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A critical examination of public policies related to indigenous health, traditional medicine, and interculturality in Mexico (1990-2016)

Aproximación crítica a las políticas públicas en salud indígena, medicina tradicional e interculturalidad en México (1990-2016)

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ABSTRACT Over the last 26 years, the Mexican government has developed a number of activities and discourses around what has been called "intercultural health," directed especially at indigenous peoples in Mexico (some 62, according to linguistic criteria). In this way, the government has built health care institutions (rural centers, clinics, and hospitals) in states like Puebla, Nayarit, Oaxaca, Chiapas, Queretaro, and Jalisco, proposing the implementation of cultural pertinence indicators (which are minimal and inadequate). Nevertheless, the health conditions among indigenous populations and the quality of health care provided by public institutions continue to be precarious in terms of human and material resources (health personnel, drugs, etc.) and discriminatory with respect to the form and content of the provided services. This paper describes some of the governmental interventions that purport to be institutional improvements in the field of interculturality, but that actually represent the continuity of arbitrary and exclusive policies.

KEY WORDS Health of Indigenous Peoples; Discrimination; Racism; Mexico.

RESUMEN En los últimos 26 años, el gobierno mexicano desarrolló múltiples discursos y actividades sobre la denominada "salud intercultural" dirigidos, en especial, a los pueblos originarios de México (alrededor de 62, de acuerdo al criterio lingüístico), y construyó establecimientos de salud (puestos de salud, clínicas y hospitales) en los que propuso la aplicación de indicadores de pertinencia cultural en algunos estados como Puebla, Nayarit, Oaxaca, Chiapas, Querétaro y Jalisco (mínimos e insuficientes). Sin embargo, la salud indígena y la atención médica institucional siguen siendo precarias en cuanto a recursos humanos y materiales (personal sanitario, medicamentos, etc.), y discriminatorios con relación a la forma y al contenido de la atención que se brinda. En este artículo, detallamos algunas de las intervenciones del gobierno que suponen un avance institucional sobre el tema de interculturalidad en salud pero que, en el fondo, significan la continuidad de políticas arbitrarias y excluyentes.

PALABRAS CLAVES Salud de Poblaciones Indígenas; Discriminación; Racismo; México.

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INTRODUCTION

Since the middle of the 1980s up to now, innovative government activities have been developed in Mexico concerning indigenous health conditions: the creation of associations comprising the indigenous therapists; the legal recognition of their remedial practices; their assimilation in hospitals within indigenous territories; the emergence of federal and state offices concerned in fostering "traditional" and alternative-supplementary health care; the opening, development and implementation of theoretical and practical platforms for courses, workshops and degrees devoted to the commonly called "intercultural health"; changes and adaptations within the public institutional buildings to endorse the cultural relevance of their facilities; the training of health workers in order to acquire skills within the intercultural field; and the teaching of medical anthropology and interculturality at university schools and higher education centers, among others.

After more than 25 years of experiences on this health policy concerning indigenous peoples in Mexico, it is time to list and evaluate its areas of progress, its shortcomings, and its possible adjustments. Opinions of professional, critical and reflexive nature have emerged as a result of the implementation of the so-called *mixed* hospitals, the intercultural agents, the courses and degrees and, in general terms, the State conception of intercultural health.[1,2,3,4]

INTEGRATIVE INDIGENISM IN MEXICO

In Mexico, the Spanish invasion, conquest, and territorial usurpation meant a little more than three hundred years of a strict colonialist control and the emergence of a combinatory reproduction – both in biological and sociocultural aspects – between the indigenous local inhabitants and the new foreign European residents, and, later, Asian and African people as well. The external colonialism, and subsequently the internal colonialism, resulted in the unchangeable political, social and economic subordination of the indigenous peoples and of the descendants of other cultural groups. Due to the emergence of the Evolutionary Theory, a new outlook was built; however, at the same time, a scientific and Eurocentric racism arose since the middle of the 19th century, which allowed for the association of race with nationality, including the idea of mixed-race as the foundation and fate of the so-called "Indian." On the basis of the alleged integration of the "Cosmic Race," experiments were carried out in an attempt to erase the ethnic-cultural differences and the apparent inequality in the distribution of wealth. This evident inequality eventually found its way to the access to education and health care services. It was in the middle of the 20th century when the State began to show concern for the disadvantageous situation of the indigenous peoples, which caused indigenous-related public policies, that is to say, those actions addressed to the "Indians" in order to be somehow normalized and contained in and by the system of growing nationalism.

