Zacapu in 1932. *Ejidal* health units expanded the revolutionary social justice programs of *ejidos*, or “agricultural cooperatives,” to include an on-site medical clinic. (34) The units were developed by a group of physicians at the Universidad Michoacana de San Nicolás de Hidalgo. Nicknamed *nicolaítas*, the physicians advocated incorporating a medical component to the social services and agrarian reform projects offered by the federal government to *ejidatarios*. (93) During his presidential term (1934-1940), Cárdenas and his policymakers worked toward the goal of treating health care as a right for all rather than a philanthropic endeavor reserved for select groups. (102) His Six Year Plan included improving social and economic conditions for peasants

as key to enhancing health. Toward this end, he tripled the DSP's budget and prioritized disease control, sanitation, and health education. (33)

In 1935, the state hosted the first Rural Hygiene Congress to discuss opportunities for rural health improvement. Paper presentations centered on the absence of medical units and trained professionals, poor living and working conditions for peasants, high infant mortality rates in the countryside, and peasant demands for improvements. (93) Department officials led roundtable discussions on disease treatment and prevention strategies, improving living conditions and community sanitation, and hygiene education. This congress shifted the way professionals thought about rural health care by using the needs of the community as criteria for establishing programs rather than the geopolitical importance of each location. (33) The success of *ejidal* clinics in servicing Michoacán's remote populations encouraged national health officials to expand the program in other states. By 1936, thirty-six units were established in the nation and by 1940 the total number rose to 141. Several more peasant communities petitioned for their own unit, which provided immediate access to care based on combined state and community resources. (34)

As a result of the Rural Health Congress, the DSP developed the Central Office of Rural Hygiene and Medical Service Cooperatives in 1936 to provide specialized medical treatment and care to rural communities. These offices coordinated regional health efforts through central hospitals. Additionally, the Cárdenas administration reorganized the Department of Public Health into two new departments: the Ministry of Health and the Ministry of Public Assistance. The Ministry of Health focused on finding ways to provide potable water and sanitation services to local communities. They were also responsible for disease control projects. Officials in the Ministry of Public Assistance developed strategies to ensure that all citizens had access to health

care. One of their first actions was to extend medical coverage to rural populations through the *Servicios Medico-Sanitarios Ejidales Colectivos* (Collective Ejidal Medical and Sanitary Services). This office formalized the work of *ejidal* health units. Cárdenas' administration recognized that by linking agrarian reform and health services, community members shared in the responsibility for building and maintaining their clinics. (93) Working in collaboration with medical schools in Mexico City, the Colectivos were staffed by senior medical students as part of their new rural training requirement. This system not only gave medical students experience working in rural settings, but also granted remote communities access to professional health services. As the national health system changed its focus from social justice to "social modernization and economic progress" in the 1940s, *ejidal* units were eventually taken over by Rural Cooperative Services. (92) These new units merged federal and state initiatives with rural health in the development of hospitals, ambulatory care facilities, and each state's public health services. (102)

The 1940s Tepalcatepec Commission river basin project in Michoacán was among the first intercultural approaches to health. The program linked economic development and social welfare initiatives to improve living conditions throughout the region. The case represents policymakers' interest in culturally unifying the nation, extending federal authority to rural communities, and industrializing available land. The program's success in offering health improvements to the Tepalcatepec river basin is attributed to healthcare providers partnering with community members to establish culturally-relevant aid. Community members, many of whom were already familiar with the benefits of *ejidal* health units, responded favorably to the efforts of providers, and this cooperation led to many short-term health gains.

### **2.5.3. Oaxaca**

In Oaxaca, the Rockefeller Foundation's hookworm campaign in the early 1920s was the first major disease eradication project in the state. By the end of the decade, the Foundation and DSP officials collaborated to establish one of the nation's first Cooperative Health Units in Tuxtepec. These units were the successors to the DSP/Rockefeller Foundation collaboration units in Veracruz. The quick expansion of units in the mid-1930s intensified the DSP's need for trained personnel. Many doctors who helped set up a Cooperative Health Unit soon returned to private practice where they could earn more money. The Foundation tried to address this gap in long-term personnel by supporting visits of Mexican doctors and students to health institutions in the United States. Foundation officials hoped that witnessing successful health units would inspire Mexican doctors to return to their nation with renewed interest in developing local programs. The Foundation also offered scholarships to train future Mexican doctors and nurses in the United States. By 1938, many of these individuals returned to local units well-trained in modern medical practices. However, DSP administrators continued suffering from lack of personnel. The newly trained professionals preferred to work near their families, in urban centers, and in private practices. At best, Cooperative Health Units like the one in Tuxtepec were staffed with part-time nurses with an occasional visit from an urban doctor. (134) Sanitary units also served select areas, but given that 82% of Oaxaca's population in 1940 was rural, it was difficult for these groups to reach many of the state's inhabitants. Furthermore, the state only had six hospitals to serve its overall population of one million people. (43) Most villages continued to rely on their own local healers without any outside assistance well into the 1950s.

For many of the Foundation's projects, long-term adoption of new health behaviors was slow to come as many doctors attempted to convert local communities into Western medical

practices without considering their social and cultural contexts. Traditional or folk medicine in Mexico combines aspects of pre-Colonial indigenous, Hispanic, and African cultures. In addition to the use of plants and other natural resources for healing, it also includes mystical elements and belief in supernatural forces with the ability to restore the cosmic order and individual balance. Local practitioners included midwives, healers, *curanderos*, herbalists, bonesetters, folk priests, mediums and masseurs. Traditional healers attribute illness to physical and mental behavior, environment, psychological emotions, nutrition, social interaction, nerves, and supernatural causes. As Institute of Social Anthropology and Mexican anthropologists learned in the 1940s, traditional medicine continued to thrive in Mexico long after discoveries in biomedicine due to its links with local cultural identity and values, positive doctor-patient relations, and ability to provide health treatments to millions of individuals who do not have alternative access to healthcare.<sup>4</sup>

Although biomedical practitioners began offering treatment and care to rural populations in the early 1900s, many indigenous groups saw modern medicine as a challenge to their social and cultural identity, and therefore hesitated to accept it as a viable alternative to their more traditional methods. (78) There were a number of reasons that rural people kept doctors at an arm's length. Medical interns usually operated rural clinics without knowledge of local customs or languages. Physicians also tended to focus more on individual cases without considering the collective ideological processes or economic constraints of the community. Pregnant women, for example, often preferred to use their local healers or home remedies even when they recognized that Western medicine might help them. The mother's personal relationship with the local

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<sup>4</sup> For examples of anthropological reports, see Isabel Lagarriga Attias, "Medicina Tradicional en México: Conceptos, actitudes y valores de sus seguidores," in Jaime Villalba Caloca, ed., *Medicina Tradicional en México* (México: INER, 2000); Gonzalo Aguirre Beltrán, *Programas de salud en la situación intercultural*, (Instituto Indigenista Interamericano: México, 1955); George Foster, ed. *A Cross-Cultural Anthropological Analysis of a Technical Aid Program* (Washington, D.C.: Smithsonian Institution, 1951); and Miguel Othón de Mendizábal, *Obras Completas* (Mexico: Cooperativa de los Talleres Gráficos de la Nación, 1946).



midwife represented the shared beliefs and practices of the community and, as a result, gave greater significance to the birthing process than working with an outside doctor. (71) Mexican anthropologists working in indigenous areas stressed that actively learning more about a community, including the definitions and treatments of disease as well as behaviors and attitudes about health, would allow doctors to take a more active approach to medical treatment with fewer concerns of acceptance or conflict with patients. (126) Therefore, ethnographic studies gained increasing importance during this period.

Many indigenous societies incorporated Western medicine into their way of life, but continued to rely on spiritualist healers and *curanderos* in times when biomedicine could not offer a cure. (68) Given that rural communities showed patterns of acceptance to new ideas that served a valuable purpose, rural health education gained increasing importance on the national agenda. The Ministry of Public Education (SEP) launched Cultural Missions beginning in 1923 to incorporate sanitation and hygiene programs into the rural school curriculum. Visiting teachers entered remote villages to educate families on modern community development. They trained locals to build latrines, improve family nutritional intake, intensify agricultural production, and organize cooperatives. (140) Additionally, they distributed pamphlets on good hygiene behavior. These documents included lessons on hair brushing, teeth brushing, bathing, and hand washing, as well as home improvements such as plumbing and drinking water. The pamphlets also carried the underlying message that following the Ministry of Public Education's instructions would improve the health of the entire nation. (4) State officials encouraged teachers and local officials to promote a spirit of national solidarity that trumped local allegiances. Policymakers hoped this new way of thinking about the national government would increase acceptance of state centralization and ease rural groups into a unified modern culture. The

Department of Indian Affairs took over the Ministry of Public Education's Cultural Missions in 1938. Cárdenas felt that this organization, which placed ethnographers, indigenous intermediaries, and activists in service roles for the state, could better provide education in each location's native language.

Concurrent to the national programs offered by the DSP, government agencies attempted to address the specific needs of indigenous groups through a series of programs and institutions. In 1917, the presidential administration of Venustiano Carranza (1917-1920) founded the Dirección de Antropología, a social science research center, to study communities and offer instruction on home sanitation, personal hygiene, and Spanish language classes. The center hoped to ease the consolidation of rural and urban areas into one nation with a shared language and culture. In 1925, this program was extended through the *Casa del Estudiante Indígena*, a boarding school in Mexico City that sought to transform individuals with indigenous backgrounds into modern citizens. (59) As school administrators saw it, students' ability to master class work and tests demonstrated their capacity to become as civilized as their mestizo urban counterparts.

Government officials in the 1920s and 1930s, while given increasing historical attention to indigenous traditions, simultaneously downgraded these customs as backward and ignorant. Eugenics, or scientific racial improvement, became part of the national discourse as public health officials sought scientific explanations for health degeneracy among the lower classes. (137) As part of the larger state-sponsored program to reconstruct Mexican society into a unified national culture, health campaigns focused on eliminating traditional medical practices. Instead, policymakers promoted an ideal of responsible motherhood in rearing future generations of healthy Mexicans. This program included greater state intervention within private lives,

including marriage, sterilization, pre- and post-natal care, child rearing, and personal hygiene practices. Social responsibility and moral reforms found their way into new laws regulating family obligations. (37)

Similar to the *Casa del Estudiante Indígena*, the *Internados Indígenas* program of the early 1930s educated indigenous adolescents in their local villages by presenting modern concepts in classrooms using the local indigenous language within their cultural context. Program officials encouraged students to act as interlocutors between the state and community representatives, and to take an active role in social leadership. The Department of Indian Education expanded local learning in 1936 by providing machinery, tools, medical kits, and other equipment to classrooms. This gave youths even more incentive to attend school. In the late 1930s, the Department of Indian Affairs took responsibility for sending bilingual teachers into communities so they could communicate easily with the native population. (140) Lastly, the National Indigenous Institute (INI), established by the Camacho administration in 1948, was designed to unify state-sponsored activities for integration. The Institute's mission was to ease indigenous communities into modern national society via culturally-sensitive projects and indigenous cooperation.

By the time the INI established a coordinating center in Jamiltepec in 1954, health and education officials had been attempting to change indigenous customs for over 40 years. The coordinating center in Oaxaca represents a new anthropological approach to rural health that incorporated local customs and participation into the treatment process. In addition to center activities, including clinical services, agricultural instruction, and regional development programs, village volunteers known as cultural promoters served as intermediaries between community leaders and healthcare professionals. By adding healthcare to the larger assimilation

campaign, Institute officials and healthcare providers used the level of community members' acceptance of modern medicine as an indicator of the community's willingness to be acculturated into contemporary Mexican society.

## **2.6 Conclusion**

The public health programs established in the mid-twentieth century continue to form the foundation of Mexico's current health care system. Linking health and well-being to economic development, officials succeeded in temporarily improving the standard of living and employment opportunities for rural workers throughout the country. The expanded infrastructure, including roads and market networks, brought remote regions and their resources into closer ties with urban centers. Indigenous groups received an unprecedented level of representation and consideration as political officials determined the most appropriate approaches to development. Life expectancy and mortality rates also drastically improved during this period. When the Mexican Revolution began in 1910, the infant mortality rate, 323 deaths per 1000 infants, was among the highest in the world; the overall mortality rate was 33.3% and life expectancy was 28. Conversely, by 1964, the death rate dramatically dropped to 9.2% per year while life expectancy had risen to 64. Infant mortality rates also had decreased to 89.7 per 1000. (97) Shortly after World War II, developing nations as a whole experienced annual gains in life expectancy and decreases in mortality rates. This acceleration, with gains three times as large as Western Europe during this period, was unprecedented in world history. (81) This dissertation explores the unique development and public health programs that led to this 30-year period of improved health.

With all these triumphs, however, Mexican officials did not establish the social cohesion and national unification they desired. One hurdle to this was the unexpected continuation of

population growth through the 1960s. Focusing primarily on building the peasant economy, policymakers made no effort to reduce high fertility rates in this period or to prepare for additional food and health needs. The increased number of people did not initially cause alarm because Mexicans have endured waves of population growth throughout history. They also did not anticipate that the Ministry of Public Health and Welfare would be so successful in dropping mortality rates by vaccination campaigns, potable water availability, sanitation services, health education classes, and access to medical care. Rapid industrialization meant more rural families relocated to urban areas. This also meant there was increased pressure on the remaining rural population to provide the nation's food staples. Ultimately, rapid population growth exhausted national resources and left the state with little to offer to rural households. (6) By the 1960s, the slowdown in economic development, social programs, and medical care in developing nations like Mexico brought health improvement rates to a halt. Additionally, while the large-scale initiatives established in this period consolidated the efforts of various agencies into new collaborations, they still had to contend with discrepancies within each organization and most importantly, with a diverse rural population that continued to have unique sets of health needs and priorities. The government's inability to find a balance between universal care and health disparities impeded long-term health improvements and continues to hinder the well-being of contemporary rural Mexicans.

### 3. THE COMISIÓN DE TEPALCATEPEC AND PROYECTO MEX-MED 4

The *Comisión de Tepalcatepec* (1947-1961) brought significant economic and social changes to the Michoacán river basin. This large-scale commission united previously independent government programs into a multi-tiered collaboration that addressed regional development through national, state, and local networks. While national policymakers and state officials designed plans to improve agricultural production, promote industrialization, utilize the area's natural resources, and expand communication channels, program managers working in local villages established unprecedented relationships with indigenous community members by introducing the *Comisión's* projects in culturally relevant ways. They used their on-the-ground experiences to learn local languages, customs, and beliefs, and incorporated these factors into their health education and treatment campaigns. The result was a cooperative relationship between healthcare providers and indigenous groups that not only reduced the major health risks in the area, but also paved the way for collective economic development.

President Miguel Alemán established the *Comisión de Tepalcatepec* in the late 1940s as one of four large river basin commissions designed to improve rural economies in Central Mexico. The commissions reconfigured rural land utilization from communal *ejidal* units to commercial agriculture production by introducing irrigation systems and modern farming techniques. They also rerouted water systems to provide hydroelectric capabilities for rural manufacturing facilities. These improvements not only increased the industrial and agricultural output of these areas, but also provided employment for the rapidly increasing number of workers living in rural areas. While the changes taking place disrupted local ways of life, national leaders succeeded in maintaining regional political stability by using the river basin commissions to address rural demands for public services. They minimized rural discontent by

offering the countryside healthcare and education programs that met the specialized needs of community members and helped improve their standard of living. (22)

The *Comisión de Tepalcatepec* integrated the economic goals of policymakers with the social needs of rural communities along the Tepalcatepec River. In addition to carrying out irrigation, hydroelectricity, and drainage projects, officials from the *Secretaría de Recursos Hídricos* (Ministry of Water Resources) coordinated the activities of health, education, labor, and agricultural specialists working as part of the commission. For the health component, sanitary engineers provided access to potable water and sewage drainage while local public health officials focused on health education initiatives. Institutional construction, including hospitals and clinics, also took place but medical brigades provided the main point of contact between health workers and community members. These teams traveled into remote villages to offer inoculations and develop health education materials based on the culture of the community. Health workers soon realized that while mestizos living in the area quickly adopted new health initiatives, indigenous groups struggled with language barriers, cultural differences, misconceptions of healthcare, and distrust of local officials. Healthcare providers, therefore, overcame these challenges by developing specialized treatment and care at the community level. They utilized local languages to create pamphlets, films, and lectures designed to correct previous false impressions of national healthcare initiatives and encourage local participation. Most importantly, they established a cooperative relationship with locals that allowed them to carry out their medical treatment and disease prevention programs while also opening the door for improved community interaction with other government officials.

The collaboration between health workers and community members dramatically reduced the major health risks in the Tepalcatepec region and strengthened ties between national and

local organizations. Rather than following previously formulaic efforts for uniform healthcare, providers went to great lengths to develop culturally sensitive health projects that appealed to community members. Once they gained the trust of indigenous groups, health workers served as intermediaries between local leaders and national policymakers on larger questions of development. They reinforced the need for both groups to work together toward the common goal of rural life enhancement and encouraged community members to take an active role in protecting their health and well-being. When the *Secretaría de Salubridad y Asistencia* (Ministry of Public Health and Welfare) could no longer afford to continue health initiatives in the area, community members contributed their own financial resources and wrote letters demanding the continuation of healthcare in their villages. They recognized the benefits provided by organized health programs and drew on their constitutional right to health in order to petition for more public service projects. By demanding the enforcement of their rights, many community members accepted their role as part of the larger national political and economic model for the first time.

### **3.1 Introduction**

On September 5, 1942, Pedro Blanco Vega wrote to Mexico's President Manuel Avila Camacho requesting a resolution to his two-year campaign for improved living conditions in Uruapan, Michoacán. (21) He argued that the city lacked basic health care facilities and suffered from unsanitary housing. The houses rented to workers in Uruapan, according to Blanco, were plagued with spiders, bedbugs, cockroaches, and disgusting, poisonous vermin. Leaky roofs and flooded floors kept each unit cold, damp, and uncomfortable. Toilets, sinks, and a clean water supply were minimal. Sleeping quarters were "small dungeons" that would not even hold the men trying to rest inside. Given this series of humiliations, and the constant discomfort and



illness that resulted, Blanco appealed to Avila Camacho to intervene with the state government for an improved living environment. He evoked Article 73 of the 1917 Constitution, mandating that “all individuals had the right to physical and mental health, and that the local or municipal government could not endanger the health of the community” as justification for government involvement. (4) In order for the workers to be healthy, happy beneficiaries of a post-Revolutionary government that promised to help them, Blanco maintained that the institutions established since the 1920s should stop abusing the citizens they were designed to protect and instead restore the culture and progress of the Mexican people.

Blanco’s petition, signed by 76 community members, addressed several themes circulating in Mexico’s political circles during the 1940s. Modernization projects were revitalized to position Mexico within the global economic market, and domestic programs endeavored to solidify the nation through education, sanitation, and government participation. Blanco’s knowledge of constitutional rights and petitioning power spoke to the expansion of an active citizenry. His appeal to the ideas of progress and modernization, in contrast to the continued humiliations of poor sanitary conditions, laid the blame for lack of development squarely on the federal government’s shoulders. He argued that for Mexican culture to truly progress, the basic rights of individuals must be upheld. Furthermore, he acknowledged the growing relationship between economic progress and public health by arguing that without healthy living conditions, workers would be unable to fulfill their economic potential.

Although there is no evidence to suggest Avila Camacho resolved the specific mistreatments presented by Blanco in Uruapan, high mortality rates and disease epidemics in Mexico throughout the 1940s sparked a renewed national interest in the public health of workers. Avila Camacho’s predecessor, Lázaro Cárdenas, specifically associated health with progress

when he asserted, “All workers should have the necessities of bread, a house, clothing, health, culture, and dignity.” (51) Increased community and bureaucratic support for this idea compelled health policymakers to move beyond their previously limited vaccination and sanitation approaches toward becoming full-fledged instruments for achieving development in rural villages. This meant not only improving living and working conditions in remote locations but also fostering closer relations between the state and local communities. The pursuit of national goals such as mining natural resources, expanding markets and access to raw materials, broadening the consumer base, and improving transportation services all relied on closing the gap between urban centers and rural outposts. This became increasingly important with the outbreak of World War II, compelling Avila Camacho to support water works and agricultural production programs in rural areas in order to provide food for Mexico’s rapidly industrializing major cities. (115)

When Miguel Alemán Valdés succeeded Avila Camacho in 1946, he sought to integrate economic development and state building with extended public works programs in rural areas. His administration developed large-scale commissions based on agency collaborations for improving living and working environments in previously isolated regions. These commissions, which included representatives from the *Secretaría de Salubridad y Asistencia*, the *Secretaría de Recursos Hidráulicos*, and the *Secretaría de Educación Pública* (Ministry of Public Education), worked to provide health care, sanitation, education, and irrigation programs as the first steps to resolving urgent health problems in areas that were otherwise economically attractive. From this base, policymakers hoped to generate community support for regional economic development led by the national government.

In 1947, Alemán established the *Comisión de Tepalcatepec* to oversee public works initiatives along the basin of the Tepalcatepec River in the states of Michoacán and Jalisco. Comprised of both Tarascan indigenous peoples and non-indigenous European descendants and mestizos, the goal of the *Comisión* was to integrate both populations into the national economy by advancing agricultural production and industrialization. Lázaro Cárdenas, who remained in public service after his presidency, served as the figurehead and spokesman for the *Comisión*. *Proyecto MEX-MED 4*, the health subset of the *Comisión* that lasted from 1948 until 1951, incorporated local, national, and international health programs into a unified collaboration that utilized the expertise of members from all three levels. This multi-tiered approach, among the first of its kind in Mexico, changed the method for addressing rural health needs from developing national programs in the capital to relying on the on-the-ground experiences of the medical brigades, clinicians, data collectors, sanitary engineers, and active citizenry for local assessments of health priorities. The subsequent customized treatment and care of individuals in the Tepalcatepec basin, developed by healthcare providers working directly with community members, eased the way for other *Comisión* subsets to initiate commercial growth projects in the area. The result was a significant reduction in health risks and a new collaborative relationship between rural and national leaders.

### **3.2 Geography and Population**

The Cuenca del Tepalcatepec encompasses the 27 municipalities that surround the basin of the Tepalcatepec River in the Mexican states of Michoacán and Jalisco. The region, approximately 22,518 km<sup>2</sup>, is surrounded by mountains to the north, south, and east, and borders the Pacific Ocean to the west. These natural barriers have been a large factor in the area's isolation. The basin's ecological diversity includes the higher altitude forests of the *Tierra Fría*,

the warmer urban centers in the *Tierra Templada*, the flat fertile lands of the *Tierra Caliente*, and the mountainous coast, or *Costa Sierra*. The total population among all four regions in 1950 was approximately 308,958. (22)

Two indigenous groups, the Nahuas and the Tarascans (or Purépecha), inhabited the region prior to the arrival of the Spanish. While much of the land remained undeveloped during the colonial period, ceramics, mining, and sugar mills joined the agricultural production of corn, beans, chiles and cotton as the main economic activities. (75) The fact that the population size of the Cuenca remained largely stable between 1520 and 1921 points to both the successes and shortcomings of colonization. Encounters with outsiders during the Conquest, Wars of Independence, Reforma, and Revolution exposed the entire region to cultural shocks, famine, enslavement, and new diseases such as smallpox that severely decimated the indigenous population. (30) While large waves of population growth among mestizos balanced the overall number of inhabitants, the Nahuas were virtually wiped out and the Tarascans were reduced to living in the *Tierra Fría*, or the *Meseta Tarasca* as anthropologists later referred to it. When mestizos in the *Tierra Templada* gradually began to form urban cities with markets, factories, roads, and irrigation, Tarascans continued to practice primitive forms of subsistence agriculture and handicrafts with little connection to the outside world. (22) The remote communal lifestyle of the Tarascans, with their own language, customs, and beliefs, also differed greatly from their more urban counterparts. As late as 1940, 20% of the *Meseta Tarasca* only spoke Tarascan. (29)

Even with ecological and cultural variations, both the indigenous and mestizo populations suffered similar health risks and environmental dangers. As economists David Barkin and Timothy King wrote, “Rapid development of the area...was held back by the lack of adequate communications and by the generally unhealthy conditions.” (22) Gonzalo Aguiñer Beltrán, a

well-known Mexican anthropologist conducting a study of the basin in the 1950s, referred to the area as a:

Deadly land where the botany and zoology exercised a stranglehold, where pestilence and vermin were regular guests of man, where deaths exceeded births and social disorganization could not be more apparent... (30)

The tropical climate of the region was favorable for agricultural production but heavy rains could leave stagnant pools of unsanitary water. (130) Drainage and irrigation, available near the regional center of Uruapan, barely scratched the surface on meeting the needs of inhabitants in outlying areas. Lava from high volcanic activity infected the soil and contributed to the population's poor health. Farmlands were also constantly invaded by vermin, which dominated living spaces and helped spread disease.<sup>5</sup>

Despite efforts to remain isolated from federal authority, prolonged poor health conditions in the Cuenca paved the way for the gradual acceptance of government officials in both rural and urban communities. Measles, whooping cough, goiter, typhus, dysentery, intestinal parasites and high infant mortality rates plagued the region throughout the first half of the twentieth century. Although Mexico's public health department established Centers of Rural Hygiene in the area during the 1930s, the lack of professional training and program emphasis on anti-leprosy campaigns and prostitution control resulted in little actual improvement to health conditions. (100) By the time the *Comisión* entered the scene, the leading causes of death per 100,000 inhabitants in the Cuenca were diarrhea/enteritis [258], pneumonia [174], homicide [80], malaria [50], measles [45], dysentery [37], whooping cough [37], scorpion bites [35], typhoid [26], and pulmonary tuberculosis [24]. (29) These rates not only indicate the high levels

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<sup>5</sup> These include coyotes, opossums, skunks, badgers, rats, chipmunks, grasshoppers, poisonous reptiles, tarantulas, scorpions, chiggers and mosquitoes. See González y González, 22-23.

of malnutrition and unsanitary living conditions in the region, but also show that implementing public works projects to address these issues could prevent the majority of deaths.

### **3.3 Comisión de Tepalcatepec**

Although Avila Camacho enacted the *Comisión de Tepalcatepec*, the project was the brainchild of Lázaro Cárdenas. Originally from Michoacán, Cárdenas first became aware of the poor health and living conditions in the Cuenca while working on his uncle's farm on the outskirts of Apatzingán. Much of his military service during the Revolution was also spent in the Tierra Caliente. (75) After being elected Governor of the state in 1928, he introduced railroad construction to the region as part of a larger plan to connect rural areas with urban centers. As President of the nation (1934-1940), he oversaw planning for interstate roadways, irrigation, market development, agricultural production, electrical plants, communications (including the telegraph and telephone), and medical care. He also began a campaign to encourage the use of natural resources toward economic development. (115) All of these initiatives, according to Cárdenas, were designed to strengthen the role of indigenous groups within the modern nation. (117)

Throughout the first half of the twentieth century, Mexican government officials used the principles of equality established in the Constitution of 1917 as a platform for integrating rural areas with their urban counterparts. They focused on a nationalist project to assimilate rural indigenous groups with relative autonomy into what historian Alexander Dawson describes as a national community based on a “new secular and modern set of cultural beliefs, a new property regime, new political institutions, and new infrastructures.” (59) In the 1930s, the group of social scientists, anthropologists, and intellectuals known as *indigenistas* advocated maintaining the cultural traditions and uniqueness of indigenous communities while also introducing modern

advances in agriculture, construction, communication, and hygiene. They hoped to transform communal laborers into productive citizens with improved social and economic conditions. Under Cárdenas' leadership, social reforms and public works programs filtered into several remote areas through newly devised *ejidal* units, or village collectives. The national Mexican identity was also revised to include more indigenous traditions. (58) In a 1937 interview with *El Nacional*, Cárdenas declared that he wanted to completely transform the relationship between the Mexican government and indigenous groups from charity casework to a full sense of equality. This transformation, he argued, could only be established through massive public works and new policies that valued the merits and possibilities of indigenous communities, created a uniform standard of living through education, and met the basic needs of all individuals by increased access to nutritious food. (117)

Even though Cárdenas had a humanitarian interest in improving the lives of the indigenous population, he also had political and economic motives for integrating these societies into the larger nation. He hoped that establishing an administrative presence in rural areas would reinforce political stability and national authority. By participating in the bureaucratic processes of the government, such as petitions, voting, and utilizing public services, he wanted indigenous groups to develop a sense of being an active part of the nation. The “desire for social balance” felt by Cárdenas and his successors, according to Barkin and King, aimed to prevent discord by reducing the social inequality of indigenous groups. (22) Cárdenas also intended to exploit the natural resources of rural areas while expanding industrial development and creating a larger cache of healthy workers. Finally, connecting urban and rural markets via roads and railways would increase exchanges of goods and opportunities for economic exportation.

Implementing integration programs proved to be a challenge for national officials. Many communities hesitated to accept government intervention because they feared losing their autonomy. In Michoacán, for example, Tarascans had an established tradition of resisting state and federal intrusion. (29) To address this “*problema indígena*,” or difficulty of the state with integrating indigenous communities into its nexus, Cárdenas supported the development of large-scale rural programs that would “Mexicanize the Indian. Respecting their blood, capturing their emotion, their affection for the land and unwavering tenacity will create a more rooted national sentiment enriched with moral virtues that will strengthen the patriotic spirit, affirming the personality of Mexico.” (49) Public health historian Anne-Emanuelle Birn contends that Cárdenas’s “belief in modernization and industrialization necessitated healthy and productive workers who accepted the legitimacy of the government.” (33) Supporting this perspective, the President’s Six-Year Plan for his tenure included public health initiatives designed to reduce infant mortality and improve sanitary conditions, while also improving health by raising social and economic conditions in rural areas.

