SALUD COLECTIVA, Buenos Aires, 7(1):73-86, January - April, 2011

Indigenous peoples' perception of the primary care system in rural areas. The case of southeastern Veracruz, Mexico

Percepción de los habitantes indígenas de áreas rurales respecto al primer nivel de atención médica. El caso del sureste de Veracruz, México

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ABSTRACT The article discusses the experience of indigenous peoples from southeastern Veracruz with primary care services at the institutional level. The information stems from 71 interviews with people suffering from coughs, as well as from participatory workshops and informal talks with people from the region. Geographic inaccessibility, lack of medication, short clinic hours, and lack of translators of local languages are the main problems that hinder use of existing health services and sometimes become reasons for users not to seek those services. The article concludes with a reflection on the present model of medical care in Mexico and the importance of primary care as a foundation of the health care system.

KEY WORDS Health Services; Indigenous Population; Social Conditions; Cough; México.

RESUMEN Se presenta la experiencia de habitantes indígenas del sureste de Veracruz con respecto a los servicios institucionales del primer nivel de atención médica. La información procede de 71 entrevistas a personas con tos, y de talleres participativos y pláticas informales con habitantes del área de estudio. El acceso geográfico, el desabastecimiento de medicamentos, los horarios establecidos y la falta de traductores de la lengua indígena se mencionaron entre los principales factores que dificultan el uso de los servicios de salud y en ocasiones lleva a no acudir a ellos. En las conclusiones se reflexiona acerca del actual modelo de atención médica en México y la importancia del primer nivel de atención médica como base del sistema de salud.

PALABRAS CLAVE Servicios de Salud; Población Indígena; Condiciones Sociales; Tos; México.

SALUD COLECTIVA, Buenos Aires, 7(1):73-86, January - April, 2011

INTRODUCTION

Social inequality, historic in the indigenous populations of Latin America, is increasingly profound in the global village and within the fictitious homogenization it proposes. According to the reports issued by national and international organizations (1-6) in Mexico, which is a member of the Organisation for Economic Co-operation and Development (7), there has been an increase in economic and social gaps among the different groups of the population. These gaps are more evident in the southeastern states of the country and in the indigenous population in comparison with the non-indigenous population. For example, the majority of indigenous people (62.4%, versus 20.8% of non-indigenous people) live in disperse localities with fewer than 2,500 inhabitants, with a high or very high degree of marginalization. Additionally, the geographic access to health care is extremely difficult in rural areas of Mexico; 38.9% of indigenous localities have little or no access to health care services, while the indicator in non-indigenous localities is 31% (8). The situation is similar for indigenous populations throughout Latin America (9-12).

In the public health field, this inequality is reflected in the epidemiological map of the country: the southern states present the highest rates of maternal mortality and death from infectious diseases (13). In the National Health Program 2007-2012, it is acknowledged that in Mexico, the differences in causes of avoidable mortality, such as diarrhea in children under 14, anemia and tuberculosis, would decrease if access to quality health care could be extended (14). Avoidable deaths reflect, among other factors, failures in health system actions as well as in other sectors that contribute either to reducing the risk of illness or death or to improving access to health care (15).

The World Health Organization (WHO) reports that as the cities become more modernized, people grow more dissatisfied with health care services. Consequently, it is necessary to reorient the way health systems work all over the world. The WHO calls for the renovation of Primary Health Care principles, seeking to end exclusion and invest people with the power to decide on matters affecting individual and community health (16-17).

The current medical model in Mexico demonstrates a gradual withdrawal of the State in its responsibility to ensure the universal right to health. This model consists of differential services for the Mexican population: commodification/privatization of health services with a tendency to offer health care in hospitals, the use of expensive technology for those who can afford it, and a limited number of services available in public health care institutions for people with scant economic resources (18-20). In the period between 2000 and 2006, the *Seguro Popular* was established with the objective of guaranteeing universal access to high quality health care and to protecting all Mexican citizens without social security from the high costs of disease treatment (21). Primary health care, as the foundation of health care system, plays an important role in ensuring that legal standards are met in the delivery of services in order to achieve equity in health. With this background established, the following question arises: How do the indigenous people of southeastern Veracruz experience this model of health care? No one can answer this question better than the people themselves.