In such period, there was an institutionalization of anthropology (in an epistemological, theoretical, methodological and even applicative vision) which oriented – to a higher or lesser extent – the public policies addressed particularly to indigenous peoples.

In Latin America and Mexico, the culturalist theory, also known as the cultural relativism theory, had a remarkable influence on the construction of indigenism; however, its main exhibitor, Franz Boas, presented research proposals that went against the American culturalism and the interests that the US had on the Mexican territory, especially on the sphere of the medical-academic tradition which influenced the physical anthropology and questioned the dominant demographic antiracist and eugenic vision.[5]

Franz Boas and his followers consider the inexistence of superior and inferior cultures (proposed by evolutionary thinkers) and justify the applicability of anthropology

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in terms of the respect to the existence of cultures deemed as *different*. An approach which is contrary to the functionalist theory that was useful for the European metropolitan nations that sought an anthropology "involved in bringing efficient tools to have control and a good government over the submitted peoples," which would lead to gradual, controlled, and harmonious changes of the peoples colonized by them.[6]

Possible bonds between the antiracist and the indigenism discourses – how they help each other and how they connect with the idea of miscegenation – are sought in order to establish the inexistence of pure races and the impossibility of degeneration by miscegenation. As Molina Enriquez stated, cited by Bonfil Batalla,[7] the mixed-race people were the only ones capable of developing a nationalist spirit: white people had a foreignizing psychology and the Indians had a local focused psychology. Thus, the solution was in promoting miscegenation: Indians should become mixed-race people, not only through miscegenation (in the American case, the interbreed of three racial groups: Mongoloid, Caucasoid and Negroid), but also through Hispanicization, education and distribution of large estates. Only in this way, the legal equality of the population would be effective: taking the mixed-race person as a synonym of progress and the Indian as a synonym of delay and racial degeneration.

This is why it was necessary to create mechanisms to take this crucial step, and consequently why *integrationist and assimilationist* actions were developed, which oriented the Mexican anthropologists Manuel Gamio, Miguel Othón de Mendizábal and Moisés Sáenz to promote the theoretical and practical ideas of the *Indigenist Inter-American Congress*, held in Pátzcuaro, Michoacán in 1940, which was pivotal for the creation of the National Indigenist Institute in 1948.

The first congress concluded that acknowledging the problem of the indigenous peoples of the American continent was of public interest. Regarding health care, it was recommended to establish, in indigenous regions, "Social, Preventive and Healing Medicine Centers to work for the improvement of the inhabitants' health conditions and to counteract diseases," especially infectious parasitic diseases (onchocerciasis, malaria, pinta, among others), to create rural medical schools, to carry out scientific researches about the indigenous medicinal botany and to improve the indigenous diet.[8]

Gonzalo Aguirre Beltrán continued Gamio's work and was an institutional actor par excellence of the Mexican integrationist indigenism. Among his writings regarding health care, medical anthropology, empiricism, and medical botany, which would address various theoretical-practical concerns, challenges and defiances, the following stand out: *Programas de salud en la situación intercultural* [Health Programs in the Intercultural Situation],[9] *El proceso de aculturación y el cambio socio-cultural en* México [The acculturation process and the socio-cultural shift in Mexico],[10] *Medicina y Magia: El proceso de aculturación en la estructura colonial* [Medicine and Magic: The process of acculturation within the colonial structure][11] and *Antropología Médica: Sus desarrollos teóricos en* México [Medical Anthropology: theoretical developments in Mexico],[12] which would guide and direct the indigenist actions related to health for little more than forty years.[13] He coins the concept and creates ways of acculturative intervention highlighting that "[the] purpose of Mexican indigenism is not the indigenous person, it is the Mexican," who must become part of the nation as a citizen produced by indigenism. The mixed-race person is "a unifying instrument of the national heterogeneity," however, a conflict stems from the mixed-race person exploiting and dominating the indigene, who attempts to counteract through "intercultural integration" based on the "planned acculturation," defined as the induced social process of change adopted and suited by individuals and social groups and that facilitates the *assimilation* and the *integration* of people into the capitalist economic and political system. The National Indigenist Institute (INI) [*Instituto Nacional Indígena*] assimilated Aguirre Beltrán's proposal about the need to create a

