SALUD COLECTIVA. 2018;14(3):461-481. doi: 10.18294/sc.2018.1838

Medical anthropology in Latin America, 1990-2015: A strictly provisional review

Antropología médica en América Latina 1990-2015: Una revisión estrictamente provisional

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ABSTRACT The article presents a provisional examination of the production of Latin American medical anthropology, especially from Mexico, and to a lesser degree Brazil, from 1990 to 2015, in an attempt to highlight the discipline's principal contributions, orientations and objectives, but also to pose critiques and doubts, especially with respect to the omission of the study of serious collective health problems and processes. The article attempts to put into evidence the importance of the discipline not only for anthropology, but also for biomedicine, suggesting the need for complementation beyond the differences and incompatibilities that exist regarding, for example, the use of qualitative techniques, and interventions – or lack of interventions – regarding the customs of the different social actors with respect to health/disease/care-prevention processes.
KEY WORDS Medical Anthropology; Biomedicine; Methodology.

RESUMEN Se presenta una aproximación provisional sobre lo producido por la antropología médica en América Latina, especialmente, en México y, en menor medida, en Brasil, entre 1990 y 2015, tratando de señalar sus principales aportes, orientaciones y objetivos, pero también planteando críticas y algunas dudas referidas, especialmente, a la omisión del estudio de graves procesos y problemas de salud colectiva. En el artículo se trata de poner en evidencia la importancia de esta disciplina no solo para la antropología, sino también para la biomedicina, planteando la necesidad de complementación, más allá de las diferencias e incompatibilidades que existen respecto, por ejemplo, del uso de las técnicas cualitativas o de las intervenciones y no intervenciones sobre los "usos y costumbres" de los diferentes actores sociales referidos a los procesos de salud/enfermedad/atención-prevención.
PALABRAS CLAVES Antropología Médica; Biomedicina; Metodología.

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PROVISIONAL APPROACH

The objective of this article is to reflect on the medical anthropology situation in Latin America from 1990 up to date to tentatively establish the themes that have been studied the most, proposing some general trends to then question certain aspects to finally refer to several contributions made and to raise some questions and concerns. I consider that medical anthropology is not the most proper term. Nevertheless, other terms such as health anthropology, medicine anthropology, or ethno-medicine are even less suitable due to their ideological connotation, their inconsistency or specificity. Therefore, we keep this term, despite criticism, simply because it is the most widely used term among anthropologists.

Although I intend to refer to Latin America, this article is mainly about Mexico, and Brazil to a lesser degree. The rest of the Latin American countries will be referred to on a second level, highlighting that my proposal is a provisional approach.

Firstly, we have to admit that there is a distinctive medical anthropology development according to each country in Latin America. Thus, for example, if I take the two countries with the current highest production and diversity of this discipline in the region, I find that at least since the 1930s, there has been in Mexico a steady development of studies about health/disease/care-prevention processes (from now onward referred to as h/d/c-p) in relation to the so-called indigenous peoples. This development consolidated in the 1940s and 1950s and has continued up to the present throughout substantive modifications made, mainly, since the late 1970s. However, we also have to admit that as from the 1930s, many of the most important North American medical anthropologists also worked in Mexico and spread the prevailing orientations in this field early, which included not only ethnographic production, but also theoretical approaches, which current anthropologists are apparently unaware of, or what is even worse, are merely being labeled as empirical.

Nonetheless, we have to remember that for the majority of these studies, a detachment and a reformulation, if not a break, of the relationship between h/d/c/-p processes and magical-religious processes is produced. This is one of the basic aspects of the development of a medical anthropology, autonomous to some extent. Although the *break* between magical-religious dimension of the disease and healing had positive consequences to recover the dimensions of suffering, mortality, and disease which were fully overshadowed by the magical-religious processes, on the contrary, this *break* led to an increasing reduction of its role within the h/d/c-p process. The best option would be to articulate both dimensions.

From this point of view, an ethnographic, theoretical, and applied interest in this field arose in Mexico much earlier than in most of Latin American and European anthropologies. To a great extent, this fact is connected with the interests and objectives not only of the initial indigenous peoples studies but also of the theoretical trends that were subsequently developed and connected to the contradictory projects that emerged from the "Mexican revolution."[1,2,3,4]

Whereas in the case of Brazil, as admitted by Brazilian specialists themselves,[5,6,7,8] the situation of medical anthropology was weak until the 1980s and mainly led from 1990 to a remarkable development which, to a great extent, is linked to its relationships with the collective health movement that has included in recent years the creation in Brazil of a distinctive medical health care service for native groups.[9,10]

In the case of Mexico, there were also early relationships with public health and social medicine as well as with non-governmental organizations (NGO) devoted to h/d/c-p processes; however, these relationships took place until recent dates in personal or microgroup terms rather than institutionally. We need to admit that during the 1970s and 1980s Latin American countries registered a remarkable NGO development that worked on h/d/c-p processes, which, to a great extent, applied anthropological perspectives.

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Now, although since 1930 North American cultural anthropology has had a notorious influence on studies about h/d/c-p processes carried out in Latin America, such influence was controversial and discontinued mostly from 1960 onward. Even when many trends – such as the one represented by Aguirre Beltrán[1,11] – adhere, though critically, to the North American orientations of the functionalist/culturalist type, other trends – such as the one boosted by Bonfil Batalla[12] – question those trends by raising alternatives and differences that articulated with the critical trends regarding social anthropology that were emerging in Latin American countries and that through works of writers such as Darcy Ribero or Pablo González Casanova questioned not only political colonialism, but also colonialism integrated in anthropological proposals.

It is important to remember that a strong tendency of the Latin American currents during this lapse of time was the criticism of "psychologism" by a sector of the North American anthropology and a correlative exclusion of the individual and its subjectivity, which prevailed as a whole in social sciences and mainly in those that adhered to "Left"[13] political and ideological proposals. Moreover, training programs of Latin American anthropologists who studied at departments of humanities between the 1940s and the 1960s referred to theoretical trends which differed from the ones prevailing in the US. Hence, both the neo-Kantian and historicist trends, and especially Dilthey, as well as the phenomenological and existentialist trends, were present in training programs at least in a few Latin American countries.

