AMERICAN INDIAN CULTURE AND RESEARCH JOURNAL 33:1 (2009) 47–63

Health Care among the Kumiai Indians of Baja California, Mexico: Structural and Social Barriers

K. JILL FLEURIET

In this article, I document the illness and health care problems facing indigenous communities in Baja California, Mexico, by using ethnographic data from research I conducted from 1999 to 2001 with rural, indigenous Kumiai and with their primary health care providers in urban Ensenada. I contend that barriers to care are structural and social, rather than constituted of competing ideas of illness causation and treatment. A history of multiple medical systems and hierarchical social relations work in concert to produce specific patterns of health care problems for indigenous communities. Multiple medical systems in Mexico rarely result in clearly differentiated models of health care, however. Individual health care beliefs and behaviors frequently blend Western allopathic, or biomedical, beliefs and behaviors with those of homeopathy, herbalism, and different spiritual healing traditions. The primary health care problem that faces indigenous communities is that health care, however defined, is frequently unavailable and rarely comprehensive. Nevertheless, most of their health care providers frequently presume that poor indigenous health is largely a result of competing indigenous illness and health care beliefs. Indigenous health and health care problems are largely a result of economic and ethnic marginalization, as the case of Don Ricardo will demonstrate.[1]

A thin, frail man, fifty-five-year-old Don Ricardo was dying of lung cancer in 1999, when I first spoke with him in his three-room house in an indigenous Kumiai community in northern Baja California. A biomedical physician provided through his employment at the nearby winery had diagnosed his cancer. Don Ricardo was too fatigued to continue his manual labor

Jill Fleuriet is an assistant professor of anthropology at the University of Texas at San Antonio. The research used as the basis for this article was approved by the Stanford Institutional Review Board and was supported with funds from the Mellon Foundation, the Department of Anthropological Sciences at Stanford University, and Philanthropic Educational Organization.

in the vineyards. His treatment regime consisted of biomedically prescribed chemotherapy and radiation, along with self-chosen herbal teas. He regularly drank *hierba buena* (spearmint) tea for general good health, *níspero* (nispero) tea to fight cancer, *manrubio* (*Waltheria americana L.*) tea to purify his blood, *epasote* (epazote/wormseed) tea for stomach pain associated with the cancer and chemotherapy, and two more herbal teas for his hacking cough. During the ensuing months he mostly stayed indoors in his rural community of San Gregorio, sick, weak, and getting thinner.

Before the scheduled surgery to remove the mass in his lungs, his daughter came down to San Gregorio from her home in San Diego, California, to insist on a second opinion from a specialist. She requested the original X-ray from the biomedical physician. The new doctor looked at the X-ray and took another one. It turns out Don Ricardo did not have cancer. Instead, the doctor diagnosed advanced tuberculosis. The new doctor immediately put Don Ricardo on appropriate antibiotic medications, and, within a month, Don Ricardo had experienced a "miraculous" recovery. After a month of treatment, though, he could no longer pay for the costly medications. With his new diagnosis, Don Ricardo returned to the first physician to see if his insurance would subsidize the treatment. Not recognizing the healthier Don Ricardo, the very same doctor chastised him for not coming in sooner to get treated for tuberculosis and gave the tuberculosis medication to Don Ricardo.

What happened with Don Ricardo? On the surface, he could access both of his preferred forms of diagnosis and treatment: biomedicine and herbalism. He received biomedical health care from the private biomedical sector (Mexican Social Security Institute, or IMSS). Biomedicine refers to the Western allopathic medical approach, which is rooted in the study of pathophysiology and its organic, observable causes.[2] By means of his daughter, who worked in San Diego, Don Ricardo could also access additional, specialist care by using transnational family financial ties. From his garden and the local store, he obtained herbs for medicinal teas. Don Ricardo did not want better, different, or more care. Nevertheless, the incorrect biomedical diagnosis easily could have been fatal. He missed months of work and income for his family. During this time, Don Ricardo experienced poor health and low quality of life.

Even though he had access to preferred kinds of care, the biomedical care he received was subpar. Fragmented and inconsistent care is the norm for rural, poor, and indigenous Mexicans such as Don Ricardo.[3] Barriers of cost, time, and transportation, to name a few, make it even more difficult for rural Mexicans, especially those in Indian communities, to seek regular or comprehensive care from any of Mexico's major medical systems, which include allopathic medicine or biomedicine, homeopathy, herbalism, manual medicine, and various forms of spiritual healing. Yet understanding, let alone resolving, problems of access to health care among indigenous Mexicans is not merely a question of barriers to care. It requires an understanding of how self-identity, unequal social relations, and a history of the hierarchy of Mexico's multiple medical systems influence indigenous preference for, access to, and interactions with different forms of available health care.

To demonstrate this, I first briefly introduce the Kumiai community of San Gregorio and describe the general health care situation there. Next, I discuss the history of medical systems in Mexico to show how medical systems have been used to promote existing social hierarchies between indigenous and *mestizo* (Spanish and indigenous ancestry) groups. I then explain how Gregorians have to contend with *mestizo* stereotypes of the indigenous communities in order to access preferred forms of health care by using a case study of a nongovernmental organization (NGO) that is the primary health care provider for Gregorians. Lastly, I provide a macro-level analysis of Gregorian health care problems to offer culturally sensitive recommendations to improve health care for indigenous communities in Baja California.