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health care program suitable to the intercultural situation of Mexico.[4] Bonfil Batalla[14] referred to this as the construction of a common solidarity ground under the sense of traditional legitimacy and not only as the legal enforcement of the official system, which would lead the way to an "intervention culturally suitable for the official medicine."

PARTICIPATIVE INDIGENISM IN MEXICO

The INI adopted in the indigenous field a Biomedicine policy of growing impact, poorly related to traditional therapists. During the presidency of Carlos Salinas (1988-1994) – which was characterized by the promotion of a liberal economic policy, privatizing state-owned companies and reducing the State's intervention – with the direction of anthropologist Arturo Warman, and with Carlos Zolla as responsible for health issues, a new *participative* period related to indigenous physicians was initiated: approximately 60 regional organizations were articulated, two national congresses took place, the Mexican Traditional Medicine Library was created with an indigenous active involvement, and in 1990 the only INI hospital of Mexico, located at Cuetzalan (Puebla), is turned into a hybrid care center, where in addition to biomedical care, within the walls of which the service of many indigenous therapists who belonged to the organization of indigenous physicians from Sierra Norte de Puebla was offered.[15,16] In 1990, it was transferred to the State Health Secretary and duplicated in other hospital units inside and outside Puebla in Jesús Maria, in the State of Nayarit.

According to its creator, this change was the result of the combination of four guiding principles: a) the existence within the indigenous communities of a "real health system" in which biomedicine, home or domestic medicine and traditional medicine coexist, b) the acceptance of the strategy of primary health care developed by the World Health Organization (WHO), c) the implementation of local health systems, promoted by the Pan American Health Organization (PAHO), and d) the complete acknowledgement of the activities of the indigenous physicians within their neighborhood.[15]

During the presidency of Vicente Fox (2000-2006), the INI was transformed (actually, degraded) into the National Commission for the Development of Indigenous Peoples [*Comisión Nacional para el Desarrollo de los Pueblos Indígenas*], adopting an ongoing welfare policy.

For the purpose of achieving the goals for the development of the indigenous peoples within the context of the Puebla-Panama Program, the area for Strategic Planning and Regional Development and the General Coordination of the Puebla-Panama Program (currently, Mesoamerica Project) was created in 2001. The Mexican South-Southeast Commission was established and appointed in charge of the states of Puebla, Veracruz, Tabasco, Guerrero, Oaxaca, Chiapas, Campeche, Yucatán, and Quintana Roo, regions where most of the indigenous population of Mexico is concentrated. Puebla, as a member state of this commission, established the Comprehensive Hospitals with Traditional Medicine. Moreover, at a federal level, the Coordination of Health of the Indigenous Peoples was created, which would later change its name and constitute the Directorate for Traditional Medicine and Intercultural Development (DMTDI) [*Dirección de Medicina Tradicional y Desarrollo Intercultural*] within the Health Secretary, whose development principle was focused on the conformation of mixed care programs and was later redirected to the intercultural vision.[4]

In this period, the specific programs of traditional medicine were left without economic and intellectual support. However, in 2006, the federal government carried out the modification of several sections of the General Health Law,[17] and included the "indigenous traditional medicine" in this legal framework which in its section 6, subsection VI bis states "to promote the knowledge and development of the indigenous traditional medicine and its practice

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under appropriate conditions" and, in its article 93 it establishes that:

> The development of the indigenous traditional medicine shall be equally acknowledged, respected, and promoted. The programs providing health and primary health care which are developed in indigenous communities shall be adapted to its social and administrative structure, as well as its concept of health and the relation between patients and physicians, always respecting their human rights.[17] [Own translation]

INDIGENISM IN MEXICO AT THE BEGINNING OF THE 21ST CENTURY

The DMTDI of the federal Health Secretary participated more discursively and through the media than pragmatically,[4,18,19,20,21,22,23,24] mainly due to the lack of an assigned budget, of enough personnel and of real contact with indigenous peoples. However, its participation can be observed in various training and "awareness" courses, which were initially supported by a non-governmental organization (NGO) directed by a group of university anthropologists who were recruited by the fleeting and disappeared Federal Coordination dedicated to health care and nutrition of indigenous peoples (2001-2004).[18]

Subsequently, the DMTDI provided online courses and, to a lesser extent, on-site courses, elaborated a book about intercultural health and several flyers dedicated to specific programs (such as reproductive health and physician-patient relationship), focused on establishing some suggestions in health care centers and endeavored to introduce the vertical delivery in many hospitals of the country (National Defense Secretary, Hidalgo, San Luis, and Potosi Hospitals among others). Its presence can be observed in some states of Mexico, particularly in the center and the southwest of the country, where the State secretaries establish units dedicated to health care comprising traditional medicine, alternative medicine, and interculturality: Querétaro, Hidalgo, Puebla, Veracruz. However, a weak influence is observed in the states with the highest indigenous presence such as Michoacán, Guerrero, Oaxaca and Chiapas.

In Querétaro, the Interculturality and Traditional Medicine Program, with ideological and budgetary limitations, conducted a training of the health personnel , and in 2013, it established in Amealco – a region of almost 57% Ñáñú (Otomi) population – a health center with hospitalization which adds a Traditional Medicine Area which provides healer consultations (healer, bonesetter, herbalist and midwife), a *temazcal* [a stone or adobe hut for hot steam sauna-like baths], delivery care, and herbal pharmacy. Usage rules were established and audiovisual techniques using short films (based on healers' life stories) were implemented for the training of the health personnel, to prove the healing existence and validity of traditional medicine.[25] The selected therapists constituted "voluntary" personnel and were offered a small monthly remuneration (6,500 Mexican pesos per month); however, they still fail to be acknowledged as a "*culturally competent health care unit*" due to the lack of certain indicators, such as the absence of signage in the local indigenous language. It is worth mentioning that the accreditation criteria for the "*Culturally Competent Health Units*" are: to have a 60% of personnel trained in an intercultural perspective; to have an intercultural and bilingual health promoter; to integrate the indigenous physicians in "dialogue communities"; to spread information about "local cosmogony" and signage in indigenous language; to promote attitudes of respect, comprehension and kindness from the health personnel to the users, calling them by their names without using diminutive names.[26] It should be noticed that vertical delivery is not included in such health institutions. Finally, there is a similar module in process in Tolimán, another region where the majority of the population is Ñáñú indigenous people.

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In Hidalgo, the personnel of the civil hospital located at Pachuca (about 1,000 employees) is trained; a care module in complementary practices (acupuncture, naturopathy and a little of traditional medicine) was created; a few vertical deliveries (which were not acknowledged in the statistics because the chief of the Gynecologist-Obstetrician Service objects to this practice as he considered it inappropriate and that they lack the material resources for its performance) were unofficially conducted; only two or three physicians answered the intercultural call and the federal Health Secretary certified that the hospital was a "*culturally competent*" unit along with the hospitals located at Huejutla, Ixmiquilpan and Tula. The former two had indigenous translators (with no specific employment status) and the latter, apparently, was turned into the national center of vertical delivery care learning (RG, personal communication). It is worth mentioning that it was from the Huejutla hospital that the so-called "Lady Huejutla" emerged, a medicine student from the Universidad Autónoma del Estado de Hidalgo, who highlighted in social media her joy for returning to "civilization" (Pachuca) after having been with those "Indians" who spoke in Nahuatl, which prevented an appropriate communication with the patients of a community near the municipal capital. The issue resulted in her discharge from social service, a sanction from the Human Rights Commission of the State of Hidalgo with a recommendation of "professional counseling" and her being sent to a hospital in Jalisco.[27]