It is also important to note that, at a Latin American level, including both abovementioned countries, medical anthropology was considered, from the start, as a "technical," empirical, applied, and even non-theoretical specialty by the theoretical *owners* of social anthropology and ethnology, a situation that remains the same at present. In this regard, it is interesting to mention that when in 2009 the epidemic of influenza A (H1N1) broke out in Mexico, during the first three weeks, newspapers included several articles written by a great number of intellectuals, social scientists included, who had had no previous connection with studies or discussions about h/d/c-p processes, but now they had found a new opportunity to "theorize" about it.[14]

There is the need to establish a connection between the central core of medical anthropology in Latin America, beyond dominant and non-dominant theoretical and methodological orientations, and the socio-economic and socio-political situation in Latin American countries, and the historical turning points within which they are developed. Therefore, in the case of Latin America, it needs to be related to the decolonization process that originated between 1940 and 1960 in the so-called Third World when nationalist populism stepped into the foreground as well as developmental policies, and as from the 1980s with the neoliberals and "neo-populists" that were present in the period of time that is being analyzed – but they are just mentioned, as it is not possible to go in depth in their study in this article.

The oscillation of these economic/political orientations helped political and theoretical trends to be developed. These trends raised not only the issue of cultural "difference" and empowerment of the indigenous peoples, but also the development of gender studies and struggles based on women's situations. Although during "neo-populist" governments poverty saw a reduction and in countries such as Bolivia and Ecuador ethnic movements became stronger, the dominant trend in the region has been the growth of socioeconomic inequalities.

Nevertheless, the development of Latin American medical anthropology should also be related to the social situation of the Amerindian peoples, callously expressed in the fact that these peoples have been and still are the social segment with the highest rates of general and age groups mortality and with the lowest life expectancy.[15,16,17,18,19] As it is described by Langdon and Cardoso:

> Apart from population size and based on incomplete epistemological data, all

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> of these countries [in Latin America] show rates that indicate a worse health situation for the indigenous peoples in comparison with the surrounding society. Different countries share a common characteristic in that scenario: the high rates regarding endemic, deficiency and chronic diseases that evidence the structural violent situations that impact on their lives as it was noticed, in another context, by Farmer. [...] In all these countries, indigenous peoples face the highest rates in malnutrition, child mortality, substance abuse, suicide and others. The problems of chronic diseases such as hypertension and diabetes reflect the deep environmental, geographical and subsistence strategy changes. Health situations of indigenous peoples also reflect prevalent historical processes of political subordination, economic exploitation, social discrimination, position of marginality and inadequate health care assistance.[20] [Own translation]

This negative health situation of the abovementioned peoples has historically remained outside the objectives of health segments in Latin America beyond currents such as integrationist *"indigenismo"* that have attempted to intervene by means of concepts created by modernization theories or critical currents that posed their expectations on radical changes of the economic/political system, the empowerment of indigenous groups included, and other more recent currents that think in terms of subjective and microgroup targeted actions in order to reduce or combat afflictions of suffering people.

WHAT DOES MEDICAL ANTHROPOLOGY STUDY IN LATIN AMERICA AND WHAT DOES IT NOT?

At present, as in the US and European countries, local medical anthropology, and particularly that of Brazil and Mexico, study almost all h/d/c-p processes in many different segments and social actors with the objectives of describing and understanding them, and to a lesser extent of intervening in them. Although social actors that are being studied now do not only belong to indigenous ethnic groups, but also they continue being the main actors in Latin American studies.

Based on the review of anthropological and public health journals, national conferences' programs, regional and Latin American, as well as of a few existing review papers, I established for the 1990-2015 period 152 categories referring to processes, themes, and problems that I classified in twenty categories that I mentioned in alphabetical order as follows: 1) nutrition/malnutrition, 2) self-service/groups of self-care/caretakers, 3) biomedicine and biomedical institutions (chemical/pharmaceutical industry included), 4) body, subjectivity, 5) traditional healers, 6) emotions, sufferings, 7) chronic-degenerative diseases, 8) infectious-contagious diseases (HIV/AIDS included), 9) mental diseases ("addictions" included), 10) traditional diseases, 11) socio-cultural epidemiology, 12) gender and health studies, 13) alternative and/or complementary medicines, 14) migration and h/d/c-p processes, 15) health care models, medical pluralism, 16) power and h/d/c-p processes, 17) public policies and health policies (human rights included), 18) cross-cultural health, 19) reproductive health, 20) violent situations. Two more sections are added; one for theory and the other for methodology. It should be remembered that all categories refer to h/d/c-p processes that have been studied by the different currents involved in medical anthropology.

Nevertheless, there are a number of important processes and topics that have been barely developed by anthropologists, although we have to admit that there are studies that have been made on them. Some of those topics are the following: socio-economic inequalities and h/d/c-p processes, the role of h/d/c-p processes in social movements – ethnic movements included, – the role of traditional healer's knowledge in ideological-political approaches of these movements, the increasing

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commercialization process of traditional knowledge and products referred to h/d/c-p processes, studies on effectiveness – not only symbolic – of traditional and biomedical therapeutic interventions observed in mortality and impairment respects in connection with ethnic groups, the negative health situation of males, the lack of studies on "bodies" labeled in terms of race and on "bodies" of workers in terms of sufferings, the lack of studies and considerations on capability and quality of the agency of different social actors and especially of the subordinates, the little importance of sufferings related to working activities of any type, the corruption in health systems, and the exclusion of actors and African American problems in medical anthropology studies.

One of the processes and problems less studied among anthropologists, although it was intensively present in almost all countries of the region, is the problem of birth control policies and, especially, the problem of women sterilization policies within ethnic groups which contrasts with the relevance of obstetric violence studies. These policies were intensively developed from the middle of the 1970s, and mainly during the 1980s and 1990s, and they persist at present.

Although several problematic issues have had a significant development in the last years, as it is the case of emotions, we observe that most of these studies seem to ignore that a substantial part of traditional diseases may be caused by emotions, fact that is expressed even in the label given to many sufferings such as courage, embarrassment, and scare or horror. Moreover, the cause of most traditional diseases is connected with envy, and we have to take into account that witchcraft is carried out because of love, hate, or revenge, that the evil eye generally refers to the desire of the other and that *chipilez* is related not only to weaning, but also to breastfeeding of another baby.

These sufferings may be connected with depression, anxiety, distress, fear, anger, desire, love, among other "emotions," which reveal the considerable collective sensitivity that Amerindian individuals and groups experience in their daily life, which they need to turn into sufferings in order to be treated at a family level and/or with traditional healers. Furthermore, one of those emotions, envy, is one of the main focuses of negative relationships especially between individuals and microgroups. Based on *emic* terminology, envy is one of the main causes of disease and maybe of death. All these sufferings require the performance of healing rituals. Hence, there is a need to admit that the *medicalization* of behaviors is prior to the development and expansion of biomedicine, although anthropologists and other experts do not understand it in that way, or do not think about it at all.