The data in this article is derived from participant observation and semi-structured interviews from 1999 to 2001 in two rural Kumiai communities; their primary NGO, the Medical Aid Network (La Red Médica), or MedNet; and affiliated doctors in the city of Ensenada, approximately twenty-five miles away. In 1999, I worked for three months in two Paipai and two Kumiai communities, interviewing fifty-nine people about individual and children's illness experiences; beliefs of causation, diagnosis, treatment, and prevention; health care experiences; and perceptions of community health and health care problems. In 2000 and 2001, I focused on one Kumiai community, San Gregorio, and MedNet. During a period of ten months, I interviewed eighty-four of the eighty-seven registered adult Gregorians, the MedNet director, and the MedNet staff. All adult Gregorians self-identified as Kumiai. I selected twenty-nine community members to participate as case studies of illness and health care experiences for four of the five most common self-reported illnesses: diabetes (12 cases/14.3% prevalence), high blood pressure (15 cases/18.5% prevalence), low or variable blood pressure (16 cases/19% prevalence), and kidney problems (15 cases/18.5% prevalence). I conducted extended interviews with the twelve biomedical care providers and one homeopathic doctor most commonly used by Gregorians. I also interviewed a variety of local health care officials involved in indigenous health care. Providers worked in government, public, and private clinics. Interview topics included opinions on community and general indigenous health and health care problems, medical histories, and illness narratives. During this time, I lived in the house of the MedNet founder, worked daily with the MedNet director, and spent most weekdays in San Gregorio, talking informally with community members, participating in daily and community activities, and interviewing community members, or in Ensenada, interviewing MedNet volunteers and government officials.

SAN GREGORIO AND ITS PRESENT HEALTH CARE SITUATION

San Gregorio is a small Kumiai community located outside of Ensenada, Baja California, approximately sixty miles south of Tijuana. It is an *ejido*, a specific form of federally designated land tenure in which a community member has the legal right to exploit a plot of the land grant to the community. The Kumiai historically were a seasonally mobile, coastal foraging Yuman group.[4]

Now they are principally located in settled communities along both sides of the California-Mexico border. In 2000 there were only between 110 and 158 people in residence in San Gregorio, depending on the availability of local or regional seasonal work opportunities. Most adults were affiliated with the Robles or Morales families, which are also traditional patrilineal clans.[5] Each clan had a traditional chief. The community also elected a *comisariado*, or public representative for the community. Relatively affluent commercial cattle ranches and wineries surround San Gregorio. Most Gregorian males had worked as cowboys or agricultural laborers in these adjacent commercial lands. Women occasionally worked in the commercial economy as agricultural laborers or as low-wage workers in nearby multinational production plants or fish-processing plants.

Local government officials and both the MedNet founder and its director cited San Gregorio as the wealthiest of the eight federally recognized indigenous communities in Baja because of its ability to participate in the regional US-Mexico border economy. Its relative wealth was evidenced by the presence of a government store in the community, electricity in most homes by means of a single light bulb, and a more or less reliable water system that transported untreated water into the majority of kitchens. Yet at the time of my fieldwork, the unemployment rate hovered around 50 percent among men, historically the primary wage earners. Averaged across all adults, working and unemployed, the weekly income per adult in 2000 and 2001 was about 285 pesos ($30). Per person including children, about 80 percent of Gregorians had less than 200 pesos ($20) available to them per week. Mirroring the pyramid-shaped class structure of the broader Mexican nation, there was a relatively small group of wealthy Gregorians with a large majority of poor Gregorians. No resident health care provider was located in San Gregorio, and few Gregorians had the means to reach one even when desired or necessary. Roads were unpaved, and the road to San Gregorio was frequently impassable during wet winters.

In San Gregorio, one type of faith-based healing and some popular herbalism existed, but no professional biomedical or homeopathic care, folk medicine, or manual medicine was regularly available. That is, no homeopathic or biomedical doctor was present in the community on a regular basis nor were there commercial herbalists or folk healers. Ritualized attempts at faith-based healing sporadically took place at the evangelical church in San Gregorio. Clergy and laypersons prayed in groups and individually for healing to take place by the grace of the Protestant god. This church managed to hold regular services in San Gregorio because a community member had been trained to conduct services by visiting *hermanos* (religious brothers). Conversely, although San Gregorio had a small one-room Catholic church in which to hold services, the Catholic priest visited only once every several months. The Catholic priest may have prayed for the sick; however, no specific ritual of faith-based healing within that religious context existed.

Although many Gregorians knew of local herbal remedies that they believed were part of an indigenous healing tradition, no indigenous healers were left. *Mestizo* folk healers were rarely used. For community members

younger than forty-five years old, all were born in hospitals or clinics with obstetrical care; no *parteras* (lay midwives) had been sought for prenatal care by any of the women in the community. A few Gregorians had seen *sobadores* (masseuses using folk notions of the body's movements) in their childhood for the folk illness *empacho* (locally defined as a heavy, constipated feeling in the stomach and bowels associated with emotional and physical problems), but no one said they had sought such care in recent years. Instead, biomedicine was viewed as more effective for acute and chronic illness.

For example, of the twenty-nine case studies, only six had not taken biomedical treatment for their conditions. Among the nine diabetics, seven used a combination of prescribed medication and herbal teas, including lemon and loquat. One of these also regularly took homeopathic medications to help manage blood-sugar levels. The other two diabetics used neither herbal nor biomedical remedies. Among the thirteen high blood pressure sufferers, five used only medicines from biomedical providers; four used a combination of medicines and lemon and/or olive leaf teas. One took biomedicine and homeopathic medicine to control the high blood pressure. Two took no teas or medications, although one regularly drank lemon tea but took no medication. Among eight case studies with kidney problems, three periodically took medications for their infections. Two drank juniper and Mormon tea to control kidney pain but did not take medications. Low or variable blood pressure did not match clinical definitions of low or variable blood pressure. Nevertheless, of the six case studies with low or variable blood pressure, three reported having taken medications prescribed by a biomedical doctor. Two also drank olive leaf tea to manage the condition. Of the remaining three, two drank olive leaf tea but took no medication, and the third did not follow any treatment when suffering from low or variable blood pressure. Overall, Gregorians used and expressed a preference for biomedical treatments for common illnesses.