This article presents the perception of indigenous people from southeastern Veracruz regarding the institutional health services available. The underlying assumption is that it is necessary for the social actors to make visible the factors they perceive as limiting their use of primary health care services. It is important to be aware of these matters when designing operational strategies for health care in marginalized rural areas.

METHODOLOGY

The information contained in this article is part of a wider investigation carried out in 2008 and 2009 entitled: *"Pobreza, género y etnicidad. La tuberculosis pulmonar en una zona indígena de alta marginación en el estado de Veracruz"* (Poverty, gender and ethnicity. Pulmonary tuberculosis in a highly marginalized indigenous area of Veracruz State) (a). The main objective of this investigation was to discover the path followed

SALUD COLECTIVA, Buenos Aires, 7(1):73-86, January - April, 2011

when seeking health care for a cough persisting for more than two weeks (attributed to a probable phymic process) and the relationship established between the population and institutional health care centers. The area of study includes four municipalities in southeastern Veracruz, Mexico: Mecayapan, Pajapan, Soteapan and Tatahuicapan, where 84.2% of the population lives in indigenous homes. The selection of the localities to be investigated was carried out using a statistical sampling. On the basis of academic and epidemiological criteria, the decision was made to work in localities with more than 50 inhabitants and fewer than 2,000, with medium, high and very high social gap indexes (b) (23) and with 70% or more of the population living in indigenous homes (c) (24). The final sample included thirteen localities, five with a rural health clinic and the rest without (Table 1).

Quantitative and qualitative techniques were used to collect information. The base of the information contained in this article comes from 71 interviews with people suffering from cough for more than fifteen days; they were selected through a household survey in the thirteen localities previously mentioned. The path taken in search of treatment for the cough was reconstructed, including the use or non-use of services provided by rural clinics in the region. Information about the experience of each interviewee with institutional health facilities in the area was also collected. In total, 71 interviews with an average duration of 40 minutes were conducted; 34 of the people interviewed had a local health care service nearby. Each interview was carried out at the informant's home, either in Spanish or with the help of a translator of Nahua or Popoluca ethnicity. Participatory workshops were also held in three of the thirteen localities selected for the research, two of which lacked a rural health clinic. Altogether, four workshops were held with the participation of adults from each locality, in which people's experience with the services provided by rural health clinics available in their areas was discussed, among other topics. Workshops were recorded in audio with the prior consent of each group. In addition, observations were noted and informal talks were

Table 1. Number of households surveyed, interviews with people suffering from cough, and participatory workshops, according to clinic availability and the level of social marginalization within the locality. Veracruz, Mexico. 2008-2009.

Locality	Local clinic	Social marginalization	Surveyed households	Interviews with people suffering from cough	Participatory Workshops
1	Yes	Medium	196	4	-
2	Yes	Medium	55	7	-
3	Yes	Medium	235	15	1
4	Yes	Medium	73	7	-
5	Yes	Medium	31	1	-
6	No	Medium	52	2	-
7	No	Medium	96	4	-
8	No	Medium	115	8	-
9	No	Medium	55	10	1
10	No	Very high	83	4	-
11	No	High	65	1	-
12	No	High	50	4	-
13	No	High	87	4	2
Totals			1193	71	4

Source: Own elaboration from data on social marginalization levels (23), INEGI (24), interviews and participatory workshops from the fieldwork.

SALUD COLECTIVA, Buenos Aires, 7(1):73-86, January - April, 2011

held with people living in each locality, including community leaders, community health promoters and school teachers. The information collected with these techniques was recorded in the form of field notes, and allowed the informants to express their points of view regarding their experience with health care services.

Before each interview, the informants had explained to them — either individually or in groups — the object of the investigation, making it clear that their participation would be voluntary and that the information would be used only for academic purposes. The researcher was the only person who had access to the complete information from the questionnaires, interviews and recorded workshops, materials kept under her protection. The names of the localities have been changed into numbers (due to the small population of each) and informants' names have also been changed to ensure anonymity.