In this regard, I consider that a "traditional medicalization" of a complete set of sufferings rules in Latin American ethnic groups. This is reflected in the large number of traditional healers, both in absolute and proportional numbers, which exists at a community level in comparison with health personnel, in the variety of traditional healers with whom the members of the population deal, and in the scenario where most of the traditional diseases, as it was already mentioned, are connected with behaviors. The role of all types of assistance, and not only biomedical assistance, is to fulfill a variety of social functions, and "medicalization" of behavior is one of them.

Moreover, there is a tendency not to apply some of the pivotal concepts of anthropology in certain studied h/d/c-p processes; thus, for example, we know that Latin America is currently the region reporting the highest homicide rate all over the world. Although this situation has been a constant feature, most of the anthropologists – if not all of them –do not use the term culture to describe and analyze homicide aggressions, and even some of them expressly deny that homicide violence is part of our culture. At a theoretical and methodological level, I believe that homicide violence is part of our culture and not only of our communities. We have to remember that many violent events are clearly cultural such as "blood violent events," "bad accident" (infanticide), physical aggression among males as part of the so-called "chauvinism" and, obviously,

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femicides. As it occurs in every cultural process, these homicidal violent events need to be framed in relation to their economic-political and ideological processes, and they need to be understood in terms of subjectivity and change.

Having said that, one aspect shown by the Latin American production is that an anthropology of *illness* is currently dominating the scenario while showing a limited development of an anthropology of *disease* and a weak production of an anthropology of *sickness*.[21] *Illness* refers to how the individual and their group perceive, feel, and act on their sufferings. *Disease* refers to how the healer perceives diagnoses and treats the disease. And *sickness* proposes to include *illness* and *disease* within its economic-political and socio-cultural conditions. In other words, the anthropology dominating the system focuses on knowledge, experience, suffering, subjectivity, and tradition of individuals and micro-groups, while in most cases some conditions are not included or are poorly included such as, the economic, social, political, ideological, and even cultural conditions within which both knowledge and afflictions are produced and experienced. This also applies to the perspective and the actions taken in biomedicine.

This anthropology studies sufferings, diseases, and emotions almost exclusively of the involved individuals. It excludes healers and is also based on one specific actor's perspective, working on social representations, discourse, narratives, and/or experiences and not with the practices or identifying such practices with representations, discourse, and experiences. It is an anthropology of what is said rather than of what is done.

This discussion does not seek to neglect the quality and contributions of most of these studies, but to highlight certain dominant orientations which I believe need to be evaluated to reflect on what is lost and what is gained under the prevalence of these orientations. This act of reflection involves at least including the role of not only the so-called "social determinants" but also that of the "cultural conditioners," both at a micro and macro-social level, not in terms of determinants, but in terms of frequently decisive factors. I prefer using the expression "cultural conditioners," given that determinant factors usually exclude social processes and actors and block or reduce comprehension as structural factors do not always establish their conditions. In addition, I believe that cultural and ideological dimensions are also structural conditioners.

Furthermore, it is necessary to keep on working on local issues – as a vast majority of anthropological studies do – but we have to attempt to spot the global element in local issues and, if possible, to spot the local element in global issues. I think that "envy" – not only the tit or penis envy – may be observed through the local and global elements in different social groups, ethnic groups included.

The review of regional anthropological production shows that the issues that are almost exclusively studied are diseases and sufferings, but not health. Although from biomedical perspectives different definitions of health had been suggested, all of them were finally questioned by physicians and non-physicians. However, some European and North American social scientists attempted not only to provide a definition of "positive health," but also to carry out studies about it such as Antonosky[22] did several decades ago and Fassin[23] more recently. Nonetheless, in Latin America, just a few authors have attempted to study what they considered public health, although with little success, which to a great extent, is due to the fact that health has little connection with the "avoidable" deaths in Latin America and with the conditions of public health services in these countries, as well as with anthropologists' ideological worries, and with the prevalent economic-political processes that we undergo and that mostly affect the inferior social sectors in a negative way.

Regarding the Latin American conditions, there are at least two processes to consider in connection with the prospective study of *health*. One of these processes involves groups whose main characteristic is high mortality rates, because most of them die or become disabled due to "avoidable causes."

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Not only do these individuals and groups mourn, experience couple separations or love misfortunes, but they also starve, are in lack of essential medication, migrate, or are discriminated against because of race. The whole group of social sectors is afraid of living in communities and countries reporting the highest homicide rates in the world. Therefore, this situation leads us not only to ask empirical questions and formulate potential interventions, but also to have the need to provide explanations from a theoretical perspective about, for example, the reason why we Latin Americans kill ourselves so much.

In other words, we Latin Americans live within contexts where the priority or immediate alternative is not to produce health, but to describe, explain and, if possible, give a solution to a full range of sufferings. Part of these sufferings is frequently easy to reduce or eliminate with the already available technologies; meanwhile other sufferings involve the necessity to study and understand them basically in terms of political-social solutions.

This situation does not deny the possibility of thinking and studying *health* by those who are interested in doing so, but first assuming that *health* is – at least in my opinion – a basically ideological concept which implies the impossibility of theoretical and applicative generalizations. Health as a total elimination of sufferings is related to ancestral myths, to the novelistic proposals presented in *Brave New World* rather than in *1984*, or to biomedical mythologies of individuals stalled in a future waiting for a complete healing.

What has been called *health* by authors who insist on studying it is related to their goals and interests in connection with disease and its groups rather than with *health*, no matter how many semantic strategies they may develop to justify their concern, which does not deny the attempts of health promotion; however, they are actually a means of disease prevention. This notion of health does not disregard the fact that middle and high class social sectors in Latin American countries seek to produce health in their bodies which is connected, to a great extent, with denial of aging. It is worth remembering that not only disease but also health has become increasingly the object of personal desires as well as the so-called health industry.

But, once again, health has to do with ideological objectives, particularly referring to h/d/c-p processes and with political objectives as it occurred between 1930 and 1960 with a set of concepts formulated by African intellectuals and politicians within the Theory of "Negritude" or as it has been occurring for a few years with the concept of "good living" introduced by Latin American ethnicist intellectuals and, to a lesser extent, by de-colonialists who introduced proposals that, beyond what has happened to them, are characterized for using *health* with ideological objectives.