During the 1940s, Presidents Manuel Avila Camacho and Miguel Alemán Valdes continued steering the nation into heightened economic progress while referencing Cárdenas’ vision for:

A charitable policy for all indigenous classes, [which] will be the way to strengthen and convert a large majority into becoming useful citizens, at the same time it will abolish the differences of caste and class; develop more efficient productive energies; end the vestiges of feudalism, which have subsisted despite struggles for emancipation, and will ultimately achieve political and social unity which forms the basis of a truly national organization and makes possible an effective inter-American solidarity. (49)

While all three leaders drew attention to the benefits indigenous groups might receive by becoming more active in Mexican society, they also hoped to improve the national economy by what scholar Anne Doremus has argued was a means of “preparing the Indian for entrance into



the mainstream work force.” (65) *Indigenistas* emphasized that the differences between indigenous and non-indigenous groups were cultural rather than biological. They asserted that with access to clean water, education, and economic opportunities, any individual could become an active participant in modern society. With regard to public health, many of the community programs initiated under Cárdenas were reorganized into federal projects with the hope of offering large-scale treatment and care to the rural population.

In order to balance the economic goals of the nation with the social needs of local communities, Cárdenas used his post-presidency political clout to develop the Tepalcatepec area. Following Alemán’s comment that “the lack of roads and public health prevented 'progress and development of the region' [of the Papaloapan river],” Cárdenas utilized this opportunity to write Alemán asking for similar assistance in prioritizing public health campaigns and providing potable water to the Tepalcatepec region. (115) He maintained that he wanted to work with Alemán’s administration to build healthy environments for indigenous communities and to continue the process of integration by helping residents in the Cuenca realize that they were part of the nation. (46) Here he introduced his larger plan to improve health conditions, agricultural development, forest use, and education in the area. Cárdenas vowed to personally oversee the program, using his popularity to gain federal and local support. (115)

Alemán reviewed Cárdenas’ plans with members of the *Secretarías de Recursos Hidráulicos, Agricultura, Comunicaciones, and Educación Pública*, as well as the *Banco Ejidal* (Agricultural Credit Bank). Like Cárdenas, Alemán recognized the vast natural resources and economic opportunities available in the region. Mineral deposits, abundant forests, and large hydroelectric capabilities could easily contribute to industrialization and paper manufacturing. Road construction, part of a larger national roadway plan, would link the Pacific Coast to Central

Mexico, and would provide access to new domestic markets in rural areas. With improvements in sanitation and disease vaccination, a large pool of new industrial workers would also be accessible. (14) Many of the region's healthiest workers had traveled north to the United States in search of better working and living environments as part of the *bracero* program, leaving a void of available employees to expand industry and agriculture. (29)

On July 17, 1947, Alemán signed the *Comisión of Tepalcatepec* into the federal books. (115) He appointed Cárdenas as director (*vocal ejecutivo*) of the *Comisión* and asked that he ensure that the combination of efforts from the varying government agencies created healthy, productive workers and consumers. According to a 1950 pamphlet published by the *Secretaría de Recursos Hidráulicos* and the *Comisión del Tepalcatepec* entitled "*La obra del Gobierno del Señor Presidente Alemán en la cuenca del río Tepalcatepec*," the *Comisión*:

Wanted to translate into concrete action their intention to establish new centers of production in those regions by the potential of natural resources at their disposal, which must be fully exploited, and, through them, make it possible not only to raise the standard of living and social welfare development of their inhabitants, but at the same time meet the growing demand for products required by the country. (131)

The *Comisión's* specific programs would utilize the rivers to build irrigation and energy generation, increase the development of agriculture and industry, harvest the forests and mineral deposits, open the necessary channels of communication, attend to public health problems, and stimulate educational development. Over the life of the project, from 1947 to 1961, the *Comisión* spent an average of 25 million pesos per year for a total of 375 million pesos over 15 years. Most of the investment (71%) went to irrigation and road construction. Administration, data collection, and regional studies consumed 13% of the budget, while electricity (6%), schools/hospitals (5%), potable water (3%) and other works (2%) rounded out the distribution.<sup>6</sup> Knowing they had sanitary brigades and rural teachers to assist in disease vaccination, the *Comisión's* budgetary

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<sup>6</sup> Calderón Mólgora, 258-259.

committee focused its monetary priority on developing infrastructure (e.g., dams, canals, highways) to prevent future epidemics and to help health workers communicate and travel more efficiently.

Cárdenas used his influence and prestige to garner support for his program from both the federal government and the local communities. (62) In addition to the bureaucratic duties of the *Comisión*, he asserted that all Michoacanos had a patriotic responsibility to support the development of the region and bring benefits to its inhabitants. He maintained that every individual had:

A moral obligation to match the strong sense of our reality and patriotic impulses and affection for our state, the broad program that the government established through the commission to make feasible the development of the region and bring maximum benefit to its inhabitants. (50)

La Voz de Michoacán, one of the state's main newspapers, touted the work of the *Comisión* as not only benefiting the Cuenca de Tepalcatepec, but also providing improved roads, electricity, industry, and agricultural development to the entire state. Several articles and editorials highlighted the economic possibilities for the state and nation that would result from the program.<sup>7</sup>

Many federal and state agencies, political groups, and private organizations collaborated with the *Comisión* to develop the Cuenca. The four largest participating federal departments were the *Secretaría de Recursos Hidráulicos*, the *Secretaría de Comunicaciones* (Ministry of Communication), the *Secretaría de Agricultura y Ganadería* (Ministry of Agriculture and Livestock), and the recently restructured *Secretaría de Salubridad y Asistencia* (SSA). With so many players involved, the motives for cooperation varied from economic desires for gaining

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<sup>7</sup> See for example, "Tepalcatepec en Marcha," *La Voz de Michoacán*, June 27, 1953; "Tepalcatepec Esperanza de Michoacán," editorial, *La Voz de Michoacán*, May 6, 1950; and Pedro Bedolla Reyes, "Tepalcatepec, Reserva y Esperanza de la Patria," *La Voz de Michoacán*, April 18, 1955.

access to natural resources and expanding new technology to social and political aims such as national integration of rural areas, urbanization, modernization, sanitation and health care, and protection of indigenous culture. All the groups shared an interest in experimenting with regional development and using the experience as a model for future programs. They hoped to establish working relationships between government agencies and to utilize their combined knowledge to best achieve their interdepartmental and national goals.

The hierarchical organization of the *Comisión* indicated the rising bureaucratic mindset of Mexican politicians. The *Secretario de Recursos Hidráulicos*, Ing. Adolfo Orive Alba, served as President of the *Comisión* and reported directly to President Alemán. His role symbolized the importance of water to the development of the Cuenca. In reality, Cárdenas' role as Director was the most prominent. He devoted significant time to coordinating the *Comisión's* major programs in collaboration with the appropriate agencies. To administer the various projects, he appointed an Executive Secretary (*vocal secretario*) to provide technical direction, contract oversight, cooperation agreements, preliminary data on topography and geology, and regular reports to the Director and President. An Administrative Head (*oficialía mayor*) staffed local units and oversaw the general store for field supplies.<sup>8</sup> Reporting to these administrators were groups of study brigades, construction teams, and leaders of the Cuenca's four zones: Los Reyes; Uruapan; Apatzingán; and Ario de Rosales. The Central Technical-Administrative offices were headquartered in Uruapan. In addition to this administrative tier, each of the main departments had specific responsibilities. The *Secretaría de Recursos Hidráulicos* developed programs to redirect water routes into communities and establish hydroelectric capabilities. The *Secretaría de Comunicaciones* expanded transportation paths into the Cuenca, including roads, railways, bridges, and airfields. They also extended radio coverage into the remote areas of the region. The

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<sup>8</sup> This includes cartographers, accountants, purchasing agents, paymaster generals, and secretarial assistants.

*Secretaría de Agricultura y Ganadería* conducted agricultural credit programs and irrigation operations. They also instructed locals on soil and livestock conservation.

The role of the *Secretaría de Salubridad y Asistencia* included improving environmental sanitation, hygiene education, and disease prevention; developing medical clinics, hospitals, and laboratories; and conducting experiments in entomology and epidemiology. In turn, the SSA coordinated with local health brigades and the *Dirección de Cooperación Interamericana de Salubridad Pública* (DCISP, Directorate of Interamerican Cooperation on Public Health) to ensure widespread application of their programs. (13) In 1943, the *Instituto de Asuntos Interamericanos* (Institute of Interamerican Affairs), a U.S. government organization designed to control and protect public health in the Western Hemisphere, established the DCISP to develop cooperative agreements with other nations. The *Instituto* originally sought to protect the health of U.S. troops stationed in strategic tropical areas during World War II and of workers manufacturing vital materials for the war effort. After the war, its purpose was extended to include improvement of sanitary conditions in these targeted areas as a way to increase productivity, standards of living, and economic expansion. DCISP agents worked with government officials in each of the 18 nations participating in the program to assess health priorities and develop funding agreements in their nation. (12) Mexican health officials viewed the DCISP as an integral collaborator for their ability to organize, promote, and financially support fundamental health development projects. The Cooperative Health and Hygiene program, established by a joint resolution between Mexico and the DCISP in 1943, included programs to provide salaries for *Secretaría de Salubridad y Asistencia* officials who acquired advanced education and certification (*Proyecto MEX-MED 1*), establish a public health demonstration and training program in Xochimilco (*Proyecto MEX-MED 2*), and improve

sanitation along the northern border of Mexico (*Proyecto MEX-MED 3*).<sup>9</sup> The success of these initiatives prompted SSA officials to seek cooperation and considerable financial support from the DCSIP when establishing its public health program for the Cuenca de Tepalcatepec (*Proyecto MEX-MED 4*).

### **3.4 Proyecto MEX-MED 4: Goals and Objectives**

Proyecto MEX-MED 4's stated objective was "to make the Cuenca a healthy region." (14) High mortality rates in the area, caused largely by preventable diseases, undercut the economic development goals of the *Comisión*. Health workers were therefore charged with treating patients quickly and effectively as the first step toward improving the river basin. Hoping to both combat existing diseases and avert future infections, SSA officials developed a multi-tiered program that included hygiene and nutritional education, disease treatment and prevention, and maternal-infant care. (13) Project leaders hoped to revitalize the Centers of Rural Hygiene established in the 1930s into modern health care facilities with adequately trained staff and emphasis on treating communicable diseases. Funding for these health initiatives would be divided between the state, DCISP, and local communities. (14) This method not only allowed state officials to develop programs with budgets that exceeded their own resources, but also prompted individuals in communities to take a stake in their own health care.

All collaborating units agreed that hygiene education would have the largest influence on public health. In his February 1948 report on work in the Cuenca, Dr. Carlos Hernandez Aguirre, Medical Director of one of the sanitary brigades, emphasized the importance of introducing modern medical practices to communities that traditionally utilized folk medicine. He stated, "To educate is to redeem!" (13) To be effective, educators needed to move beyond language barriers

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<sup>9</sup> For more information on these projects, see AHSSA-SSA-SubSyA, box 19, file 8; AHSSA-SSA-SubSyA, box 2, file 2; and AHSSA-SSA-SubSyA, box 18, file 9.

and high illiteracy rates to develop new ways of communicating health information that could be understood and, more importantly, utilized by the Tarascans.

The majority of health problems in the Cuenca revolved around the issue of water. With the highest incidence of illness linked to unsanitary conditions and contaminated food and water consumption, it was crucial to establish these water systems immediately. The region's vast supply of mineral deposits and lava created areas with soil too thick to absorb water. As late as the 1940s, no drainage systems existed to filter the stagnant water created by heavy rain seasons. The stagnant water was also an excellent breeding ground for mosquitoes, resulting in high malaria rates. Additionally, sewage runoff contaminated drinking water and produced high levels of diseases such as diarrhea, enteritis, dysentery, and intestinal parasites. While other health risks, such as pneumonia and measles, existed in the region, sanitation and education about the proper use and disposal of water and sewage became the key priority of health workers. Sanitation engineers, working with the SRH, recognized that the rainy climate combined with lack of drainage made the area extremely unhealthy. To reduce endemic diseases such as malaria, tuberculosis, and gastrointestinal diseases, the engineers needed to develop a fresh water supply and a sewage system, and provide drainage for the wetlands. (130)

Preventive medicine was the second essential component of the project. *Comisión* officials hoped epidemiological studies of the area, including health data collection on both individuals and the environment, would provide critical information on current living conditions and disease contraction. They established sanitary districts in Los Reyes, Uruapan, Apatzingán, and Ario de Rosales to allow specialized sanitation engineering and treatment at the local level. The development of Brigades of Investigation and Emergency promised nearby support in times

of health crises. Finally, expanding medical center development from urban centers to more rural locations would ensure that health care was accessible to more populations. (14)

### **3.4.1 Proyecto MEX-MED 4: The Project in Action**

With these goals firmly established, health officials began their work in 1948 in the centrally located city of Apatzingán within the Tierra Caliente. *Comisión* delegates used epidemiological and anthropological studies to determine that this site was the Cuenca's prime area for the worst health conditions and the most economic potential. Apatzingán became both a testing ground for implementing new health programs and as a development model that would hopefully be replicated in other regions. The Director of the *Proyecto*, Gustavo Viniegra Osorio, assigned an epidemiology brigade, a sanitary planning *Comisión*, and a sanitary engineering unit to conduct:

Reconnaissance work and health surveys and the collection of indices and all the data necessary to achieve the knowledge of health conditions prevalent in the Cuenca which will allow a firmer basis and, to develop future work programs with the most effective campaign and effective results. (14)

The three groups provided data on health conditions and proposed measures for establishing a potable water supply, waste draining system, and food and beverage sanitation. With this information, sanitary brigades entered new communities with what they hoped would be appropriate medical treatments and programs.

Alongside the sanitation efforts, the preventive medicine component worked to control transmittable diseases through antiviral immunizations and anti-malarial public health campaigns. Health officials expanded existing medical clinics and established new clinics to treat tropical diseases, parasites, malaria, tuberculosis, *mal de pinto* (a tropical skin disease) and venereal diseases. They also built maternal-infant care centers and nursing stations. The Apatzingán hospital, established in 1928 by Cárdenas as the first regional care facility, was



refurbished to provide up-to-date medical care, and plans for hospital construction in the other sanitary districts soon followed. (92) Finally, twelve aid stations were established throughout the region to provide local accessible care.

Institutional expansion helped to establish a strong presence of professional medical care in the region. Additionally, medical researchers established laboratories to study, diagnose, and treat local diseases. Entomologists cataloged insect species to determine environmental conditions and disease transmission. Biostatisticians collected demographic data on the health and well-being of local inhabitants. Hygiene educators established programs in schools through the use of film and radio. On paper at least, Apatzingán quickly became a hotbed for scientific studies. In reality, the *Proyecto*'s workers faced many of the financial, personnel, and local acceptance problems of previous health officials. For instance, in his February 1948 report, Sanitary Brigade leader Carlos Hernández Aguirre noted that his team could not adequately complete their goals due to lack of technically-prepared personnel. He questioned, "What can one doctor do, where there are multiple health care problems, with little hygiene education for the people, and a township of more than 7,000 people?" (13) Furthermore, many of the recruited health workers seemed reluctant to travel within the region and made it clear they had no long-term plans to stay. Aguirre petitioned the *Proyecto* main office to establish training for local staff to assist his team and to provide an additional nurse and sanitary engineer in the interim. This would not only ensure that future health workers had adequate skills and preparation, but also that they would be more likely to remain in their villages for longer periods of time. Aguirre also mentioned that the number of burials taking place in the area without a medical certificate indicated the low acceptance of scientific medicine. (13) Overall, these early medical brigades

quickly realized they were facing an uphill battle to provide adequate care to inhabitants along the basin.

Even with these initial setbacks, it did not take long for the program to reach beyond Apatzingán into the other sanitary districts. The recent completion of the Carapan-Uruapan highway, along with additional project funding allocated for transportation, allowed the brigades to reach a larger percentage of the population than previous medical services. Mobilized sanitation brigades entered these remote areas for the first time and administered much needed medical attention. In addition to medical care, the brigades became the main outlet for the *Proyecto*'s programs at the local level. They worked with epidemiologists to collect spleen samples and study local environments to learn about determinants of malaria. They collaborated with local hygiene centers to provide smallpox vaccinations and weekly anti-pinto clinics. They also trained local health workers and rural teachers to properly detect and treat intestinal parasites. Although their efforts were slightly delayed due to personnel training, the program established a new medical team that included an executor of the eradication campaign, a sanitary official, three brigade leaders, six group leaders, and thirty-two vaccinators. (30)

The 1949 outbreak of smallpox in the northwest region of the Cuenca caught locals and health officials by surprise. First visible in late 1948, the disease reached epidemic proportions before word could get to health authorities. Loaded down with bags of supplies, the men and women of the sanitary brigades traveled by cars, horses, or on foot to administer the vaccine to communities along the Tepalcatepec basin. Female workers typically treated individuals in urban areas while males traveled out to ranches and communities. Word of their work soon spread between villages, helping some groups to more readily accept treatment while others developed

an even greater fear of outsiders.<sup>10</sup> Additionally, some communities had heard about an earlier outbreak in the *Tierra Caliente* and *Tierra Templada* and were terrified of the high mortality rates that followed. Gonzalo Aguirre Beltrán recounts that during the 1949 epidemic, mestizos triggered alarmist rumors in local communities to discourage cooperation with health officials and to protect their own local power. Stories that the vaccine made women unable to have children, reduced men's strength, and killed children and the elderly quickly spread throughout indigenous villages in the *Tierra Caliente* and increased the challenges for health workers to gain acceptance. Even with this hurdle, sanitary brigades administered over 71,000 inoculations in twenty municipalities by September 1949 through persistence, patience, and establishing trust with inhabitants. (30)

Brigades often worked with local guides to locate remote villages and to comply with local customs before administering medical treatment. Often a small group approached a village ahead of the medical team to explain the purpose of their visit and to garner support from local officials. Brigade #2 Director C. Francisco Chavarria V. reported that the sanitary brigade successfully worked with a local priest in the rebellious region of Quitupan, Jalisco, to help carry out vaccinations. The priest used his pulpit to explain why the medical team was in the area and to encourage community members to participate in their programs. Chavarria also commented on the mixed results of these collaborative introductions:

I must add to all these precedents that the cooperation requested with the Municipal Authorities and *Ejidales* has been effective in only a few cases; in others, the indifference, the bad faith, the suspicion, and the absence of authority have been motives for not providing us with assistance, including the practice we have of approaching locals for free use of their horses. For everything previously exhibited, if this Brigade is not provided with cyclical funding and the confidence of this Superiority, our works will be obstructed. (13)

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<sup>10</sup> Historian Claudia Agostoni's work sheds light on this long history of rural resistance to obligatory vaccinations. See Claudia Agostoni, "Estrategias, actores, promesas y temores en las campañas de vacunación antivariolosa en México: del Porfiriato a la Posrevolución (1880-1940)," *Ciencia & Saúde Colectiva* 16, no. 2 (2011): 459-470.

In other words, part of the difficulty brigades had in developing relationships within the communities stemmed from the lack of funds and supplies provided by their supervisors. The fact that they often needed to borrow horses and rely heavily on the kindness of community leaders to successfully complete their mission made many locals skeptical about the nature of their work and of their authority.

On several occasions, the brigades had to negotiate with community leaders and rebellious individuals before they could enter a village. One report noted that a Commissioner in Quitupan refused to lend his collaboration to the brigade and gave them the impression that it was in their best interest to leave without attempting to administer vaccines. Given the rocky terrain and long distance traveled (82 kilometers), the brigade decided to risk upsetting the Commissioner by completing their work before leaving. Ultimately, the vaccinations were well received and laid a positive foundation for future work in the area. In another case, the brigade encountered resistance in Los Reyes, a community connected to large population centers and ranches. Although local leaders had refused treatment for their community once before, the brigade hoped to quietly infiltrate the area and administer vaccines before the illnesses of unhealthy individuals spread to their larger neighboring communities. Upon arriving into the city, they encountered a group of armed, rowdy men playing cards and drinking. Once the men realized what the brigade was trying to do, they began hurling insults at them. Undeterred, the brigade continued administering vaccines and using a calm, tactful approach even persuaded the rowdy men to be inoculated despite their shouting. (13)

The brigades' larger mission was to break community prejudices against modern medicine through hygiene education. They worked with translators to develop bilingual pamphlets explaining the aims of the health programs to local Tarascans. In *pámpiri*, a weekly

newsletter for bilingual teachers published by *La Sección Técnicos de la Campaña contra el Analfabetismo entre los Tarascos Monolingües* (Technical Section of the Campaign against Illiteracy among Monolingual Tarascos), the authors explained the history of smallpox, the national eradication campaign, and the importance of protecting the local community. The pamphlet encouraged citizens to help control the disease by receiving a vaccination, maintaining, “This entrusted task is noble and highly beneficial to the people, but for this to take place in all its aspects requires the collaboration of all inhabitants.” (14) Additionally, educators fluent in Tarascan addressed audiences unable to read, and screened films developed by the *Secretaría de Salubridad y Asistencia* and the *Secretaría de Educación Pública* to be supplemental learning aids. Topics for the films included latrine building to prevent intestinal parasites, the use of clean water to prevent typhoid, the link between flies and diarrhea/enteritis, the danger of mosquitoes and gnats in spreading malaria, the administration of serum to treat scorpion stings, and general hygiene practices. The films were often followed by information sessions in community centers. SSA officials reported that many parents were unaware that smallpox was contagious or that their children were at risk. As a result, they had been hesitant to administer medicine to their children. Health workers worked diligently alongside families to educate parents and children by encouraging them to visit local clinics on a regular basis, regardless of their current health, in order to become more comfortable with both treatment and prevention practices. Stressing the importance of health education, one official wrote, “Overcoming ignorance creates a healthy and vigorous country.” (13)

The lengths healthcare providers went to in order to effectively educate community members speaks to their cultural sensitivity and acumen. Their work in villages convinced them that most communities wanted medical treatment and education. Indigenous groups responded

favorably to health initiatives that included familiar cultural aspects, and taking the time to explain and demonstrate new procedures to local families resulted in overwhelming support for health programs. Additionally, indigenous groups utilized the new collaborative relationships they forged with health officials to recount their grievances with public services, or lack thereof, in their communities. This dialogue between national and local representatives changed the way healthcare treatment took place in the Tepalcatepec basin's rural villages.

Although there was not a well-defined ethnic component to the *Proyecto*, the above examples show the customized treatment required to be effective in indigenous communities. Health officials in the urban centers of Uruapan and Apatzingán were able to more quickly establish relationships with residents because of their shared language and culture. Balancing both types of encounters became a primary focus for both the *Proyecto* and the larger *Comisión*. These instances allowed officials to utilize their multi-tiered collaborations to exchange information and develop plans for customized treatment in all of the region's different populations. Whereas previous health care programs emphasized either the indigenous or the modern scientific approach, this collective effort sought to ensure that no group fell between the cracks.

In cooperation with the *Comisión*, and concurrent to the work of the SSA and the *Proyecto*, the *Instituto Nacional Indigenista* (INI) initiated its own series of studies in the Cuenca. The *Instituto*, founded in 1948 to help the federal government integrate isolated indigenous communities into the national framework, utilized anthropological studies of local languages, customs, and cultural practices to establish relations in remote villages. With these relationships in place, INI officials introduced education, hygiene, and economic development programs that were sensitive to the cultural differences within each community. In 1950,

*Instituto* anthropologists agreed to conduct research in the Cuenca to determine the most appropriate measures for transforming and improving the local land without harming Tarascan settlements and ways of life. This was particularly important in areas where the *Comisión* needed to transfer indigenous groups from their long-held frequently flooded lands to newly irrigated lands without disrupting the unity of the community. Careful negotiation was required to improve living conditions and economic levels while respecting the customs and wishes of the Tarascans. Cárdenas offered full cooperation to the *Instituto* in these initiatives in the hope that the shared experience of developing the Cuenca could be recreated in other areas throughout Mexico. (53)

Just as the *Proyecto* was starting to make headway, however, the *Comisión* received a major setback. In November 1949, the DCISP decided to reduce its financial contribution to the preventive medicine program from \$450,000 to \$100,000. Most likely, DCISP officials were satisfied with the success of administering smallpox vaccinations and felt that the Mexican government could sustain other, less internationally threatening diseases. In reality, this budget cut significantly lowered the number of services local sanitary brigades could offer. With assistance from the *Campaña Nacional Contra el Paludismo* (National Campaign against Malaria), local units shifted their focus to anti-malaria campaigns. But as the *Proyecto*'s director, Gustavo Viniegra, noted, "The future situation of the delegation is grave." (14) Moreover, policymakers continued to show their vocal support for the programs but did not offer any additional financial resources from the state budget.

To help offset the expenses required to carry out its health objectives, *Proyecto* leaders increasingly relied on contributions from the local communities themselves. In 1951, for example, the sanitary district in Apatzingán received \$351,748 from the national government,

\$100,000 from the DCISP (all of its contribution to the *Proyecto*), and \$84,200 from local villages. In the districts of Nueva Italia and Lombardia, the national government and local villages made equal contributions of \$200,000 and \$140,000 respectively. (14) These numbers highlight two important changes taking place in the Tepalcatepec basin. First, local communities were clearly seeing the benefits of vaccination, hygiene education, and potable water services. They not only wanted to ensure the continuation of these programs, but also realized that they could not rely on the state to provide adequate resources and therefore supplied their own contributions. Second, as the Blanco Vega letter in the introduction exemplifies, individuals in the region became increasingly aware of their rights as citizens to health care in the 1940s and 1950s. Healthcare workers, schoolteachers, sanitary engineers, industrial employers, agricultural specialists, and international aid officials all brought new ideas of citizenship to local communities. Cárdenas and his team continually emphasized the importance of feeling like part of the larger nation. As community members started to understand the benefits that came with being integrated into Mexican society, they also began expressing their rights as individuals participating in the state system. If they were going to become part of the modern nation, they expected the modern benefits that came with it.

Historical scholarship in the last thirty years has debated the long-term advantages of these changes. Natividad Gutiérrez criticizes the work of the *Instituto Nacional Indigenista's* work in the Cuenca as “institutionalized indigenism.” (80) She contends that INI officials serving as intermediaries on behalf of the *Comisión* persuaded indigenous communities to relocate away from their traditional settlements, slated to soon be submerged by dam waters, by appealing to their shared cultural connection. The result was the displacement of several communities without conflict under the guise of respecting local traditions in the face of



development. Gutiérrez portrays this system as a contradiction, intending to help but actually hurting local communities as they encounter modernization processes. While she is fair in questioning the cultural approach to economic development, she does not fully consider the added public welfare benefits that the program brought to community members. Indigenous groups obtained crucial health care treatments they might not otherwise have received. Furthermore, these groups recognized the value of these services and contributed their own limited resources toward continuing the project. Intermediaries worked diligently with community members to maintain many traditional practices, beliefs, and customs while also improving their living conditions through sanitation and potable water. The restructuring of Centers of Rural Hygiene into professional medical clinics with trained staff and well-received health education programs gained widespread acceptance and application. More importantly, the ability of sanitary brigades to enter previously unreachable communities by providing treatment and education created a healthier environment in both rural and urban settings. As a result, the major health risks cited in 1940 were all significantly reduced by 1950. The number of malarial cases in the Cuenca dropped from 268 in 1942 to 116 in 1949; diarrhea/enteritis fell from 1040 to 507; dysentery from 218 to 37; typhoid from 125 to 50; pneumonia from 537 to 416; and whooping cough from 190 to 87. (30)

Health conditions continued to improve with the help of the Comisión's other public works programs. By 1957, 72 communities in the area had electricity generated from the new hydroelectric dams. Agricultural technology advancements led to the development of a rice mill and processing plants for cotton, limes, and other fruits. More than twenty schools were constructed. (47) At the end of the project, 110,000 people in 42 municipalities had access to potable water. (62) Between 1950 and 1976, irrigated land increased by 258% from 45,000

hectares to 116,136 hectares. (105) Historian Elinore Barrett's study noted that, while the irrigation system had a positive effect on the area, the *Comisión*'s greatest contribution was the improvement of living conditions. According to her report, the drainage system, potable water, and anti-malaria campaigns in Apatzingán, in addition to the establishment of regional medical centers throughout the area, significantly reduced health risks. Furthermore, hydroelectric plants, street sanitation, and the establishment of parks and playgrounds all added toward the development of healthy behaviors. On the other hand, Barrett also concluded that the indiscriminate use of insecticides harmed the region's health and ecology. She argued that land redistribution and changes to the agricultural credit system "only reinforced economic colonialism." (23) While population expansion did occur, she noted that this phenomenon only took place in areas that made the economic changes recommended by the *Comisión*. In other words, areas that cooperated with development plans received the best care.