During the analysis, the field notes were organized and interviews and workshops were fully transcribed. The information collected was then read and coded and categories of analysis were defined. Preliminary results of the research were presented in meetings with representatives of the communities to ensure appropriate interpretation of the information. The suggestions made in these meetings contributed to the improvement of the final research report. It is important to remember that the information contained in this work corresponds to localities with fewer than 2,000 inhabitants. The discussion within this text centers solely on the experience of inhabitants of the mountain region of Veracruz regarding the use of institutional health care services.

RESULTS

Context of the region studied: geographic and social space

The municipalities of Mecayapan, Pajapan, Soteapan and Tatahuicapan (hereafter referred to as "the mountain region" for better readability) are situated in southern Veracruz and

Table 2. Characteristics of social marginalization, nutritional risk and health care eligibility in the state of Veracruz and the municipalities studied. México, 2008-2009.

Characteristics	State	Municipal			
	Veracruz	Mecayapan	Pajapan	Soteapan	Tatahuicapan
Social gap index	0.95039	1.14218	1.01152	1.61387	0.93557
Rank according to social marginalization level (national)	5	353	406	183	444
Rank according to nutritional risk index (national)	4	120	273	106	316
PDH%*	39.6	40.9	41.5	35.2	17.7
PDH% in social security institutions and others*	30.7	8.9	4.3	3.4	5.6
PDH% in the *Seguro Popular**	8.9	32.0	37.2	31.8	12.1

Source: Own elaboration from data on the social gap index, level of social marginalization (23), nutritional risk index (25) and indicators of healthcare beneficiaries in the population (24).

PDH = Beneficiaries in the population (from the Spanish *población derechohabiente*).
*Includes the population possessing health insurance for private medical institutions and the population that has the right to access medical services provided by the state governments and other types of public health institutions.

SALUD COLECTIVA, Buenos Aires, 7(1):73-86, January - April, 2011

present a high social gap index (23). They are also considered to be at extreme nutritional risk, especially Soteapan and Mecayapan (25) (Table 2).

The total population of the mountain region is 68,708 inhabitants distributed in 214 localities, 184 (86%) of which have fewer than 500 inhabitants; 84.2% of the population lives in indigenous homes and 76.2% of people aged five years or older speak an indigenous language. The Popoluca language prevails in Soteapan while Náhuatl is spoken in Pajapan, Tatahuicapan and Mecayapan. Of the total population, 3.4% are monolingual, 2.4% of men and 4.3% of women. The illiteracy rate is three times higher than the State indicator: 38.0% as compared to 13.4%, with women at a disadvantage in comparison to men: 47.1% versus 27.9%, respectively. The main activity of the inhabitants is the cultivation of maize for family consumption. Other crops in the region are beans, palm oil and papaya, and in Soteapan, coffee. These crops are marketed on a small scale. The amount of land per family group is variable, ranging from 1 to 30 hectares, although there are those who no longer possess land. The farming technique used is slash-and-burn, employing traditional instruments such as stakes, axes, mattocks, hoes and machetes. Neither tractors nor sowing and harvesting technology are available and the use chemical herbicides and fertilizers is common. For income, men work as day laborers in neighboring lands (with an average wage equivalent to six dollars a day), or they migrate seasonally and sometimes permanently.

The leading causes of death are chronic degenerative diseases, especially cancer and diabetes mellitus as well as some persisting infectious diseases such as pneumonia and tuberculosis. Other important causes of death are accidents, injuries, suicides, homicides and environmental pollution by toxic waste (d).

Health care options in the mountain region

Medical care in the mountain region is provided in four ways: a) domestic medical practices involving self-care or advice from relatives and neighbors; b) allopathic medicine, which includes institutional and private medicine and pharmacies; c) indigenous traditional medicine practiced by healers, bonesetters and midwives; d) herbal medicines, sold in natural pharmacies and by street vendors who periodically visit the localities, or prepared by groups of women in each locality. These are the four medical practices available for those seeking health care. None of them excludes the others and, on occasion, they complement one other.