In Veracruz, in 2006 the Indigenous Health and Traditional Medicine Program with Intercultural Approach was formally created, and training workshops for health personnel (64% biomedical professionals and 15% nurses), and other workshops addressed to constitute "*intercultural mediators,*" whose function was to seek dialogue between them and the indigenous physicians were carried out there. At the end of that year, a meeting was held with 115 indigenous physicians from the north of Veracruz (Poza Rica, Pánuco and Tuxpan) where the indigenous peoples sought acknowledgment as well as a respectful and equal treatment, while the state government offered to continue supporting the practice of indigenous medicine in the entire territory of Veracruz.[28] Subsequently, a State Coordinator of the Interculturality Program branch of the Migrant and Indigenous Peoples Health Department was created, which designed, in 2013, a project of an Indigenous Health Model with Cultural Relevance whose main objectives – based on national and international law – were to train health personnel in the intercultural and gender approach positioning the use of indigenous languages, to strengthen traditional medicine, to carry out intercultural communitarian workshops in order to promote health, and to adapt the health care units to the "*users' culture*" of indigenous communities.[29]

In operative terms, the following improvements can be mentioned: in the training of jurisdictional officers and health units officers; the effective recruitment of fifteen intercultural and bilingual health promoters, graduated from the Universidad Veracruzana Intercultural (UVI); the teaching of Nahuatl language in Orizaba and Río Blanco; and the culturally competent health centers, one of them in Filomeno Mata, a Totonaca community from Sierra Madre Oriental, the first of the 140 centers to be completed in indigenous regions.[26] It must be highlighted that the recruitment, the acknowledgement and the labor treatment have been in the capacity of "health promoters" and not of undergraduates from the university career of intercultural management (information provided in April 2015 by A. Isunza, the previous person in charge of the ties between the UVI and the Health Secretary of Veracruz).

In a recent research study on human rights and intercultural health conducted in the hospital of Tonalapan, municipality of Mecayapan, Veracruz, which assists Nahua and Popoluca populations and is considered as an "intercultural hospital," it was found: that interculturality is limited only to the use of signage; that there is no specific training for health personnel; that there used to be

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an undergraduate in intercultural management acting as translator but served for many purposes (messenger); and that the relation with the midwives is of a submitted and instrumental nature, as they are not allowed to handle deliveries in spite of the training offered by the health secretary itself. It is concluded that:

> ...the hegemonic medical system does not respect particular and individual cases of the submitted model, but imposes, subjugates and never coordinates [...] intercultural health policies; as in the implementation of such policies in the hospital of Tonalapan, they hinder the enforcement of the right to health of the indigenous.[30] [Own translation]

In Puebla, the project of mixed hospitals continues. A new general hospital was built in the outskirts of Cuetzalan and up to 14 more hospitals called "comprehensive hospitals with traditional medicine" were replicated in many indigenous regions of the state. Several research studies with evaluation purposes have been carried out, some of them known through social media and others remain pending. Through these studies, the developments, blockages and conflicts are verified. Interculturality has been focused exclusively in the presence of the Traditional Medicine Modules in biomedical spaces with the notorious submission of traditional therapists.[31,32,33] In the website of the Health Secretary of the state of Puebla, the information about comprehensive hospitals which have a traditional medicine module remains deactivated. Thus, as pointed out by Duarte *et al*.:

> The hospital of Cuetzalan and the project of Comprehensive Hospitals with Traditional Medicine constitute an improvement and a plausible attempt to comply with some of the commitments of the ILO Convention 169 and the suggestions of the PAHO/WHO, but they are still being planned, performed and evaluated "from above" by government institutions, through processes where the communities have no power of decision and are hardly consulted.[31] [Own translation]

The only state of Mexico that decided to imitate the experience of the mixed hospital of Puebla was Nayarit. In the Cora community of Jesús María, a hospital was built offering biomedical care with a section dedicated to traditional medicine. The health personnel perform rotations every 15 days and their relation with traditional therapists is minimal. All deliveries are attended by physicians (in the traditional way with no use of the furniture for vertical delivery which was recommended by the federal level). Every day there is an indigenous midwife dedicated exclusively to the care of pregnant women requesting her services. In addition to *marakame* healers [healer and shaman in the Huichol tradition], there are herbalists and a huge scarcity of material resources of the module is observed.