SOME CLOSE CRITICISM

While we recognize the relevant contributions that Latin American medical anthropology has made to knowledge and to criticism of certain issues and to solution proposals and intervention performances included, we still need to admit a whole array of debatable aspects in order to reflect on those contributions.

A steady tendency, to which I have already referred to, is the one of exclusion and putting certain problematic issues and social actors in second place, so I will not insist on it. However, there is a past tendency that still remains which by means of traditional diseases suffered by people and assisted by traditional healers seeks for (re)building ancient worldviews. This tendency seeks to rebuild such worldviews, at least partially, in current life of ethnic groups and places its interests in the past and not in the processes of disease by which people suffer and die. Without denying – and I highlight it – the archaeological, ethno-historical, and/or ideological importance that this objective may have, the questionable point is that part of the anthropologists is driven to have greater concern for realities imposed by anthropology than for

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current health situations of groups characterized not only for their sufferings, but also for high mortality rates, low life expectancy, and early aging. One of its consequences is also the tendency to study certain diseases and to exclude others. According to Imberton:

> A really strong tendency in anthropological studies about diseases in the indigenous communities but also about other issues has been the one that highlights those aspects considered of their own worldview: *ch'ulel*and *naguales* among Mayans have been in a privileged position within this perspective [...] and have led the anthropological point of view towards this issue though they have disregarded other issues.[24] [Own translation]

Therefore, if a member of a *choll* community from Chiapas suffers from a disease which does not involve "soul loss" – like the case of the sense of shame – anthropologists are not likely to study it. Cuadriello and Megchún[25] corroborate Imberton's proposal making reference to a new disease called "soil-borne disease" which is not connected with ancient aspects and which has not been studied by anthropologists. And as Freire[26] concludes in relation to Venezuela with Kelly's citation:

> Anthropological studies show a strong preference for focusing on "traditional culture" of patients as well as on adjustments with the aim of articulating health system with its particular characteristics but they have no knowledge of the fact that the most important factor in medical service provisions to indigenous patients is focused on the "culture of institutions."[26] [Own translation]

However, I would like to highlight that, although cultural rehabilitation of ethnic groups is important, those who rehabilitate, for instance by not analyzing the causes that determine the high mortality rates of these groups and the current approaches to reduce them which – it is worth noting – have nothing to do with autochthonous worldviews, should specify what they are really looking for.

There is a strong tendency, complementary to the previous one that searches for the worldviews of current ethnic groups mostly of the pre-Columbian "remains" and excludes or relegates the content coined by Catholicism from the late 15th century, although they are strongly present in ethnic and non-ethnic communities, to start with alcohol usage in all sets of healing rituals and also in rituals which are not related to h/d/c-p processes, although they are part of the structure and identity of these groups. Nevertheless, it is also noteworthy that there is a stronger presence of spiritual knowledge or certain new religious practices than the ones coined from Catholicism onward.

I believe that the idea of the world view and particularly the common sense – as Gramsci would say – from all walks of life, and especially from lower social sectors, have to be searched for in the daily life of individuals and groups to see what individuals do/live in connection with them. Thus, we observe that a great number of anthropological studies show that pre-Columbian worldviews substantiate their knowledge of current ethnic groups from the diseases they suffer from in terms of harmony and balance among community, individual, and "nature." That may be possible, but when these actors present their ethnographies, we see that individuals and small groups do not connect disharmony and imbalance with the worldviews, but with envy produced among individuals, small groups, and even communities and frequently organized in connection with economic and symbolic processes as Anthropology shows from at least the 1930s, and that was explained by means of Foster,[27] Erasmus[28,29] or De Martino[30] theories. And I say "explained" because at present there are not new theories that anthropologically explain the role of envy in connection with indigenous and non-indigenous peoples.

The bibliographic review shows that most of the disease episodes were referred by the respondents to conflictive relationships

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that they have had with individuals/small groups, to the violation of community rules, to the role of warlocks, and/or to divine or magical plans. Most of the interviewed individuals do not relate their diseases to the loss of the harmonious nature/society/individual relationships nor to the cosmic imbalance, but to the everyday cold/hot relationship, to something that happened with his neighbor, to an unfulfilled whim, or not having money and/or milk to feed their new born baby, or to the fact of having seen certain sexual scenes that they should have not at their age, or to the fact that God brought the disease or just wanted it this way.

Individuals also use organic or physical explanations of traditional or allopathic types and even use simultaneously or sequentially several of the explanations above. In all of them, the power of warlocks or magical or divine plans may be present. I need to highlight that Evans-Pritchard's[31] proposal repeatedly confirms these explanations regarding the simultaneous use of diagnosis and "empirical" and "magical" therapeutics by patients and their families in African groups. Beyond any formulated criticism to this proposal, this should not lead us to disregard worldviews but to see if they are part of the common sense and of the individual and group practices that different social segments create and currently use in their daily lives with respect to the h/d/c-p processes.

We have to stop searching for ancient worldviews in current social actors if we want to understand them because if we do not, we will not understand, for example, why currently young people do not want to be either shamans or warlocks any more or "empirical" midwives, although many of them want to be health assistants, promoters, nurses, and doctors. Neither will we understand why indigenous parents, mostly in urban scenarios, stop using their mother tongue when talking to their children or disagree with the idea of bilingual education. Even if they agree, they prefer their children to learn Spanish or English. The search for at least certain past events in individuals currently leads almost inexorably to *find* those past events, but they distort the objectives and orientations that some individuals and microgroups use in their daily lives.

This situation does not deny – and I highlight this – that due to the researchers' personal agenda, ancient worldviews and lifestyles are sought to document the existence of other lifestyles, h/d/c-p processes included. However, admitting that a great part of what is called worldview is an intellectual makeover characterized by its coherence and rationality and it has little to do with the daily life of people who typically break the rules, have conflicts and are inconsistent regarding what they say and what they do or even regarding what the individual says about the same topic in different situations, all of which would imply the need to develop a situational anthropology.

Those worldviews are usually ideal types whose creators – and mostly their followers – identify with the reality drawing the attention of anthropologists to those "ideal types" when it is in daily life where we need to observe what individuals and microgroups do, think, use, and of course say, not only through their own experience, but through experiences with other people with whom they have relationships. I need to clarify that I do not object to the use of ideal types – or models – but to the idea of identifying them with reality.