The analysis of the information collected through the different techniques used in the field allowed us to identify the relationship established between the population and the institutional health care services offered in the mountain region. It is an active relationship, involving a questioning process and the search for alternatives to cure diseases. The main points discussed can be summarized as: geographic accessibility, clinic hours, saturation of clinic capacity, shortage of medications and lack of translators of indigenous languages. For descriptive purposes each of these points will be briefly addressed, highlighting their differences and similarities with respect to the presence or lack thereof of a local clinic in the area. Finally, a reflection is made on primary care in the area studied.

Primary care: the perception of the population

Primary care in the mountain region is provided at the rural clinics of the Secretariat of Health and of the IMSS-Opportunities Program, organized based on geographic accessibility criteria. Of the thirteen localities included in this research, the populations of seven localities receive health care in an IMSS-Opportunities clinic, and the other six from the Secretariat of Health. These clinics are the first contact the population has with health care services and they provide a basic service package at no cost which includes activities connected with health promotion, preventive health, and ambulatory medical visits. The work team is made up of a medical intern doing social service and a nurse who works from Mondays to Fridays. On Saturdays and Sundays in the IMSS-Opportunities

SALUD COLECTIVA, Buenos Aires, 7(1):73-86, January - April, 2011

clinics there is a nurse on duty in charge of treatments and injections. In localities where no rural clinics are available, a community health promoter (rural health aid or assistant) serves as a link between the population and the rural clinic and sees patients in a "Casa de Salud" (House of Health).

Roberto is the community health promoter of one of the towns visited. He is native to the town and speaks Popoluca and Spanish fluently. He performs several activities related to health care: he follows up with pregnant women needing prenatal check-ups, he measures the height and weight of children under five, and he treats symptoms related to the most frequent illnesses occurring among people in the town. He is also one of the three traditional indigenous medicine doctors in the town.

According to health sector protocol, community health promoters regularly receive a package of medicines including antiparasitic, antitussive and antipyretic drugs used for the symptomatic treatment of illnesses like respiratory infections and diarrhea, among others. However, as this supply is irregular, health promoters buy allopathic drugs at pharmacies in nearby cities and then sell them to their patients. Roberto explains that his treatments are a combination of medicinal plants and allopathic medicine. Allopathic drugs are used, for example, for those patients who reject medicinal plants and believe that they will recover more quickly if they are administered medication parenterally. He also remarks that each health clinic has a number of localities under its charge (called "areas of influence") that assigned medical and paramedical personnel should visit at least once a month to provide preventive health activities including information about sexually transmitted diseases and infectious diseases that can be avoided through vaccination. Unfortunately, this requirement is not always fulfilled. For example, at the time this fieldwork was being carried out, a locality with a high social gap index had not been visited by a doctor for seven months. The residents explained that when they inquired at the clinic about the reasons for the doctor's absence, they were told that they did not receive support from the institutional administration to pay the medical team's travel expenses.

Specialized medical care is offered at the IMSS-Opportunities hospital in the city of Jáltipan, 20 km away from the mountain region, and also at the hospital of the Secretariat of Health in Tonalapan, in the municipality of Mecayapan. Due to its geographic location, the latter is easily accessed by all four municipalities of the mountain region. It is generally the first place the inhabitants seek out in case of a health emergency or when their health care needs are not met satisfactorily at the local clinic. At the hospital, the care is differentiated in terms of cost: those not covered by the *Seguro Popular* are informed in advance of the cost of health care services. At the the IMSS-Opportunities hospital in Jáltipan, health services are free.

When this fieldwork was being carried out (2008-2009), the only people affiliated to the *Seguro Popular* were those who received care from the Secretariat of Health; users of IMSS-Opportunities were excluded. The only exception was the municipality of Soteapan, where the entire population was offered affiliation. The cost of hospital services is a serious problem for indigenous people in the mountain region, who cover costs of disease treatment by selling part of their land or livestock animals, by requesting loans from friends and relatives or through the support of religious groups.