Gutiérrez and Barrett both draw attention to the strong connection between development programs and public works. In order for indigenous groups to receive the benefits of welfare projects, they had to participate in the economic restructuring of their environment. This not only meant land redistribution and modifications to agricultural production, but also acceptance of new industrial plants, markets, roadways and railroads. In exchange, these communities gained access to education, vaccination, potable water, and medical care. The main point left out of both arguments is that citizens like Pedro Blanco Vega specifically requested assistance. These citizens played an active role in securing political support and contributed financially to ensure the *Proyecto*'s success. While the case in Tepalcatepec shows that this arrangement can end favorably for those who participate, both scholars convincingly note that the flip side of the coin can be harmful in both a cultural and political sense. Areas that were economically attractive to

the state risked losing their political autonomy and cultural distinction by succumbing to rapid changes, while areas that were not deemed valuable were not given the same opportunities to partake in the social services being offered.

In 1953, INI Assistant Director Gonzalo Aguirre Beltrán produced an anthropological study of the Cuenca that included a frank analysis of the *Comisión*'s work in the high altitude *Meseta Tarasca* compared to that in the *Tierra Caliente*. He wrote that, although the *Comisión* initiated several new projects that included all the regions of the Cuenca, the urban areas within the *Tierra Caliente* received more completed programs than those in the *Meseta*. He believed this difference was due to a larger ethnic separation between indigenous and non-indigenous groups in Mexico at the time. (29) He cited the case of the water source network established by sanitary engineers in the indigenous village of Paracho. While the *Comisión* drilled a well and installed a pump, they left the completion of the water distribution network in the hands of community members. When the pump engine shut down and the group encountered difficulty constructing the channels, they received almost no assistance from the *Comisión*. The community used their own resources and skills to try to correct the problems, but was unsuccessful. As a result, the community continued to suffer from the extremes of having too much water or not enough. The prolonged droughts continued to keep illness rates high in diarrhea, enteritis, pneumonia, and malaria. Furthermore, no adequate sewage system had been established anywhere in this section of the region, which also contributed to disease and unsanitary living conditions long after the program was completed. (30)

Beltrán also noted the limited health services available in the *Meseta* in comparison to the rest of the Cuenca. Under the SSA, the *Servicios Sanitarios Coordinados* (Coordinated Sanitary Services) were small teams, usually a doctor, nurse, and sanitary engineer, sent to provide health

care and treatment to large rural regions. Beltrán described these units as bureaucratic, underpaid, and ultimately insufficient given the sizeable population they were designed to serve. He contended that many groups never knew these services existed, and only encountered health workers from this program when epidemics in the area threatened to reach urban centers. In contrast, the health services provided under *Proyecto* MEX-MED 4 consisted of a large, well-paid and dynamic staff including a medical director, an epidemiologist, and three physicians, along with several medical officers and nurses. These teams could provide significant prevention and treatment programs to the indigenous communities, but according to Beltrán, they largely focused on malaria and smallpox in the region, and included the *Meseta* only in their final phase of vaccination. No action was taken to prevent or treat other diseases common in the area, such as rickets and goiter, which indicate nutritional deficiencies in the local diet. When the DCISP completed its funding commitment to the Project, health services were not fully developed in the *Meseta* and therefore gradually died out. Consequently, indigenous communities in the region continued to rely on traditional medicine. (30)

Beltrán's work is significant because he highlights a sizeable hiccup in the work of the *Comisión*, the inequality of care and services based on the economic potential of an area. While the project initiated several important economic and health programs in the urban centers like Apatzingán, the program needed additional measures to ensure that all communities benefited from these services. He does not suggest that these programs are not valuable but instead questions the way officials went about implementing them. Beltrán asserted that further scientific exploration of natural resources, intensification of land cultivation, incorporation of modern agricultural machinery and fertilizers, adaption of electricity by artisans, extension of road networks to expedite exchanges of goods with other regions, and expansion of sanitation and

education programs would all be essential next steps toward meeting the needs of indigenous populations in the *Meseta Tarasca* and throughout Mexico. (29)

In addition to critiques of the Proyecto itself, journalists in the early 1950s began to question Cárdenas' motives in establishing the *Comisión*. Historians still debate whether this happened because Cárdenas was losing his political clout or if government leaders hoped to reduce his level of involvement in the project and politics in general.<sup>11</sup> The most scathing article maintained that he “pretended to create internal and external problems while situating himself as a political Maximato in a time that no longer operates under caudillos and coups.” (48) Others challenged his participation as “unofficial overseer” of a forest development project for the industrial forestry unit, Michoacana de Occidente. (39) While the project brought employment and modern machinery to the region, it also shut down four small logging groups and generated local animosity. Cárdenas' response to these accusations focused on the larger national economic development plan and emphasized that the Tepalcatepec region was meant to be one of many similar programs throughout the nation. He stated, “As we can see, it has not been a privilege for the state of Michoacán to receive the works of the Tepalcatepec but rather is part of a program that the government has been undertaking in the different areas of the country to increase its economy.” (48) Furthermore, he reaffirmed his interest in helping indigenous groups improve their standard of living by maintaining, “The transformation of areas with natural resources, unproductive due to lack of works to allow its use, has not yet been achieved due to the poverty of the people without the government's attention.”<sup>12</sup> In short, Cárdenas firmly denied any personal motives for developing the Cuenca and reiterated his goal of improving the economic and social conditions of the nation as a whole.

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<sup>11</sup> For examples of this debate, see Barkin and King, *Regional Economic Development* and Calderón Mólgora, “Lázaro Cárdenas...”

<sup>12</sup> Ibid.

Even with this public response to his critics, pressure continued to mount against Cárdenas. A wave of support came from within Michoacán, but this was not enough to swing national opinion.<sup>13</sup> In November 1952, at the end of Alemán's term, Cárdenas officially stepped down from his role as Director. Although he would become the honorary *Vocal Ejecutivo* again a few years later, Cárdenas wrote at the time:

This 16<sup>th</sup> [of November], I presented my resignation to Mr. President in order to avoid discomfort by my presence on the job entrusted to me. And today, with my character as a simple citizen, I will continue the same invariable rule of friendship to his government and adherence to national institutions. (48)

He maintained that the groundwork had been successfully laid for others to continue carrying out the work of the *Comisión*. Five years into the program, the *Comisión* had indeed produced an impressive number of accomplishments. Irrigation works were well underway in numerous areas. Construction of 36 rural schools, 64 learning centers, a specialized agricultural school, two hydroelectric plants, four new hospitals and expansion of a fifth, and twelve medical aid stations provided the institutional framework to carry out future economic and development projects. (130) Sanitation programs reached a broad audience. Studies of natural resources and minerals to determine the best means of exploitation, as well as investigations into potential establishments of industrial plants, rounded out the list. (62)

In 1958, the *Secretaría de Salubridad y Asistencia's Bienestar Social Rural* program selected the Tepalcatepec basin as one of five sites for its second round of pilot centers. The director of the program stated that he selected areas that “would feel the spirit of patriotism, faith in action and full knowledge of the goal to achieve a shared ideology.” (18) The region had gained notoriety for the willingness of its inhabitants to collaborate with government officials on

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<sup>13</sup> See for example, Tomas Perrin, “Tepalcatepec Ahora, Mañana Grijalva...¿Pasado?” *La Voz de Michoacán*, March 18, 1955 and Eduardo Rubio, “La Personalidad del General Lázaro Cárdenas y el Tepalcatepec,” *La Voz de Michoacán*, August 28, 1954.

public works projects. Largely the result of the relationship between healthcare providers and indigenous community members, the foundations established during the *Proyecto*'s brief three-year tenure opened the door to more community-based health treatment and care in the Cuenca.

### 3.5 Conclusion

Although the work of the *Comisión* continued until 1961, *Proyecto* MEX-MED 4 officially ended in 1951. The DCISP terminated its funding commitments and officials in the *Secretaría de Salubridad y Asistencia* felt the developments achieved throughout this short period in reducing health risks were sufficient to establishing long-term improvements in the Cuenca. As historian Luis Gonzalez y Gonzalez ascertained, the *Comisión* effectively ended the isolation of the Cuenca de Tepalcatepec as the region became significantly more accessible via roads, airports, and telephones. Furthermore, he contended that Cárdenas and the *Comisión* converted Michoacán “into an attractive region out of one that was traditionally repulsive.” (75) Immigrants, investors, capitalists, and developers all made their way to Michoacán in response to its new economic potential. The population almost tripled over two decades from 46 million people in 1940 to 120 million in 1960. Literacy rates also rose, from 25% in 1940 to 43% in 1960. (75) Although no longer the official leader of the *Comisión* after 1952, Cárdenas continued to work on various *Comisión* projects until 1958. He also took steps to fulfill his goal of expanding the work of the *Comisión* into new areas. Many of the same government agencies teamed up with him again to form the *Comisión de las Balsas* in the 1960s. (115) This new initiative used the Tepalcatepec experience to offer similar development plans and public services along the Pacific coast in the states of Oaxaca, Guerrero, Colima, Jalisco, and Michoacán. In February 1965, Cárdenas wrote that he encountered a spirit of coordination throughout the country to elevate the living conditions of the Mixteca in the same manner as the

Tarascans in Tepalcatepec. He reiterated that schools, industry, potable water, technology, and welfare services were key to the success of the project. (52)

The health programs within *Proyecto* MEX-MED 4 established new and/or improved relationships between healthcare providers and indigenous populations. Through the *Comisión*, the *Proyecto* became a laboratory for providing health care to address the immediate needs of rural indigenous and mestizo communities while determining longer-term solutions in sanitation, environment, and preventive medicine. Project leaders carefully negotiated a balance between raising the standard of living for individuals in the area while also raising economic possibilities for the nation. They successfully administered disease vaccinations, implemented large-scale hygiene education programs, and joined forces with other agencies to oversee water treatment and irrigation projects in previously remote villages. They assembled a network of local and national administrators to continue the public works started during their tenure. Finally, they established a national presence that helped connect these communities with their urban counterparts.

In addition to the achievements in the Cuenca, *Proyecto* MEX-MED 4 also paved the way for future *Secretaría de Salubridad y Asistencia* programs throughout México. The *Proyecto* served as a leading example of SSA's successful collaboration with other recently formed departments and institutions, including the *Secretaría de Recursos Hidráulicos*, the *Dirección de Cooperación Interamericana de Salubridad Pública*, and the *Instituto Nacional Indigenista*. They proved their ability to create and implement new programs, and solidified their bureaucratic position within the national administration. They made adjustments to future *Comisión* programs based on the trial and error of implementing health campaigns in the Cuenca and garnered local support to continue their efforts. Most importantly, their work brought to light



rural health problems and the need for specialized research in indigenous culture, language, health practices, and environmental conditions in order to be effective in rural communities.

The integration of indigenous villages along the Tepalcatepec River into the nation achieved most of the political and economic development sought by national policymakers, including access to markets and natural resources, rural industrialization, commercial agricultural production, and political stability. The key failure of the project was its inability to reduce social inequality. While public services reached a larger percentage of the rural population as a result of the *Comisión*, health treatments and resources varied based on the economic attractiveness of an area. Many groups agreed to more government involvement in the region's economic development in the hopes of improving their way of life. Instead, they faced miniscule wages, few new employment opportunities, and natural resource depletion. Even though healthcare providers established cooperative relationships with indigenous community members, the ability of either group to sustain political and social momentum for long-term improvements in living and working conditions became even more challenging once the *Comisión* achieved its objectives and ended its programs.

#### 4. BIENESTAR SOCIAL RURAL

The *Bienestar Social Rural* (BSR, Rural Social Well-Being) project in the 1950s transitioned health service in Mexico from individual to collective care. Rather than focusing exclusively on disease treatment and prevention, the program incorporated all aspects of daily life—work, home, school, social activities, and environment—into a broader “well-being” campaign. This differed from the Tepalcatepec Commission, which addressed health issues in targeted communities as a first step toward extensive economic development, by instead merging health and economic prosperity under the banner of social health. *Bienestar* officials wrote that they wanted to organize and empower communities to change the conditions of their lives based on community interests and participation. (108) Program leaders designed regional centers to serve as new social and economic hub from which healthcare professionals, educators, and community leaders could work to raise the standard of living for individuals and the larger community. This emphasis on collective care, where communities were encouraged to contribute resources, manpower, and leadership to center programs, appealed to several rural community leaders who wanted to be actively involved in the betterment of their region. Contradictions between the *Bienestar Social Rural*’s program objectives, national administrative goals, and center staff interactions with community members ultimately hindered community leadership and specialized care in the centers. Nevertheless, *Bienestar* project leaders succeeded in gaining widespread rural support for their initiative and supplied notable health treatments, public works programs and education workshops.

The goal of the *Secretaría de Salubridad y Asistencia* (SSA- Ministry of Public Health and Welfare) in introducing the *Bienestar Social Rural* program was to divide rural areas into

smaller service zones and establish regional centers that could adequately address the lack of health care available to communities. Other than medical brigades providing emergency relief in times of disease outbreaks, many rural inhabitants had no contact with state-sponsored health services. They relied primarily on their own local healers for treatment. *Bienestar* administrators hoped to extend national healthcare by embracing the new internationally-accepted definition of health to include the well-being of individuals, communities, and the nation. This philosophy of community development as part of healthcare quickly became the backbone to the program. To *Bienestar* officials, community development meant actively encouraging community members to participate in improving the health, environment, and economy of their village. By raising the standard of living, they maintained, rural areas would eventually achieve greater economic prosperity and social cohesion for the nation as a whole. Officials also hoped locals would consciously become more closely affiliated with national politics and culture.

Although the program did not have a formal ethnic component in its design, it is evident that indigenous communities were meant to be the primary recipients. *Bienestar* officials established many of the early centers in or near *ejidatarios*, or indigenous villages linked by a shared legal right to the land. Centers located in more municipal areas did not develop workshops or treatment centers with residential mestizos and upper class professionals in mind. Rather, all of the plans focused on introducing indigenous families to modern conveniences. In contrast to the Tepalcatepec Commission, less attention was given to cultural understandings of selected regions. Instead, community promoters selected from within their villages were educated on modern health practices and civic duties, and charged with disseminating this information back into the village. Community promoters, as opposed to healthcare providers, served as intermediaries. However, promoters were often more concerned with living up to the

expectations of *Bienestar* officials than representing the customs of their village to a larger audience.

The *Bienestar* initiative set out to improve daily life in rural communities throughout Mexico. The selection criteria program officials used when deciding where to establish *Bienestar* centers included small populations with regional networks and community solidarity. In reality, the majority of centers were built in municipal areas that policymakers believed had the greatest economic potential. This variance is an example of the discord between the social and economic goals of the program. Over time, this discrepancy also caused effectiveness problems for the project because the program was designed to build on existing community cohesion. Instead, center staff members often faced the challenge of overcoming social and ethnic disparities before they could move forward with the specific projects they were there to implement.

In spite of these problems, the *Bienestar Social Rural* centers brought healthcare clinics, educational courses, and social events to communities. Program administrators appealed to the collective well-being of their assigned zones and encouraged community members to get involved in center activities. Like the leaders of the Tepalcatepec Commission, they appealed to the rights of individuals to be healthy. Both projects succeeded in strengthening government influence, economic development, and healthcare services in their targeted communities. The Ministry of Health and Welfare received petitions from community members in both cases demanding their right to health and requesting additional social services. The main difference between these two studies is the approach each program took in influencing local villages. Whereas the Tepalcatepec Commission utilized healthcare providers to form collaborative relationships with locals and to gain cultural insight into community ways of life, the *Bienestar Social Rural* project attracted local participation by giving community members a stake in

providing for their own well-being. This approach to health appealed to many indigenous community members because they felt they could influence how the projects were administered. Even though the *Bienestar* program was less culturally sensitive in designing specific projects, they were alert to the fact that indigenous communities were more likely to accept health care and social services if they felt they could play an active role in them. The philosophy behind the program, however, contrasted sharply with the actual implementation of center and community development. While the *Bienestar Social Rural* program did bring more health services to rural areas and forged closer links between communities and the nation, it failed to live up to its promise of establishing permanent self-sustaining rural healthcare centers that prioritized the needs of their communities.

#### 4.1 Introduction

On December 14, 1954, José Villaseñor Sanguino, *Secretario General for the Comité Central Ejecutivo de la Confederación Nacional Campesina* (CNC – National Campesino Confederation), wrote a letter to the *Presidente de Comisariados Ejidales* (President of the *Ejidal* Commission) in Guanajuato expressing the importance of community participation and support for the newly established *Centros de Bienestar Social Rural* (Centers for Rural Social Well-Being) in the area. He stated:

This National Executive Committee [of the CNC], with the desire to give greater impetus to effectively and efficiently carry out the social work of the Centers for Rural Social Well-Being sponsored by the Ministry of Health and Welfare, which are attacking the entire problem of our farming communities to transform their livelihoods and raise them through a tenacious effort to higher [economic] levels. Believing that the organization mentioned deserves our support and cooperation to achieve better results, we politely ask you as the leaders of the peasantry in that State to...consent to the benefits offered by the Centers for Rural Social Well-Being... (10)

The CNC, established in 1938 by then President Lázaro Cárdenas as a national peasant organization, promoted cooperation between *ejidal* communities and the *Bienestar Social Rural*

centers as a means to supply rural areas with much needed medical attention and to further consolidate the relationship between peasants and state officials. CNC officers petitioned local leaders to endorse the work of the BSR centers in order to expedite acceptance of state health officials in these largely autonomous regions. What distinguished the *Bienestar Social Rural* program from other peasant-state interactions, according to Villaseñor Sanguino, was the direct economic and social benefit to the *ejidos*.

Mexico's *ejidal* communities, each comprised of a group of people that have obtained communal land rights from the state, sustained a modicum of autonomy from the central government in the twentieth century through negotiation and resistance. *Ejidal* leaders hesitated to permit government representatives into their communities under any circumstances. The main exception to this rule was in cases of health crises.<sup>14</sup> After exhausting the knowledge and resources of local doctors and healers, communities would occasionally allow outside help to treat patients. Usually in the form of *Sanitarios Medicos Rurales Cooperativos* (Rural Sanitary Medical Cooperatives), these traveling medical brigades worked with *ejidal* communities to deliver short-term treatments to individuals in disease-prone areas. By supporting the work of the *Bienestar Social Rural* program, organizations like the *Confederación Nacional Campesina* hoped to expand the relationship between government health officials and local groups by establishing permanent BSR centers in the communities. The centers, designed to provide medical treatment and disease prevention, also offered developmental resources to launch these areas into greater economic prosperity. President Adolfo Ruiz Cortines, along with the heads of

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<sup>14</sup> See Jeffrey W. Rubin, *Decentering the Regime: Ethnicity, Radicalism, and Democracy in Juchitán, Mexico* (Durham: Duke University Press, 1997); Mary Kay Vaughan, "Cultural Approaches to Peasant Politics in the Mexican Revolution" *The Hispanic American Historical Review* 79, no. 2, Special Issue: Mexico's New Cultural History: Una Lucha Libre (1999): 269-305; Paul Gillingham, "Ambiguous Missionaries: Rural Teachers and State Facades in Guerrero, 1930-1950" *Mexican Studies/Estudios Mexicanos* 22, no. 2 (2006): 331-360; Thomas Rath, "'Que el cielo un soldado en cada hijo te dio...': Conscription, Recalcitrance and Resistance in Mexico in the 1940s," *Journal of Latin American Studies* 37, no. 3 (2005): 507-531.

national departments and agencies, anticipated that making genuine health improvements in rural areas a reality would more effectively consolidate governmental authority in the countryside than previous economic development schemes. The result, they hoped, would be greater agricultural and industrial productivity by a healthy, active peasant citizenry. (16)

Poor health conditions in rural Mexico prompted this renewed effort of government intervention. By the time Ruiz Cortines took office in 1952, smallpox had successfully been eradicated but malaria and tuberculosis infection rates remained a constant concern. Nearly 60% of the national population lived in rural areas with fewer than 2,500 residents. The average life expectancy for men was forty-eight and for women was fifty-one. Only 21% of the overall population had indoor plumbing. Infant mortality rates remained high in rural regions and were largely attributed to preventable conditions such as malnutrition, diarrhea, and lack of prenatal care. (6) In short, while the health treatment programs of the *Secretaría de Salubridad y Asistencia* in the 1930s and 1940s made considerable improvements in disease eradication, many areas of Mexico remained underserved. Public health officials appealed to the President for a more inclusive approach, one that included the installation of a permanent medical staff in rural towns, campaigns that encouraged preventive medicine in addition to treatment, and recreational projects outside of health that aimed to establish relationships between field staff and local citizens. (122)

*Secretaría de Salubridad y Asistencia* officials were heavily influenced by the World Health Organization's (WHO) redefinition of health in 1948 as not just the absence of disease, but rather the complete physical, mental and social well-being of an individual. (107) As translated by SSA representative Dr. Pilar Hernández Lira, the WHO document that set forth this new definition stated:

Without health, one cannot work or progress; without work and resources, there can be no material prosperity; without this minimum of well-being, one cannot achieve human dignity or exercise their rights. (16)

Several Mexican public health leaders incorporated this new concept of health, including economic development, community integration with the nation, and individual human dignity, into their programs and publications. They incorporated the WHO's connection between health and progress to link the well-being of individuals to collective social and economic measures. As a result, *Secretaría de Salubridad y Asistencia* leaders established the *Bienestar Social Rural* program to gain access to previously semi-autonomous indigenous communities. They hoped to succeed where previous rural health campaigns had failed by appealing to community rights, integrity, and active participation.

The *Bienestar Social Rural* program sparked a cultural transition as national leaders embraced the changing international definition of health to include psychological and social well-being. The program initiated community-led health projects based on the distinctive health needs and priorities of rural areas. Health officials collaborated with communities to establish program centers offering classes, activities, and health treatment to the regional population. They sought to harness community solidarity to community medicine. Designed as a national health improvement project, the program also incorporated community development initiatives into the campaign, drawing on an evolving global discussion of community well-being. While state leaders in the 1940s attempted to move toward individual care as part of its larger conservative political shift, BSR helped to produce a national movement in the 1950s toward increased collective health that hinged on community mobilization. This strategy granted government representatives greater access to regions typically adverse to state intervention because local groups felt they had a choice in their level of participation in and acceptance of the program.



## 4.2 Creating the Bienestar Social Rural Program

Nine months after taking office, President Ruiz Cortines introduced the *Bienestar Social Rural* program in 1953 to intensify “*la colonización interior*.” (122) This loaded term indicates both the president’s desire to expand his political influence into the remote regions of the nation and his intention to use health as a means to achieve rural development and integration. He hoped that the new global emphasis on collective health, as presented by the World Health Organization, would lay the groundwork for larger economic projects connecting rural and urban areas. The aims of the BSR program, he stated, were:

To reinvigorate the sense of nationhood, raise the cultural level of our people, provide new generations with the minimal knowledge needed to improve and strengthen the individual and national economy, and spread the benefits of social security, health and well-being. (122)

Linking health and well-being to national economic and social cohesion, Ruiz Cortines and his policymakers sought to use the *Bienestar Social Rural* program to tap into the growing international and national scientific shift toward community health as a means of promoting their own modernization agenda.

Faced with economic strain, including a devaluation of the peso and political demands to address unequal distribution of income among classes, President Ruiz Cortines began his administration by supporting small-scale public works programs that attempted to provide relief to rural areas. Moreover, the dramatic population growth in the 1940s and 1950s required additional governmental resources to address the inconsistent quality in health care delivery. The rapid dispersal of people resulting from post-revolutionary land redistribution made it increasingly difficult to bring social services, health and education to rural communities. It was equally hard for these communities to feel that they were participating in national programs. Ruiz Cortines believed all of these issues could be resolved under the banner of community

development. Policymakers felt that a larger *bienestar*, or “well-being,” initiative would achieve their intended goals of widespread political cohesion, higher national standards of living, and increased economic productivity.

The challenge to carrying out this type of initiative would be securing community participation. Most community interaction with the state had been limited to economic scavenger hunts and temporary interventions during health crises. These efforts were rarely well-received and, in fact, left a bitter taste in the mouths of groups seeking to protect their semi-autonomous ways of life.<sup>15</sup> Modernity projects inevitably carried with them the belief that indigenous communities operated on out-of-date economic and social practices, and these sentiments continually crept into official rhetoric and instruction.<sup>16</sup> Many officials believed that indigenous groups had no understanding of either their right to health guaranteed in the 1917 Constitution or their obligation to elevate the health and economy of the nation. This elitist view of indigenous people as “reluctant citizens” negatively affected collaboration attempts in the 1920s and 1930s. (42) By the 1950s, public officials recognized the inefficiency of these unwelcomed programs and hoped to shift the dynamic toward more effective ends through active community engagement. As Ruiz Cortines’ pejorative concept of “interior colonization” indicates, however, the transition from top-down to more cooperative programs would not be limited to attracting local involvement. Instead, national, state and regional government officials would also have to rethink their relationship with rural workers before any meaningful change could occur.

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<sup>15</sup> See examples in Marcos Cueto, “Appropriation and Resistance: Local Responses to Malaria Eradication in Mexico, 1955-1970,” *Journal of Latin American Studies* 37, no. 3 (2005): 555; and Anne-Emanuelle Birn, “A Revolution in Rural Health? The Struggle over Local Health Units in Mexico, 1928-1940,” *Journal of the History of Medicine*, 53 (1998): 43-76.

<sup>16</sup> Cueto notes that “indigenous people were often perceived as disease carriers and their culture as an obstacle to health.”

#### 4.2.1 Philosophy of Community Development

The philosophical underpinnings of the *Bienestar Social Rural* program reflected several new strands of thought about community development and public health in Mexico and internationally. One was a shift from imposing public health initiatives onto communities to recognizing that community support and participation was necessary to sustain public health efforts. Dr. Gonzalo Aguirre Beltrán, a prominent Mexican anthropologist and deputy director of the *Instituto Nacional Indigenista* (National Indigenous Institute), advocated for the active participation of indigenous community members in public health campaigns. At the 1955 World Health Assembly in Mexico City, he argued:

All health programs require for their success and continuity the active participation of the community. Whatever progress is made along the road to better health ought to be achieved by the primary group through its own efforts, whether the going be easy or difficult. This assures the group that the objective which has been reached is the result of their own tenacity and, consequently, is a benefit which deserves to be retained. (32)

His speech, although made after the *Bienestar Social Rural* program was created, is useful in understanding the thinking behind the project. His comments were part of a growing academic criticism to the history of health promotion activities that attempted to uniformly transplant national programs designed by the *Secretaría de Salubridad y Asistencia* into rural areas. Without the cultural background and conscious collaboration of indigenous communities, these programs had been largely ineffective, Beltrán maintained.

Beltrán's speech represents a shifting tide in Latin America from intermittent rural health treatment to purposeful community development in the 1950s. (60) While countries including Mexico had a long history of encouraging community members to share the burden in providing resources and labor toward health improvements, the emphasis had largely been placed on offsetting state resources and providing volunteers to fill the void of qualified health workers. By

the mid-twentieth century, policymakers hoped that by actively engaging local groups to prioritize their own health needs, health officials could guide these communities in achieving genuine improvements that would be sustainable over time with closer linkages to the state and mainstream society. The result, they envisioned, would be wider acceptance and greater influence of government agencies in rural areas.

Dr. Fernando Escarza Martinez, *Secretaría de Salubridad y Asistencia* official and *Bienestar Social Rural* spokesman, hit upon this concept when he wrote that the nature of public health changed in the 1950s from disease treatment, environmental factors, and physical rehabilitation to also include the dignity and welfare of individuals, families, and communities. Building on the work of his colleagues, international scholarship, and World Health Organization concepts, Escarza Martinez linked health and well-being to the community using the following equation:

Health = Well-Being  
 Public Health = Community Organization  
 Social Well-Being = Community Organization  
 Social Well-Being = Public Health (106)

He believed that this shift in focus to the *salud colectiva* (collective health) was designed by international and national health professionals to ensure a happy, healthy and efficient standard of living for individuals and society; to instill the right to be healthy collectively and individually, and to strive for it; and to break the vicious cycle of poor health by addressing all factors of social life, including cultural, economic, and environmental. (106) He aimed to establish a national collective of healthy workers who contributed to the national economy and society, participated in government, utilized the social services provided by government agencies, and ultimately solidified the rural and urban areas under a national umbrella. This radically expanded definition of health served as the backbone to the BSR program.

Simultaneously a community development, national integration, and health promotion project, the philosophical underpinning of the *Bienestar Social Rural* program moved beyond previous health attempts to include the active participation and mobilization of community members. Not only were health officials offering individuals the opportunity to improve their own health, but they also gave them a stake in the health of the local and national community.

Dr. Jose Figueroa Ortiz, the first director of *Bienestar Social Rural*, incorporated many of these themes into a formal philosophy for the BSR program. He described this philosophy at the ninth Reunion of the Mexican Hygiene Society in 1955, maintaining:

Individual health is not just the absence of physical or mental illness. Rather, it requires that man is and feels well, adapts well to living in society with his peers, and has effective work that provides for his needs and makes him happy. (118)

He said that the goal of BSR was to stimulate development of the material elements required for economic life and social conjunction, and to offer families and communities solutions to “material and spiritual problems.” (118) He, along with other SSA officials, refer to the concept that:

Man is not an isolated individual, but a social being, living in both a family and community, adapting to the physical and interpersonal environment of a community constituted by the combination, not a mere continuation of, the various family environments. (118)

The emphasis of health promotion clearly shifted from the individual to the collective group. Based on the pilot projects of the program in 1953, Ortiz recognized that active involvement of all family members, including the father at work, the mother at home, and the children in school, determined the success of health promotion campaigns. Equally important, home, work, community, and the nation all contributed to an individual’s psychological well-being and affected social health at each level. Consequently, these previously distinct elements of community development became incorporated into BSR’s health initiative.