Biomedicine had an intermittent professional presence in San Gregorio. A few popular biomedical remedies, such as aspirin, were regularly sold in the small, sparsely stocked community store. There was a clinic consisting of a two-room building set aside for doctor visits. Rarely did it contain any medical equipment or medications. Nor was it regularly staffed. *Pasantes* (recent medical school graduates serving a required year in a medically underserved area) visited San Gregorio from nearby towns once or twice a month, but these visits were not reliable. A nurse and a community health worker consistently visited twice a month. The *pasantes* and nurses focused on vaccinations, tests for diabetes and high blood pressure, and acute care for children and the elderly. If the medicines were not given during these visits, residents were expected to travel to a pharmacy in a nearby town to purchase them. Frequently this did not occur due to lack of immediate funds and/or transportation. Similarly, hospitals were difficult to access because of their urban locations.

The most regular professional medical presence in the community was through MedNet. MedNet staff organized medical brigades two to three times a year that consisted of available health care providers. They provided on-site free dental, chiropractic, and biomedical care, including preventive and acute

care. Medicines, vitamins, and personal health items, such as toothbrushes and toothpaste, were distributed. Gregorians were willing to use these services because the MedNet director, who was a member of their own community, organized the brigades. The director of the Medical Aid Network and the director and staff of MedNet's parent institution, the Native Cultures Institute (Instituto de Culturas Nativas), had built trust and social ties with Gregorians. The high turnout for the medical brigades sharply contrasted with the reluctance to visit *pasantes*, who did not enjoy this level of trust, even though they were licensed physicians.

Due to the difficulty inherent in accessing services outside of the community, most Gregorians evaluated their health care options in terms of perceived efficacy (alleviation of symptoms), severity of disease, and cost.[6] Fifty percent of adult Gregorians had no health insurance. MedNet served the overwhelming majority (35 Gregorians/87.5% of uninsured population) of these. In order to be served by MedNet, indigenous community members must have had their community membership and poverty validated by the *comisariado*, with input from the community, during a community meeting. Public and private employer programs covered forty-two (50.0%) adult Gregorians. MedNet volunteer providers included biomedical doctors, homeopaths, herbalists, chiropractors, and, if requested, folk healers. Provided sufficient funding existed, MedNet covers patients' transportation costs to and from Ensenada as well as medicines. State-sponsored programs did not provide transportation, though some of their clinics provided some medicines that are free of charge.

In light of these many constraints, long-term care for chronic illness was a serious problem for Gregorians. Supervised and coordinated care for a patient that required multiple visits was rare, particularly for the poor of San Gregorio who lacked the means to advocate for themselves. Even MedNet did not have a basic medical chart filing system by which to follow a patient, and its providers did not exchange information about shared MedNet patients. This lack of record keeping was a nationwide problem in Mexico and was not restricted to NGOs. The ability to follow a rural, poor patient from a primary care visit through a hospital stay is extremely limited in Mexico.[7] As a result, patients such as Don Ricardo can and do receive substandard, inconsistent, and even damaging health care.

MEDICAL SYSTEMS IN MEXICO: A HISTORY OF INEQUALITY

The relationship among preference of medical systems, local health care options, and the complete array of health care in a society reflects economic, political, and social relations between a community and the larger society.[8] Local issues of access and preference in Mexico are also connected to national and historical hierarchical processes. These connections often explain past and current health and health care disparities.[9] A brief history of competing and complementary medical systems in Mexico will demonstrate how current health care issues in San Gregorio are tied to historical relations between indigenous and nonindigenous Mexicans.

In a marginalized community such as San Gregorio, rarely are multiple medical systems fully articulated, present, or available. A medical system consists of the inclusive concepts, practices, and institutions associated with diagnosis, treatment, and prevention of locally identified illnesses.[10] Each system has three primary sectors in which its health care is produced and accessed: popular, folk, and professional. The popular sector includes family and community care. The folk sector includes noninstitutionalized curers. In Mexico, popular and folk sectors are further separated into nonindigenous and indigenous. The professional sector consists of Western-originated biomedicine as well as any other professionalized healing tradition. Most societies encompass multiple medical systems. The presence of multiple systems implies that most individuals utilize more than one system.[11] Yet any given community may have only partial access to one or two medical systems. Moreover, an individual may not distinguish among medical systems but may have a plurality of beliefs and behavior from different healing traditions.[12]

Historically, indigenous medical systems in Mexico were actively, sometimes violently, discouraged by religious and government officials. There were isolated instances in which they were integrated into nonindigenous medical systems. Indigenous medical codices were destroyed during the Spanish conquest in the early sixteenth century, yet some Aztec and other indigenous medicines were soon recognized as superior to those of contemporaneous Spanish Hippocratic-Galenic medicine. Queen Isabella of Spain and the reigning pope ordered scribes to record oral indigenous medical knowledge. Selected indigenous herbal medicines were slowly incorporated into colonial health practices while the accompanying etiological beliefs and curing ceremonies were ignored. Of particular note is that in the middle of the sixteenth century, the Colegio de Santa Cruz de Tlatelolco in Mexico City was founded to educate indigenous students in European culture in an overt attempt at acculturation and assimilation. Nevertheless, this same *colegio* also employed elder Aztec healers to teach Aztec medicine.