In the state of Oaxaca, the impact of the federal program is weak; there are actions still carried out in some health care centers of traditional medicine (such as in Capulalpam de Mendez), an "intercultural" delivery model in Tlalixtac de Cabrera is in effect and there is a municipality that has implemented measures to improve obstetrician care, this is the case of Santa María Tlahuitoltepec, which regulates treating pregnant women and their families with respect and dignity.[34]

Conversely, the actions of academic groups and NGOs which aim to improve the intercultural care of the pregnancy/delivery/postpartum period and the reduction of the maternal mortality in the state are noteworthy. An assertive evaluation of the government health services in Oaxaca shows that the health centers tend to handle with relative success the prenatal phase, although delivery care is referred to hospitals, in either normal or difficult cases, and that health personnel are not competent in the intercultural field. The authors recommend: to spread the regulatory framework and the rights related to maternal health in the health sector; to reinforce the intercultural and obstetrician technical

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competences of the entire health personnel; to get an adequate stock of equipment, medications and other supplies; and to establish that hospitals must focus on difficult delivery care and that health centers may attend normal deliveries meeting the quality standards registered in the institutional regulation.[35]

Moreover, recent anthropological studies in Oaxaca show the high social inequality and structural discrimination suffered by indigenous women when faced with difficulties during the pregnancy/delivery/postpartum period, as pointed out by Paola Sesia:

> The indigenous municipalities have the worst roads, are the least communicated and are the most distant from health services in Oaxaca. The indigenous families from these municipalities of extreme marginalization do not have actual possibilities of accessing health services, even though this exclusion is still a severe violation of the federal and state laws and rules which explicitly grant the right to health.[36] [Own translation]

In the state of Chiapas, the most remarkable event is the building in Los Altos of a hospital opened in May 2010 which, due to its Traditional Medicine Section, is called the "*Hospital of Cultures*." In addition to being incomplete, it is the best example of a hospitable health unit built with its back to indigenous peoples, an event that infringes the previous consult ordered by Convention 169 of the International Labor Organization (ILO). It was built – partially – above a graveyard (which is why now the health personnel calls it "Hospital of the Graves"), and, although it has ample spaces to perform "vertical" delivery care, this service has not been used at all: women in labor do not arrive at this facility given that most of them are referred to the currently called Woman Hospital (previously known as Regional Hospital), located at the center of San Cristobal de Las Casas. It also has a *temazcal* which is not used due to engineering failures and the midwives who work there are trained (and monitored) by local health authorities with little respect for their customs and traditions in their obstetric practices.

The two hospitals located at San Cristobal had negative experiences in health care to indigenous patients which show that racism and discrimination are still unsolved problems despite the intercultural discourses put forward by the State health officers.[37,38]

In Guerrero, the federal efforts concerning the State public policies have not succeeded either. The NGOs are the ones making a greater effort towards reducing maternal mortality which is the highest mortality rates in Mexico.[39]

In the case of Colima, since 2007, efforts have been made in order to include actions promoting traditional medicine in the primary health care level in the community of Suchitlán, Comala, through dialogue with the health personnel regarding the need of interculturality and through the building of a *temazcal* – actions which did not succeed. Afterward, so as to comply with the public policy demanded by the DMTDI, a professional midwife from the school of San Miguel de Allende, Guanajuato, was recruited by the Women Hospital, and is still employed.[4]

In the Huichola region of Jalisco, the so-called Multicultural Communitarian Hospital has been recently opened in Huejuquilla, El Alto, where both the customary biomedical services and indigenous therapists can be found.[40] A recent visit showed that patients could not be admitted yet (although it has been two months since its opening, due to supply problems). An enthusiastic translator works there coordinating the Traditional Medicine Service where the different specialists (midwives, *sobadores* [healers who specialize in the treatment of tense muscles and sprains], bonesetters, herbalists and *marakame* healers) work on a rotational basis by agreement with the communitarian assemblies. Until this point, patients are mostly mixed-race, and it is said that indigenous delivery care will not be allowed, thus, the midwife will be limited to making pregnancy checks. Finally, there is absolutely no intercultural training of the health personnel (field diary, 2016).