Ortiz hoped the program would strengthen Mexican society and its economy by promoting economic development, environmental sanitation, civic consciousness, social solidarity, a revitalized sense of nationality, interpersonal relations, and the direct intervention of the SSA. He also aimed for “the elevation of culture and education levels” of rural populations by introducing libraries, sports, artistic spaces, and classes on nursing, childcare, and nutrition. (118) Although low access to resources appeared to be the main hindrance to proper nutrition in rural areas, health professionals contended that cultural influences also played an important role. In one report, an SSA official contended:

[In] many regions of intense economic development...even if the income of rural families have been increased, the rural population continues to eat poorly, so it is easy to conclude that the cultural aspect should not be underestimated because deficiency in the diet for this type of population is due to ignorance and lack of habit. (132)

To address what professionals were calling a “cultural” problem, Ortiz stated that the BSR program needed to introduce modern food customs to malnourished indigenous groups. SSA officials, including Ortiz, did not acknowledge the evident contradictions between proposing a community-based program designed to meet local needs and continuing to make reference to the alleged cultural backwardness of these groups. By stating that indigenous communities lacked educational resources, Ortiz indirectly implied that he and his contemporaries looked down on existing rural customs and planned to impose a “superior” culture on these groups for their own benefit. As the principles of *Bienestar Social Rural* were put into effect, it would quickly become clear that underlying preconceptions such as these would have to be corrected in order for the program to truly become community-driven.

BSR officials often used “rural” as a euphemism for unassimilated indigenous groups. *Bienestar* education, health behavior, and economic development programs all pointed toward implementing modern advancements to seemingly backward people. Officials did not

acknowledge the cultural diversity or social and ethnic stratifications that resulted from the high number of mestizos who often also inhabited their target areas. Instead, they viewed these locations as homogenous and paternalistically approached them as a single unit. As a result, the terms rural and indigenous were used interchangeably in official reports.

At least in theory, Ortiz described integrating social and economic progress into prevailing indigenous culture. He cited the work of the United Nations Educational, Scientific, and Cultural Organization (UNESCO) as a prime example, maintaining that the organization encouraged national health officials to work within rural communities to “enable them to take their place in the modern world” and to “raise awareness of human dignity and develop a sense of cultural and moral solidarity of mankind.” (118) As a result, Ortiz called for cultural solidarity and a more inclusive modern model of citizenry into the BSR’s health agenda.

What distinguished BSR’s program from previous health promotion projects, he posited, was the level of community participation:

This is their distinguishing characteristic – the program should be considered necessary by the local community, not in a general planning sense, but happily engaged in the development and progressive expansion. The rhythm and dynamic of the project depends exclusively on the mobilization and participation of the community. (118)

Community members would be responsible for making the decisions, priorities, and implementation of programs for their constituents. Although SSA and BSR officials would be on hand to guide the development of these projects, it would be up to the community members to maintain and sustain the programs. Ortiz made a great case for community participation, and ultimately this concept proved to be the most effective means of mobilizing local groups.

#### **4.2.2 Goals and Objectives: The Program Outline**

With a solid foundation of international and national dialogues on modernizing health behaviors by incorporating economic, cultural, and social structures, SSA officials established

the *Bienestar Social Rural* program to actively engage indigenous community members in a new and lasting way. They drew on previous rural health campaign experience to evaluate why early efforts were poorly received and to propose alternate designs for making the BSR program effective. Given that their target populations resided in remote areas, the officials conceded that many communities were unaware of or uninterested in national solidarity. Consequently, they believed that indigenous groups had no understanding of either their right to health or their obligation as citizens to elevate the health and economy of the nation. In reality, many communities probably did have some awareness of these state-initiated duties, but were not compelled to put these responsibilities above their local allegiance. SSA officials diagnosed this divergence as being the result of inadequate government representation in rural regions. The main point of contact local groups had with national authorities were rural schoolteachers and emergency medical brigades treating diseases. These individuals, easily detected as outsiders, rarely established long-term relationships with community members, and accordingly had little to no affect in the countryside. The disjointed efforts of government departments, including the *Secretaría de Salubridad y Asistencia*, *Secretaría de Educación Pública* (Ministry of Public Education), and *Secretaría de Recursos Hidráulicos* (Ministry of Water Resources), meant communities might briefly encounter various emissaries throughout the year, but without any cohesive focus or program. The consequence of these dealings, BSR designers concluded, was the community's apathetic or even suspicious response to government initiatives. When community members did interact with these representatives, they stressed that employment and sustenance were higher priorities to them than education, irrigation, and sanitation. (60)

To address this lack of community interest in government programs, *Bienestar* officials aimed to develop wider-reaching social and economic projects that had more potential of



attracting community member participation than projects that focused exclusively on health.

*Bienestar* spokesman Escarza Martínez stated that the three goals of the BSR program were to 1) operate with the modern concept of health as provided by the WHO, 2) secure the active participation of rural communities in accepting their right to health and their obligation to fight for it, and 3) coordinate the programs and activities by government agencies to improve living conditions in rural areas, including education, agrarian reform, and industrialization. (107) The specific components of the larger program included orienting and educating community promoters on modern treatments; protecting mothers and infants by providing pre- and post-natal care; expanding social and communal public works programs; utilizing the human resources and materials of the community; and elevating education levels to improve nutrition, promote agriculture, establish healthy home environments, raise economic standards of living, and enhance the moral and civic spirit of the community. (9)

With programs designed to reach child-rearing mothers, hard-working fathers, and growing children, Escarza Martínez's detailed *Bienestar Social Rural* program description laid out an idealized portrait of community engagement. He reiterated, "Humans live with their immediate family, but also within the larger groups of society, community, and still more in a national community." (106) Furthermore, the value of health depended on the happiness and efficiency it produced by allowing individuals to meet their personal needs and fulfill "their mission in society." (106) Community participation, with assistance from federal agencies, provided a unique platform for incorporating nationalistic elements into the discourse. Escarza Martínez envisioned a program that empowered community members to organize social events, workshops, and health campaigns at local centers. In exchange for accepting social assistance and exercising their right and responsibility to be healthy, community members participated in

the national government as active citizens. And by participating in government programs, Escarza Martinez and other SSA officials hoped to strengthen the “*Mexicanidad*” of the community through patriotism and civic obligation. (107) Community promoters selected from within the community encouraged social support for the health and well-being of the nation. Rural education programs strove to create a spirit of national community in their students to replace their local affiliations. (122) Hernández Lira of the SSA concluded that the BSR program “is but a noble and patriotic effort to strengthen the lives of rural communities.” (16)

To carry out these objectives, SSA officials formulated the concept of BSR centers. Each center would be located in a rural community, defined as those with populations less than 2,500, that served as an economic and social hub for smaller villages nearby. Selected locations were distinguished as communities with predominantly agrarian economies, few public services (including limited access to potable water and sewer drainage), and minor distinctions between jobs and social classes. (132) BSR spokesman Escarza Martinez defined community as:

An association of individuals, families, and groups that live close together in a common setting, including a spirit of community and social solidarity, that share: resources, needs, problems, institutions, traditions, aspirations, interests and ideals. (132)

Together, these criteria implied a cohesive, egalitarian society that had little exposure to national development and public works programs.

The goal of the BSR centers was to become a base for community action. Each center would have a central administrative office, clinical space, and common areas for sponsored activities. Additionally, centers would serve a network of smaller, nearby communities with similar health problems. (107) Community promoters, recruited locally to serve as intermediaries between government representatives and community members, would staff the central office and work closely with BSR representatives to learn the program’s objectives. Their main task would

be to create culturally-relevant programs, mobilize the community to participate in them, and maintain the projects indefinitely. (133) BSR centers would erect small general surgery units, usually containing between 10 and 16 beds, and establish emergency maternity and pediatric units in the nearest hospitals. A troop of doctors, nurses, and community midwives would operate the on-site clinic. Additionally, two sanitary brigades would be assigned to each center to dispense medical care in surrounding areas. Staff for the brigades would include a medical chief, agricultural engineer, social worker, sanitary official, community promoter, and chauffeur. (9)

In addition to providing medical care, BSR officials determined six main themes for program development in the centers: maternal and child protection, sanitation, agriculture, cultural education, recreation, and basic necessities. (15) They laid out specific goals for each theme and designed a detailed plan to achieve them. Mother-infant clinics would work to gain the confidence of indigenous midwives through social activities. After establishing a relationship, the center could offer midwives opportunities to improve their techniques through modern scientific classes. Additionally, a trained obstetric assistant would work in each center to monitor newborns and post-partum mothers in their homes. Through this approach, officials hoped to significantly reduce infant mortality rates by providing hands-on treatment for health problems at the child's most vulnerable stage of development.

Public works projects in sanitation would improve standards of living at the household and community level. In individual homes, cement floors would be poured to replace dirt and windows installed to provide light and ventilation. In yards, latrines would be built and water pumps installed to supply potable water. In public spaces such as village plazas, the development of sewer drainage systems, water pumps, irrigation, streets, parks, and markets would sanitize and beautify the town. Community involvement in these efforts might include contributing a

third of the costs for latrine installations and overseeing their completion, and attending clinics and programs that trained them to understand their community's medical and sanitation programs while encouraging them to participate in health promotion campaigns to address these issues. (107)

A major component of all BSR center programs focused on socioeconomic development through agriculture. In his 1953 overview of the program's objectives, Dr. Ignacio Morones Prieto, then the Minister of Health and Welfare, highlighted "the intimate relationship that exists between social well-being and economic progress." (133) Socioeconomic projects included training community members to utilize government services, improve their agricultural yield through advanced techniques in land use, and promote handicrafts and production cooperatives to enhance small industry in BSR-designated areas. One important role for community promoters was to improve agricultural resources to sustain the regional economy. They would encourage small vegetable gardens, orchards, beehives, poultry and pig farming on a household scale as a way to affordably and sustainably improve family diets. Milk production and consumption would also be encouraged, as well as the incorporation of new agricultural crops, such as soybeans and chickpeas to improve the quality of available proteins. Community promoters would foster a spirit of economic solidarity by organizing artisans and small industry workers to collectively negotiate better prices, broader markets, and wider transportation networks. They would also encourage production of local food with quality and quantity controls, and teach families hygienic food preparation and preservation that did not violate local customs.

BSR officials developed cultural education and recreation programs to foster community spirit through shared activities. This included organizing opportunities to introduce rural parents and children to modern social programs such as sports and recreation groups, local theater

productions, youth clubs, parent clubs and child care. Center leaders would establish lecture rooms for discussions of community-suggested topics and build libraries to provide resources of local interest and to promote literacy. Integrating educational materials on topics selected by the SSA (e.g., sanitation, nutrition, hygiene, right to health) with those that appealed to community members, they hoped, would allow centers to non-intrusively bring new ideas into the region.

Finally, the BSR program aimed to address the issue of prevalent malnutrition in rural areas by providing basic necessities through breakfast programs for children. Designed to educate mothers on the preparation and preservation of nutritious meals for their families, the program would offer children and their mothers an opportunity to interact with each other and with center volunteers regularly. The free breakfasts were meant to lure community members skeptical of BSR programs, provide a valuable health service, and entice families to participate in additional activities within the centers. However, the program also required the delicate balance of not appearing like charity or insulting mothers about the way they fed their families.

Overall, initial plans for *Bienestar Social Rural* incorporated cultural, social, and economic projects into the health agenda. Project funding would be divided between the *Secretaría de Salubridad y Asistencia*, community contributions, and proceeds from the National Lottery. (9) Program leaders intended to establish a multidimensional initiative that improved living conditions and ways of life for rural communities. Not only would community members learn how to defend themselves against illness and disease, but they would also take the lead in protecting the community's well-being.

#### **4.3 Lessons from the Pilot Centers**

With a detailed program outline in place, *Bienestar Social Rural* officials established four pilot centers for a four-month trial beginning in the summer of 1953. The centers were located in

four rural locations: Tlaltizapán, Morelos; Villa Cardel, Veracruz; La Laguna, Coahuila y Durango; and Tamún, San Luis Potosí. These locations were selected based on “their anthropological, cultural, economic, and sanitary peculiarities.” (107) Although designed as a community health project, the descriptors of the four selected areas catered to their economic makeup more than their health problems and community interest. This fact hints at the underlying development priority for administrative officials above that of local participation. Tlaltizapán was an *ejido* in central Mexico with pre-Hispanic origins and, given its proximity to Mexico City, was an important location during both the colonial and national phases of Mexican history. Its main source of financing came from a *crédito cañero*, or a credit system from a sugarcane refinery. Villa Cardel was also an *ejido* with *crédito cañero*, but it was a relatively new city along the Gulf of Mexico that served as a commercial hub for its region. In the north, La Laguna was an *ejido* with a collective system of credit provided through the *ejidal* bank *Banjidal*. Tamún in the north central region had neither an *ejidal* nor credit system in place. (9) Together, the four pilot centers tested the effectiveness of the project programs in sustaining community participation and providing genuine improvements to the standards of living.

At the end of the trial period, the *Bienestar Social Rural* central office in Mexico City commissioned Dr. Isabel Kelly, an American field anthropologist for the Health Division of the Institute of Inter-American Affairs, to evaluate the pilot center in Villa Jose Cardel, Veracruz. SSA officials felt that this center had been the least successful in developing community participation and hoped Kelly’s years of anthropological experience in Mexico would allow her to appraise the community’s response within the local context. They also assigned two students from the *Escuela Nacional de Antropología e Historia* to accompany Kelly in order to gain field experience. Kelly and her team lived in the community for six weeks, underplaying their

affiliation with the BSR program and speaking with a wide variety of community members. They were particularly interested in “people that appeared to live in strained circumstances, feeling that it was they in particular whom the center was designed to assist.” (95) In the final week, they also hired local residents to interview families in the remote borders of the town. Given the prevalence of fatherless families among the lower classes, Kelly’s evaluation team members were exclusively women. They hoped this approach would help mothers in the community feel more comfortable relating their experiences. Kelly’s detailed report documented the successes and failures of the center, and made several suggestions for improvement when developing future centers. Her account provides a useful window into the program’s initial implementation and evolution.

Kelly described Villa Cardel as the commercial and political center of a coastal plain approximately 60 kilometers north of the port of Veracruz. Originally the heart of colonial occupation in the region, the town was formally established in the 1920s as a station on the Interoceánico Railroad. Kelly noted that Villa Jose Cardel was “an aggressive, rapidly growing, frontier-type town.” (95) Seven prostitution houses and over 80 liquor stores were thriving at the time of her visit. Although the majority of the population was young, undoubtedly part of the nationwide population boom in the 1940s, educational facilities were limited. Attendance in the main elementary school was high in first and second grade, but dwindled in further grades.

Two large-scale sugar refineries and the *Secretaría de Recursos Hidráulicos*’ (SRH) irrigation project in nearby La Antigua provided most of the town’s employment. The townspeople consisted of a large fluctuating population of short-term laborers, merchants, property owners, tradesmen, artisans, and unskilled laborers. Kelly found the city had a noticeable social stratification based on economic levels. Merchants and property owners

comprised the highest economic echelon, while sugar refinery and irrigation workers also enjoyed economic security and a level of social prominence. Unskilled laborers, tradesmen, artisans, and women comprised the lower economic groups and rarely interacted with their wealthier counterparts.

The town had a modern layout with a central plaza, but dusty, uneven streets lined with young trees and power lines. While wealthier families lived in brick or adobe houses with tile roofs, water, electricity, and outhouses, poorer families resided in houses built from planks and palm leaves, with dirt floors, no water, no electricity, and no outhouses. Potable water was expensive and often difficult to obtain. Prior to the introduction of the BSR center, the SSA's *Servicios Medicos Rurales and Servicios Coordinados* provided the area's only public medical services, along with two private practice doctors and two volunteer doctors. According to Kelly, the sugar refineries and SRH provided healthcare to their employees. She noted that the low number of medical services available signaled poor community health.

The first and perhaps largest problem Kelly discovered was the discrepancy between the urban realities of Villa Cardel (population 3,600) and the stated BSR ideal rural community. Given the criteria originally outlined by Escarza Martinez, Kelly concluded that Villa Cardel was too complex to be a good location for a pilot program. It served a large, urban population that lacked social unity. She argued:

Relative cultural uniformity within the community seems an important backdrop for the rapid and effective functioning of a Bienestar center. Such homogeneity is most likely to be found in a community—be it mestizo or indigenous—which has considerable time depth. It need not be sought in a settlement established only a few decades ago, by colonists from widely separated zones. (95)

Rather than working with a close-knit community tied to the land, Kelly maintained that the constantly shifting population of Villa Cardel meant that community allegiance was minimal.



The social stratification of society and lack of internal cohesion hindered collaboration. If one group went to the BSR center, another avoided it. Finally, local politics also undermined the function of the center. There was little support for the local mayor (*presidente municipal*), who acted as the self-appointed chairman of the BSR center. Many locals felt he was a foreigner, appointed by the governor, with no ties to the community or commitment to make improvements. Furthermore, Kelly recounted, the *presidente municipal* “pre-empted the [BSR’s] official jeep” for his personal use and left the center staff without transportation. (95) Rather than rallying community members to participate in the BSR center, the mayor made many locals even more disinterested in the program.

While health officials based the BSR programs on the idea that rural people possessed a strong sense of community based on a shared culture and way of life, regional studies published during the same period presented a different picture. Oscar Lewis, an American anthropologist conducting fieldwork in Mexico for the Inter-American Indian Institute, found that rural Mexican communities tended to be individualistic and argued that the combined influences of pre-Hispanic, Spanish colonial, and modern industrial civilizations in rural areas created “a wide range in the ways of life and in the value systems among so-called primitive peoples.” (98) His study of Tepoztlán is a useful comparison to the characteristics found by Kelly in Villa Cardel. Both cities were the commercial hub of their regions, were never isolated from state and local politics, were socially stratified based on class, and had established economies that combined communal and capitalist systems. Similarly, both locations had little village unity and apathetic personal and administrative relationships. Kelly maintained that these characteristics prevented BSR program officials from meeting their objectives. She contended that a proper BSR center location should be rural and small, with a culturally homogenous and stable population. Rather

than being socially stratified, the ideal community for a BSR center should be internally cohesive, with support for the local authorities, she wrote. Most importantly, the attitudes of the community members should be of interest and cooperation.

Precisely because the Villa Cardel center location did not meet these criteria, Kelly believed that its programs in turn were not successful in reaching poor families, the BSR's target population. The stratified society meant that community promoters were selected based on their prestige rather than their influence among poorer classes. As a result, the economically successful attended the center while the poorer groups did not. Elite volunteers, including the wife of the *presidente municipal* and her friends, hosted the children's breakfasts. Although this program sought to attract poorer households, lower class families saw the project as a charity and were therefore less interested in attending. The professional staff members, who were mostly from other towns, associated more closely with the upper strata than the people they were there to help. Kelly pointed out that center administrators approached lower class families more in the capacity of government representatives rather than peers. Working by the book instead of by personal relationships, staff members did not develop a sense of local needs and culture needed to improve their effectiveness. Combined, these actions reemphasized social divisions among economic classes and made the staff less influential in their campaigns.

Historian Mary Kay Vaughan found a similar class division in her study of rural schoolteachers in 1930s Mexico. (140) Teachers depended on community members to support their programs and permit their children to attend class. They also relied on the community for basic needs, including food and accommodations. At the same time, they were closely linked to the state, which provided resources and legitimacy for their efforts. Although teachers attempted to emphasize their ability to serve as mediators between the community and state, many

encountered local resistance to secular education and national ideas. Correspondingly, Christopher Boyer's scholarship noted that community members frequently felt that rural schoolteachers looked down on them and often chose to abandon their posts in favor of spending time in a nearby city. (38) Kelly's Villa Cardel study indicates that relations between state employees and rural community members continued to be strained well into the late 1950s. While the government sought new ways to engage with local groups, their long-standing attitude of superiority continually put off their intended audience.

Kelly's recommendations for the center focused on correcting the social stratification issue. While she agreed that programs well-attended by the middle and upper classes, including dressmaking and nursing, should be maintained, it was imperative that the center finds new ways to attract the poorer families. The best approach would be by determining the actual interests of these community members. In her interviews, Kelly learned that many poorer women wanted to learn math, how to tell time, and how to read. Literacy was particularly important. Both the anthropologists and the poorer women realized that it was key to understanding more advanced subjects. Given that most of these women were the heads of their households, they were interested in sewing, knitting, and crocheting goods to sell, and learning how to provide injections and conduct basic nursing methods at home. They were also interested in improving their opportunities for employment by learning how to type. They were not interested in cooking, one of the center's primary education programs, because they felt that they were already competent in this. Kelly argued that developing classes based on local interest could serve as bait to make the women feel welcome and gain interest in other programs. Classroom sizes should be kept small and separate from the more privileged groups, she advised. Organized sports, social

activities, games, and a playground would entice children to attend with their mothers and might encourage them to stay for programs of their own.

She also recommended the center hire permanent staff members without ties to other cities and with well-defined duties and sufficient wages based on their level of competency. She asked that the center's classroom be equipped with a wall clock, bulletin board, syringes, a tape measure, and professional equipment such as stethoscope and exam table. Kelly stated, "If the *Bienestar* center manages to give local citizens some national and international perspective, it will contribute notably to the integration of Mexico." (95) As a result, she suggested books, manuals, magazines, and newspapers be stocked in the library so that staff members could work with individuals to build their interests in different subjects.

Moving beyond her evaluation of the Villa Cardel center, Kelly also made general recommendations for BSR centers. Prior to selecting sites, she recommended a brief, intensive study be conducted of a prospective location to ensure that it meets the BSR's established criteria of a rural community. After a site was selected, she advised that a more detailed study of the cultural scene be prepared before the center started operating. Kelly contended that BSR officials needed to know the existing cultural patterns of an area to effect change:

After all, any program such as *Bienestar* is trying to change existing cultural patterns. Essentially, it is trying to substitute those we consider desirable for those we condemn as less desirable. This is delicate business, and in the process, cultural values may be destroyed. To change the normal course of culture growth means that, in a sense, we are playing God. It means that we are so sure that our culture patterns and our judgment are superior that we are trying to impose them. Whether or not we are justified in such conceit, one conclusion is self-evident. If we are trying to change existing culture patterns, it is only common sense for us to find out in advance what are the existing culture patterns. Otherwise, we are working blindly—even more blindly than necessary. (95)

To complete the initial phase of culture evaluation, she wrote, the center should identify key local persons to serve as promoters based on their level of influence in the community.

Classroom programs should be designed to attract the majority of families. Subsequent classes should fill the local needs and retain community interest. While SSA officials might object to the inevitable delay in opening centers while waiting for detailed cultural studies, Kelly maintained that it would be more economical in the long run to establish a center with a solid foundation rather than quickly assembling something that might not have any support. To justify her request for cost increases for staff and equipment, Kelly concluded that having “half a dozen centers, well founded, well supported, and operating effectively, are worth far more than half a hundred which are limping along unsatisfactorily.” (95)

Kelly’s work highlighted the initial problems faced in Villa Cardel and the potential for other centers to face similar problems unless the *Bienestar Social Rural* leadership redeveloped sections of the program. The continuation of top-down approaches to health treatment by center staff contradicted the well-defined goals of the BSR program. Furthermore, without establishing positive relationships with community members, healthcare workers in the BSR centers could not attract the level of community participation they set out to develop. Rather than bringing a village together around the common themes of well-being and national community, community promoters used their new role to gain professional advancement and local status. Collectively, the work of healthcare staff members, center leaders, and community promoters all failed to appeal to their intended audience or to improve the social health of the community. Above all, Kelly emphasized, “Success is the best possible propaganda.” (95) For BSR officials, success meant negotiating with community members to revamp their programs within local cultural context.

*Bienestar Social Rural* officials incorporated many of Kelly’s recommendations into their modus operandi for establishing future centers. This is most clear in the addition of detailed

cultural studies in possible locations prior to location selection. Addressing bigger questions of state and community relations, as well as between locals and staff members, took place in the second phase of the program.

#### **4.4 Implementing the Program on a Large-Scale**

In a 1954 presentation to the *Academia Nacional de Medicina*, *Secretario* Morones Prieto praised the work of the four original pilot centers and announced the SSA's intention to expand the program to communities throughout the nation. He stated:

This experience leads us to expand our program to areas even more varied than those chosen and throughout the entire republic. Our demographic distribution, with the large number of small towns that exist in the country and the difficulty to install health services, education, etc., in them, leads us to think about the imperative integration of larger communities, with an organization that will be self-sufficient. (122)

In order to help new centers achieve self-sufficiency, he noted that the program required additional coordination between scientific institutions, government entities, professional groups, and the active participation of all Mexican people. Given his vested interest in the success of the *Bienestar Social Rural* program, Morones Prieto put forward an idealistic vision for its expansion. He also proposed increasing the economic development process through a reexamination of the *Ley de Credito Agricola* (Law of Agricultural Credit). In the same way that the law authorized *ejidal* contributions to the *Banco Ejidal* (Agricultural Credit Bank) to help finance Rural Medical Cooperatives in the late 1930s, Morones Prieto felt the role of *ejidal* contributions should be extended to support BSR centers in developing local cooperative education programs, sports recreation centers, social and professional preparatory classes, and hygiene workshops. The contributions also helped to provide public works such as potable water and environmental improvements to reduce waterborne disease. (122)

Drs. Ignacio Chávez and Federico Gómez, prominent physicians who attended the *Secretario's* presentation, issued a commentary challenging his plans for extending the BSR program nationally. They maintained that the task to “Mexicanize” and incorporate three million indigenous people into the larger nation was a massive undertaking considering the diverse languages, customs, prejudices, religions, and cultures involved. Additionally, these people, according to the authors, produced and consumed little, and were as completely unaware of the national integration movement in the 1950s as they were in the three prior centuries. While they agreed with Morones Prieto’s suggestion to modify the structures of agrarian reform to widen the base of the social pyramid, they also expressed concern about the effectiveness of BSR pilot centers. They believed that these centers were established without the necessary economic cooperation, experience and contributions of other state departments. Prior to continuing, they argued, the SSA should unite with other government agencies to strengthen their effort. Finally, they stated that BSR community promoters must no longer be trained in local facilities but rather in a national school designed to teach them how to use the necessary authority to carry out their efforts without colliding with the present political system. (122) Their opposition to Morones Prieto alluded to a key discrepancy within the program. While the *Secretario* and his advocates followed the BSR principle of establishing centers to be self-sufficient, others focused on the larger bureaucratic goal of integration. Chávez and Gómez clearly felt that expansion required additional government collaboration and that state agents should supervise the training of promoters. In their minds, these communities were ill equipped to deal with health programs on their own and therefore sought to ensure the state’s active involvement.

The debate between Morones Prieto and Chávez and Gómez reiterated many of the issues raised by Kelly. It drew attention to the lack of local research conducted prior to establishing

pilot centers. It also showed that BSR officials did not seek out collaborations with other state agencies at a time when the national government encouraged consolidating resources. Finally, it pointed out the inconsistency between asking community members to establish programs based on local needs and the requirement of community promoters to attend state-sponsored training to ensure that the programs they administered complied with national objectives. In essence, hints of continued patriarchal sentiments overshadowing genuine health improvements started to become clear. This point is underlined by the insinuations of Chávez and Gómez that indigenous groups have been unaware of government initiatives for centuries. Notable dignitaries' continued portrayal of rural communities as ignorant implies that the individuals influencing national policies harbored a persistent interest in maintaining top-down approaches to public health while continuing to limit their resources for improvements. This lack of basic services, rather than an inherent inferiority, prevented indigenous communities from improving their health and well-being. Even though the SSA established *Bienestar Social Rural* centers to combat this exact problem, the first year of the program proved ineffective in removing these attitudes.

The debate also called attention to the growing chasm between BSR objectives and implementation. Morones Prieto stressed that it was crucial for each center to develop according to the particular needs of its community. He emphasized that they needed strong community leaders to prioritize the health problems of their members, understand the symptoms, and maintain active community participation in determining appropriate culturally sensitive resolutions. He maintained that BSR officials only served the centers in an advisory capacity, providing technical direction and materials as needed, but that community promoters themselves conducted the bulk of education and promotion activities. (133) Despite this, monthly progress reports from the centers only describe the accomplishments of BSR professionals. They refer to



promoters' work only abstractly and never mention a time when these local representatives assumed leadership in the centers. Ethnographic information from outside sources is similarly vague on this topic.<sup>17</sup> This either means that SSA officials were not interested in the work done by community members or that BSR officials did the majority of the work themselves. Both options contradict the established BSR objectives and imply larger core deviations.

For example, all local programs were purportedly planned and executed by mutual agreement of a BSR official and the community, and were mindful of the location's cultural, social, anthropological, and health considerations. (107) Yet, the SSA archives contain no written agreements or communication regarding any such mutual understanding. More likely is the possibility that BSR officials portrayed their relationships with local communities as being more reciprocal and accommodating than they actually were. This approach might have been necessary to support the program financially and politically until positive results could be obtained. Nevertheless, the reports give a distorted picture of early successes within BSR centers. The idea that a given community had the power to change its conditions of life based on its own interests, confidence, and participation certainly must have appealed to rural communities otherwise resistant to national interference. (132) Unfortunately, the competing economic, social, and political interests of national leaders diluted the process. The goals of the *Bienestar Social Rural* program meant to consolidate the health and well-being of rural communities with endeavors to integrate these groups into the modern nation, but in reality the economic strain and political repression of this period limited their efforts.