Although indigenous herbalism was incorporated into Spanish biomedicine, indigenous healers and citizens were most often persecuted or, at the least, politically and economically marginalized by colonial programs and authorities.[14] For example, Catholic missionary priests often claimed indigenous spiritual practices to be pagan. Because mission resources for their newly enforced sedentary lifestyles frequently depended on professed conversion, many indigenous communities nominally agreed to the priests' assertions and, in so doing, gradually lost vital aspects of their pre-Hispanic culture.[15] In rural regions such as those in Baja California, this included the loss of specific healing practices and even entire indigenous healing traditions.[16] It is possible some became hidden and persist today. During this research, no one mentioned the presence of any current or recent indigenous healers.

Mexican independence from Spain in 1821 and the subsequent secularization of the missions in 1835 ushered in significant changes in health care. Church and state were separated so that hospitals began to operate under the aegis of the state. At the time, Mexican relations with France were particularly strong. French medical practices, such as positivism, significantly

influenced Mexican medical practice. Mexican physicians switched allegiances from Hippocratic-Galenic medicine to French biomedicine, and French texts emphasizing reductionism and positivism became standard in Mexican medical universities. Even though prestige and economic and political power were increasingly in the hands of Mexican physicians, indigenous herbal medicine also continued to flourish. In fact, the constitution of 1857 guaranteed freedom for all health practices.[17] Correspondingly, doctors continued to use herbal medicines, though secondarily to French biomedicine, so that herbalism has survived as a vital part of *mestizo* healing culture today as well as a potential part of a biomedical doctor's professional healing repertoire.

Similarly, homeopathy has long been a part of the national medical repertoire in Mexico. In the mid-1800s, homeopathy arrived and since then the government has sanctioned it.[18] That is, homeopaths have the legal right to practice in government hospitals though biomedical doctors control admission onto hospital staff. Homeopathic physicians follow a philosophy that medicines containing minute amounts of substances that produce similar symptoms of the illness will initiate the body's natural defenses.[19]

Today's Mexican government sanctions some of these medical systems. Biomedicine, homeopathy, and herbal medicine are all considered valid medical systems.[20] There is also a flourishing folk sector of health care. For example, *curanderismo* combines ancient and recent Native American and Judeo-Christian healing traditions; Moorish and Aztec herbalism; and New Age, Eastern, and parapsychological healing practices.[21] Although not a medical system per se, various other forms of religious faith healing are also popularly supported. Faith healing is tied to a religious system, such as evangelical Protestantism or Mexican spiritualism, and is variably accepted by Protestant Mexicans.[22] In a related vein, several forms of manual medicine are available in the folk sector: *sobadores* and *hueseros*, or lay bonesetters.[23] Another type of folk healer is a *parteras*. These lay midwives are used with or without formal obstetrical care.[24]

In a few states such as Chiapas and Oaxaca, indigenous healing systems have survived. Current forms blend to different degrees with *mestizo* faith-healing traditions. In most states, including Baja California, it is rare to find a flourishing indigenous medical system. Instead, a few partial indigenous etiologies and treatments remain that are most often engaged when drawing on other medical systems such as biomedicine and herbalism. The majority of Mexicans, including indigenous Mexicans, use multiple medical systems and sectors, varying in scope and content with each different illness and/or due to access.[25] In 1998, for example, the majority of health expenditures were out-of-pocket expenses for popular and folk health care.[26]

If Mexico is so clearly medically plural from a structural perspective, why is health care so limited in indigenous communities? Unlike the United States, the Mexican government has confirmed the right to health care several times over. The "right to health care is guaranteed in Article 4 (amended in 1983) of the political constitution, which states that every person has [the] right to health protection and the law will define the conditions for access to the

services."[27] Yet in a country with 48 percent of the population uninsured and a poverty rate of 43 percent, half of which is extreme poverty, many individuals do not have the income or other means to have all systems at their disposal.[28] This frequently applies to indigenous Mexicans, who, along with their medical systems, have been historically, economically, politically, and socially marginalized. As a result, they have partial access to only some medical systems or, in some cases, access to only certain sectors of a given medical system. Even if indigenous Mexicans had full knowledge of the various systems available, the task of choosing and then accessing an appropriate system would be difficult with existing barriers of cost, transportation, and time.

These barriers are a result of a historical lack of employment opportunities in indigenous communities on rural lands chosen by the government. Access to the biomedical system primarily rests on employment. Table 1 details how the government organizes and finances biomedical care.[29] Additionally, there is private fee-for-service care and some NGOs that coordinate free or prorated care and/or medications for certain groups. Between the years 1995 and 2000, Mexico instituted a Health Sector Reform Program that was designed to facilitate information and services exchange among the systems.[30] Except for inclusion of family in the IMSS (see table 1) programs, none of these changes had reached members of San Gregorio by 2001.