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Moreover, the Mexican Social Security Institute (IMSS) [*Instituto Mexicano del Seguro Social*], previously known as IMSS-*Opportunities* and currently as IMSS-*Prosper*, from its former program for the interrelation of traditional medicine, has only prioritized the dialogue with midwives for instrumental purposes, it is partially related to the regulations of the DMTDI, and it has a Support to Indigenous Peoples Care Office which attempts, since last year, to design and implement an intercultural care model in two or three hospitals with a majority of indigenous population, including the presence of intercultural mediators and spaces for delivery care under intercultural conditions. However, this process – in spite of its good intentions – is still paralyzed.

To summarize, for half a century, the Mexican government took indigenist actions of integrationist nature; however, since the 1990s, other public policies were initiated concerning participative indigenism, giving rise to diverse and innovative attempts which eventually became known as "intercultural."

However, from a critical approach, in this period, socio-anthropologist research studies increasingly emerged showing the discriminatory and exclusive nature of the public policies to the indigenous, Asian and Afro-descendant peoples, and expressing the high social inequality these peoples endure, and that, in the biomedical care field, there are structural (economic-political) barriers, although not many cultural barriers, which interfere with the real access to health services.[3]

SOME CONSIDERATIONS

After going through this brief description of the State activities regarding indigenous health care in Mexico, it is noticeable that the actions are incomplete, limited, and insufficient to properly address (in terms of quantity and quality) the indigenous peoples, which constitute at least 10% to 15% of the Mexican population.

The suitability of the health services – in intercultural terms – remains extremely precarious, bearing many contradictions and ambiguities in their institutional plans, programs and strategies. To top it all, between 2015 and mid 2016, Peña Nieto's government has made adjustments to the Mexican economic development aim, and consequently has cut public expenditure, the health field being one of the most damaged.[41] This will mean fewer resources allocated to programs, hospitals, and research centers. Although there are legal principles at the international level (ILO Convention 169, signed and ratified by Mexico in 1990), at the federal level (the Constitution, the General Health Law) and at the state level, noncompliance is the rule. The Mexican traditional medicine projects do not seem to be receiving real political and financial support, which is a clear reflection of the hegemony of Biomedicine in the governmental apparatus (be it federal, state and municipal).

The positive interrelation project with traditional therapists that historically the IMSS maintained during the 1980s is currently in full-blown decadence (except for the relation – also restricted – with the midwives, due to reasons of political management in birth control programs).

Currently, the Health Secretary, and its DMTDI, is the federal dependence responsible, however inadequately, for indigenous health care with little contact and presence in and within the indigenous peoples. It facilitates the national and international presumption and discourse. For example, Mrs. Margarita Zavala, wife of the former president Felipe Calderón, in an official visit to Margaret Chan, Director of the World Health Organization (WHO), in Geneva, Switzerland, boasted in February 2012 – and it was so recorded by the newspapers of that moment – that the Mexican government was providing a clear support to the issue of interculturality in health services:

> Margarita Zavala highlighted the impulse toward an intercultural approach in the Health National System and the creation

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> of traditional medicine centers in states such as Puebla and Chiapas, among others, as a supplement to the work carried out by health units, mainly in order to ensure the care to the indigenous population.[42] [Own translation]

And, above all, the Health Secretary influences the level of insertion in the pre-existing institutional health platforms, where the intercultural public policies materialize and vanish in a broken and unequal structure that generates:

> ...parallel, overlapped, and often conflicting responsibilities among political-bureaucratic actors, which imply, in addition to difficulties in communication and administration, severe inequities in the distribution of the resources allocated to different sectors of the population.[43] [Own translation]

This fragmentation and inequity are shown in the decisions and omissions made in the different government levels of health care. Thus, for example, there are similarities and disparities between the federal Health Secretary (which supports the Public Health Coverage) and the IMSS-Prosper program, each one with its own model of medical-communitarian action (and their different resources) in the Mexican indigenous populations.