As government entities, the *Secretaría de Salubridad y Asistencia* and the *Bienestar Social Rural* program played direct roles in creating Ruiz Cortines' authoritarian state and in

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<sup>17</sup> See Oscar Lewis, *Life in a Mexican Village: Tepoztlán Restudied* (Urbana: University of Illinois Press, 1951); Robert Redfield, *The Little Community and Peasant Society and Culture* (Chicago: The University of Chicago Press, 1960); and Fernando Benítez, *Los indios de México* (México: Ediciones Era, 1967).

binding the Mexican public to it. The increasingly patriarchal nature of Mexico's political system, beginning with the institutional reforms of President Manuel Avila Camacho in 1940, solidified the influence of government policies in the daily lives of its citizens. During Ruiz Cortines' term, BSR teams actively exhorted center participants to acknowledge their role in national politics and the economy. While they maintained their position of addressing local needs, BSR officials simultaneously ensured that nationalistic rhetoric tinged every interaction with community members. Community promoters, trained to entice local residents into allowing previously unappealing economic and social programs, further perpetuated this linkage to government objectives. The BSR program's unique role as health care providers allowed its officials unfettered influence in rural communities. Even if communities expressed little desire to join in nationalist efforts, undisclosed links between the local and national economy, society, and political authority were slowly being established.

In spite of the fact that these contradictory motives were unresolved, the BSR program moved forward with its expansion phase in 1954. Between September 1954 and August 1955, forty-one new centers were established serving 415,000 citizens in fourteen states. (17) Local and state volunteers staffed the centers, along with a small group of professionals on hand to oversee the technical aspects of the projects. The rapid growth of the program compelled SSA officials to request a second evaluation of their centers in the spring of 1955. They commissioned the Health Division of the Institute of Inter-American Affairs to evaluate the newly established BSR center in the region of Los Tuxtlas, Veracruz. Specifically, officials sought to learn how well the center was integrating with the community and with other existing SSA programs in the area. Although *Servicios Coordinados* (Coordinated Services) began assisting Los Tuxtlas in the 1930s, infant mortality rates remained high throughout the 1940s and into the 1950s. Ninety-five

percent of children suffered from parasites, most notably hookworm, and respiratory ailments. Malnutrition and water shortages were also prolonged concerns. To address these largely treatable issues, the SSA founded a BSR center in the region's central town of Santiago in 1954. Isabel Kelly reprised her role as leader of the field study and joined forces with Héctor García Manzanedo of the SSA's *Dirección de Estudios Experimentales* (Division of Experimental Studies) for a nine-week investigation. Their final report supplies significant insight into the continued shortcomings of *Bienestar Social Rural*.

One of the first problems Kelly and her team encountered was the lack of local enthusiasm and participation in SSA programs. She wrote, "At the time of our visit, neither the Coordinated Services nor the Rural Social Welfare center enjoyed much popularity." (94) Her team believed that the addition of a BSR center in the area led to "considerable overlap in function and services." While both programs attempted to clarify their individual roles to community members within the first year of co-operation, "the earlier conflict and duplication have left the public understandably confused." (94) Part of this confusion was attributed to the shared personnel between the two programs. Many citizens were unclear which days staff members worked in each facility and how their roles changed depending on their assignment. To them, for example, it seemed pointless to establish a relationship with a pediatric nurse they might never be able to meet with again.

Kelly noted that the number of activities promoted by the center was too overwhelming for the community. She stated, "In view of the [BSR] program's wide range of endeavors, it has the problem of attracting people to the center and of interesting them in activities connected, directly or indirectly, with health." (94) She argued that recreation activities and other diversions were probably the best way to attract participants. Once local residents viewed the center as a

social community space, the team maintained, they would be more inclined to enlist in the health programs offered. Moreover, Kelly wrote, “Imposed ideas and undertakings, in the long run, are not likely to bear fruit.” (94) This finding emphasizes the lack of influence, and therefore investment, community members actually had in determining projects and priorities even though BSR officials still maintained that this was a primary objective of the program. In fact, the entire impetus for community participation revolved around the careful negotiation of power between BSR staff and local leaders. As long as BSR officials encouraged cooperation through community promoters, who attempted to create projects that merged regional interests with national objectives, locals would support and participate in the program. On the other hand, if community leaders felt that their needs were not adequately being addressed and their ideas were not getting the weight they deserved, they would dissuade their members from involving themselves with the center.

Another main concern for Kelly’s team was that some of the BSR programs were overly limited in scope. While the center offered first-aid classes for women, the men were not invited to attend the courses. This not only meant that they were less prepared to deal with emergencies at home, but as Kelly pointed out, many of the region’s men had recently been conscripted for military service and would benefit from rudimentary medical training. Along these same lines, children’s breakfasts conducted by the center provided thirty children with nutritious breakfasts over a period of three months. But surprisingly, mothers were not invited to join in the meals. As a result, none of the improved diet lessons were continued once the children completed the program. In a third example, the team observed that cooking classes were poorly attended due to the fact that the utensils, ingredients, and cooking equipment used in the center were drastically different from those in a typical Santiago household. The team suggested modifying the supplies

to replicate those that were already being used by families and to “emphasize dishes prepared from foods which are available locally, at reasonable cost.” (94) All told, SSA officials needed to adjust their aims for the BSR program to more directly benefit community members. Their idealized household picture contrasted sharply with their intended recipients.

Kelly concluded that, while local interest, participation, and implementation could be modified to address the team’s short-term concerns, BSR representatives had a larger internal contradiction that would take significant revision to properly address. She wrote:

[*Bienestar Social Rural’s*] very name indicates that it is designed for rural areas yet, as a rule, it establishes itself in the municipal seat, in the best buildings available, and, from that base, undertakes work in outlying rural areas. The situation is not understood by the local people and tends to result in criticism. (94)

Indeed, this observation is similar to her evaluation during the pilot phase of the program. In both cases, a sizeable discrepancy existed between BSR officials’ definition of a rural community and the selection of locations for actual centers. As long as representatives continued to establish centers in commercial hubs, rural community support would be limited.

While SSA officials no doubt read the report proffered by Kelly and her team, they also sustained a steady stream of interest in creating new centers. By August 1957, the BSR office had established 386 centers throughout Mexico. In an effort to keep up with this rapid extension, the program also expanded its training programs. Approximately 200 new recruits, including social workers, midwives, nurses, teachers, and graduates of agricultural schools and high schools, attended a series of four promoter training courses. The 300 existing community promoters continued their education through auxiliary classes. Nine regional seminars were held for promoters to exchange experiences and observations. In the centers, nearly 30,750 women attended sewing classes; 11,340 attended cooking demonstrations; 17,580 attended first aid courses; and 3,620 attended horticulture training. BSR officials showcased these numbers to

emphasize that all of these individuals became indirect agents of the program by passing on their knowledge to family and friends. (11) Community participation levels continued to rise over the next two years, and by August 1959, BSR offices received 2,328 commissions requesting new centers and the expansion of activities in existing centers. (18)

A deciding factor in continuing the development of BSR was the unexpected number of solicitations SSA officials received from rural communities requesting their own center. (18) Given the paternalistic and nationalistic nature of the program, the intention of these community leaders is not immediately apparent. In fact, Kelly's research showed rural support for centers to be minimal. Even so, historical patterns point to several potential objectives for their requests. First, Mexican indigenous communities have a long history of negotiation with state officials. Historian Peter Guardino's research examines the proactive role indigenous communities took in shaping the national state during the nineteenth century. Community leaders effectively balanced local traditions with modern laws to gain a voice in the political process. Moreover, they formed strategic alliances with politicians to ensure that their local concerns reached national attention. Guardino concluded, "These purportedly backward rural people displayed remarkable flexibility, subtlety and astuteness." (79) Similarly, Ethelia Ruiz Medrano's work explores the "ideological flexibility" of rural groups from the sixteenth to the twenty-first century. (110) Rather than strict adherence to a specific cultural or ideological framework, indigenous communities learned to incorporate a broad spectrum of ideas and identities to navigate state authority and maintain as much of their autonomy as possible. They utilized the resources available to them through laws, procedures, and cultural exchanges to pursue their objectives within the nationalistic political structure. Indigenous groups not only grew adept at being recognized as a community, but also used their community status to gain more collective rights and privileges over time. By opting to

request a BSR center in their community, local leaders could exploit the bureaucratic system to reconfirm their communal status in the midst of an increased push for national consolidation.

Second, initiating collaboration with government officials often gave community leaders a larger bargaining chip than waiting for intervention. For the most part, national politicians were primarily concerned with obtaining a spirit of collaboration with rural areas as part of their larger centralization process. For instance, Jeffrey Rubin's scholarship analyzes the negotiating relationship between a Zapotec grassroots movement and the central Mexican government in the 1970s. He concluded that the village he studied "coexisted with the outside, accepting a position within the nation rather than defining itself as separate and hostile." As a result, the village "gained considerable autonomy—a 'domain of sovereignty'—in exchange for recognizing the authority of the postrevolutionary state." (125) Many communities learned, on their own or through organization like the *Confederación Nacional Campesina*, that early cooperation with government officials could lead to more influence over the enforcement of new policies. In the same way, applying for a center might give community members more say in their level of participation and open the door to negotiating their degree of control over the program.

Third, indigenous communities rarely let their traditional practices prevent them from adopting new procedures that were value added. When they recognized the genuine benefit of modern techniques, inventions, or processes, they often incorporated them into their local customs and were willing to use community funds to procure them. Steven Palmer's study of public health in Costa Rica determined a "medical pluralism" existed in local villages that utilized the benefits of both folk and scientific medical practices. Palmer stated, "The relationship between popular and conventional practitioners was characterized by coexistence, complementarity, and dialogue more than outright rivalry and ideological warfare." (119) This

correlation points to the extension of indigenous ideological flexibility to include health practices and behaviors. Marcos Cueto found a similar medical pluralism developed in Mexican villages, “where Western medicine was accepted as a resource for some conditions and coexisted with traditional medicine.” (56) Furthermore, one of the primary benefits local communities received by acknowledging their national citizenship was the right to state healthcare. As a result of the Cárdenas administration’s renewed effort to safeguard the constitutional rights of communities, *ejidal* leaders began soliciting the government for local clinics in the late 1930s. (92) The legitimate health improvements offered by the BSR program, as well as the increasing local acceptance of constitutional rights to healthcare, might have been sufficiently enticing for leaders to actively solicit their own center.

In addition to medical care and health education, the economic development assistance offered by BSR centers surely tempted communities. In the first year of its program expansion, the BSR office established 144 communal and 3,900 family vegetable gardens. They built 86 small family poultry plants, 52 apiaries, and 15 agricultural experiment fields. Hundreds of thousands of orange trees and coffee plants were transplanted to home gardens. Over 300,000 trees were planted as part of a reforestation effort. Bakeries and small craft workshops were founded and job training sessions took place throughout the BSR network. All of these efforts helped create employment opportunities and expanded agriculture from sustenance to commercial production. (17)

The success of the *Bienestar Social Rural* program in appealing to communities demonstrates the insight health officials had in recognizing that community members wanted to participate in and lead projects that addressed local health needs. The program provided a platform from which state and community officials could work together and share the financial



responsibility for improving the collective health of rural villages. Over the life of the program (1953-1958), the *Secretaría de Salubridad y Asistencia* contributed 29,375,000 pesos directly and an additional 9,895,000 pesos through various indirect programs. The National Lottery provided 8,563,098 pesos toward child breakfasts and transportation vehicles. The remaining amount of the final budget, approximately 44,850,000 came directly from community contributions. (9) Regardless of how BSR representatives implemented their policies, program officials effectively engaged previously apathetic indigenous communities in national health services.

#### **4.5 Conclusion**

In 1958, SSA officials shifted the *Bienestar Social Rural* program from health and well-being to a more economic-focused project. They instituted a new wave of pilot centers directed specifically at field workers. These centers were established in five economically promising regions: San Blas, Sinaloa; Las Tuxtlas, Veracruz; Bajío de Tepalcatepec, Michoacán; Sierra de Hidalgo, Hidalgo; and Cacahoatepec, Oaxaca. Each center, in collaboration with the *Secretaría de Educación Pública* and the *Secretaría de Agricultura y Ganadería* (Ministry of Agriculture and Livestock), explored new mechanisms for mobilizing these agrarian communities. They hoped that the success of BSR centers, coupled with a growing sense of national patriotism, would entice agrarian communities to more fully participate in their own economic development. While continuing to include a health aspect to the program, BSR officials made a deliberate move toward improving commercial agricultural production and integrating rural farmers into the nation. (9) The results of this effort are difficult to obtain, but it is clear from the quick transition of the program back to a health focus within a year that it did not have a lasting impact.

In fact, by the mid 1960s, the BSR program merged into the SSA's larger *Instituto Mexicano del Seguro Social* (Mexican Social Security) program. (74)

Regardless of this dissolution, *Bienestar Social Rural* centers did achieve genuine rural health improvements. In his 1957 report to the SSA, Hernández Lira provided compelling evidence of the BSR program's expansion of health care access into rural communities. Mother-infant care centers developed in a variety of forms to meet the needs of their patients, including 10 regional centers, 354 centers affiliated with rural health facilities, 209 maternity-infant specific centers and 97 maternity wards in hospitals. Sixty small general hospitals were also founded with the capacity for 12 to 18 patients each. Furthermore, the nation was divided into integrated sanitary districts, each of which usually contained an urban health center, regional and local hospitals, urban and rural hygiene centers, one or more BSR centers, and auxiliary rural centers such as *Servicios Médicos Rurales Cooperativos* (Rural Medical Cooperative Services). BSR center leaders also collaborated with national sanitation and disease eradication campaigns, most notably the *Campaña de la Erradicación del Paludismo* to combat malaria. (16) SSA leaders' satisfaction with the overall project is reflected in the rapid expansion of centers and programs throughout the nation, as well as the significant budget increase from 700,000 pesos in 1953 to over 8,000,000 pesos in 1958. Statistically, the BSR program helped the SSA to reduce mortality rates from 21.9 per 1000 in 1941 to 12.5 in 1957. Infant mortality rates dropped from 123 per 1000 in 1941 to 84 in 1956. Deaths caused by diarrheal diseases dropped from 300 per 100,000 in 1951 to 180 in 1956 and mortality from pneumonia decreased from 117 to 80. In total, rural life expectancy was on the rise.

The economic development projects of BSR are harder to evaluate. Commercial agricultural production and artisan market expansion did take place, to some extent, but these

results were reached in association with many other development programs. Where BSR did accomplish real progress was in engaging rural communities to solicit and participate in collective health. By appealing to their constitutional rights, communal status, and general consensus, health officials secured the collective mobilization of previously apathetic local groups. This mobilization had the potential to effect real change in the well-being or *bienestar* of rural citizens. Yet, right at the moment where community participation and greater rural integration were within reach, the Ruiz Cortines administration reverted back to their economic development priorities. They did not provide adequate infrastructure, finances, or personnel to make centralized healthcare a reality. Rural community leaders arrived at the table only to find that Ruiz Cortines and his administration could not live up to their end of the bargain for community-led health programs.

## **5. THE INI COORDINATING CENTER: MIXTECA**

By the mid 1950s, prolonged high mortality and low birth rates in rural Mexico compelled national health authorities to collaborate with the newly founded *Instituto Nacional Indigenista* (INI, National Indigenous Institute) to offer specialized treatment to the nation's indigenous communities. *Bienestar Social Rural* centers, regional Coordinating Sanitary Services, and river basin projects like the Tepalcatepec Commission offered short-term care and disease prevention services to their targeted villages, but communities in harder to reach locations continued to suffer from lack of treatment. The *Instituto*'s mission to modernize indigenous cultural practices while respecting the contributions of community traditions presented a new strategy for effectively introducing Western healthcare to isolated areas. Anthropologists studied the language and customs of intended recipients and developed culturally-appropriate Coordinating Centers to fill the void of health and other social services in their villages. The success of their pilot center in Chiapas, established in 1950 with the goals of treating disease and improving living conditions in the area while maintaining the cultural integrity of local communities, encouraged *Instituto* officials to expand their program to other neglected areas in Mexico. In contrast to the experience in Chiapas, other coordinating centers were less effective in achieving health improvements and advances in economic development. The lack of resources and personnel, along with increasingly contradicting institutional policies of modernization and sustaining indigenous traditions, limited the long-term success of the program. In the short term, however, the *Instituto Nacional Indigenista* provided medical services and created a tentative alliance with the Mixteco community in the state of Oaxaca that

allowed them to continue working in the region throughout the remainder of the twentieth century.

*Instituto* officials selected the Mixteca region of Oaxaca for one of its early coordinating centers based on its underutilized fertile lands and large indigenous population. They intended to reallocate land use in order to maximize agricultural production and develop a manufacturing industry. This would not only provide food staples for the areas malnourished communities, but would also help to elevate the local economy by offering jobs and products to trade. National policymakers also expected to gain access to more import and export markets, and to incorporate community members into the state system. Anthropologists working on behalf of the *Instituto* were commissioned to integrate indigenous communities into the larger national society and acculturate the area by encouraging indigenous groups to adopt the health and education practices suggested by national policymakers. By understanding and appreciating local customs, anthropologists hoped to bridge state officials' modernization agenda with indigenous traditions to create a new unified effort against regional health and economic problems.

Poor sanitation and living conditions contributed to high mortality rates and low birth rates in the Mixteca. Primary illnesses included measles, malaria, whooping cough and pneumonia. Regional communities in Mixteca and throughout Mexico desperately needed vaccinations, potable water, and health education services to prevent these illnesses and restore health to the communities. *Instituto* officials felt that the combination of anthropological studies, cultural sensitivity, and local volunteers would ease community member acceptance of outside assistance. Like the *Bienestar Social Rural* program, the *Instituto* program designed coordinating centers to serve as new social and economic development headquarters in selected villages. *Instituto* officials similarly staffed their centers with *promotores culturales* (community

promoters), or volunteers recruited from within local villages. As in the Tepalcatepec Commission, healthcare providers, including both the community promoters and trained professionals, served as intermediaries between state agents and community members. Both the Commission and *Instituto* leadership decided to prioritize health treatment as the first step toward rural economic development. All three programs emphasized a collaborative relationship with indigenous community members. What differentiated the *Instituto Nacional Indigenista* from previous healthcare organizations was the broad strategy to incorporate cultural context into all of its programs as an institutional practice. Rather than testing the cultural sensitivity aspect to healthcare in one program like the *Bienestar Social Rural*, or discovering the importance of cultural context while implementing a new project in Tepalcatepec, *Instituto* officials made indigenous cultural factors and community participation essential to all of their efforts. The emphasis on anthropology underlined all of the INI's institutional and on-the-ground agenda. Lastly, *Instituto* officials used the level of a community's acceptance of Western medicine as a measure of its national acculturation. They believed that steering indigenous groups toward modern health and medical practices established a new cultural link between these populations and their urban equivalents.

The results of the Coordinating Center Mixteca show that a proactive cultural component to healthcare achieved positive short-term results and a new partnership with the community. Project coordinators and community promoters faced the impossible challenge of balancing state needs for economic development and rural integration with indigenous community priorities of maintaining local traditions. Limited funding, staff and community participation made it even more difficult to maintain the program over time. In contrast to the Tepalcatepec Commission and the *Bienestar Social Rural* program, however, INI officials continued to rework their efforts

in the Mixteca from the 1950s into the 2000s. Even though they still have not resolved the poor living and working conditions in the area, the *Instituto* and its staff are determined to maintain the alliance established with Mixtecos in the 1950s to push for state assistance and local collaboration to make these goals a reality.

## 5.1 **Introduction**

The idea for the *Instituto Nacional Indigenista* originated during the *Primer Congreso Interamericano Indigenista* (First Interamerican Indigenous Congress). This Congress, which took place in Pátzcuaro, Michoacán in April 1940, included delegates from fifteen Latin American countries and the United States. Together they agreed to form an *Instituto Indigenista Interamericano* (Interamerican Indigenist Institute) to solicit and disseminate information on scientific investigations, political legislation, economic development and sociocultural recommendations pertaining to regional indigenous groups. In addition to these hemispheric efforts, the Congress recommended that each participating nation establish an internal National Indigenous Institute to address the specific needs of local indigenous populations. While the government of then-President Manuel Ávila Camacho focused on its international obligations to the Interamerican Institute, the tide shifted to developing the national agency when Miguel Alemán took office in 1946. Over the next two years, Alemán met with a group of experts on indigenous affairs to determine the most appropriate form of organization to meet the Interamerican Institute's domestic requirement. Officials at the meetings advocated for coordinated action between federal, state, and municipal governments, along with specific organizations, to bring public works programs into isolated areas. Alemán's administration hoped that incorporating this plan into a new central agency would quiet international and

national indigenous criticism after he chose to close the ineffective Department of Indigenous Affairs (DAI) in 1946. (59)

On December 4, 1948, Alemán passed legislation formally creating the *Instituto Nacional Indigenista*. (90) As historian Steven Lewis explains:

Whereas Cárdenas and the SEP [Secretaría de Educación Pública] had attempted to ‘Mexicanize the Indian’ and incorporate them into the mestizo mainstream, the INI’s policy took its cue from [anthropologist Manuel] Gamio and aimed to respect and protect all ‘positive’ elements of indigenous culture. It promoted change only where it was believed that the indigenous would benefit. (99)

Accordingly, the primary goal of the *Instituto* was to become “an organization that studies and plans resolutions for providing basic necessities and utilizing the contributions of indigenous groups, who form an integral part of the nation.” (54) INI officials aimed to conduct studies on improving living conditions for the four million indigenous people living in Mexico while respecting their distinct cultural traits and community organizations. In doing so, they anticipated providing improved economic and social attention to these groups while also conserving the cultural heritage of the nation.

The INI was designed to be a collaborative agency that centralized previously disparate works in education, health, and agriculture by their respective agencies. Building on the work of the former Department of Indigenous Affairs, the organization’s primary functions included investigating problems relative to the nation’s indigenous communities, studying the methods and requirements for improving these communities, and promoting the application of these methods to the Federal Government. When policymakers chose to support a new initiative, *Instituto* officials oversaw the coordination of activities among various departments. They also formed a consulting body for official and private institutions, and published anthropological studies on indigenous communities. (54) The Director of the *Instituto* was appointed by the



President, and worked with a Council of representatives from the *Secretarías de Educación Pública* (Public Education), *Salubridad* (Health), *Gobernación* (Government), and *Agricultura* (Agriculture), as well as the *Instituto Nacional de Antropología e Historia* (National Institute of Anthropology and History), *Banco Credito Ejidal* (Ejidal Bank), university researchers and various scientific societies.

Although the aim of the *Instituto Nacional Indigenista* was to facilitate federal development programs in remote areas while maintaining existing indigenous cultures, the organization was established as a bureaucratic model that reported to national policymakers. As a result, INI concepts of community improvement carried with them the economic and social objectives of the government. In *México Profundo*, historian Guillermo Bonfil Batalla wrote, “The recent history of Mexico, that of the last five hundred years, is the story of permanent confrontation between those attempting to direct the country toward the path of Western Civilization and those rooted in Mesoamerican ways of life, who resist.” (25) While INI officials hoped to balance these two longstanding opposing sides, the reality, according to Bonfil Batalla, was “conditional responses to [indigenous] problems. The benefits to be provided to these Mexicans would be at the same time the instruments for their integration, that is, for their de-Indianization.” (25) Rather than calling for the preservation of indigenous customs, Bonfil Batalla criticized INI representatives for using healthcare and education to grease the wheels for a smoother transition of indigenous populations into the modern national culture. While his critique draws attention to the continuous state influence in *Instituto* integration activities, the early efforts of the *Instituto* were certainly innovative for their time. Never before had a Mexican organization synchronized and presented indigenous needs on a national platform. While their health, education, and economic successes varied by region, INI officials in the 1950s made

headway in areas previously opposed to or hidden from national infiltration. What they did once they were established in each community, however, depended on their ability to tackle the social conditions impeding economic development.

The *Instituto*'s primary tools for establishing relationships with indigenous populations were *Centros Coordinadores* (Coordinating Centers). With the help of local recruits and technical advisors, the centers focused on regional development including health, education, social assistance, agricultural improvements, and encouragement of rural artisans and industry. Each center maintained a professional staff of doctors, anthropologists, and agricultural specialists, and served as headquarters for sub-centers that were established in local villages. Four initial coordinating centers were established in Tzeltal-Tzotzil, Chiapas (1950); Tarahumara, Chihuahua (1952); Mixteca Alta and de la Costa, Oaxaca (1954); and Mazateca, Cuenca de Papaloapan (1954). These sites were selected because they were municipal centers that acted as a metropolis for a several nearby indigenous populations. By 1955, the centers covered 27,883km<sup>2</sup> and served a population of 381,471. (27)

Center directors were charged with the task of designing unique economic and social development programs to elevate community living conditions. They introduced new agricultural crops and established associations of producers and consumers to control prices and establish credit for seeds, animals, and farm implements. They also instructed community members on modern industrial techniques and promoted new types of industry. Agricultural specialists studied regional topographical challenges to land agricultural development and presented suggestions to exploit forests and pastures for commercial production. Sanitary engineers provided new community water sources and installed latrines. For health issues, officials established a central clinic with modern equipment that offered affordable pharmaceuticals and

treatments. Schools received first aid kits and health education training. Local volunteers administered vaccinations against smallpox and oversaw DDT spraying of individuals, homes, and clothes to prevent malaria. New peripheral health posts increased community access to emergency medical services. Culturally, officials believed that traditional “*conceptos mágicos*” or “magical concepts” were the main hindrance to indigenous understanding of hygienic precautions and scientific medicine. They worked to gradually change these local concepts of health and illness from supernatural to natural explanations. (90)

From this outline, four important contradictions between the *Instituto*’s foundational principles and community practice stand out. First, INI officials entered communities with a predetermined checklist of activities and benchmarks. While they touted the importance of their role as indigenous representatives and anthropological investigators, there was little on-the-ground consultation or assessment of community interests. Anthropologists did conduct regional studies prior to establishing a coordinating center, but center directors set up each facility using the same INI blueprint. (27) Consequently, even though indigenous areas commonly suffered from similar adversities, the lack of cultural distinction within INI programs contravened the basic premise of the organization. Center directors administered programs in the same manner as any other government unit and did little to differentiate themselves in the eyes of community members.

Second, all of the listed projects refer to introducing new ideas, techniques, and treatments. There is no mention of cultural preservation or “utilizing the contributions of indigenous groups” in any of the program objectives. (53) This feature, which is what INI officials hoped would distinguish their work from other agencies, was largely absent in program development. Bonfil Batalla’s evaluation of the centers exemplifies this discord:

It was true that in some cases impetus was given to the study of the culture and life situation of populations that inhabited the regions served by the Indigenous Coordinating Centers. These corresponded to the systems defined by [INI official] Aguirre Beltrán as ‘refuge regions.’ However, these investigations were not destined to found programs for the development of medicine, agriculture, or any other aspect of Mesoamerican knowledge. Rather, they were to establish diagnostic information for finding the best ways of introducing into Indian communities the corresponding practices from national, modern, Western culture. (25)

Center leaders did not incorporate ideas or priorities from community members into their program design. While the end result of these initiatives could still potentially improve local standards of living, INI programs revealed their close connection to national development projects over indigenous cultural preservation almost from the outset.

The best on-the-ground example of INI officials’ contention between modern and indigenous priorities can be seen in their education programs. The educational goals of each center included not only academic objectives but also the acculturation of villages. Elementary education centered on reading and writing in the local indigenous language as a stepping stone toward teaching reading and writing in Spanish. Rudimentary math, care for crops and domestic animals, and hygienic instruction were also included in the lessons. Media such as films, cartoons, and puppet theaters were utilized to provide visual aids to students. In addition to classroom instruction, bilingual teachers spent time training adults and children to adopt the idea that they were not just part of the local community, but were also citizens of their state and nation. These teachers, or community promoters, were selected from within their community to help facilitate the Institute’s goals. Social scientist Arthur Rubel explained that these individuals were selected based on “some considerable motivation to become closely identified with Mexican national culture.” (124) In other words, promoters were usually ambitious young men with an interest in learning beyond the limited education provided in their villages. Once accepted into the program, Bonfil Batalla adds:

The best would be picked, removed from their communities, and taken to 'civilized' surroundings... There they would be submitted to brainwashing, as a result of which they would recognize the inferiority of their own culture and the superiority of national culture. Finally, they would be returned to their place of origin, now converted into 'agents of change.' (25)

While Bonfil Batalla's analysis carries strong notes of disapproval, in the case of Chiapas these individuals found ways to engage local involvement where other state officials had failed. (99)

Once they completed the training program, promoters returned to their villages as bilingual school instructors and encouragers of participation in INI-sponsored projects. Center directors hoped that these individuals would become an important resource for both community assistance and tacit national integration. (90) Conversely, as the Mixteca case will show, this outcome did not always occur and promoters could quickly become displaced within their own community.

Further complicating the balance between state and indigenous interests, INI official Gonzalo Aguirre Beltrán noted that the intercultural reality of these rural communities made it difficult to distinguish between someone of mestizo or indio origin. Even though mestizos typically lived in the regional center while indigenous were pushed to the periphery, they shared social and economic interdependence. Taking action in one community, such as land reallocation or redirection of the central water supply, could indirectly harm another. As a result, centers aimed their activities on development programs that would benefit both groups. Beltrán wrote that many previous intercultural activities sponsored by government agencies ultimately benefitted mestizos and the metropolis more than their indigenous counterparts. The advancements proffered by government officials in the 1940s focused on replicating the economic, sanitation, and cultural accomplishments of the nation's large urban areas. As these initiatives made their way into rural areas, mestizo culture and metropolitan location helped expedite the acceptance of new ideas in these groups more quickly than among the indigenous.