Therefore, although there is an increasing trend to modify these orientations, there is still a prevailing interest of a lot of writers in past worldviews to expose the difference, legitimacy, and capabilities of societies that have been undermined and exploited. And this trend has led, for example, to the fact that a part of the researchers on h/d/c-p processes are more worried about death than mortality. Thus, in light of groups that reported and continue to report sky-high child mortality rates, researchers are more interested in healing or in death rituals through which they verify the presence of worldviews than in analyzing, in ethno-epistemological terms, current mortality rates and, where possible, mortality rates in the past as well. It is evident that what we should study are both death rituals and

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mortality rates as well as the knowledge to limit and stop deaths as part of a socio-cultural epistemology of mortality; however, polarization of objectives rules researchers' worlds.

Although the most recent anthropological trends related to collective health are increasingly including more epidemiological data, we need to assume that the omission of that data is part of a strong anthropological tradition given that, not only in the past but today, scholars of the so-called traditional diseases neither produce nor use mortality data for almost any traditional disease, except in certain cases frequently related to witchcraft which are only referred to as mortal cases. Furthermore, studies about traditional healers, midwives included, are characterized by the fact that healers report no dead patients, thus projecting the idea that all the death cases are domestic or hospital deaths. It is important to highlight that a team coordinated by Zolla[32] codified the main diseases suffered by all ethnic Mexican groups and listed the diseases which may be the cause of death. Such work is an invaluable contribution although it does not present ethnographic descriptions and fewer statistical data regarding mortalities.

There is also a marked trend to continue exclusively working with one social actor instead of working with a group of meaningful ones who are related to h/d/c-p processes already studied. In other words, the whole focus is on one actor's point of view in a way that it is possible to get strategic and quality information, although it cannot explain certain processes. Additionally, it can distort the interpretation of studied h/d/c-p processes. As I have been highlighting since too many years ago now, although I acknowledge the ideological – and obviously methodological – objective of this approach, I think that it limits not only the understanding of the problem, but, eventually, the fulfillment of the ideological objectives as well. Therefore, we consider that it is necessary to boost a logical approach to this issue.

During the last years, a whole series of studies about the narrative of h/d/c-p processes have arisen which, apart from their symbolic achievements, have not reflected too much about criticisms made on these streams of analysis in the countries where they have been developed since at least the 1970s and where not only is the literary interpretation of the sufferings questioned, but also the elimination of the cultural and economic-political component. In this way, diseases are just limited to subjectivity.

This is an individual whose routines and repetitions that characterized all their life have disappeared and whose customs may be seen as personal and frequently heroic products.[33,34] By this way, anthropology has evolved from the anthropology of "the" culture of rules and roles, that is to say of routine and repetition, to an anthropology of the action or at least to an individual narration. Social anthropology, sociology, and to some extent social psychology, were built through the observation of life as routine and repetition, which put the change in second place and the individual above all, but currently we have moved on to an anthropology that subordinates and pays no attention to guidelines, rules, or practical-motionless action as were referred to by Sartre.

An increasing number of anthropologists in Latin America say that they apply with aptitude a phenomenological approach which, especially in Brazil, has a development of almost three decades.[35,36] Works related to cognitive, semiotic, and hermeneutics orientation have been tacitly or explicitly questioned by part of the above mentioned studies due to the fact of having reduced h/d/c-p processes – especially the body – to social representations, texts, and interpretations where not only experiences disappear, but also the role of social practices decreases or is even eliminated.

However and despite these contributions, serious doubts have arisen to me about the phenomenology used by many of those who apply this approach. When I asked several writers which type of phenomenology they apply, they usually start talking about Husserl and mainly Merleau Ponty and about the theory of embodiment but without specifying what they do. As we already know,

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both Husserl[37] and religion scholars such as Leeuw[38] consider the use of phenomenological reduction decisive as:

> ...the research of consciousness suggests that all the theories about it, every preconceived opinion and explanation should be set aside in order to observe without prejudices what happens in my consciousness here and now.[39] [Own translation]

Although, from Safranski´s point of view, "The phenomenological reduction is the aspect of phenomenology which decides everything."[39] Although other phenomenological trends do not apply this reduction, they highlight how they do go "toward the things themselves," which I exceptionally observe in the published works by Latin American anthropologists. In addition, I cannot distinguish the difference between a phenomenological report and an ethnographic one in their articles. I have the impression that what they do is one of the many ethnographic variants which focuses on some individual aspects of the social actors and that are referred to scarcely discussed topics until a few years ago, such as those referred to the "body."

This lack of clarity and anthropological reflection draws attention mainly because several anthropologists not only make reference to phenomenology, but also adhere simultaneously to Bourdieu's proposals. But it so happens that for this author and his disciples,[40,41] the methodological starting point must be to give evidence of the researcher's assumptions/prejudices due to several reasons but especially to avoid that "self-fulfilling prophecies" made by researchers establish "self-fulfilling prophecies" as it was repeatedly highlighted by Bourdieu. Additionally, I have to admit that in the case of Latin American social anthropology, assumptions and ideological goals of diverse type carry a significant strength which has been repeatedly noted in several of my articles, which I do not question because it is part of "our way of being in the world."

But what I do not observe either in phenomenological or Bourdieu's terms is a reflection about the role that those assumptions have, or the way they are methodologically handled, or how they influence ethnography and the given explanations. Furthermore, there is a certain dominant trend to mix theories and contradictory concepts. As a result we observe in Bourdieu's case that although his theoretical proposal about the *habitus* and the field entails that the position of the different social actors who compete for specific goals be included, it happens, however, that almost all of those who use it focus their ethnography and analysis on a sole social actor.

There is a methodological aspect which dominates not only the anthropological medical production, but also the social anthropology and ethnology. Its importance is based on the fact that it is the "technique" by which anthropologists identify ourselves as stereotypes and to a great extent by which we differentiate: the so-called participating observation to which most anthropologists say to adhere to but which most of them – myself included – do not practice or at least we partially practice due to the fact that the participating observation includes observation, and anthropologists neither learn to observe nor practice systematic observation. That is why our works are almost exclusively based on the words of the other.

At least from the 1980s, American and European anthropologists[42,43] are worried not only about medicalization, but also about the danger that medicalization of medical anthropology[44,45,46] means, which is also seen in Latin America.[47] Most cases of medicalization – although not exclusively – are observed in anthropological projects characterized by intervention in such a way that several studies on reproductive health and interculturalism use biomedical approaches rather than anthropological ones, apart from their appealing to concepts as culture and subjectivity. Sometimes that situation is due to the fact that at least a part of the interventions about h/d/c-p processes simplify, schematize, and exclude aspects of the reality in order to enable the intervention, particularly

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when it attempts to be widespread. Thus, complex processes are schematized, simplified, or excluded to be able to intervene. Thereby, for instance, shamans and wizards were excluded from the intervention proposals in intercultural activities in Mexico – even if they have been programmed by anthropologists – because the health sector opposed them, although midwives and herbalists were allowed to work.