Being indigenous in Mexico also restricts access to health care because access has always been linked to hierarchical social relations. Class structure in Mexico devalues indigenous identity and culture. Class position is based on income, ethnicity, and geographic location. Rural, poor, indigenous Mexicans are on the lowest rung of the class system, while wealthy, urban *mestizos* are at the top.[31] Likewise, indigenous medicine is considered the least prestigious and effective medical calling in Mexico, while biomedicine carries the most social and political power.[32] Homeopathy ranks second after biomedicine, followed by *mestizo* faith-based/religious healing.[33]

Table 1
The Formal Structure of Mexican Health Care in 2000–2001

	Private Sector Employees and Self-Employed		Military	Public Sector Employees	Uninsured		
Name	IMSS	PEMEX	SEDENA	ISSSTE/ISSSTECALI	IMSS-Sol	SSA	Other
	Mexican Social Security Institute	Mexican petroleum industry	Secretary of National Defense	Social Security and Services Institute for Government Employees	IMSS Solidarity	Secretary of Health	e.g., Medical Aid Network
Financed by	Employees, employers, and federal government	Petroleum industry	Federal government	Employees and government (ISSSTE—federal, ISSSTECALI—state of Baja California)	Federal government		Private funds, grants

GREGORIANS AND MEXICAN MEDICAL SYSTEMS

Poverty and an indigenous identity affect access to care in Mexico, irrespective of any preference for a medical system. Poverty clearly limits access, but indigenous identity paradoxically limits and increases access. In an historic sense, indigenous communities were geographically and socioeconomically marginalized. Most care is in urban areas and for the wealthy. But through MedNet, a formally recognized indigenous identity could get Gregorians more of their preferred health care because the first criterion for MedNet eligibility was recognized membership in an indigenous group. Because MedNet was the primary health care provider in San Gregorio, a conscious use of indigenous identity was necessary for most Gregorians to procure their preferred form of health care.

Identity is a multivalent phenomenon. It is differentially and variably defined and applied by any given individual or group. The Mexican concept of *indigenismo*, or being indigenous, has been actively produced by local indigenous communities, by the regional and national movements of Mexican indigenous groups, and by state and national institutions that historically have little to no indigenous representation within them.[34] Within any given indigenous community, being indigenous has a similar diversity of meanings and applications. In the health care arena, Gregorians defined *indigenous* as a means to access preferred health care while recognizing their own blended identities. They also treated the terms *indigenous* and *mestizo* as binary oppositions when discussing certain aspects of lifestyle, health, and illness. In interviews and conversations, they referred to an older, healthier lifestyle as "indigenous," one in which people ate a diet low in refined carbohydrates, were rarely ill, and lived to an old age. Although they saw their ethnic identity as still indigenous, it rarely extended past a definition of common ethnic and linguistic heritage and clan affiliation. Even the latter two were in flux. Clan affiliation increasingly did not figure into marriage and residence patterns of younger generations. Only a few elders spoke Kumiai regularly and fluently. The majority of Gregorians were Spanish speaking and knew only a handful of Kumiai words. Daily activities were not remarkably distinct from nonindigenous rural and/or poor populations. No Kumiai artisan work or occupations were practiced at the time of research. Their preferred health care was professional biomedicine. Not one community member said current illnesses were better treated with indigenous medicines. No Gregorian I spoke with claimed to have known or visited an indigenous healer. Neither did anyone say that they had recently used a folk healer, such as a *curandero*. The Gregorians nevertheless had to use their indigenous identity to access biomedical care. Defining themselves as "indigenous" to access preferred health care, though, was at odds with Gregorians' use of this concept in other contexts.

In interactions with health care providers, clearer binary oppositions of indigenous and *mestizo* were reproduced and employed. MedNet required participants to be documented as a member of an indigenous community in Baja California. In order to garner funding and support, MedNet

administrators had to demonstrate a need, and this need was easily understood by biomedical doctors when they said their target population was indigenous and poor. Thus, in San Gregorio, in order to garner access to the optimal professional *mestizo* health care, one had to prove their indigenous identity, lack of health insurance, and poverty. For Gregorians, it was obvious they were entering the health care system with the stigma of being indigenous. With a Medical Aid Network affiliation, it was assumed they were rural "Indios," even when they actively attempted to combat these assumptions.[35]

One common effort was to dress in nicer, borrowed clothes and jewelry to appear wealthier and more urban to the doctors. Unfortunately, at least three doctors interpreted their appearance differently. In conversations with the MedNet director, each of these providers questioned how deserving these patients were of free care, if they could afford such clothes and jewelry. The director, also from San Gregorio, had to explain the intentions of these MedNet patients. Therefore, although Gregorians are able to access the professional *mestizo* health care sector, they do so only by using their indigenous Kumiai identity that historically has been associated with poverty and substandard care by the very health care system they prefer to utilize.

The social relations resulting from historical economic and political processes produced these false dichotomies of indigenous and *mestizo* identity, and they also were reproduced in the indigenous patient-biomedical provider interaction. From their dedication to improvement in indigenous health and their lack of financial motive, MedNet doctors can be considered a select upper socioeconomic group of liberal-minded *mestizos*. They were all professionally established doctors with offices and hospital assignments. They volunteered for MedNet and received no financial benefit from serving MedNet patients. Without fail, the doctors explained their participation in MedNet as something they felt obligated to do as a health care provider. During interviews with me, despite their relatively nonjudgmental stances, the doctors' beliefs frequently supported class and ethnic hierarchies and binary oppositions of *mestizo*/indigenous.

A certain sense of *noblesse oblige* emerged during interviews with MedNet doctors. This translated into a jaundiced view of their indigenous patients. Each identified indigenous patients as having poor health. Explanations for these conditions varied. Most providers recognized structural barriers of geography and poverty, yet they also treated ethnicity as a reason for indigenous illness patterns, beliefs, and behaviors rather than as a historically produced label that was a barrier in and of itself. One provider contended that the high rate of illness in indigenous communities was because of *mestizaje*, or the mixing of European/Mexican and indigenous blood, which made them weaker and more susceptible to illness. But providers also attributed the severity and frequency of indigenous illness to poor hygiene and an unwillingness of indigenous patients to come in until later, less treatable stages of illness. One doctor explained this by saying that indigenous peoples had a higher pain threshold that was most likely a genetic trait that allowed them to withstand the levels of pain that brought other patients to the doctor. Another posited that due to "ignorance," indigenous patients had more fear of

doctors than *mestizos*.[36] When the issue of geography was raised, some doctors connected a rural living situation with barriers to care, although it was more common to hear that rural communities were the most ignorant. Following this assertion, two doctors claimed that the rural patient, regardless of his or her ethnicity, had the least amount of education. One doctor equated uneducated, rural patients with indigenous patients.