In contrast, Beltrán maintained that the goal of the INI would be to directly benefit indigenous communities through specialized attention to local development, recognizing that these efforts would also benefit the region as a whole. (26) What Beltrán neglected to add is this approach also blurred a center's target population. Not only were indigenous cultural beliefs being deemphasized in INI programs, but in areas where populations were more evenly divided between indigenous and non-indigenous, INI officials adopted more generic methods for regional development. This not only further aligned the coordinating centers with state economic objectives, but in the case of the Mixteca also drew unanticipated resistance from mestizo groups.

Fourth, the seemingly unique qualifications of anthropologists to take on these initiatives were not always beneficial in practice. According to Alfonso Caso, the *Instituto's* first director, centers were administrative instruments designed "to elevate the levels of acculturation of indigenous groups which has been established in order to promote their integration into the economic and social life of the nation." (90) INI officials aspired to use the centers as a way to introduce technological and industrial elements in isolated areas while conserving preexisting aspects of indigenous culture, as long as the cultural traditions did not impede improving living conditions for the indigenous or mestizos. The solution to balancing local traditions with modern advancements, according to Beltrán, would be to gradually integrate cultural change. He asserted:

The main tendency in regard to action in indigenous areas is to promote cultural change, introducing a process of acculturation in underdeveloped indigenous communities, as a first step toward integration in the grand national community. (26)

While cultural change had been a prominent idea among several public works organizations as part of their larger national integration agenda, Beltrán argued that what would distinguish the

work of the INI from these other units was their reliance on anthropological studies to determine the most appropriate approaches to carry out their goal. He stated that most of these remote groups successfully resisted four centuries of attempted changes by Spanish and Mexican officials. He went on to add that anthropologists were essential to guide INI officials in determining the best practices for introducing new ideas without enticing resistance. He maintained that these specialists understood the cultural differences, distinct moral values, aesthetics, religions, and processes for intercultural cohesion. In fact, to become a center director, an individual had to be an anthropologist. As a result, Beltrán hoped they would be able to reinterpret modern industrial and cultural elements in the context of indigenous culture. (26)

In general, the role of anthropologists in social sciences significantly increased during the 1950s. INI officials, as well as other national organizations, utilized the expertise of these professionals to augment their work in local communities. Their findings provided valuable insight into cultural histories among indigenous groups. However, despite being armed with background information collected through case studies, many officials working in these rural areas encountered resistance or apathy from indigenous peoples. Local communities often declined the modern advancements being promoted by the *Instituto* until disease and impoverishment forced them to capitulate. As a result, balancing the INI's simultaneous goals of modernization and cultural preservation proved to be a difficult challenge for its officials, and, as a deeper analysis of their work will show, led only to short-term improvements.

## **5.2 Problems in the Mixteca**

In the fall of 1949, the recently established *Instituto Nacional Indigenista* sponsored a study of economic and social problems among the Mixteca population in the state of Oaxaca. Conducted by economist Moises T. de la Peña, the organization hoped to use this investigation

of the region's extreme poverty and high migration rates as part of a larger analysis on indigenous life in Mexico. De la Peña's findings emphasized economic disparities between rural and urban environments, and attributed these to the impoverished living conditions resulting from inadequate social welfare in indigenous areas. He encouraged *Instituto* officials to petition President Miguel Alemán Valdés for executive action to:

Solve the national problem that the majority of the population were poorly located and wasting the richest natural resources, while the nation is floundering in poverty of irreducible appearances. We believe that national policy should be directed to condition and make accessible and attractive the most exploited areas and thus facilitate the resettlement of the surplus population of the plateau, the paths to guide the most successful economic and social development of México. (61)

Consequently, members of the *Instituto* took active steps to increase national awareness of the poverty of Oaxaca's rural communities and to establish programs that fostered economic development and resettlement in the Mixteca by addressing the social needs of the indigenous population.

The *Instituto Nacional Indigenista*'s leadership selected the Mixteca region as the best representative case to study because of its diverse climate, geography, economy, and social conditions. In 1949, Mixtecas formed one of the largest indigenous groups in Mexico. (84) They accounted for 36% of Oaxaca's 433,704 inhabitants and occupied 34% (31,918 km<sup>2</sup>) of its land. Of this group, nearly half spoke only indigenous languages. (61) Other indigenous groups, including the Triqui, Nahuatl, and Amuzgo, along with mestizos and blacks also comprised the region's multiethnic population. (123) Climate and geography varied among the region's three primary environments: the cold, mountainous *Mixteca Alta*, the mild hills and valleys of the *Mixteca Baja*, and the warm flat lowlands along the *Costa*. Intricate waterways weaved throughout the *Mixteca Baja* and *Mixteca de la Costa*, and contributed to widespread flooding during the late May to early November rainy season. De la Peña's study noted that, while the



*Mixteca Alta* had high population rates with few natural resources, the *Mixteca Baja* had abundant natural resources with fewer inhabitants. (61) This dichotomy, he contended, resulted from the large portion of indigent residents overtaxing the natural resources in the *Mixteca Alta*.

To help correct the imbalance of resources per person, and therefore improve economic conditions in both areas, de la Peña encouraged national politicians to make the low fertile lands of the *Mixteca Baja* more accessible and attractive to inhabitants of the *Mixteca Alta*. He stated that the *Mixteca Alta* only had enough land to grow one-third of its agricultural needs. Conversely, land in the *Mixteca Baja* could potentially double its agricultural production and accommodate a small industrial economy if it could attract additional workers. By populating and exploiting the natural resources of the *Mixteca Baja*, de la Peña hoped indigenous groups could improve the economic and social development of the state and of Mexico. (61) He asserted that the *Mixteca Baja* areas of Jamiltepec and Juquila, low hill lands almost entirely occupied by community-owned *ejidos* and *comunales*, were eager to accept new members wishing to establish residence there. He believed an influx of new workers would diversify agricultural production beyond corn and beans to include tobacco, chile, and sugar. He also thought extra hands would help build irrigation and transportation systems and thus allow for trade expansion.

De la Peña felt that the leaders of the Comisión Nacional de Colonización (National Commission of Colonization), established in 1946 by President Alemán to develop good quality land in idle areas, should oversee an agreement between *Mixteca Alta* members willing to relocate and their *Mixteca Baja* counterparts. (129) He recommended appealing to *Mixteca Alta* workers to help expand *Mixteca Baja* industry by providing them with attractive salaries, comfortable homes, and well-balanced diets in the hopes of acclimating them to a higher standard of living and encouraging them to permanently resettle in the *Mixteca Baja* region. In

exchange for helping *Mixteca Baja* communities establish silos and industrial plants, new settlers from the *Mixteca Alta* would be given bank credit to relocate their family and belongings, build an economical and hygienic home, and obtain a piece of redistributed land to contribute to regional agriculture. (61)

Beyond land and population redistribution, de la Peña called for large-scale public works programs to make both the *Mixteca Alta* and *Mixteca Baja* regions more economically stable and attractive to potential immigrants. He hoped to improve communication and trade routes by building roadways to connect towns throughout the region. Schools and hospitals, along with access to potable water, were listed as crucial to the social development of the Mixteca. Economically, he recommended broad agricultural and forestry programs in the *Mixteca Alta*. This included agricultural experiment fields, cultivation development projects, soil conservation, and the popularization of fruit, fodder, potato, cactus, agave, poultry, pigs, and cattle. For the *Mixteca Baja* region, he emphasized industrial plants and agricultural technology improvements to help expand the erratic development initiatives already in place. His overall goals were to raise the standard of living for the entire Mixteca region, encourage indigenous and mestizo inhabitants not to emigrate outside of Oaxaca, and fully incorporate the area into the exchange economy by “*un rápido proceso de mexicanización*” or “a rapid process of Mexicanization.” (61)

Specifically, de la Peña’s study linked the region’s poor economic and social conditions to the rampant sanitary and health problems affecting its inhabitants. He maintained that health issues were perpetuated by an overall lack in social welfare services, and that an organization like the *Instituto Nacional Indigenista* should coordinate these programs by collaborating with other government agencies. While the *Mixteca Baja* population rate increased 18% between 1930 and 1940, the *Mixteca Alta* only increased 5%. De la Peña attributed this disparity to high

emigration rates, low birth rates, high mortality rates, and extreme poverty in the *Mixteca Alta*. Furthermore, his team determined that medical coverage throughout the Mixteca was insufficient. Only seven villages in all eleven districts had a doctor. Although the state of Oaxaca received 20-30 medical interns each year, the *Mixteca Baja* only received one or two and the *Mixteca Alta* never received any. The interns reportedly refused to provide service to the *Mixteca Alta*, where healthcare was most needed, because there were no doctors onsite to train them. De la Peña concluded:

In their service, interns visit wealthy towns where there is often a doctor or two already. As a social service that should preferentially be responding to poor areas without doctors, it is clear that government subsidies are needed [to help correct this].” (61)

He petitioned INI officials to appeal to the *Secretaría de Salubridad y Asistencia* (SSA - Ministry of Public Health and Welfare) for government-subsidized training of interns in both the *Mixteca Alta* and *Mixteca Baja*.

With additional hands, INI workers could then begin to address the health crisis taking place throughout the Mixteca. The most common diseases in the *Mixteca Alta* during the 1940s included whooping cough, measles, chickenpox, colds in the winter, pneumonia and intestinal diseases in the rainy season, and outbreaks of typhoid. In the *Mixteca Baja*, malaria, measles, whooping cough, the tropical skin disease mal de pinto, and goiter were the most prevalent. By the time of his study, de la Peña found that state-sponsored mobile medical brigades, *Los Servicios Sanitarios Coordinados de Oaxaca*, did not provide adequate medical service to treat the needs of patients. Nurses conducted house visits and offered free injections and other drugs as available, but had no resources to provide treatment or care beyond this. As a result, the majority of inhabitants continued to rely on local healers and home remedies. De la Peña surmised that, while both state and federal governments made efforts to expand regional health

services, these appeared to be a “a drop of water in a furnace” compared to the vast needs of the Mixteca population. (61) De la Peña’s conclusion that a large-scale development initiative was needed to collectively address the prevalent health issues and the economic and educational opportunities available in the Mixteca prompted leaders of the *Instituto Nacional Indigenista* to initiate a modernization program in the region. Over the next decade, INI representatives worked with national, state, and local organizations to establish an administrative model that would serve the needs of the Mixteca community and carry out the development goals formulated by de la Peña. They incorporated his socio-economic study, along with agricultural, anthropological, and medical assessments from other INI agents in the region, into a localized project in Jamiltepec that focused on improving indigenous health as a stepping stone toward larger economic and social development. (123)

### **5.3 Coordinating Center: Mixteca**

The economic potential of the Mixteca, as identified by de la Peña, coupled with the high percentage of impoverished indigenous groups living in the region led INI officials to establish two coordinating sub-centers in 1954: Jamiltepec in the Mixteca Baja and Tlaxiaco in the Mixteca Alta. Rafael Mijangos Ross, the Jamiltepec center’s first director, summarized the geographic and ethnographic factors he encountered during his initial year of service. Given the diversity of ecologies, the *Mixteca Alta*, *Mixteca Baja*, and *Mixteca de la Costa* had a longstanding tradition of trading crops and raw materials. Regional communities established a rudimentary network of animal cargo trails in the colonial period to ensure agricultural products reached the *Mixteca Alta* in exchange for artisan goods, especially sombreros, to the *Mixteca Baja* and *Mixteca de la Costa*. Difficult routes to other states contributed to underdevelopment in the seventeenth to nineteenth centuries, as well as high prices for imported manufactured goods

and fuel in the twentieth century. The rocky mountainous areas were as impassable as the flooded lowlands. (123) Both factors hindered road development and limited access to the 800 pueblos identified in the area. As late as the 1950s, only a small percentage of the population had access to the International highway. (83) The intricate waterway system made ship boarding and landing maneuvers costly and treacherous. Air transportation was successful when skies were clear, but services were often suspended when the six-month rainy season caused atmospheric disturbances and poor visibility. (123)

According to archeological, ethnohistorical, and linguistic studies, humans began occupying the Mixteca region around 7000 B.C. Descendants from the otomangue family, Mixtecas began culturally and linguistically distinguishing themselves through glyphs and ceramics between 200 B.C. and 800 A.D. In the Prehispanic period, the region was densely populated with an estimated 1.1 million inhabitants. After colonization, however, many of these individuals quickly disappeared. Not only did the Spanish bring changes to the economy and political and social structures, but also widespread epidemics wiped out much of the Mixteca demographic. Agricultural areas were transformed into grazing pastures or new colonial towns. (67) The Mixteca who survived participated in early international economy by mining the area's gold and silver for Spanish extraction. Additionally, the European demand for cochineal quickly developed Mixteca commercial production. Nevertheless, by the sixteenth century, Spanish authorities took control over both the mining and manufacturing industries, forcing the inhabitants into manual labor. Spanish exploitation during this period led to longstanding ecological degradation, soil erosion, abuse of natural resources, and the impoverishment of the Mixtecas through disease, hunger, and disorganization. These setbacks initiated a tradition of

migration away from the region as inhabitants sought better opportunities for work, food, and housing. (114)

Anthropologists found that cultural variations also fell along regional lines.<sup>18</sup> Most Mixtecos identified with their location, usually a town or village, more than their ethnicity. Inhabitants of the Mixteca de la Costa, for example, most closely maintained the traditional language and clothing of Mixteca ancestors. Villagers in the Mixteca Alta and Mixteca Baja zones modified these into their own local customs over time. Shared Mixtec medical beliefs were largely a blend of indigenous traditions and Spanish medical concepts. While they learned to recognize the pragmatic symptoms and classifications of common diseases, including malaria, typhus, and dysentery, many Mixtecos maintained longstanding beliefs that these illnesses were linked to hostile spirits that constantly watched them. As anthropologist Cornelia Mak observed, “a large part of Mixtec ‘preventive medicine’ consists of placating spirits.” (104) Many believed a spirit beating the patient caused dysentery and diarrhea. Malaria was attributed to soul loss, or the spirit’s capture of an individual’s soul for an indeterminate amount of time. Typhoid and typhus were ascribed to outsiders, such as research teams, bringing the diseases to the village. Infant mortality was attributed to children being snatched and beaten by evil spirits. Ailments with “hot” or “cold” qualities, including broken limbs, chest ailments, and sore throats, had correlating home remedies. Given the spiritual aspects associated with disease, Mak showed that medicine men and women were consulted only in cases of persistent sickness or illness attributed to supernatural causes. In all other cases, home remedies were applied. (104) These beliefs remained prevalent throughout the Colonial and National periods, and would be a constant challenge for INI officials upon their arrival in the mid-twentieth century.

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<sup>18</sup> See for example, Sherburne F. Cook and Woodrow Borah, *The population of the Mixteca Alta, 1520-1960* (1968); Barbro Dahlgren de Jordán, *La mixteca, su cultura e historia prehispánicas* (1954); Jeffrey P. Blomster, *Etlatongo : Social complexity, interaction, and village life in the Mixteca Alta of Oaxaca, Mexico* (2004).

In keeping with de la Peña's model for regional development, the *Instituto Nacional Indigenista* established the Jamiltepec coordinating sub-center in the *Mixteca Baja* not only to serve the local community but also to make the area more attractive to residents in the overpopulated *Mixteca Alta*. Sub-center director Mijangos Ross worked alongside a team of technical advisors from the *Secretarías de Educación, Salubridad, and Agricultura* to help address the *Mixteca Baja*'s economic, social, and cultural problems. Additionally, the *Secretaría de Comunicaciones y Obras Públicas* (Ministry of Communications and Public Works) assigned a designer to develop a road construction plan. State representatives and delegates from local communities completed the Director's advisory group. (90) Together, they planned to provide roadways, potable water, hospitals, schools, agricultural experiment sites, irrigation, and electricity. They also hoped to expand fruit and vegetable growth in the higher regions while advancing industrialization in the lower areas. (83) The sub-center had a staff of four administrators, ten health officials (five of whom were indigenous), nine local cultural promoters, and two non-indigenous education specialists to carry out these aims. (123)

According to a population survey conducted in 1949, Jamiltepec had 53,383 people spread over its 3,566km<sup>2</sup> area. Of these, 39% spoke only indigenous languages. (61) In addition to Mixtecos, who accounted for half of the area's population, blacks, mulattos, mestizos and a small group of indigenous Amuzgas resided in the region and helped to create a large intercultural setting. (123) Jamiltepec also held the largest numbers of *ejidatarios* in all of the Mixteca – 224,640 out of 375,311 total. While the *Mixteca Alta* region divided their land into *comunales*, this was uncommon in Jamiltepec, with only 1,930 *comunales* out of 363,889 total. (61) This meant that portions of arable land were still available to turn into small private properties. Jamiltepec was also the only region to practice irrigation in the Mixteca. Contributing

factors to this included its variable land, including valleys and plateaus, and good water sources from the abundant river systems. Beans and corn were the primary agricultural crops and diet staples. (61) Given its central location, diverse population, unique land distribution and utilization, and opportunities for expansion, Jamiltepec fit de la Peña's model of a regional center in the *Mixteca Baja* that had the potential to attract inhabitants from all three areas of the Mixteca.

When Mijangos Ross arrived in 1954, the *Mixteca Baja* suffered high rates of mortality and morbidity due to the extensive spread of measles, mumps, whooping cough, typhus, goiter, and mal de pinto. Sanitary officials working in regional hygiene centers had little success in treating these diseases due to their faulty medical equipment, lack of medicine, and low remuneration. The main sources of these illnesses, according to Mijangos Ross, stemmed from inadequate water supplies and lack of human waste control. Animal troughs, washing basins, toilets, and drinking water were all in close proximity if not shared as the sole water source. He reported to INI headquarters that finding solutions to this problem would be the first priority of the new sub-center. (123)

To prepare the region for economic development, Mijangos Ross and his team needed to address the health problems affecting its inhabitants. Campaigns to inoculate residents with the smallpox vaccine and to conduct residual spraying of DDT to control malaria began immediately. The sub-center's sanitary official met with community leaders to discuss his public health plans. Joined by two bilingual nurses, the official spent over an hour explaining the existence of the *Instituto Nacional Indigenista*, the installation of the sub-center and its role, the government goal to improve living conditions of indigenous groups and rural populations, and the health services offered by the center. The next day, the team hosted a large exhibition of



scientific medical work as practical solutions to health problems initiated by evil spirits. The team realized that locals would have more faith in the health officials if they acknowledged the supernatural aspects of illness. This effort to include local medical beliefs was well received by community leaders, who agreed to communicate with local families that the presence of these strangers in the area, as well as in their homes, was acceptable. In exchange, health officials agreed to solicit verbal agreements from each household before entering or DDT spraying. Additionally, movies sponsored by the World Health Organization and translated by community promoters informed residents about vaccinations, potable water, latrines, and personal hygiene.

(123)

The result of these efforts was a primarily cooperative relationship between officials and the public. The immediate results of DDT sprayings in reducing previously constant attacks by roaches, scorpions, chiggers, fleas and wild rats reportedly erased much of the initial distrust community members felt toward the campaign. Health officials also noted elevated participation in inoculations after offering explanations on the protections provided by the treatment and consequences for not receiving treatment. Even so, these workers did encounter some amount of local resistance. They reported cases of indigenous, black, and mestizo families fearing that insecticides also killed humans. Many adults felt that the pain and fever side effects of inoculation were worse than their symptoms or that they were too old to be protected from disease. Opposition also came from local healers, who begrudged competition from strangers and used their influence to dissuade residents from accepting scientific treatment. Finally, mestizos, were noted as being the most resistant. According to INI reports, mestizo merchants hesitated to accept any form of state health services as part of their larger goal to remain isolated and insulated from national authority. They wanted to protect their level of influence in the area, and

felt that new roads and services would bring new investors to displace their businesses and compete with their market prices.

Along with these more general forms of opposition, certain center employees were particularly unpopular. Cultural promoters, handpicked by INI officials to serve their community as intermediaries, were often unwelcome when they returned from training. Indigenous populations expressed doubt in the technical capacity of the promoters. Until recently, these individuals had shared the same community background and beliefs. The quick education of community promoters by the *Instituto* did not convince locals of their newfound preparedness to effectively understand and explain complex medical concepts. Rural mestizo schoolteachers and other non-indigenous personnel faced additional hostility for their inability to speak Mixtec, and prompted intensive language courses offered by the *Instituto* to correct this. (123)

Even with these setbacks, officials in the sub-center Jamiltepec completed many of their primary aims in their first year of service. In collaboration with the *Mixteca Alta* sub-center in Tlaxiaco, INI health officials provided 38,294 smallpox vaccinations; 23,172 individual and 4,498 house DDT sprayings; 4,268 medical consultations; 169 dental extractions, and 367 hair cuts to treat lice. Wells, water fountains, and human waste systems were all under construction, along with two new roadways connecting the region to the coast and state capital. New agricultural techniques, including use of the plow and heavy equipment, and cultivation of new fruits set economic development plans in motion. All told, Mijangos Ross and his sub-center team felt they achieved the first steps toward genuine progress and assistance by 1955. (123)

In September 1956, the sub-center hosted a second meeting with indigenous leaders in Jamiltepec to discuss their expanding health agenda. They worked to persuade these dignitaries that their aims remained altruistic, to reiterate the benefits of scientific medicine, and to suggest a

social plan for introducing hygiene instruction, crop organization, and kitchen fireplace construction in homes. Center officials ensured the leaders that they would not attempt to launch initiatives by force or coercion, and requested support to promote participation and cooperation among their respective constituents. Although there is no documentation regarding the leaders' deliberation over these matters, within the same month INI officials reported building five small vegetable gardens, 44 indoor fireplaces, two communal latrines, and 15 trash incinerators with local cooperation. One neighborhood, according to the report, had 30 families gathering materials to build a well. Health staff began teaching families basic hygiene, especially with regard to children. Nine pregnant indigenous women agreed to receive clinical care and three newborns received clothing from the center's sewing workshop. This workshop offered women the opportunity to learn how to operate modern machinery and gain employment. As of August, 20 students were enrolled and had produced 163 pieces for an income of 482.25 pesos. The report mentioned that the low cost of clothing led to additional community cooperation and consumption. All of these activities, according to INI reports, helped to ease the path for future center initiatives. (86)

By 1957, health officials stated that communities recognized the benefits of working with center members to improve their living conditions. They maintained that disease prevention and hygienic practices proved to be effective and convinced many groups to embrace the scientific methods being presented to them. (87) Furthermore, they felt that their disease eradication and treatment, especially of malaria, fostered a collaborative relationship between locals and officials. Lastly, they reported that trained community promoters reentering their local villages also helped to foster acceptance of the assistance being offered by center workers. Undoubtedly, Mijangos Ross responded to formal questions of early success favorably, in part, to justify the

sub-center's existence. The Institute's programs, like most government activities at the time, were routinely evaluated to determine their effectiveness. With so many disparate projects competing for limited funding and personnel, each organization had to make the best case for being indispensable. INI officials succeeded in convincing federal bureaucrats of their value and gained funding for continued program development in the Mixteca. Be that as it may, the ability of center delegates to know the level of confidence locals placed in these programs is debatable. Not only were language barriers still a factor, but also it is unlikely that individuals would express personal sentiments regarding government-sponsored activities to INI representatives. Consequently, Mijanos Ross's reports must be read with care.

Examining the ideals under which INI officials operated, as well as the faults scholars have found with them, offers a more realistic explanation of the relationship Mixtecos had with members of the *Instituto*. The anthropologists and archeologists who comprised the majority of positions within the *Instituto Nacional Indigenista* had pre-existing careers as regional specialists. Alfonso Caso, Gonzalo Aguirre Beltrán, and many others spent considerable time in rural communities, studying their cultures, languages, religions, and social frameworks.<sup>19</sup> They undoubtedly became involved with the *Instituto* in the hopes of providing real benefits to these suffering populations. Working in a very conservative political climate, they were part of the *indigenista* movement that recognized the inevitability of rural modernization, industrialization, and national integration, and sought to ease this transition and protect indigenous traditions as best they could. They were incredibly limited in their efforts, as all of their funding was controlled by national bureaucrats, but aimed to negotiate the interests of the state while serving

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<sup>19</sup> For early works by Caso, see *El Teocalli de la Guerra Sagrada* (1927), *Las Esteles Zapotecas* (1928) and *La Religión de los Aztecos* (1936). For Beltrán, see *El señorío de Cuauhtochco. Luchas agrarias en México durante el virreinato* (1940) and *La población negra de México 1519-1810* (1944).

the immediate needs of indigenous groups. As Cynthia Hewitt de Alcántara wrote, INI officials believed:

Increasing interaction with, and integration into, 'the great national community' brought with it only benefits; and the idea that extending the socioeconomic ties of rural people (most especially those of Indian communities) ever further from the local level might entail greater, rather than lesser, risk was never entertained. (7)

Not only were these anthropologists convinced that bridging the state to indigenous communities would be beneficial for both groups, they felt that their understanding of each side's cultural background uniquely qualified them to serve as intermediaries. Their recruitment of cultural promoters from within local communities ensured, so they thought, a close relationship between coordinating centers and the native population. These officials believed that their consideration and adaptation of indigenous customs while encouraging cultural changes set them apart from previous economic development programs.

On the other hand, critics of the INI maintain that the adaptation and cultural changes initiated by the *Instituto* were exactly what kept indigenous groups from accepting them. Rodolfo Stavenhagen argued that the organization's role in rural areas undermined the indigenous struggle against capitalistic encroachment and instead placed them in the exploitative hands of the national bureaucracy. He wrote that attempting to nationally integrate rural communities perpetuated indigenous marginality and reemphasized their inferior role in society. (135) Rather than offer services that would allow indigenous community members to gain an equal footing within the larger Mexican society, these efforts instead further alienated them economically and culturally from their urban counterparts. Arturo Warman took this argument even further by maintaining that the opening up of the rural countryside to capitalism allowed bureaucrats to drain these areas of their resources and lay the burden on its inhabitants. (138) George Collier noted that INI programs did not factor in class differences within indigenous communities but

erroneously treated each group as a cohesive unit. (55) As a result, they never understood local dynamics or how to work within them. Carole Nagengast and Michael Kearney came to a similar conclusion in their study of Mixtec ethnicity. They contend:

Village identification in the Mixteca has historically prevented or at least retarded collective intervillage action and has handicapped Mixtecs in efforts to defend themselves in the modern world of capitalist production into which they have been thrust. (116)

Without local solidarity, *Mixteca Alta* residents would have little motivation to relocate to the *Mixteca Baja*. All five authors convincingly suggest that the end result of INI officials' efforts did not better the lives of indigenous communities and moreover, are partially responsible for the poverty and malnutrition that continue to debilitate these groups today.

The tension between anthropological idealism and the effects of state intervention in indigenous communities is encapsulated in an *Acción Indigenista* article on public health. The author of the piece, an unidentified INI spokesperson, laid out the parameters for improving health conditions in indigenous areas. They wrote:

In indigenous societies, conditions indicate that inconvenient customs should be modified, renovating adverse habits, refurbishing, in short, ways of unhealthy behavior. To achieve this, we must avail ourselves of the process of reinterpretation and in it, the procedures offered by hygiene education, which are not directed to convey established practices and ideas, but efforts to modify them, to renew them, give them a new rendition, for deep cultural change is indispensable to the life of the inhabitants. (82)

The underlying difficulty this quote raises is that acknowledging local traditions and behaviors only, in effect, to change them might not be adequate middle ground for encouraging indigenous people to adopt new practices. As modern anthropologists in the Mixteca have discovered, "much of what is regarded as the inwardness, stoicism, passivity, and 'traditionalism' of the indigenous pueblo may actually constitute a subtle and not immediately perceived resistance to repression." (116) It is for this reason, above all else, that indigenous groups in the Mixteca

probably accepted immediate relief and treatment from INI workers in their community, but did not retain many of their newly learned techniques and behaviors over a longer term. In other words, while INI officials felt their approach offered a new, more effective way of integrating indigenous areas with the modern nation through science, agriculture, and education, to the Mixtecos themselves, this must have seemed like any other state attempt to change their way of life and, consequently, their reaction was a similar level of indifference or resistance.