Geographic access

The municipal seats of the mountain region are connected by a paved highway to the cities of Coatzacoalcos, Minatitlan y Acayucan, which are places of social and economic exchange. Within the municipalities, most of the localities are connected by dirt roads or local paths. People from localities without clinics go the clinics that correspond to them, either on foot or in public transportation trucks that offer services in the area. The number of runs the trucks make depends on the number of people traveling, therefore, in some areas the service is provided only once a day. Distances and transportation costs to the clinics vary, as is summarized in Table 3. In the event of a medical emergency, or when a sick person is very

SALUD COLECTIVA, Buenos Aires, 7(1):73-86, January - April, 2011

physically weak, a special transportation fare is paid which may vary between 200 and 400 Mexican pesos (between 15 and 30 dollars), depending on the distance to the hospital.

In rainy seasons the roads are blocked and the transportation service is discontinued. Therefore, people walk to a road in good condition and wait for a vehicle to pass by. However, even when public transportation is available, if the residents of the mountain region lack the money to pay for the trip, especially those from highly marginalized locations, they walk to the health clinic along paths or dirt roads in moderate condition. Apart from transportation difficulties, people may not find a satisfactory response to their health problems at the clinic and have to resort such alternatives as a hospital or a private clinic, among others. These difficulties are also experienced by people in localities with a health clinic.

Localities with clinics have a medium level of social marginalization, but there are geographic barriers restricting access that the indicators do not show. During the fieldwork, for example, visits to two localities with clinics had to be postponed as access to the localities had been cut off by mudslides caused by heavy rains. The difficulties in geographic access and the irregularity of public transportation lead to absenteeism among doctors or the resignation of medical interns who ask to be assigned to another place. In such cases, the health authorities find it difficult to hire another doctor. These localities are unattractive to doctors who are not willing to work in marginalized rural areas even when positions are available.

Saturation of clinic capacity, service hours in rural clinics and shortage of medicine

In addition to the difficulties in geographic accessibility, rural clinics, much like their urban counterparts, work Mondays to Fridays and Saturdays from 8 AM to 12 PM. In some clinics, especially those belonging to the IMSS-Opportunities, a nurse is in charge of treatments and injections during weekends. Since a fixed number of consultations is available per day, a person requiring medical attention must reach the clinic before all the appointments have been distributed. These restrictions become a barrier even for those who live in localities with a local clinic. For example, Maricela says that

Table 3. Characteristics of geographic access of the localities according to availability of health clinics and level of social marginalization. Veracruz, Mexico, 2008.

Characteristics of geographic access	Localities without a clinic		Localities with a clinic
	High and very high social marginalization	Medium social marginalization	Medium social marginalization
Average distance to the clinic	8 km	4-6 km	Local
Quality of public transportation	Deficient	Deficient to regular	Deficient to good
Travel time to reach the clinic			
Walking	120-180 minutes	20-60 minutes	Does not apply
With public transportation	20-30 minutes	5-30 minutes	Does not apply
Cost of public transport	$10 to $30*	$10 to $14*	Does not apply

Source: Own elaboration from data on social marginalization (23), observation and interviews.

*Expressed in Mexican pesos.

SALUD COLECTIVA, Buenos Aires, 7(1):73-86, January - April, 2011

when she gets ill, she does not go the clinic, and gives her reasons for not doing so:

> *...look, the doctor at the clinic is good but I don't go to the clinic when I get sick. The clinic is always crowded, you have to be there at seven in the morning to get an appointment and I can't because at that time I have to prepare breakfast for my children before they go to school.*

For those without a local clinic, travel time, cost and irregularity of public transport are added to the limited service hours. Men and women, especially those with no local clinic, commented that, sometimes, when they ask for an appointment, the nurse tells them that the number of daily consultations has already been filled. According to the informants, one reason clinics may become so saturated is the periodic appointments required by the Opportunities Program as a condition for beneficiary families to remain in the program. Josefa mentioned that families served by this program are given priority in health care by the clinic personnel:

> *...I arrived at the clinic and the doctor was busy with the people who have Opportunities. So the nurse gave me two pills for my cough and told me to return the next day. I never returned.*

The organization of activities in the clinics with regards to the Opportunities Program has gendered consequences which result in disadvantages to men's health. As was noted in different interviews, men consider going to the clinic for a consultation to be "women's business." As stated by Javier, a man with a clinic in his locality:

> *...I only go to the clinic to support my wife when she has the appointment for Opportunities. When I need a consultation I go to the pharmacy or if I have money, I see a private doctor.*