The impact of the intercultural policies is still unknown and unclear. This is partly because there are no official statistics with ethnic differentiation. It was only in 2014 when inpatients of the General Hospital of Mexico "Eduardo Liceaga" started to be asked about their indigenous origins. The first data obtained suggest that, of all the people admitted in the hospital for 2014, an average of 5% were indigenous patients,[44] with a probable underreporting factor when taking into account only the linguistic criterion and not including the self-ascription. Through specific and strict epidemiologic studies concerning morbidity and mortality differentiated by ethnicity in regions and micro-regions, the examination of the changes and impacts of the intercultural policies on health care can be carried out, with better possibilities to establish a cause-effect relation.

Health services within indigenous peoples are still qualified as absent and, if they exist, they are qualified as terrible and irregular. In 2015, in Simojovel, Chiapas, Tzotzil indigenous region, there were 2 deaths and 29 people affected by vaccination against hepatitis B, tuberculosis and rotavirus, the investigation of its causes proved it was due to bad management of the material. The municipal agent Higinio Pérez López bitterly complained:

> It's not just the lack of physicians; there aren't medications or healing materials either. And when there're physicians, they don't speak our language and it's difficult for us to explain our ailments at ease. And in many cases, we suffer physical and verbal abuse from the health personnel due to being indigenous.[45] [Own translation]

In the capital of Oaxaca, there was a strike in the health care and administrative activities of the main public hospital, in which the physicians demanded the necessary expansion of the obstetrics and gynecology service because it was completely inadequate to the obstetric care of patients.[46] Moreover, it is an institutional nonsense that every delivery should be dealt with at the secondary care level, that is to say, in hospitals, and that there are no improvements in the network of rural and suburban health institutions, where several deliveries have been reported to be poorly attended.

Regarding the role of anthropology in the health-disease-care processes, its qualitative approach is relevant for perceiving the progress and limitations of public policies, understood both as government actions but also as the involvement of social groups, and which are the needs and demands of a good service in the health institutions, and its better orientation toward the peoples, indigenous or not.

The developments of Critical Health Anthropology and Sociocultural Epidemiology lead to a better understanding of the

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health-disease-care phenomena where the structural limitations (and social inequalities) of the biomedical care are understood, as well as the true role of traditional medicine and self-care in the rural and urban communities. Several researchers, some of them from the very indigenous peoples, have assumed a critical approach toward the current intercultural policies because, although the discourse they highlight the respect for the culture and the active involvement of the indigenous communities, in practice the pragmatic ways of exclusion are confirmed.[47,48,49] The critical approach to interculturality in health care, among other aspects, points out that the intercultural discourse, when emphasizing the symbolic-cosmogonic aspect of the indigenous therapists, tends to nullify the sociocultural context in which they are expressed, such as the impoverishment process, land dispossession, discrimination based on racist stereotypes, as well as the little or lack of access to goods and services.

At the same time, there is a broad diversification in the use of the concept of interculturality, either as an approach, a methodological tool, a public policy, or a certification. In this day and age, some indigenous peoples in Mexico and other parts of Latin America have assumed interculturality as a useful discourse to be identified and to strengthen trade, since the schemes through which the interculturality policies in health are proposed do not allow dialogue between the communities' and peoples' knowledge in order to establish the ways of involvement; as a result, they show polarized behaviors for and against regarding the assimilation and resistance.[50]

Based on the issues discussed above, now more than ever we need a formal, flexible and constructive dialogue regarding the insertion of anthropology in health care and other disciplines, and in the current health issues, comprising indigenous, Afro-descendant and Asian peoples and citizenship in general.

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