Even with this more complicated picture of relations between *Instituto* officials and the Mixtecos, the two sides worked together to treat local diseases. By 1959, coordinating center leaders shifted their health agenda to disease prevention. Health officials supplied systematic antiviral vaccination for diphtheria, whooping cough, and tetanus to early age groups. They also made penicillin available to control possible cases of mal de pinto. After the April 1959 outbreak of measles, small brigades of INI health workers visited communities to apply doses of *triple toxoide* to communities until their supply of the vaccine ran out. Goiter also spread quickly throughout the communities. The goal of working with salt producers to include iodine in the local diet suffered from a manufacturing delay. In June 1959, INI and SSA officials recommended that the President declare Jamiltepec a “*bociogena*” or “goiter zone”. Given the lack of medicine available, the ability of the center to carry out its preventive medicine mission was minimal. Instead, workers focused on intestinal deworming campaigns and environmental improvements. With assistance from sanitary engineers, the group installed latrines and water hydrants in central locations within each village. Health workers encouraged home improvements, including the addition of cement floors, fireplaces, beds, tables, and modern cooking utensils. They worked with communications experts to extend radio broadcasts to outlying areas in the hope of reaching remote black indigenous groups. Finally, they worked

with the anti-malaria commission, *Comisión Nacional para la Erradicación de Paludismo*, to explore organized disease prevention activities. (88)

By 1964, illness contributing to high mortality rates continued to include dysentery, vitamin deficiency, respiratory ailments, diarrhea and enteritis, rheumatic fever, and skin disease. Ten years after initiating public health campaigns, officials in Jamiltepec struggled to overcome these preventable ailments. Part of the problem was the continued resistance underlying many of the INI programs. In 1963, education supervisor Nicolas Mendoza Jarquin reported the failure of a breakfast program initiative in public schools due to the parents' misunderstanding or "mala interpretación" of the project. (91) In 1964, Dr. Roberto Cabrera J. noted that adults, especially among black and mestizo communities, continued resisting vaccination efforts even after the majority of indigenous groups consented to them. (44) While it is clear that INI officials anticipated a modicum of indigenous resistance, they seemed ill equipped to handle resistance from other groups in this intercultural area. Their relationship with indigenous communities continued to develop during the 1960s, as more of the population began to welcome medical visits at home, attend prenatal and postnatal clinics, and build latrines and wells. They also accepted new mango, cacao, pineapple, avocado, and tomato plants. Finally, they probably enjoyed the organization's focus on indigenous needs and indirect threat to mestizo economic and political domination. While reports of minor resistance continued to appear in official documents, it is evident that this factor alone was not strong enough to impede development in Jamiltepec.

A much stronger reason for Jamiltepec's stagnant health and economic situation is the amount of annual funding the sub-center received. By examining the differences between coordinating centers in the Mixteca and Chiapas, it is possible to see a direct link between



economic development and budget allocations. The center in Chiapas, founded in 1950, had a strong team of nurses, community promoters, and puppeteers who were able to effectively overcome indigenous resistance to public health campaigns in a short period of time. Historian Stephen Lewis found that INI officials successfully negotiated with the Tzeltal and Tzotzil Maya as well as the region's non-indigenous groups to establish positive relationships and effectively "fostered a development model that focused inward, on the indigenous communities themselves, and avoided clashes with powerful [outside] interests." (99) Although many indigenous families in Chiapas "hedged their bets" by utilizing INI programs while also maintaining their traditional beliefs, they did gradually respond to the health initiatives proposed by INI officials. (99) The coordinating center in Chiapas also gained a large following after introducing the Teatro Petul, a traveling puppet troupe that promoted literacy, public works, and hygiene campaigns in local languages. The main character Petul became a model for embracing both modern and spiritual Mayan customs, and acted as a crucial negotiator for INI programs in the region. By 1954, the center was able to move on to education, road construction, and economic development through agriculture and livestock programs. (99)

As a result of the Chiapas center's success, local officials received a larger budget to devote toward land preparation, crop rotation, seeds, equipment, roadways, and schools. The center in Chiapas established eight medical clinics to serve their community by 1956, whereas the Mixteca only had three. (85) In 1969, the Chiapas center received 4,006,500 pesos of the INI's budgeted 30,000,000 pesos for all ten coordinating centers. In contrast, the Mixteca sub-center in Jamiltepec received 1,897,140 pesos, although it served a similar population size.<sup>20</sup> (27) Almost all of this money went toward health-related projects, including sanitation,

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<sup>20</sup> Chiapas served 102,812 inhabitants while the Mixteca sub-centers of Jamiltepec and Tlaxiaco served 210,649, or roughly 100,000 each.

immunization, medical clinics, mother-infant exams, and personnel training. (89) The intercultural dynamics of the Mixteca, especially the resistance of the large non-indigenous population sector, further hindered INI officials' health programs. Due to the fact that the Mixteca sub-center could not get the region's health problems and cultural variances under control, they did not receive additional resources for economic development.

These unresolved issues continued to deteriorate the region's socio-economic position in the 1970s and 1980s, when INI officials had no choice but to relinquish some of their responsibilities back to the *Secretaría de Salubridad y Asistencia* and other government agencies. (55) Still, *Instituto* members continued to use what resources they had to aid indigenous communities. In 1982, Jamiltepec subdirector Hermógenes Beltrán García reported, "The hygienic situation is quite unfavorable, and greatly affects the health of the population." (73) The region's poverty, unhygienic living conditions, and unemployment all contributed to illness, malnutrition, and alcoholism. Beltrán García listed understaffed clinics, insufficient local medical facilities, inadequate communication routes, lack of specialized personnel, illiteracy, and local sensibilities regarding health as causal factors. The 25 municipalities serviced by the sub-center had only one regional health center, two clinics, twelve local health houses, eleven doctors (nine of which worked in the health center), 17 paramedics, and no hospital. Six municipalities had no piped water system. Limited infrastructure, including electricity, roads, banks, telephone, and mail service, further removed the area from its more developed counterparts. Agricultural development also languished. Only one-eighth of the region's 318,011 hectares of land proved to be workable. Rocky terrain, livestock illnesses, limited agricultural specialists, and insufficient financial resources all hindered real economic development. (73) Relocation efforts within the

Mixteca did not produce significant change and emigration rates remained high. These numbers, as dire as they might be, only worsened throughout the 1980s and 1990s.

#### **5.4 Situation in 2000**

In 2000, the *Comisión Nacional Para el Desarrollo de los Pueblos Indigenas* (National Commission for the Development of Indigenous Villages), the organization that replaced the *Instituto Nacional Indigenista* in 2003, appointed social anthropologist Dubravka Mindek to investigate the economic and social hardships faced by contemporary Mixtecos. Mindek noted, “The region and its population have been subjected to constant change, largely due to the roles of the government and migration.” (114) Her primary concern was the lack of social welfare programs available to assist these communities.

Mindek described medical services in the Mixteca as inadequate and inefficient. In the state of Oaxaca, the ratio of doctors to indigenous patients was 1:3000. Many areas still did not have a rural medical unit. Inhabitants had to leave their village in order to receive medical care, which was expensive and complicated. According to the author, people died from curable diseases because they could not afford to travel to an urban center for treatment. The medical units that did exist in rural areas were poorly equipped and run by inexperienced interns. Linguistic and cultural barriers between patients and medical staff only exacerbated the situation. Indigenous groups felt intimidated by the medical staff, who did not know their language and disparaged their values and customs. Mindek concluded that this situation further marginalized these individuals from their urban counterparts.

Additionally, Mindek determined that educational services were insufficient. Most communities had preschools and primary schools, but offered no services beyond these levels. As a result, the region had higher illiteracy rates than the state and national averages. Of the

726,601 Mixtecos living in the area, 61% primarily spoke indigenous languages. Of the 421,436 individuals age 15 and older, 31% received no education, 42% attended primary school, 26% attended post-primary school, and 1% did not specify. Universities were available only in urban centers, which meant many rural students could not access them even if they could cover the expense. Many young Mixtecos chose to attend teachers colleges instead of universities because they were more conveniently located, less expensive, and took less time to earn a degree. Occupations for the majority of Mixtecos were split between 44% in agriculture and 32% self-employed artisans, street vendors, and tradesmen. (114)

Agricultural goods remained largely subsistence based, including corn, beans, squash, and chiles. The land yielded these crops during the 6-8 month growing season, and soil erosion and seasonal rains limited additional cultivation. Livestock, primarily goats and lambs, roamed freely and often led to the destruction of vegetation. Artisanal production, including textiles and palm fabric for sombreros, were sold in regional markets as well as in Puebla, Guerrero and the United States.

Due to soil erosion, underdevelopment, an absence of basic services, social violence, and the lack of available jobs, many Mixtecos were forced to look for alternative opportunities outside of Oaxaca. This region was a primary zone of out-migration in the nation. Members of the Mixteco community made their way to Veracruz, Valle Nacional, and the United States in search of temporary, seasonal, or permanent jobs. Remittances from workers who migrated away were used to offset government negligence in providing for the region's essential services. Funds sent home from seasonal workers were used to pave roads, build schools, rebuild homes with brick, install telephones and telegraphs, and cover expenses for patron saint festivals. Almost all houses had electricity by 2000, but only the minority had running water and drainage. Wood was

still the primary fuel used for cooking, even when gas stoves were available. Roadways, including the *Carretera Pan America*, *Carretera Internacional Cristóbal Colón*, and *Supercarretera Oaxaca-México*, helped connect the region to large important towns in Central and Coastal Mexico. However, most villages continued to rely on local transport along rough roads.

Mindek's report is shockingly similar to de la Peña's findings in 1949. Both researchers concluded that government programs were insufficient in the Mixteca. Mindek stated that public works programs were often designed behind a desk and with little knowledge of the needs or reality of the region. Additionally, they ignored the ethnic and cultural variations within a given zone. The result was uneven internal development and increased external migration. De la Peña similarly argued that the lack of internal development and social programs were contributing factors to high migration rates among Mixtecos. Both Mindek and de la Peña reported that mestizo neighborhoods benefited from a municipal government, major agricultural areas and a host of social services. They lived in residential areas separated from the rest of the community. They operated under different political and ceremonial systems, and only identified with the term Mixteca as a geographic and cultural region that they have inhabited for centuries. Mindek added that contemporary black inhabitants along La Costa also felt a sense of superiority over their indigenous counterparts who they viewed as passive and submissive. The result of this ethnic hierarchy meant increased marginalization and isolation for indigenous communities. While Mindek's evaluation does not offer resolutions to these problems, her underlying message is clear: not much has changed in the social and economic conditions of Mixtecos in the last fifty years.

## 5.5 Conclusion

Moises T. de la Peña's economic development plan for the Mixteca was an unrealistic mission for the *Instituto Nacional Indigenista*. Founded with the intention of improving economic and social conditions in indigenous communities, the *Instituto* had limited success in bringing long-term benefits to the Mixteca populations. While coordinating centers in regions like Chiapas were able to negotiate with Tzotzil and Tzeltal Mayans through the Teatro Petul, the two sub-centers in the Mixteca could never find a common base from which to address the rampant health problems plaguing the region. Even when cultural differences between traditional and Western medicine were temporarily parlayed during health crises, resistance from mestizos and lack of an authentic adoption of new health behaviors by indigenous community members impeded disease prevention strategies. Furthermore, village allegiance over regional or ethnic ties reduced the collective spirit required to carry out a resettlement plan. It also meant that national integration programs foundered. The lack of arable land, employment, and public welfare services prompted many inhabitants to lose hope in sustaining themselves in the Mixteca and to relocate outside the state or country to gain the resources their families needed to survive.

Anthropologists Nagengast and Kearney draw attention to the fact that state-sponsored indigenous projects in Mexico are notorious for their inability to look beyond these populations as a singular component requiring outside assistance. They wrote:

The task often set for themselves by social planners, applied anthropologists, and agencies of the state dedicated to 'indigenous affairs' is to devise means of overcoming the negative traditions while not injuring the positive. But indigenous peoples are more often the object of theoretical and applied research and development projects than they are subjects who have played an active role in their own past and have a voice in their present and future. (116)

This is certainly true in the Mixteca case. Indigenous communities became a laboratory to test the *indigenista* model of economic development through anthropological intervention. While

researchers in the field attempted to elevate local standards of living, they did not allow residents to become active participants in their own betterment. The only community members the sub-centers worked with on a regular basis were the cultural promoters they trained to help encourage compliance with their mission. Stephen Lewis notes that this was also true for the Chiapas center, which “relied heavily on its promoters, many of whom empowered and enriched themselves instead of (and at the expense of) their communities.” (99) Neither case resulted in widespread community participation, and if anything discouraged community members from becoming too involved in INI sponsored activities.

The *Instituto*’s leadership failed to recognize the incongruity between their anthropological respect for indigenous traditions, their goal of directing rural modernization, and the cultural diversity in the Mixteca. By connecting public health programs to economic development, INI officials thought they were offering communities the chance to accept modernization in a tangible, immediately beneficial way. For some coordinating centers, this approach proved successful. In the Mixteca case, the social stratification of Mixtecos, mestizos, and blacks thwarted the *Instituto*’s efforts to offer culturally specific programs. Center leaders succeeded in gaining the trust of indigenous groups for carrying out short-term health treatment campaigns, but failed to consolidate regional ethnic groups with the larger national society.

The Coordinating Center Mixteca case denotes three important conclusions about rural healthcare in 1950s Mexico. First, local level cooperation with state officials did not naturally extend to national cooperation. While indigenous groups may accept state-sponsored assistance in their community, this may or may not sway them to align with national culture and political authority. Cooperation with state health officials is more a sign of a community’s need for immediate relief than an acquiescence of community members that modern national programs

are preferred. Acculturation by Western medicine, therefore, was a much larger challenge than INI officials anticipated.

Second, the intermediary role of health officials working for the *Instituto* was designed to be a temporary relationship. Similar to the Tepalcatepec Commission and the *Bienestar Social Rural* programs, the *Instituto* made no permanent plans for this collaboration. Once a program was completed or terminated, no designated representatives remained to fill the position. As a result, the Mixteca had to continuously form new relationships with INI agents coming into the region. This constant fluctuation undoubtedly impeded prolonged social services. Health problems continued to reappear and, consequently, economic development remained financially out of reach. State officials, agreeing in theory to sponsor indigenous public welfare programs, nevertheless limited budgetary efforts for development in areas that could not get their health problems under control and were therefore not economically viable.

Third, the *Instituto Nacional Indigenista* example points out a central underlying problem Mexican officials faced in their approach to health and economic development. The *Instituto's* leadership placed great emphasis on developing culturally-sensitive health programs, but they did not create similarly sensitive economic programs. Economic projects were still designed by national policymakers and neglected to include indigenous beliefs or traditions. Furthermore, the economic aspects of the broader modernization campaign had no intermediaries to coordinate activities between state officials and indigenous communities. The Coordinating Center Mixteca, in short, had the resources to treat illnesses but not the capability to effect economic improvements. The result was a series of temporary health benefits in the midst of prolonged poverty and increased hesitation of indigenous community members to have confidence in state programs.



## 6. CONCLUSION

In this dissertation, I have shown that healthcare providers changed the nature of public health in rural Mexico by serving as intermediaries between state officials and indigenous community members. Rather than strictly adhering to national health policies, healthcare workers reconfigured health programs to provide more personalized care to rural Mexico. By approaching indigenous families in their local language, with knowledge of their traditions and mores, health workers also opened a new door for collaboration. They established, or attempted to establish, culturally relevant hygiene and sanitation programs to replace previously uniform procedures. They utilized innovations in anthropology, epidemiology, and hydrology to improve health promotion campaigns. National policymakers linked economic progress to health, and incorporated disease prevention and public health projects into their larger modernization efforts. As evidenced in the three case study chapters, rural health programs in Central Mexico focused on improving the standard of living for indigenous communities as a step toward integrating these groups into national society. Yet the discourse of politicians and public health officials did not always align with the on-the-ground experiences of health workers in indigenous communities. As the debate between Ignacio Morones Prieto, Ignacio Chávez and Federico Gómez showed, health officials struggled to balance the competing interests of providing adequate care to rural villages, empowering locals to lead health programs, and entrusting communities to collectively take care of themselves. (122)

This dissertation argues that there are several reasons why the shift from individual to collective care took place in this period. International dialogues on health, prompted by the establishment of the World Health Organization, emphasized communal health as the best way to

redevelop political and economic stability after World War II. Health officials felt that gaining local participation in the well-being of a nation's population would expedite the process of rebuilding and reduce social tensions based on inequality. They also equated economic progress with healthy communities, and felt that giving community members a stake in local, national, and international prosperity would further entice them to work collaboratively with health officials.

From an economic perspective, Mexican politicians had two primary reasons for transitioning to collective healthcare. First, they hoped to use health campaigns as a way to integrate rural communities into the national economy and society. National politicians offered healthcare to communities with the unwritten obligation that healthy workers would contribute to the national economy by joining in the process of industrial development and commercial agricultural production. Health officials developed programs that they hoped would appeal to community members and, as shown in the *Comisión de Tepalcatepec* case, enticed them to participate in subsequent economic and political projects. While the *Comisión* and *Instituto Nacional Indigenista* (INI) Coordinating Center attempted to use health programs as a first step toward economic development, the *Bienestar Social Rural* program incorporated health into a larger well-being initiative that tried to resolve all of the environmental, cultural, social, and health challenges in rural areas simultaneously. This approach drew the most local support because of the program's potential to quickly transform rural life, but also produced the least long-term results by not offering community members opportunities for participating in the project design.

Second, national policymakers wanted to quickly reduce high mortality rates and control disease epidemics. Achieving this goal would not only give national industries a larger pool of

healthy workers, but would also help to improve Mexico's international reputation as a developed nation. Health officials in all three case studies emphasized raising the standard of living in their targeted indigenous populations. The limited number of trained medical professionals and state resources available for this effort necessitated collaborations between Mexican officials and rural community members. As the *Comisión* case showed, establishing a dialectic relationship between healthcare providers and community members could lead to genuine health improvements aided by local staff and community financial contributions. Health officials working on behalf of the *Bienestar Social Rural* program and the INI Coordinating Center in the Mixteca attempted to replicate this exchange, which would significantly ease the state burden to provide adequate healthcare, but never really developed a collaborative model beyond initial dialogues. The lack of resources and personnel in Veracruz and Jamiltepec decreased the confidence community members had in the power of the state and consequently lessened the possibility for establishing relationships. Reports by Moises T. de la Peña and Dubravka Mindek on the problems in the Mixteca indicate that the region's lack of resources did not change in the second half of the twentieth century. Both researchers attribute this, in part, to the inability of rural health programs to sustain long-term personnel in remote areas. The rapid turnover of professionals, many of whom stayed in rural clinics only as long as their educational requirements dictated, left locals disinterested in forming any meaningful ties with these officials.

To assist in establishing links between communities and the state, health officials appealed to indigenous groups by highlighting their rights as part of the nation. This practice, first introduced by rural schoolteachers during the 1920s and 1930s, succeeded in both the Tepalcatepec river basin commission and the *Bienestar Social Rural* program. Pedro Blanco's

letter to President Manuel Avila Camacho demanded a resolution to the poor living and working environments in Uruapan, Michoacán. He grabbed the attention of national officials by equating health to the economic potential of local workers. If policymakers wanted to succeed in expanding industrialization, he argued, they needed to help workers establish healthy habitats. Similarly, and on a much broader scale, peasant organizations and communities throughout Central Mexico petitioned for their own *Bienestar Social Rural* centers. The proactive campaigns of indigenous community leaders in requesting state health interventions underlines their adeptness in using the political system to reconfirm their communal rights. “Ideological flexibility” allowed indigenous groups to combine their traditional beliefs with modern adaptations to improve their living conditions. (110) Local leaders recognized that they were more likely to maintain autonomy by cooperating with officials whose primary interest was to preserve an illusion of national solidarity. By appealing to their rights, policymakers succeeded in attracting indigenous community members to participate in the national political and economic system.

Beyond economic considerations, policymakers had social motivations for promoting rural health programs. First, all three cases show that healthcare providers altered the relationship between state officials and indigenous groups. Inhabitants of the Tepalcatepec river basin accepted their role as contributing members of the national society after receiving public works and welfare programs. The *Bienestar Social Rural* program prompted community leaders to acknowledge that consenting to state-sponsored healthcare came with obligation that workers would contribute to the national economic development. In the case of Jamiltepec, INI health workers conducted far-reaching vaccination campaigns and temporarily reduced emigration out

of the state by offering modern medical services and assisting in land reallocation and industrialization efforts.

Second, improved relations with indigenous community leaders helped national policymakers to expand their modernization agenda. Industrialization in rural areas occurred quickly and, as a result of health campaigns, a new cache of able-bodied workers were available to perform mechanical, agricultural, and public works tasks. In addition to economic progress, policymakers also established bureaucratic agencies to systematize health care and produced new multi-tiered collaborations that addressed health factors from social, economic, and public works approaches. The *Comisión de Tepalcatepec* brought teams from the Ministries of Water Resources, Education, Health, and Agriculture together to improve living conditions along the river basin. The *Bienestar Social Rural* and *Instituto Nacional Indigenista* offices similarly formed new cooperation-based initiatives designed to streamline development while not duplicating efforts. While agencies continued to duplicate their efforts in health services, often leading to confusion among local populations, policymakers attempted for the first time to consolidate them in this period. They hoped that combining the skills and specialties of each agency would expedite the two major improvement goals for rural areas: potable water and adequate sewage drainage. Health reports conducted in Mexico and internationally confirmed that these two public works efforts were essential for the health and well-being of society. They also seemed like manageable goals for Mexican officials. By bringing water services into remote areas, policymakers hoped to leave a lasting state presence while raising rural standards of living.

Another key to modernization, according to policymakers, was resolving the much-debated “Indian Problem.” *Indigenistas* worked with state officials to design integration programs that respected the traditions of indigenous communities while also introducing them to

modern conveniences and educating them in Spanish. Leaders in the *Instituto Nacional Indigenista* prioritized culture as central to all of their rural programs. The experimental process of simultaneously preserving and changing indigenous culture was best seen in the case of the Coordinating Center in Jamiltepec. Critics of this approach, I think correctly, argued that anthropological studies of indigenous mores were used by policymakers only to learn about the communities that they intended to change. INI officials had no intention of preserving the cultures their representatives were instructed to study. In fact, program officials in the *Bienestar Social Rural* and Jamiltepec cases explicitly stated that their goal was to “Mexicanize” rural populations. (61) They hoped that offering Western medicine to remote areas would acculturate rural groups into national society. This dissertation draws attention to the challenges that arose from this approach, including the incorrect assumption that compliance with health professionals in times of local crises extended to a larger community acquiescence with national development goals. While residents in the Tepalcatepec river basin did comply with many of the regional improvement models offered by the state, rural populations in the other two cases steered clear of any long-term cultural changes.

After examining the motives of policymakers for changing the role of rural health campaigns, this dissertation also evaluates how health providers actually implemented new health policies at the local level. Providers in all three cases established their base of operations in the targeted region’s metropolis. This choice allowed health workers to come into contact with many local inhabitants, which soon changed their preconceived ideas that these hubs were largely homogenous. They did not anticipate encountering social inequalities and cultural variations among indigenous, mestizo, and black families living in the area. Consequently, preparatory anthropological studies of indigenous culture only partially equipped health workers

for managing day-to-day interactions with locals. Health providers working in the Tepalcatepec area adapted their programs based on their own intercultural relations with community members. Conversely, community promoters and health officials in Villa Cardel and Jamiltepec did not modify their original program blueprint and therefore struggled when community members chose not to follow along. While both programs attempted to appeal to the communal lifestyle of indigenous families by establishing institutional centers, they were not prepared to face resistance and indifference from their targeted populations. The ability of healthcare providers to reformulate national policies into regionally relevant programs ultimately determined their effectiveness.

Further adding to the discrepancy between design and implementation was the fact that all three cases listed community participation as an essential component to carrying out health campaigns. As discussed below, this approach appealed to many community members, but ultimately failed to offer real opportunities for local involvement. The *Comisión de Tepalcatepec* accepted community volunteers and financial contributions, but made no plans for regional leaders to assume any responsibility for program maintenance. The *Comisión* did open the door for indigenous leaders to converse with health providers, and this involvement improved the overall effectiveness of the region's health campaigns. The *Bienestar Social Rural* program theoretically centered on community participation, but in reality no plans were made for local leaders to take control of center operations or offer input on customized treatments. As Isabel Kelly pointed out in her assessment of the center in Villa Cardel, health professionals rarely interacted with community members, and community promoters spent their time attempting to emulate their urban counterparts rather than represent their rural equivalents. Finally, the constantly shifting staff in Jamiltepec's coordinating center highlights the lack of opportunities

for community members to forge relationships with health officials. Patients rarely saw the same nurse or doctor twice, and community promoters similarly left the state for training in the nation's capital. While community members and health officials joined forces for short-term vaccination campaigns, they did not habitually work to sustain existing programs or develop new ones together. Community promoters did not become intermediaries between the two sides but instead became more closely affiliated with the trained professionals hoping to relocate to urban areas.

All of the points mentioned thus far represent the health provider perspective of their on-the-ground experience in rural Mexico. This dissertation also addresses the actions and reactions of indigenous community members and their mestizo counterparts. Community members responded differently to each of the three health programs. In the Tepalcatepec river basin, indigenous and mestizo communities participated in the economic and environmental changes brought about through the *Comisión*. Indigenous families influenced health campaigns by interacting with health professionals in clinics, home visits, and public programs. Together, the two sides collaborated to develop specialized care delivered in local languages, following cultural traditions and mores. In Villa Cardel, indigenous families initially dismissed recruitment efforts for center participation because they felt that the program did not offer them useful services. Later, after center officials reformulated their projects to more appropriately target indigenous groups, many locals attended the center's activities. The flexibility of the *Bienestar Social Rural* program eventually appealed to indigenous community leaders throughout Mexico, who petitioned for their own BSR centers as a way to reconfirm their communal status and determine their level of care. In Jamiltepec, indigenous groups saw the INI coordinating center as just another state attempt to mandate cultural changes to their village. They cooperated with



health officials in order to receive short-term treatment, but were otherwise apathetic to the programs being introduced.

In addition to indigenous communities' support or resistance of programs, the case study in Jamiltepec highlights the incompatibility of *indigenista* efforts to preserve indigenous traditions while teaching new behaviors, activities, and norms that fell in line with the uniform national culture mandated by policymakers. Hoping to use indigenous community acceptance of Western medicine as a measure of their national acculturation, INI officials did not anticipate that rural groups would adopt practices they felt were useful while disregarding others. Many indigenous groups practiced "medical pluralism," combining traditional and Western beliefs about health into what they felt was a useable system. (56) Furthermore, while *Comisión* officials worked with indigenous families to better understand their choices about health, they did not factor in the intercultural dynamics of the region. Mestizos in the Tepalcatepec basin resented the encroachment of urban professionals, which they saw as a threat to their economic and political authority. Mestizos, more than their indigenous counterparts, wanted to maintain the status quo of relationships in the area. Similarly, mestizos in Jamiltepec viewed the work of health officials as reducing the social inequality that helped them to thrive. Ultimately, both the INI Coordinating Center and the *Comisión de Tepalcatepec* missed the mark in providing intercultural care that served (and satisfied) both rural indigenous and mestizo communities.

The issues raised in this dissertation suggest possibilities for future research in the history of public health. The political climate, push for economic development, and promotion of a unifying national cultural in Mexico during the 1940s and 1950s resulted in a new period of negotiation, cooperation, and resistance between health officials and indigenous populations. Further research on this understudied time in Mexican history will offer deeper insight into the

crosshatching of national and international goals with indigenous community development. The three case studies analyzed in this dissertation focus on Central Mexico. Comparative evaluations with rural health programs in Northern and Southern Mexican states during the same time period will add to a larger discussion on policymakers' preferential regionalism. Why did some areas like Chiapas receive more national attention than others? How were campaigns in border states prioritized, and did this change over time? While scholars have evaluated the role of the Rockefeller Foundation and the Pan American Health Organization in Mexico, how did international organizations like the Institute for Inter-American Affairs intersect with local development in Mexico during the 1950s? How did this experience compare to other Central and South American nations that also received international assistance such as Honduras, Nicaragua, Guatemala, Peru and Brazil? What new insights can ethnographies of Mexico's rural communities offer into the relationships between anthropologists, state officials, and native people? Were the findings and accounts of anthropologists in rural communities similar or different from those of government agents, and if different, why? Did anthropologists like Gonzalo Aguirre Beltrán continue pushing for intercultural approaches to public health campaigns after the 1960s? Why or why not? And finally, how can historians better incorporate the fields of medical anthropology and public health into their methodology? The conclusions will not only provide vital insight into the development of Mexico's existing healthcare system and how it continues to incorporate and/or isolate indigenous populations, but will also appeal to scholars in many academic fields by shedding new light on the development of worldwide rural health policies.

The broader significance of this dissertation to the fields of Mexican and Latin American history is the recognition by mid-twentieth century politicians that social reforms and population

growth were essential to development. Rural communities, constituting the majority of the population, could no longer be pushed to the periphery and ignored. They needed adequate healthcare in order to participate in the national economy. Healthcare providers in the 1940s and 1950s became increasingly aware of the difficulties in providing services to a large disparate rural population. Their experiments in culturally-sensitive healthcare, improved communication with indigenous groups, and opportunities for community participation changed the nature of healthcare and opened the door for revolutionary social programs by conservative politicians.