The shortage of medication in rural clinics is an issue of great concern to the inhabitants of the mountain region, who explain that sometimes part of the medicines for the treatment is supplied and then the patient is asked to buy the rest in the pharmacy. Sometimes only a prescription is given. In a Popoluca locality with high marginalization, all the informants mentioned that people are reluctant to go to the clinic because they must spend money to get there and though the medical consultation is free, they do not receive treatment:

> *...it's no use going to the clinic because they never have medicine and you spend your money traveling. The consultation is free but if they don't have medicine they give you a prescription, and if you don't have money you see if you can do without it. If you have a serious disease, one of those you can get at any moment, you try to find the money, even if you have to borrow it.* (Julio)

> *Sometimes, we are given medicine but just a part of it. They tell us to buy it. They give us half of it and we have to buy the other half. We have the Seguro Popular but it is useless. Buy your medicine, they tell us.* (Violeta)

The population that took part in this study live in marginalized localities where there are no pharmacies, independently of whether or not they have a local rural clinic. Filling a medical prescription means, in addition to the cost of the medication, spending money on public transporation to the municipal seats or nearby cities. Drug shortage problems still persist even for people covered by the *Seguro Popular*. A 73 year-old man, with a clinic 20 minutes away from his locality and public transport available, asked the following question: "What is the use of being covered by the *Seguro Popular* if we are not given the medication?" This situation is a reason why people sometimes do not return to the clinic, choose another alternative or just postpone medical consultation at the clinic in the hopes that the symptoms disappear. The inhabitants of the localities studied reported repeatedly that to a larger and larger extent people use the clinics for two reasons: routine checkups for the government Opportunities Program and in the event of a medical emergency.

The alternatives for health care are to turn to the community health promoter or, in the case of those who can afford the costs, to private medicine. Another option is to consult in a

SALUD COLECTIVA, Buenos Aires, 7(1):73-86, January - April, 2011

pharmacy of generic medications, which is appealing for several reasons: the cost of a medical consultation is an affordable 20 Mexican pesos (one and a half dollars); the wait time is short; and, to Popoluca women from the localities studied, because the person who regularly works the counter is native to the region and speaks Popoluca. One of these women, Inés, said:

> *...at the pharmacy there is a girl who speaks Popoluca and she can translate into Spanish. I don't know where she is from, but she works there. Because it's painful to try to explain what what's happening to us to the doctor at the clinic.*

Other alternatives are found in informal health care services like buying medications at pharmacies in nearby cities or drugs from the local stores to treat symptoms.

Lack of interpreters of indigenous languages

The medical staff at the rural clinics and regional hospitals, including the Tonalapan hospital, located in the mountain region, does not speak any indigenous languages; consultations are therefore held in Spanish. Although only 3.4% of the population in the mountain region is officially monolingual, many people, especially women over 40, find it difficult to express themselves in Spanish. The Popoluca women openly expressed their need to have interpreters of indigenous languages at hospitals and rural clinics. Some women stated that they do not go to the clinic because they cannot "answer the question," "because I didn't go to school and I don't understand." For these same reasons they feel unable to go to the hospital on their own. As Rubicelia, a 43-year old woman, explained:

> *...we arrive and we are told that are no more appointments. And they don't understand us because they speak Spanish. How can we explain anything to them? They should speak Popoluca, like me, or get somebody to explain to them what we say.*

Different strategies are used to overcome the communication barriers between indigenous languages and the Spanish language. In some clinics, especially in those belonging to the IMSS-Opportunities Plan, the nurse is native to the locality and acts as an interpreter in medical consultations during her work shift. Sometimes, the community health promoter acts voluntarily as an interpreter, without receiving compensation. Another option, especially for Popoluca women who find it difficult to speak Spanish, is to have a Spanish-speaking relative accompany them to the clinic. As José Manuel explained:

> *...most women go to the clinic. Even if they don't understand very well they go with their sons, who help them to translate. Some people here don't speak Spanish well. Even when they do understand, they can't translate. Since they have children, their sons or daughters help them to translate. In my case, I have to go with my wife to translate for her. I don't go to the clinic for consultation but my wife does, because she has Opportunities.*