CONTRIBUTIONS AND PROPOSALS

According to María Cecilia Minayo,[48] medical anthropology is presently one of the most dynamic disciplines among those that are part of the collective health field in Brazil, not only by its remarkable bibliographic production, but also by its contributions to collective health thinking. It is worth mentioning that medical anthropology is not a discipline subordinated to medicine but one that develops its own prospects and produces theoretical and methodological contributions. At the same time, Sebastián García, Director of Quality and Education for Health in the Secretary of Health of Mexico, highlighted that the new areas required to strengthen the different branches of medicine are medical physics, medical engineering, robotics, and health anthropology.[49] In other words, the recognition of Latin American medical anthropology comes both from this discipline itself and from biomedicine.

Latin American medical anthropology has made remarkable contributions in different fields and problematic issues that have justified and encouraged the use of qualitative techniques and methodologies in the study of h/d/c-p processes, obtaining strategic information and interpretation that cannot be produced through techniques and statistics approaches, which has led to the intensive use of these techniques by biomedical researchers whose uses have been frequently questioned by anthropologists.

Medical anthropology has shown not only articulation that individuals and groups do among the different forms of attention that operate in a specific context, but also the appropriation process that all social sectors develop from biomedical knowledge. It has noted that traditional and alternative medicines are a standardized part of the disease attention paths and that all forms of attention – not only biomedicine – are characterized by change. Medical anthropology has shown that society and culture, as well as biomedicine and traditional healers, may cause illness. It has increasingly included power processes referred to the healer/patient relationship, particularly those related to gender. Moreover, medical anthropology has continuously highlighted the permanent importance of field works in opposition to the development of constant and discontinuous "theoretical" proposals. Besides, a holistic view of the h/d/c-p processes that questions the unilateral and excluding direction of the biomedical model has been posed as much as possible.

One of the most steady contributions made by medical anthropology is to keep records and to attempt to understand the popular knowledge about h/d/c-p processes. All currents of thoughts, even the most antagonistic ones, have tried to describe the rationality of the different groups – particularly that of the ethnic ones – to explain and act against the sufferings that affect them, as well as to understand their behaviors of alleged or real rejection of biomedicine. Nevertheless, we need to note that unlike the position of writers like Byron Good[50] – I suppose – regarding anthropologists from his country, most of Latin American anthropologists have tried to describe and understand secondary knowledge without considering them false or wrong no matter how effective they may be, which constitutes one of the points that shows the biggest gap with biomedical knowledge and institutions.

Facing the medical questions of why the hypertensive individuals, diabetics, or individuals suffering from HIV-AIDS do not accomplish the "recommended" treatments or why an increasing rejection of different vaccines has been developed, anthropologists

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try to find not only the cultural rationality of those behaviors, but also the economic, political, and ideological rationality referred also to the context where those behaviors are developed. They search for rationality that begins with the assumption that scientific evidence does not change the behavior of specific social sectors, at least not immediately. Furthermore, in particular social sectors scientific arguments and new technological media are used to justify, for instance, the rejection of vaccines.[51] This is paradoxically reinforced in certain cases, given that it is the health staff that reject to be vaccinated as it happened during the A virus subtype H1N1 influenza epidemic that occurred in Mexico and many European countries.

As I have already remarked, medical anthropology criticism of biomedicine, including proposals of change, is one of the main anthropological contributions. This criticism has covered theoretical, methodological, learning, and intervention aspects, particularly the ways of acting with "indigenous" peoples and lately with women not only from those peoples, but also from different social sectors. This criticism ranges from establishing the structural impossibility of biomedicine – and especially of the Health Sector – of taking into account and applying certain cultural, political, and subjective aspects that have an impact on the sufferings and their understanding and solution up to those that question specific aspects of knowledge and medical institutions while relying on their modification and complementarity with socio-anthropological proposals.

Meanwhile, the first proposals concluded that there is a radical incompatibility between anthropological and biomedical approaches supporting that every professional – anthropologists included – who works in biomedical institutions will prescribe medicines not only to their interventions, but also to their way of thinking, which is held by Brazilian writers.[8] Other proposals have expectations that non-biomedical ways of thinking and acting may be maintained, even working in biomedical institutions. This could be made through a type of labor division where medical anthropology, from its viewpoint, would basically work on the complementation of what is not developed by biomedicine, whether in teaching, research, or even intervention, especially through NGO.

Nevertheless, all trends agree on the fact that dominant biomedical orientations tend to impose their ways of thinking and acting with respect to, for example, the management that the health sector does of self-help groups, of the negative way of thinking about prevention applied by social groups, of the simplistic ideas they have to influence in lifestyles of social groups, and of the management that this sector usually does in connection with qualitative techniques which have turned them into quick investigation techniques or into stigmatization of self-attention and particularly of self-medication.

For the Latin American anthropologists, there is no doubt that h/d/c-p processes are an intrinsic part of the culture where they operate; they are part of the cultural identity, which is the reason why part of these professionals understand biomedicine expansion as one of the main threats, even among traditional healers, not only with respect to traditional medicine, but also to cultural identity of ethnic groups.

These anthropological ways of understanding biomedicine should assume that there are radical differences between medical and anthropological training and particularly between doctors and anthropologists' personal and professional aims. While biomedical training has biological and biologist basis, anthropologist training has been based on culture, knowledge, and meaning. Furthermore, the objective of medicine has been to work on diseases, while that of anthropologists has been "to understand" them. For that and other reasons, I consider it is necessary that anthropologists should attempt to describe and understand biomedical rationality in the way they have been doing it with respect to the rationality of popular knowledge.

Meanwhile, most of the mentioned criticism refers to biomedical medicine and to a lesser degree to certain currents of social medicine and public health, with which there is a

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coincidence about criticism made about biomedical institutions as well as about public health. Moreover, in certain situations – particularly in the field of mental health – there has been coincidence between anthropological proposals and critical psychotherapeutic currents. During some time, this was the case of the closing and reformulation process that took place in mental hospitals and of the application of certain ways of attention and coexistence with a mental disorder.