This conflation of class, ethnicity, and geography corresponded to the local characteristics of marginality: rural, poor, and indigenous. Indirectly, each provider reinforced the notion that the Kumiai were the most marginalized of Baja Californians. Four providers also talked explicitly about what they perceived to be a culture of dependency among indigenous patients. One provider believed that indigenous communities were self-marginalized. According to his theory, paternalistic practices of charity in the past had created a sense of entitlement for indigenous patients. He asserted that aid programs should empower rather than dole out privileges. The providers put a value judgment on the indigenous patient, perceiving her to be more helpless and ignorant than the typical urban *mestizo*. Several providers told me that they did not discuss causes and prevention of illnesses with indigenous patients because they would "not be able to understand." This comment explained in part why few Kumiai reported any communication between themselves and their providers regarding cause and explanation of their illness.[37]

Two doctors stood out against the rest in terms of their holistic and culturally relativist positions. The first was an occupational health specialist. In his discussions of indigenous health, he focused on the lack of education of basic health issues among indigenous patients and programs ostensibly aimed at preventing chronic conditions. He saw the lack of resources as the primary barrier to care. When he worked as a *pasante* he noted the relationship between increased resources and earlier medical care. Although it was equally difficult for him to understand how barriers could influence beliefs about treatment, this occupational health doctor was more interested in community-wide prevention programs and resisted a reductionist approach to health problems.

The other exception was a medical doctor who was also a chiropractor. He attributed the indigenous disease load to structural constraints on health and well-being and general poverty. Were there sufficient funds, resources, and education, he reasoned, indigenous health would be equivalent to urban, wealthier *mestizos*' health. To promote alleviation of symptoms and earlier health care–seeking behavior, he encouraged indigenous patients to use the multiple systems available to them: *sobadores*, chiropractors, and biomedical doctors. He criticized MedNet and other doctors of reductionism.

This review of provider attitudes regarding indigenous patients' illnesses and health care behavior and beliefs demonstrates the variability of perceptions in an otherwise similar group of health care providers. Yet aside from the two notable exceptions of one biomedical doctor and one biomedical doctor and chiropractor, all considered the indigenous patient to be uneducated, unhygienic, and noncompliant. Most attributed lack of strict adherence to the biomedical model of disease and treatment as evidence of ignorance

characteristic of indigenous communities; others focused on poverty. To their credit, these providers nevertheless recognized socioeconomic barriers to care.

These providers can be seen as reflective of biomedical practice in Mexico, its status, and its relationship with medically underserved patients. Biomedicine enjoys prominence in mainstream Mexican formal health care. This is particularly true in northern Baja, where there is not another major healing tradition that professionally competes with biomedicine. Most MedNet doctors reflect their professional and social status and prestige by focusing on how the indigenous patient does not comply with biomedical standards, rather than contemplating how biomedicine could reach out to these communities. Although no doctor directly blamed indigenous patients for becoming ill, there was indirect responsibility placed on the indigenous patient to seek care earlier and more frequently. As in the case of Don Ricardo, it was implied that if an indigenous patient did not come in until later stages of the illness, it was the fault of the patient and not the system. The biomedical providers' unarticulated assumptions of responsibility of the patient, combined with Mexican notions of class and ethnic hierarchies, manifest as a passive blaming of the indigenous patient for persistent illnesses. Access to the preferred health care is thus dependent on negotiating these unequal social relations in marginalized health care environments. The perceptions of indigenous and *mestizo* on the parts of Gregorians, their providers, and aid organizations drive preference for and access to biomedicine. These perceptions suggest a lower standard of care delivered to the indigenous patient. Clearly, a better understanding of the indigenous cultures and their particular economic and political histories by the biomedical providers is warranted, with the hope that better health care will be delivered.

A MACRO-LEVEL ANALYSIS OF GREGORIAN HEALTH CARE WITH RECOMMENDATIONS

It is possible that the mismanagement of Don Ricardo's case was, in part, due to the individual provider's decisions. Yet, as the above analysis of MedNet providers demonstrates, common themes shape how MedNet providers approach the patient-provider interaction. These themes emerge from a distinct political economic history of indigenous communities and Mexican medical systems. Thus from a macro level, Mexico is medically plural, suggestive of a scenario in which the indigenous sift through a multiplicity of coexisting beliefs and various options for care within existing medical systems. When brought to the local level of isolated, rural communities, Mexico's medical systems become disconnected. Likelihood of usage is mostly based on limited finances and local preferences of care. Negotiating an indigenous identity becomes a barrier to care during patient-provider interactions. The result is inadequate medical care.

Between 2001 and 2006, Mexico instituted sweeping health care reform to provide biomedical health care to more Mexicans. One target area was health inequalities, many of which are found among Gregorians. A major legislative

reform in 2003 provided universal health insurance to the self-employed, unemployed, and those employed in informal sectors through the newly established Social Protection in Health. Called Popular Health Insurance, the program aimed to enroll 45 million Mexicans by 2008.[38] Early analyses suggest that this program has improved access to care for more Mexicans.