## CITED LITERATURE

1. Agostoni, Claudia, ed., *Curar, Sanar y Educar: Enfermedad y Sociedad en México, Siglos XIX y XX*. México: Universidad Nacional Autónoma de México, 2008.
2. Agostoni, Claudia. "Estrategias, Actores, Promesas y Temores en las Campañas de Vacunación Antivariolosa en México: Del Porfiriato a la Posrevolución (1880-1940)." *Ciencia & Saúde Colectiva* 16 (2011): 459-470.
3. Agostoni, Claudia. *Monuments of Progress: Modernization and Public Health in Mexico City, 1876-1910*. Calgary: University of Calgary Press, 2003.
4. Agostoni, Claudia. "Popular Health Education and Propaganda in Times of Peace and War in Mexico City, 1890s-1920s." *American Journal of Public Health* 96 (2006): 52-61.
5. Alba, Francisco. *The Population of Mexico: Trends, Issues, and Policies*. Piscataway, New Jersey: Transaction Publishers, 1981.
6. Alba, Francisco and Joseph E. Potter. "Population and Development in Mexico since 1940: An Interpretation." *Population and Development Review* 12 (1986): 47-75.
7. Alcántara, Cynthia Hewitt de. *Boundaries and Paradigms: The Anthropological Study of Rural Life in Postrevolutionary Mexico*. Leiden Development Studies, no. 4, 1982.
8. Alvarez-Alva, Rafael. "La Enseñanza de la Medicina Preventiva en Mexico." *Gaceta Medica De Mexico*, 109 (1975), 307-308.
9. Amézquita, José Alvarez, Miguel Bustamante, Antonio López y Francisco Fernández del Castillo, eds. *Historia de la salubridad y de la asistencia en México, 4 vols*. Mexico City: Secretaría de Salubridad y Asistencia, 1960.
10. Archivo Histórico de la Secretaría de Salubridad y Asistencia (AHSSA), AHSSA-SSA-SPr, box 21, file 2, Mexico City, Mexico.
11. AHSSA-SA-SPr, box 184, file 3, Mexico City, Mexico.
12. AHSSA-SSA-SubSyA, box 11, file 4, Mexico City, Mexico.
13. AHSSA-SSA-SubSyA, box 25, file 16, Mexico City, Mexico.
14. AHSSA-SSA-SubSyA, box 33, file 9, Mexico City, Mexico.
15. AHSSA-SSA-SubSyA, box 51, file 2, Mexico City, Mexico.
16. AHSSA-SA-SubSyA, box 55, file 1, Mexico City, Mexico.

17. AHSSA-SA-SubA, box 70, file 6, Mexico City, Mexico.
18. AHSSA-SubS, box 1, file 1, Mexico City, Mexico.
19. Armus, Diego. "Disease in the Historiography of Modern Latin America." In *Disease in the History of Latin America: From Malaria to AIDS*, edited by Diego Armus, 1-23. Durham: Duke University Press, 2003.
20. Attias, Isabel Lagarriga. "Medicina Tradicional en México: Conceptos, actitudes y valores de sus seguidores." In *Medicina Tradicional en México*, edited by Jaime Villalba Caloca, 17-54. México: INER, 2000.
21. Ávila Camacho, Manuel. "Concretándonos a exponer causas que exigen el aumento de población dentro de la higienización," Archivo General de la Nación, MAC 503/444.7-66, Mexico City, Mexico.
22. Barkin, David and Timothy King. *Regional Economic Development: The River Basin Approach in Mexico*. London: Cambridge University Press, 1970.
23. Barrett, Elinore M. *La Cuenca de Tepalcatepec, Vol. II: Su desarrollo moderno*. México: SepSetentas, 1975.
24. Bashford, Alison. "'The Age of Universal Contagion': History, Disease and Globalization." In *Medicine at the Border: Disease, Globalization, and Security, 1850 to the Present*, edited by Alison Bashford, 1-18. New York: Palgrave Macmillan, 2006.
25. Batalla, Guillermo Bonfil. *México Profundo: Reclaiming a Civilization*. Austin: University of Texas Press, 1996.
26. Beltrán, Gonzalo Aguirre. "Declaración de México en Materia Indigenista." Comisión Nacional para el Desarrollo de los Pueblos Indígenas, Centro de Documentación "Juan Rulfo" (hereafter CDICDJR), FD 09/0012, Mexico City, Mexico.
27. Beltrán, Gonzalo Aguirre. "Los Centros Coordinadores: Proyectos Regionales de Desarrollo Integral." CDICDJR, FD 09/0012, Mexico City, Mexico.
28. Beltrán, Gonzalo Aguirre. *Obra Antropológica V: Programas de Salud en la Situación Intercultural*. México: Fondo de Cultura Económica, 1994.
29. Beltrán, Gonzalo Aguirre. *Problemas de la Población Indígena de la Cuenca Del Tepalcatepec, Vol. I*. México: Fondo de Cultura Económica, 1995.
30. Beltrán, Gonzalo Aguirre. *Problemas de la Población Indígena de la Cuenca Del Tepalcatepec, Vol. II*. México: Fondo de Cultura Económica, 1995.

31. Beltrán, Gonzalo Aguirre. *Programas de Salud en la Situación Intercultural*. México: Instituto Indigenista Interamericano, 1955.
32. Beltrán, Gonzalo Aguirre. "The Interpretation of Health Programs in Cross-Cultural Situations." CDICDJR, FD 09/0013, Mexico City, Mexico.
33. Birn, Anne-Emanuelle. "A Revolution in Rural Health?: The Struggle over Local Health Units in Mexico, 1928-1940." *Journal of the History of Medicine and Allied Sciences* 53 (1998): 43-76.
34. Birn, Anne-Emanuelle. *Marriage of Convenience: Rockefeller International Health and Revolutionary Mexico*. Rochester: University of Rochester Press, 2006.
35. Birn, Anne-Emanuelle. "The stages of international (global) health: Histories of success or successes of history?" *Global Public Health* 4 (2009): 50-68.
36. Bliss, Katherine Elaine. *Compromised Positions: Prostitution, Public Health, and Gender Politics in Revolutionary Mexico City*. University Park, PA: Pennsylvania State University Press, 2001.
37. Blum, Ann S. *Domestic Economies: Family, Work, and Welfare in Mexico City, 1884-1943*. Lincoln: University of Nebraska Press, 2009.
38. Boyer, Christopher R. *Becoming Campesinos: Politics, Identity, and Agrarian Struggle in Postrevolutionary Michoacán, 1920-1935*. Stanford: Stanford University Press, 2003.
39. Bray, David, Leticia Merino-Perez, and Deborah Barry, eds. *The Community Forests of Mexico: Managing for Sustainable Landscape*. Austin: University of Texas Press, 1999.
40. Briggs Charles L. and Clara Mantini-Briggs. *Stories in the Time of Cholera: Racial Profiling During a Medical Nightmare*. Berkeley: University of California Press, 2003.
41. Brown, Theodore M., Marcos Cueto, and Elizabeth Fee, "The World Health Organization and the Transition from 'International' to 'Global' Health." In *Medicine at the Border: Disease, Globalization, and Security, 1850 to the Present*, edited by Alison Bashford, 76-94. New York: Palgrave Macmillan, 2006.
42. Buffington, Robert M. *Criminal and Citizen in Modern Mexico*. Lincoln: University of Nebraska Press, 2000.
43. Bustamante, Miguel E. "Public Health and Medical Care." *Annals of the American Academy of Political and Social Science* 208 (1940): 153-161.
44. Cabrera J., Roberto. "Instituto Nacional Indigenista: Centro Coordinador de la Mixteca Baja en Jamiltepec, Oax., Sección de Salubridad: Síntesis de Actividades Desarrolladas." CDICDJR, FD 20/0029, Mexico City, Mexico.

45. Cañedo, Luis. "Rural Health Care in Mexico?" *Science* 185 (1974): 1131-1137.
46. Cárdenas, Lázaro. "Comunicado sobre la creación de la Comisión del Tepalcatepec y las obras a ejecutar: Uruapan, Mich., 1 de agosto de 1947." In *Palabras y Documentos Públicos: Mensajes, Discursos, Declaraciones, Entrevistas, y Otros Documentos, 1941-1970*, by Lázaro Cárdenas. México: Siglo XXI, 1979.
47. Cárdenas, Lázaro. "Datos proporcionados por el Vocal Ejecutivo de la Comisión de Tepalcatepec a la prensa sobre los trabajos realizados de 1947 a 1957: Apatzingán, Mich., 26 de febrero de 1958." In *Palabras y Documentos Públicos: Mensajes, Discursos, Declaraciones, Entrevistas, y Otros Documentos, 1941-1970*, by Lázaro Cárdenas. México: Siglo XXI, 1979.
48. Cárdenas, Lázaro. "Declaraciones sobre 'El Tepalcatepec.' México, D.F. 27 de julio de 1954." In *Palabras y Documentos Públicos: Mensajes, Discursos, Declaraciones, Entrevistas, y Otros Documentos, 1941-1970*, by Lázaro Cárdenas. México: Siglo XXI, 1979.
49. Cárdenas, Lázaro. "Discurso del Presidente de la República en el Primer Congreso Indigenista Interamericano, Pátzcuaro, Mich., 14 de abril de 1940." In *Palabras y Documentos Públicos: Mensajes, Discursos, Declaraciones, Entrevistas, y Otros Documentos, 1928-1940*, by Lázaro Cárdenas. México: Siglo XXI, 1978.
50. Cárdenas, Lázaro. *Mensajes discursos, declaraciones, entrevistas y otros documentos, 1941-1970, tomo 3*. México: Siglo XXI Editores. Quoted in *La Tierra Caliente de Michoacán*, edited by José Eduardo Zárate Hernández. Morelia: El Colegio de Michoacán, 2001.
51. Cárdenas, Lázaro. *Obras: I-Apuntes 1941-1956, Tomo II*. México: UNAM, 1986.
52. Cárdenas, Lázaro. "Palabras de Vocal Ejecutivo de la Comisión del Río Balsas al Pueblo de Ayuquila de Juárez, Oax. 12 de octubre de 1966." In *Palabras y Documentos Públicos: Mensajes, Discursos, Declaraciones, Entrevistas, y Otros Documentos, 1941-1970*, by Lázaro Cárdenas. México: Siglo XXI, 1979.
53. Caso, Alfonso. "Informes de Actividades, 1949-1970." CDICDJR, FD 09/0045, Mexico City, Mexico.
54. Caso, Alfonso. "Proyecto de Ley Que Crea El Instituto Nacional Indigenista." CDICDJR, FD AI/0004, Mexico City, Mexico.
55. Collier, George A. "Peasant Politics and the Mexican State: Indigenous Compliance in Highland Chiapas." *Mexican Studies/Estudios Mexicanos* 3 (1987): 71-98.

56. Cueto, Marcus. "Appropriation and Resistance: Local Responses to Malaria Eradication in Mexico, 1955-1970." *Journal of Latin American Studies* 37 (2005): 533-559.
57. Cueto, Marcos. *The Value of Health: A History of the Pan American Health Organization*. Washington, D.C.: Pan American Health Organization, 2007.
58. Dawson, Alexander S. "From Models for the Nation to Model Citizens: *Indigenismo* and the 'Revindication' of the Mexican Indian, 1920-1940." *Journal of Latin American Studies* 30 (1998): 279-308.
59. Dawson, Alexander S. *Indian and Nation in Revolutionary Mexico*. Tucson: The University of Arizona Press, 2004.
60. De Kadt, Emanuel. "Community Participation for Health: The Case of Latin America." *World Development* 10 (1982): 573-584.
61. De la Peña, M.T. *Problemas Sociales y Económicos de Las Mixtecas: Memorias del Instituto Nacional Indigenista Vol. II, Num. I*. México: Instituto Nacional Indigenista, 1950.
62. Díaz, Gerardo Sánchez. "Agua para una tierra sedienta." In *La Tierra Caliente de Michoacán*, edited by José Eduardo Zárate Hernández, 203-232. Morelia: El Colegio de Michoacán, 2001.
63. Dion, Michelle. "The Political Origins of Social Security in Mexico during the Cárdenas and Avila Camacho Administrations." *Mexican Studies/Estudios Mexicanos* 21 (2005): 59-95.
64. Domínguez, Jorge I. and Rafael Fernández de Castro. *The United States and Mexico: Between Partnership and Conflict, 2<sup>nd</sup> edition*. New York: Routledge, 2009.
65. Doremus, Anne. "Indigenism, Mestizaje, and National Identity in Mexico during the 1940s and the 1950s." *Mexican Studies/Estudios Mexicanos* 17 (2001): 375-402.
66. Escobar, Arturo. *Encountering Development: The Making and Unmaking of the Third World*. Princeton: Princeton University Press, 1995.
67. Espinosa, Alejandra Gámez and Ernesto Licona Valencia. *Diagnóstico Sociocultural de la Mixteca Alta y Baja*. México: Comisión Nacional para el Desarrollo de los Pueblos Indígenas, 2009.
68. Finkler, Kaja. *Spiritualist Healers in Mexico: Successes and Failures of Alternative Therapeutics*. New York: Praeger Publishers, 1985.
69. Foster, George ed. *A Cross-Cultural Anthropological Analysis of a Technical Aid Program*. Washington, D.C.: Smithsonian Institution, 1951.



70. Friedlander, Judith. *Being Indian in Hueyapan: A Revised and Updated Edition*. New York: Palgrave MacMillan, 2006.
71. Galante, Cristina, Paola Sesia-Lewis, and Virginia Alejandre. "Mujeres y parteras: Protagonistas activas en la relación entre medicina moderna y medicina tradicional." In *Las Mujeres en el Campo*, compiled by Josefina Aranda Bezuary, 345-354. Oaxaca, Mexico: Universidad Autónoma Benito Juárez de Oaxaca, 1988.
72. Gamio, Manuel. *Forjando Patria (Pro Nacionalismo)*. Translated and edited by Fernando Armstrong-Fumero. Boulder: University Press of Colorado, 2010.
73. García, Hermógenes Beltrán. "Centro Coordinador de la Mixteca de la Costa: Jamiltepec, Oaxaca." CDICDJR, FD 20/0092, Mexico City, Mexico.
74. Gobierno del Estado de México. *Manual de Organización para Coordinaciones Municipales*. México: Instituto de Salud del Estado de México, 2005.
75. González y González, Luis. "Introducción: La Tierra Caliente." In *La Tierra Caliente de Michoacán*, edited by José Eduardo Zárate Hernández, 17-66. Morelia: El Colegio de Michoacán, 2001.
76. Grad, Frank P. "The Preamble of the Constitution of the World Health Organization." *Bulletin of the World Health Organization* 80 (2002), 981-982.
77. Grunwald, Joseph. "The Alliance for Progress." *Proceedings of the Academy of Political Science* 27 (1964), 78-93.
78. Guadarrama, María Teresa and Ruth Piedrasanta Herrera. "El papel de las mujeres en la medicina popular y tradicional." In *Las Mujeres en el Campo*, compiled by Josefina Aranda Bezuary. Oaxaca, Mexico: Universidad Autónoma Benito Juárez de Oaxaca, 1988.
79. Guardino, Peter F. *Peasants, Politics, and the Formation of Mexico's National State: Guerrero, 1800-1857*. Stanford: Stanford University Press, 1996.
80. Gutiérrez, Natividad. *Nationalist Myths and Ethnic Identities: Indigenous Intellectuals and the Mexican State*. Lincoln: University of Nebraska Press, 1999.
81. Gwatkin, Davidson R. "Indications of Change in Developing Country Mortality Trends: The End of an Era?" *Population and Development Review* 6 (1980): 615-644.
82. Instituto Nacional Indigenista. *Acción Indigenista* 21 (March 1954).
83. Instituto Nacional Indigenista. *Acción Indigenista* 25 (July 1955).

84. Instituto Nacional Indigenista. *Acción Indigenista* 32 (February 1956).
85. Instituto Nacional Indigenista. *Acción Indigenista* 36 (June 1956).
86. Instituto Nacional Indigenista. *Acción Indigenista* 39 (September 1956).
87. Instituto Nacional Indigenista. *Acción Indigenista* 55 (January 1958).
88. Instituto Nacional Indigenista. "Informe Jamiltepec, 1959." CDICDJR, FD 20/0025, Mexico City, Mexico.
89. Instituto Nacional Indigenista. "Programa de Acción Indigenista y Presupuestos, 1969." CDICDJR, FD 09/0024, Mexico City, Mexico.
90. Instituto Nacional Indigenista, *¿Que es el I.N.I.?* México: Instituto Nacional Indigenista, 1955.
91. Jarquin, Nicolas Mendoza. "Informe General de Actividades Desarrolladas Durante el Año de 1963." CDICDJR, FD 20/0026, Mexico City, Mexico.
92. Kapelusz-Poppi, Ana Maria. "Physician Activists and the Development of Rural Health in Postrevolutionary Mexico." *Radical History Review* 80 (2001): 35-50.
93. Kapelusz-Poppi, Ana María. "Rural Health and State Construction in Post-Revolutionary Mexico: The Nicolaita Project for Rural Medical Services." *The Americas* 58 (2001): 261-283.
94. Kelly, Isabel T. and Héctor García Manzanedo. *Santiago Tuxtla, Veracruz: Culture and Health*. Mexico: Secretaría de Salubridad y Asistencia, 1956.
95. Kelly, Isabel T. "The Bienestar Social Rural Program, with Special Reference to the Pilot Project in Villa Jose Cardel, Veracruz." CDICDJR, FD 05/0012, Mexico City, Mexico.
96. Langley, Lester D. *The Americas in the Modern Age*. New Haven: Yale University Press, 2003.
97. Lechuga, Augusto Fujigaki. "Los Programas de Bienestar Rural en México." In *La Atención Medica Rural en México, 1930-1980*, compiled by Héctor Hernández Llamas, 253-268. México: Instituto Mexicano del Seguro Social, 1984.
98. Lewis, Oscar. *Life in a Mexican Village: Tepotzlán Restudied*. Urbana: University of Illinois Press, 1951.
99. Lewis, Stephen E. "México's National Indigenist Institute and the Negotiation of Applied Anthropology in Highlands Chiapas, 1951-1954." *Ethnohistory* 55 (2008), 609-632.

100. Lira, Pilar Hernández. "State of Michoacán – Geographical Review and Report of the visit to the Coordinated Sanitary Services of Michoacán." Folder 1726, Box 145, Series 323J, Record Group 5.3, The Rockefeller Archive Center, Sleepy Hollow, New York.
101. Lomnitz-Adler, Claudio. *Exits from the Labyrinth: Culture and Ideology in the Mexican National Space*. Berkeley: University of California Press, 1992.
102. Lopez-Acuña, Daniel. "Health Services in Mexico." *Journal of Public Health Policy* 1 (1980): 83–95.
103. Loyo, Engracia. "La empresa redentora: La Casa del Estudiante Indígena." *Historia Mexicana* 46 (1996): 99-131.
104. Mak, Cornelia. "Mixtec Medical Beliefs and Practices." *América Indígena* 19 (1959): 125-150.
105. Malkin, Victoria. "Narcotrafficking, Migration, and Modernity in Rural Mexico." *Latin American Perspectives* 28 (2001): 101-128.
106. Martínez, Fernando Escarza. "Dirección Coordinadora del Programa Bienestar Social Rural (Sección Técnica: Concepto Moderno de Salud: Individual, Familiar Colectiva y Publica." CDICDJR, FD AI/0011, Mexico City, Mexico.
107. Martínez, Fernando Escarza. *El Programa de Bienestar Social Rural*. México: Secretaría de Salubridad y Asistencia, 1958.
108. Martínez, Fernando Escarza. "S.S.A. – Dirección Coordinadora del Programa de Bienestar Social Rural: Organización de Comunidad." CDICDJR, FD 09/1213, Mexico City, Mexico.
109. McCrea, Heather. *Diseased Relations: Epidemics, Public Health, and State Building in Yucatán, Mexico, 1847-1924*. Albuquerque, University of New Mexico Press, 2010.
110. Medrano, Ethelia Ruiz. *Mexico's Indigenous Communities: Their Lands and Histories, 1500-2010*. Boulder: University Press of Colorado, 2010.
111. Mendizábal, Miguel Othón de. "La capacidad económica de los municipios de la República Mexicana." In *Obras Completas, tomo quinto*, by Miguel Othón de Mendizábal. Mexico: Cooperativa de los Talleres Gráficos de la Nación, 1946.
112. Mendizábal, Miguel Othón de. "Los problemas indígenas y su más urgente tratamiento." In *Obras Completas, tomo quinto*, by Miguel Othón de Mendizábal. Mexico: Cooperativa de los Talleres Gráficos de la Nación, 1946.

113. Mendizábal, Miguel Othón de. "Por el mejoramiento de la salubridad en Mexico." In *Obras Completas, tomo sexto*, by Miguel Othón de Mendizábal. Mexico: Cooperativa de los Talleres Gráficos de la Nación, 1946.
114. Mindek, Dubravka. *Mixtecos México*: CDI: PNUD, 2003.
115. Mólgora, Marco A. Calderón. "Lázaro Cárdenas del Río en la Cuenca Tepalcatepec-Balsas." In *La Tierra Caliente de Michoacán*, edited by José Eduardo Zárate Hernández, 233-266. Morelia: El Colegio de Michoacán, 2001.
116. Nagengast, Carole and Michael Kearney. "Mixtec Ethnicity: Social Identity, Political Consciousness, and Political Activism." *Latin American Research Review* 25 (1990): 61-91.
117. Noriega, Raül. "Mexico postpone cualquier plan de colonización." In *El Problema Indígena de México*, by Lázaro Cárdenas. México: Departamento de Asuntos Indígenas, 1937.
118. Ortiz, Jose Figueroa. "Filosofía y Dinamica del Programa de Bienestar Social Rural: Ponencia Presentada a la IX Reunion de la Sociedad Mexicana de Higiene, 1955." CDICDJR, FD AI/0011, Mexico City, Mexico.
119. Palmer, Steven. *From Popular Medicine to Medical Populism: Doctors, Healers, and Public Power in Costa Rica, 1800-1940*. Durham: Duke University Press, 2003.
120. Patiño, Emilio Alanis. "La Población Indígena de México." In *Obras Completas, tomo uno*, by Miguel Othón de Mendizábal. Mexico: Cooperativa de los Talleres Gráficos de la Nación, 1946.
121. Pineda, Cuauhtémoc. "Los programas de salud rural en México." In *La Atención Medica Rural en México, 1930-1980*, compiled by Héctor Hernández Llamas. México: Instituto Mexicano del Seguro Social, 1984.
122. Prieto, Ignacio Morones. *Bienestar Social Rural en México*. México: Secretaría de Salubridad y Asistencia, 1954.
123. Ross, Rafael Mijangos and Pablo Velazquez Adrian Breña G. *Un Año de Trabajo en el Centro Coordinador de las Mixtecas*. México: Instituto Nacional Indigenista, 1955.
124. Rubel, Arthur J. "Social Science and Health Research in Latin America." *Milbank Memorial Fund Quarterly* 46 (1968): 21-33.
125. Rubin, Jeffrey W. *Decentering the Regime: Ethnicity, Radicalism, and Democracy in Juchitán, Mexico*. Durham: Duke University Press, 1997.

126. Ruz, Mario Humberto. "Los Profesionales de la Medicina," In *La Antropología Médica en México*, edited by Roberto Campos Navarro. México: Instituto Mora, Universidad Autónoma Metropolitana, 1992.
127. Saenz, Moises. *Some Mexico Problems*. Chicago: The University of Chicago Press, 1926.
128. Saldana, Juan Jose and Luz Fernanda Azuela. "De amateurs a profesionales. Las sociedades científicas mexicanas en el siglo XIX." *Quipu*, 11 (1994): 135-172.
129. Sánchez, Jesús Carlos Morett. *Reforma Agraria: Del Latifundio al Neoliberalismo* México: Universidad Autónoma Chapingo, 2003.
130. Secretaría de Recursos Hidráulicos. "Comisión de Tepalcatepec." CDICDJR, FD 39/0033, Mexico City, Mexico.
131. Secretaría de Recursos Hidráulicos and the Comisión del Tepalcatepec. *La Obra del Gobierno del Señor Presidente Alemán en la Cuenca del Río Tepalcatepec*. Uruapan, Michoacán, 1950.
132. Secretaría de Salubridad y Asistencia. "Dirección Coordinadora del Programa de Bienestar Social Rural: La Promoción Agropecuaria y el Mejoramiento de la Alimentación Popular del Programa de Bienestar Social Rural." CDICDJR, FD 9/1213, Mexico City, Mexico.
133. Secretaría de Salubridad y Asistencia. "Programa de Bienestar Social Rural." CDICDJR, FD 9/1213, Mexico City, Mexico.
134. Solórzano, Armando. "La influencia de la Fundación Rockefeller en la conformación de la profesión médica Mexicana, 1921-1949." *Revista Mexicana de Sociología* 58 (1996): 173-205.
135. Stavenhagen, Rodolfo. "La sociedad plural en América Latina." *Diálogos* 55 (1974): 5-10.
136. Stern, Alexandra Minna and Howard Markel. "International Efforts to Control Infectious Diseases, 1851 to the Present." *JAMA* 292 (2004): 1474-1479.
137. Stern, Alexandra Minna. "Responsible Mothers and Normal Children: Eugenics, Nationalism, and Welfare in Postrevolutionary Mexico, 1920-1940." *Journal of Historical Sociology* 12 (1999): 369-387.
138. Warman, Arturo. *Ensayos Sobre el Campesinado en México*. México: Editorial Nueva Imagen, 1980.
139. Whetten, Nathan L. "Salud y Mortalidad en el Mexico Rural." In *La Atención Médica Rural en México, 1930-1980*, compiled by Héctor Hernández Llamas, 147-180. México: Instituto Mexicano del Seguro Social, 1984.

140. Vaughan, Mary Kay. *Cultural Politics in Revolution: Teachers, Peasants, and Schools in Mexico: 1930–1940*. Tucson, AZ: The University of Arizona Press, 1997.
141. Voekel, Pamela. *Alone Before God: The Religious Origins of Modernity in Mexico*. Durham: Duke University Press, 2002.

## STEPHANIE L. BAKER

### EDUCATION

- 2004-2012      **University of Illinois at Chicago** Chicago, Illinois  
 Ph.D. in History 2012 (Dissertation Defended 4/30/12)  
 Advisor: Christopher Boyer
- Dissertation: “Salud Colectiva: The Role of Public Health Campaigns in Building a Modern Mexican Nation, 1940s-1960s”
- Dissertation Committee: Christopher Boyer (chair); Molly Doane; Robert Johnston; Gabriela Soto Laveaga; Javier Villa-Flores
- 2000-2001      **Brown University** Providence, Rhode Island  
 M.A. in History 2001  
 Advisor: R. Douglas Cope
- Thesis: “Refuting the Pigeonhole: The Role of Dwight Morrow’s Diplomacy in Portraying a Realistic View of Mexico to the United States after the Mexican Revolution.” *Added to the Dwight W. Morrow Collection, Amherst College Archives*
- 1996-1999      **Auburn University** Auburn, Alabama  
 B.A. in History / Minor in Spanish (Summa Cum Laude) 1999  
 Advisor: Joseph Kicklighter

### AREAS OF CONCENTRATION

- Fall 2007      **PhD Preliminary Examinations**  
 Major Field: Latin American History  
 Minor Fields: Mexican History; Immigration History; US Diplomatic History

### HONORS, SCHOLARSHIPS, AND AWARDS

- Spring 2009      Provost’s Award for Graduate Research  
 Spring 2009      Marion Miller Dissertation Fellowship  
 Spring 2009      Rockefeller Foundation Grant-in-Aid recipient  
 Summer 2008      Fellow, Oaxaca Summer Institute  
 May 1999      Distinguished Undergraduate History Major Award  
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### PRESENTATIONS

- 2013      Baker, S.L. *The Science of Improvement: Race, Public Health and Politics, Part II*. Panel Chair, Organizer, and Presenter at the American Historical Association Annual Meeting, New Orleans, Louisiana, January 3, 2013. (accepted)
- 2012      Baker, S. L. *Salud Colectiva/Collective Health: The Role of Mexico’s Health Promotion Campaigns in Building a Modern Nation, 1940s-1960s*. Presentation at the Center for Latin American and Caribbean Studies Graduate Student

Conference “Latin American Studies in Practice: Theory Beyond the Academy,”  
Bloomington, Indiana, April 13, 2012.

- 2011 Baker, S. L. *Salud Colectiva/Collective Health: The Role of Mexico's Health Promotion Campaigns in Building a Modern Nation, 1940s-1960s*. Presentation at the New England Council for Latin American Studies Annual Meeting, Hanover, NH, November 5, 2011.
- 2010 Baker, S. L. *The Limits of International Health Campaigns: Mexico's Experience with the Rockefeller Foundation, 1940-1950*. Presented at the Rocky Mountain Council for Latin American Studies Annual Meeting, Boulder, CO, April 10, 2010.

## PUBLICATIONS

- 2012 Baker, S.L. “Salud Colectiva/Collective Health: Mexico's Bienestar Social Rural Pilot Program,” *Endeavour*. (manuscript in progress)
- 2012 Baker, S. L. Review of *Mexico's Indigenous Communities: Their Lands and Histories, 1500-2010*, by Ethelia Ruiz Medrano. *Bulletin of Latin American Research*. (forthcoming)
- 2011 Baker, S. L. “Health and Medicine” in *American Centuries: The Ideas, Issues, and Trends that Made US History, Volume 5*, ed. Robert Johnston. New York, N.Y.: Facts on File, 2011.
- 2010 Baker, S. L. “Immigration”; “Immigration Restriction”; and “Imperialism” in *Encyclopedia of U.S. Political History, Volume 4, 1878-1920*, ed. Robert Johnston. Washington, D.C.: Congressional Quarterly Press, 2010.
- 2009 Baker, S. L. *The Limits of International Health Campaigns: Mexico's Experience with the Rockefeller Foundation, 1940-1950*. The Rockefeller Archive Center. <http://www.rockarch.org/publications/resrep/baker.pdf>

## ACADEMIC SERVICE

Fall 2011	Teaching Assistant, Latin American History to 1850 HIST 261
Spring 2011	Teaching Assistant, Western Civilization from 1648 HIST 101
Fall 2010	Teaching Assistant, Latin American History to 1850 HIST 261
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## PROFESSIONAL EXPERIENCE

2003 – 2008	Assistant to the Director, Institute for Health Research & Policy University of Illinois at Chicago
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## LANGUAGES

Spanish	Proficient reading, writing, speaking
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