Latin American anthropologists have studied the knowledge that groups and communities possess regarding different aspects of reality, although these studies have no knowledge of the subjectivity of social actors they studied at least until the 1990s, and despite the fact that between 1930 and 1950 a series of anthropological currents was developed in the US which recovered the individual or at least the person. But despite the mentioned North American anthropology influence, specifically in Mexico and Central America, these trends were frequently questioned for having been considered psychology-oriented trends by writers who adhere to anti-colonialist and/or class proposals.

Under neo-liberal domain, along with cultural difference, empowerment, and ethnicism, the concept of subjectivity is recovered, which is why mainly due to the influence of trends developed in the US, a concept of anthropology as a science that started to take into account afflictions, sufferings, experiences, and emotions arose in the region. This is not only necessary to include subjectivity, but also to complement previous approaches and to look into the possibility of understanding even more cultural rationalities at individual and group levels.

It is interesting to note that anthropological trends in the region which at present recover the figure of the individual do not make reference, for instance, to the huge quantity of biographies, self-biographies, or life stories developed by North American anthropologists and sociologists between 1930 and 1950. Furthermore, either reference to Juan Chamula's biography developed by Ricardo Pozas or to almost the whole works of Oscar Lewis is practically not mentioned. This is the reason why I consider that present social anthropology rules, not only in Latin America, an increasingly notorious theoretical non-historicism which is also related to with certain unawareness.

Thus, for instance, although this is one of the most dynamic trends at present, I do not understand why many anthropologists who work on the individual resort to Bourdieu's proposals, and especially to those suggested by Foucault, which particularly exclude the individual instead of using concepts and proposals such as, for instance, those suggested by Linton or Sartre, which are precisely characterized for the inclusion of the subject, obviously using other names. This inconsistency probably explains why most of those that use concepts like subject, subjectivity, and experience do not define them.

During the 1940s Linton developed a conceptual model much more dynamic than the Bourdieu's structuralist one when he proposed that if we want to understand what Bourdieu named *habitus,* we should simultaneously study ideal, real, and built patterns which are used either by groups or individuals. Obviously, the abovementioned model does not question what Bourdieu says regarding what his interest of study is, but it proposes that for anthropologists who want to study individuals, it is more relevant to do it following Linton's proposal[52] or Sartre's *Search for a Method*.[53] In any case, fashion is fashion and so is "forgetfulness."

I consider that one of the main contributions to medical anthropology is to provide evidence that many of the traditional diseases have been caused by social relationships, in a way that individuals, minority groups, and communities consider that conflicts that operate at a familiar or neighbor level are the cause of physical sufferings. And this is one of the aspects we should study the most but not only related to traditional diseases since, explicitly or not, anthropological approaches have considered that traditional and non-traditional diseases have social cultural and psychosomatic components, where individuals and minority groups' meanings and actions work.

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I have detected about fifty traditional sufferings generated by social relationships based on the material compiled by Zolla[33] and collaborators for Mexico about traditional diseases. Some of them are frequent conditions suffered by individuals of Mexican ethnic groups and some of them are mortal cases. Although many of these sufferings are attributed to God or to mythical characters, the ethnographic description shows that not only most conditions are generated by conflicts or daily social problems which have to do with land ownership, marriage agreements between families or with violence of different types but, as I have previously highlighted, in most of these relationships there is a component of envy which refers to poverty situations, fact that has already been described and interpreted from the 1940s onwards by culturalists, functionalists, structuralists, and Marxists.

DOUBTS AND UNCERTAINTIES

Meanwhile, with respect to several processes and problems studied by medical anthropology in Latin America, several doubts arise concerning some goals and consequences in which our discipline has participated in different ways beyond the way of its past participation. During this period of time, as it is already known, in various countries of the region, special health services for ethnic groups have been created and intercultural health politics have been applied, all of them supported by the Pan American Health Organization. Although it is worth highlighting that most services lack financing or financing is insignificant and that the intercultural health politics have a little impact and are characterized – with some exceptions – by their discontinuity or failure, this is the case of mixed hospitals. It should be remembered that several intercultural trends developed during the 1980s proposed and expected a kind of articulation between biomedicine and traditional medicine which did not occur, a fact that for too many anthropologists meant an incompatibility between anthropology and biomedicine. However, I consider it relevant to analyze not only the viability of a special health system for indigenous peoples, but also the implication that it might have in economic, political, biomedical, and even racial terms.

One of the explicit or tacit indications of anthropological studies refers to the gradual or rapid biomedical expansion over indigenous peoples, although articulated in different ways, with domestic knowledge but with increasing hegemony due to the effects of various processes known to all. Most of the anthropological indications toward the mentioned expansion involve critical components, but do they limit, stop, or modify that expansion or not? Additionally, what balance can we have, in specific terms, of the mentioned biomedical expansion? Has it been positive, negative, or ambiguous? And regarding which specific problems?

Although not only anthropological proposals, but also those of the medical healthcare and Pan American Health Organization (PAHO) teams specify the necessity of improving the doctor/patient relationship and of boosting the health personnel understanding regarding social-cultural patient's characteristics, not only those belonging to ethnic groups, we, however, observe that these objectives become secondary in opposition to determinant situations such as those referred to the persistence in health care inequalities and few and differential investments in health by local and federal governments in general and particularly in those of the indigenous groups, which is related to the growing demand for health services by inferior social sectors and for the times increasingly reduced of medical consultations. Although both objectives are not antagonistic, the question is: where is the incidence of the development of health care systems put in "ideal" terms and possibilities?

This matter is related to a process which I have been worried about and that, in simplified terms, has to do with the agency capacity of the inferior sectors with respect to the h/d/c-p processes,[54] with the possibility of

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creating autonomous organizations as well as options coming from the civil society which are not co-opted or redirected by the prevailing social forces, and with the possibility of creating resistances, empowerments or alternative concrete actions regarding the h/d/c-p processes. I am worried about what I observe because my review shows that h/d/c-p processes are not considered vital processes either for ethnic movements or their leaders, unless in rhetorical terms. In other words, we do not find movements that really boost ways of self-healing as possible options to biomedical ones. However, we verified the push of small activist groups in the case of HIV-AIDS, particularly in cases that affected women but focused almost exclusively on cases of violence and reproductive health. It should also be remembered that different types of professionals, anthropologists included, are involved in these groups.