Reforms and interventions must also be culturally sensitive. The issue of indigenous identity management and pervasive indigenous stereotypes persist. Understanding how social relations between the indigenous patient and *mestizo* biomedical providers and how perceptions of social relations affect health care behavior and choices provides applied health-needs research with powerful tools. For example, because of the prestige and preference for mainstream *mestizo* medicine, the most obvious health intervention is a permanent biomedical health care provider that is easily accessible to the community. There are several ways to accomplish this. A community health worker, or *promotora*, program could be funded by MedNet to train and put in place community members who could serve as a first line of health care and constant resource to navigate the limited but varied health care resources. The *pasante* program could also be strengthened by predictable, frequent visits accompanied by experienced doctors who reside and practice in nearby towns. These experienced doctors are known to and respected by Gregorians and give credence to the *pasante*'s work. Moreover, if doctors recommend and work with nearby popular sector healers, such as *sobadores* and *curanderos*, rather than reject them, MedNet could more inexpensively provide maintenance physical and mental health care. Even more effective would be a constant, trusted biomedical presence in the community to lend prestige and encouragement to what care is available.

Increased communication among providers from the various medical systems in Mexico could also increase consistency and quality of care for Gregorians. MedNet could initially gather a coalition of healers from different medical systems to exchange information among one other with the specific intent to find inroads to collaboration. The goal would be to provide the most comprehensive care to indigenous patients, not to exclude one form of treatment. For major illnesses, an ideal treatment protocol incorporating multiple systems' care could be designed. By using this protocol, a MedNet coordinator could schedule multiple interactions with providers in Ensenada. If managed correctly, patients would receive more overall care and more comprehensive care addressing mental and physical aspects of illness.

The next step is to bring healers from multiple systems to San Gregorio. An existing, effective medium is the MedNet brigades. MedNet invites all providers, but the majority of providers who participate are biomedical providers. In one instance, a chiropractor joined the brigade. Community members were initially reluctant to let the doctor manipulate their bodies. When the MedNet coordinator made the analogy to lay *sobadores*, several community members agreed to chiropractic care. This, in turn, led to other community members observing and deciding to participate.

This example serves to demonstrate that when explicit, tailored bridges can be assembled from existing forms of care and new forms of care,

community members are willing to try the provided care. It might be beneficial to coordinate a preliminary discussion among MedNet officials, providers, and community members about the different systems, what conditions they address, and their standard treatments. Through this discussion, not only would community members and providers understand the relationship among the systems, but they would also learn more about each system. During several such meetings, community members would become more informed about their options for care. It is also important to note that the success of previous medical brigades has largely occurred because care came to the community and was free. In these circumstances, there were no barriers to trying new care. This approach is essential to any intervention seeking to introduce more health information or new systems.

FUTURE RESEARCH

Clearly, more research is needed to place the Gregorian situation in a regional context and to determine what lessons can be exported to similar health care problems in other indigenous and poor Mexican communities. Future research should include a larger comparative study between *mestizo* and Kumiai patients. Are Kumiai patients really different in their beliefs and behavior from *mestizo* patients? That is, is the ethnic distinction between Kumiai and *mestizo* so frequently cited both in the literatures and between Kumiai and *mestizos* truly a "cultural" difference when it comes to health beliefs and behaviors? Perhaps, instead, health beliefs and behaviors among poor, rural Kumiai and *mestizo* patients are more similar than different because of a shared lack of access to sufficient health care and health-promoting resources. Certainly from the perspective of Gregorians, interventions should focus on socioeconomic conditions affecting health and illness beliefs and behavior rather than presumed cultural beliefs associated with Kumiai traditions.

Research needs to extend into the clinics and hospitals. Patient-provider interactions need to be analyzed, attending to the micropolitics of interactions and the impact of individual provider's decisions regarding the quality of care received. The same political and economic processes that have influenced indigenous access to health care and shaped social relations with health care providers also logically impact resources at clinics and hospitals that provide health care to poor Mexicans. Future research could address the social geography of these clinics and hospitals as well as how federal resource allocation impacts the delivery of health care to poor Mexicans, including indigenous Mexicans.

In sum, indigenous health and health care problems in Baja California can only be understood through a simultaneous analysis of the unique position of indigenous communities in Mexico, Mexican medical pluralism, and the social relations that both of these reflect. The analysis here demonstrates that even with a perception of sufficient and available care, indigenous community members still suffer from fragmented care. Reforms and interventions for the indigenous must continue at the systemic level and the local level.

NOTES

I thank the community members, health care providers, government officials, and MedNet employees for their participation in the research. I also thank Randy Fleuriet, Anne Hardgrove, Catherine Nolan-Ferrell, Kolleen Guy, Erin Finley, and the anonymous reviewers for suggestions on the manuscript.

1. "Don Ricardo" is a pseudonym.

2. Kaja Finkler, *Physicians at Work, Patients in Pain, Biomedical Practice and Patient Response in Mexico*, 2nd ed. (Durham, NC: Carolina Academic Press, 2001).

3. Mariana Barraza-Llorens, Stefano Bertozzi, Eduardo Gonzalez-Pier, and Juan Pablo Gutierrez, "Addressing Inequity in Health and Health Care in Mexico," *Health Affairs* 21, no. 3 (2003): 47–56.

4. For a review of ethnographic history of the Kumiai, see K. Jill Fleuriet, "An Anthropology of Health: The Relevance of Medical Anthropology to the Health and Health Care Needs of the Kumiai of San Antonio Necua and Their Indigenous Relatives, Baja California, Mexico" (PhD diss., Stanford University, 2003a). Primary sources also include William D. Hohenthal Jr., *Tipai Ethnographic Notes: A Baja California Indian Community at Mid-Century*, ed. Thomas Blackburn (Menlo Park, CA: Ballena Press, 2001); Ralph Michelson and Roger C. Owen, "A Keruk Ceremony at Santa Catarina, Baja California, Mexico," *Pacific Coast Archaeological Society Quarterly* 3, no. l (1967): 33–4l.