Additionally, except for the case of groups similar to Alcoholics Anonymous characterized by their autonomy, which are the groups, associations, or movements referred to h/d/c-p processes that have been created, organized, supported, or/and financed by subordinated social sectors, either to ask for better biomedical services or to boost traditional or alternative ways of healing? The associations and movements I know – and only referred to Mexico – have been created and organized by individuals who belong to middle social sectors, including intellectuals and professionals who have led such groups. By highlighting this, I do not deny that after this organizing "trigger," individuals and minority groups may boost the mentioned processes although they continue being externally financed. Furthermore, I am worried about the penetration of the chemical-pharmaceutical industry in financing and leadership of these groups, at least in European countries and in the US, given that we do not have studies done on Latin American countries.

In contrast, to specify what resistance means, not only in terms of social movements but also in individual ones, minority groups or community terms, entails interpretative decisions that are difficult to establish. When is not going to the doctor the result of lack of doctors or economic resources? And when is it due to a negative attitude toward biomedicine? When does self-medication mean a way of empowerment with respect to biomedicine? And when does it mean a social process which rationalizes the individual's own time or determines what is cheaper for the individual or minority group?[55,56]

But the pivotal point for us is to be able to establish the individuals and subordinated groups' agency capacity not only for self-care or resistance but also for negotiating or even imposing proposals to improve or modify activities and health policies developed in their territories. This is one of the processes that we should analyze the most in Latin American countries.

Now, as I have already highlighted, the bibliography has documented that most of traditional diseases reflect social conflicts that occur generally between close people who work in contexts of poverty and scarcity. Nevertheless, according to several authors, part of traditional diseases also shows the limitations or obstacles that certain social actors, particularly children and youths, and especially women, have during the development of specific behaviors or if it is preferred to call them "desires." For example, this fact may lead to the situation that in certain communities a woman may refuse to get married to the person chosen by her family. This behavior may be denoting her refusal to *get* a condition recognized by the community, which can be assisted by a traditional healer.[57]

This implies that the so-called "customs" can generate negative consequences for some of the community members, which are sometimes "solved" through diseases or other mechanisms, but frequently they are not. In spite of that, the diverse anthropological currents, and not only the culturalists and indigenous ones, have entirely recognized the positive role and the legitimacy of the customs, which have been reinforced by the development of the ethnic movements and for the political empowerment of some of these groups during the period of time we are analyzing.

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Let's remember that while a part of these movements and analysts denies – or at least does not mention – the possible negative consequences of certain customs, as they are only used to being identified with the so-called "good living" or "communalism," other trends, whose main expression has been feminist anthropology, note that certain customs limit, annul, and exclude the role of women, subduing them to conditions of inferiority that culturally justify – among other actions – the application of different types of violence, which can end up in death.

This critical trend is also confirmed through studies about h/d/c-p processes that show the current situation of certain social actors, at a general level, and of ethnic groups, in particular, with respect to certain sufferings. Thus, it is increasingly frequent to find proposals that, given the seriousness of certain problems such as the spread of HIV-AIDS in indigenous and non-indigenous peoples in rural areas, consider that:

> ...we, anthropologists, cannot continue repeating either the defence at any cost of customs as a *status quo* or of factors of cultural preservation. We must provide the necessary elements to adopt a dynamic concept, in which indigenous peoples have the right to transform themselves and their own culture. In the same way, we have the role of supplying the theoretical and analytical inputs to understand vulnerability and the best ways to fight against it [...] that implies many challenges, perhaps the most important and essential one is that communities assume the responsibility of speaking about sexuality and particularly about sexual/love diversity.[58] [Own translation]

Obviously, what these and other authors propose[59,60,61] does not refer only to the indigenous peoples customs, but to all those who in different societies favor the development of sufferings, even lethal ones, especially in some social actors confined to certain roles and status.

Customs refer to *the* community, but to that one where certain social actors can apply them without problems, while for others they are restricted. Within the communities, even homogeneous ones, there are always actors with greater possibilities and differential benefits not only in socio-economic terms, but also in terms of power and culture.

It should be noted that although Ponce and Nunez's text proposes defined actions, it does not clarify a basic problem, as it does not indicate what we can or should do with regard to the indigenous and non-indigenous groups that do not want to modify their own culture with respect to diseases that are affecting and even decimating them and prefer to continue with their customs; this was the case of recent scenarios in several African countries with the Ebola disease or also in the Dutch Calvinist segment with respect to the epidemic of influenza A virus subtype H1N1. Not only is this a sole Latin American problem, but also an exclusively ethnic problem.

We need to assume that for Latin American medical anthropologists the h/d/c-p processes are an intrinsic part of the culture of every social group, and particularly of the indigenous peoples. This is the reason why they see the biomedicine expansion as one of the main threats to the cultural identity of those peoples. This expansion is usually analyzed in terms of the increasing dominance of an instrumental rationality and of a biomedical hegemony, which can be questioned by appealing to native medicines. Although Latin American medical anthropologists do not usually theorize about these proposals, a part of them adheres to those who talk about epistemologies of the South or to the self-denominated decolonial orientations. However, these proposals are not only basically ideological but, in the case of the former ones, they also repeat what was developed between 1920 and 1950 by part of the European thinking, and in the case of the decolonial orientations, they do not go beyond the proposals of theories such as those of "negritude" or "the West decadence."

The abovementioned proposal is the last theoretical and ideological uncertainty that I

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introduce in this article and is, as usual, resolved in practice which indicates that anthropologists increasingly opt for intervention or, at least, its follow up, and we solve our conflicts and contradictions by appealing to the established methodologies, committed or simply useful.

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CITATION
Menéndez EL. Medical Anthropology in Latin America, 1990-2015: A strictly provisional review. Salud Colectiva. 2018;14(3):461-481. doi: 10.18294/sc.2018.1838.

Received: 17 Apr 2018 | Modified: 25 Jun 2018 | Accepted: 16 Aug 2018

http://dx.doi.org/10.18294/sc.2018.1838

The translation of this article is part of an inter-departmental and inter-institutional collaboration including the Undergraduate Program in Sworn Translation Studies (English < > Spanish) and the Institute of Collective Health at the Universidad Nacional de Lanús and the Health Disparities Research Laboratory at the University of Denver. This article was translated by Carolina Paula Giambelluca and María Inés Giménez under the guidance of María Pibernus, reviewed by Emily Leeper under the guidance of Julia Roncoroni, and prepared for publication by Aldana Sacco under the guidance of Vanessa Di Cecco. The final version was approved by the article author(s).

SALUD COLECTIVA. 2018;14(3):461-481. doi: 10.18294/sc.2018.1838