5. "Robles" and "Morales" are pseudonyms.

6. K. Jill Fleuriet, "Health and Health Care Problems among the Kumiai of San Antonio Necua and Their Indigenous Relatives in Baja California: Reflections of Poverty, Marginality, and a History of Colonization," *California Journal of Health Promotion* 1, no. 1 (2003b): 140–57.

7. Pan American Health Organization (hereinafter referred to as PAHO), *Health in the Americas* (Washington, DC: PAHO, 1998).

8. Paul Farmer, *Infections and Inequalities* (Berkeley: University of California Press, 1999).

9. Hans Baer, *Biomedicine and Alternative Healing Systems in America* (Madison: University of Wisconsin Press, 2001); Libbet Crandon-Malamud, *From the Fat of Our Souls: Social Change, Political Process, and Medical Pluralism in Bolivia* (Berkeley: University of California Press, 1991); Paul Farmer, *AIDS and Accusation: Haiti and the Geography of Blame* (Berkeley: University of California Press, 2006).

10. Farmer, *AIDS and Accusation.*

11. Barbara Burns McGrath, "Swimming from Island to Island: Healing Practice in Tonga," *Medical Anthropology Quarterly* 13, no. 4 (1999): 483–505.

12. S. Frenkel and G. Lewis, *A Continuing Trial of Treatment: Medical Pluralism in Papua New Guinea* (Norwell, MA: Kluwer Academic, 1989).

13. G. Schendel, *Medicine in Mexico: From Aztec Herbs to Betatrons* (Austin: University of Texas, 1968); B. Ortiz de Montellano, *Syncretism in Mexican and Mexican-American Folk Medicine* (College Park: University of Maryland, 1992); Kaja Finkler, "Diffusion Reconsidered: Variation and Transformation in Biomedical Practice: A Case Study from Mexico," *Medical Anthropology* 19 (2000): 1–39.

14. Schendel, *Medicine in Mexico.*

15. Finkler, *Physicians at Work*; M. d. C. Hernandez Ortíz and J. Vargas Ramirez, *Grupos Étnicos de Baja California: Paipai, Kumiai, Cochimí* (Mexico City, DF: Subdirección de Investigación y Promoción Cultural de Instituto Nacional Indigenista, 1997).

16. Schendel, *Medicine in Mexico*; Kaja Finkler, *Spiritualist Healers in Mexico: Successes and Failures of Alternative Therapies*, 2nd ed. (Philadelphia: University of Pennsylvania Press, 1994).

17. Finkler, "Diffusion Reconsidered"; Finkler, *Physicians at Work*.

18. Finkler, *Physicians at Work*.

19. M. B. Whiteford, "Homeopathic Medicine in the City of Oaxaca, Mexico: Patients' Perspectives and Observations," *Medical Anthropology Quarterly* 13, no. 1 (1999): 69–78.

20. Finkler, *Physicians at Work*; Finkler, "Diffusion Reconsidered"; Kaja Finkler, *Women in Pain: Gender and Morbidity in Mexico* (Philadelphia: University of Pennsylvania Press, 1994).

21. Robert Trotter, "Curanderismo: A Picture of Mexican-American Folk Healing," *The Journal of Alternative and Complementary Medicine* 7, no. 2 (2001): 129–31.

22. J. C. Young and Linda Garro, *Medical Choice in a Mexican Village*, 2nd ed. (Prospect Heights, IL: Waveland Press, 1994); Finkler, "Diffusion Reconsidered."

23. Whiteford, "Homeopathic Medicine."

24. Paula Sesia, "'Women Come Here on Their Own When They Need To': Prenatal Care, Authoritative Knowledge, and Maternal Health in Oaxaca," *Medical Anthropology Quarterly* 10, no. 2 (1996): 121–40.

25. Young and Garro, *Medical Choice*.

26. PAHO, *Health in the Americas*.

27. Ibid., 12.

28. Ibid., 1367, 2, respectively.

29. Table 1 uses material extracted from PAHO, *Health in the Americas*. Note for the uninsured indigenous population: the National Institute of the Indigenous conducts health-related research and coordinates health-related activities, but it does not provide health care directly to indigenous populations.

30. PAHO, *Health in the Americas*.

31. Schendel, *Medicine in Mexico*; Finkler, *Physicians at Work*; PAHO, *Mexico: Profile of Health Services* (Washington, DC: Organization and Management of Health Systems and Services Program, Division of Health Systems and Services Development, PAHO, 1998).

32. Barraza-Llorens et al., "Addressing Inequity."

33. Finkler, "Diffusion Reconsidered"; Finkler, *Physicians at Work*.

34. Analisa Taylor, "The Ends of *Indigenismo* in Mexico," *Journals of Latin America Cultural Studies* 14, no. 1 (2005): 75–86.

35. "Indio" means "indigenous," but it has a derogatory implication. It stands in contrast to *indígena*, which is the most respectful way to identify someone as having primarily indigenous heritage.

36. The provider used the Spanish word *ignorancia*.

37. See Fleuriet 2003a, *An Anthropology of Health*, for elaboration.

38. Julio Frenk, Jaime Sepúlveda, Octavio Gómez-Dantés, and Felicia Knaul, "Evidence-Based Health Policy: Three Generations of Reform in Mexico," *The Lancet* 362 (11 November 2003): 1667–71.

39. Frenk et al., "Evidence-Based Health Policy"; Rafael Lozano et al., "Benchmarking of Performance of Mexican States with Effective Coverage," *The Lancet* 368 (11 November 2006): 1729–41.