The Secretariat of Health acknowledges that linguistic barriers are an impediment to accessing health care services and recommends establishing strategies to hire interpreters of indigenous languages in hospitals. It is also recommended that the medical and nursing staff prove their cultural competence (26). However, there is a huge gap between the recommendations of the health care system and what is really implemented, reinforcing the social and health inequalities that already exist. Taken all together, geographic and cultural barriers as well as the quality of the health care make inhabitants of the mountain region doubt that they will find satisfactory solutions to their health problems at rural clinics. Such is the case of Jazmín, a 52 year-old woman suffering from a persistent cough for one year and with no record of having gone for a consultation at the corresponding rural clinic. In accordance with her perception, she does not attend the rural clinic because *"I'm not old enough for dying and people go to the clinic to die."*

The perception of the population of the mountain region is that people die in institutional

SALUD COLECTIVA, Buenos Aires, 7(1):73-86, January - April, 2011

clinics, owing to the negative experiences of people who have attended rural clinics in a medical emergency and were then referred to regional hospitals for specialized medical care. These people die due to different circumstances, such as: complications from the disease, lack of economic resources to afford treatment costs or inadequate infrastructure for proper health care in the institutional health services. These experiences require a separate analysis, but it is worth mentioning that during the fieldwork in the mountain region, we learned of deaths that could have been avoided with existing medical technology. This technology is not available in public hospitals and due to its cost in private health care, it is not accessible to inhabitants of the mountain region. The social cost for people who lose a family member in these circumstances is summarized in the testimony of this Popoluca man:

> *...my sister died from breast cancer three months ago. We knew she could have been cured because the doctor told us so. We could not raise the money they asked from us for the operation and we returned without her.*

REFLECTIONS

The results of this work make visible the difficulties the inhabitants of the mountain region of Veracruz perceive as limiting their use of health services. This perception is not only limited to respiratory symptoms as was evidenced by the results of interviews with the general population. If the relationship between health institutions and the population were carried out as prescribed by official regulations, a person with specific symptoms would need only go to a clinic to receive a diagnosis and adequate treatment. But it is not that simple.

In Mexico, as in every country in the world, there is not only one way to diagnose and treat an illness. There are also social, cultural and economic factors that may cause a person not to consult health care services and rather to seek other alternatives for treatment. One of the explanations given for inequalities in the health of indigenous peoples is that they postpone seeking medical assistance as a consequence of their magical-religious beliefs regarding the etiology of illnesses. For example, in a research study carried out in two indigenous communities of Oaxaca, Romero (27) reports that the population perceives the cause of tuberculosis to be a bad chill or witchcraft, this belief being crucial at the moment of seeking medical assistance. The author concludes that people fail to adhere to anti-phymic treatment in particular due to lack of biomedical information regarding the etiology of tuberculosis rather than to limited access to medical resources for economic and geographic reasons. Other authors, from different parts of the world, state that a cultural explanation of the causes of tuberculosis does not predict adherence to the treatment. The election of allopathic medicine when seeking medical care is not limited by "non-scientific perceptions" regarding the origin of the symptoms, but rather by political and economic factors which restrict the use of those services, or because the medical clinics available are not well-equipped and are not able to make a proper diagnosis. All of these elements lead indigenous people to resort to closer alternatives, among them traditional medicine (28,29).

Undoubtedly, in the mountain region of Veracruz as in the rest of the Mexican territory, there are some culture-specific diseases such as *"susto"* (fright) and *"empacho"* (indigestion), among others, which are cured by folk healers. But it is also true that there are diseases, like tuberculosis, that urge people to turn to allopathic medicine rather than to these healers. During a previous study in the mountain region, in which 40 indigenous people newly-diagnosed with pulmonary tuberculosis participated, the origin of the disease was explained as an imbalance between cold and hot principles and to a lesser extent, as a result of transmission. However, this perception did not keep people from accepting and successfully completing anti-phymic treatment. The delay in the diagnosis was due mainly to the fact that the doctor did not suspect the disease in the first consultations as well as to difficulties reaching a diagnosis based on sputum smear (30). What can be inferred from the previous statement is the importance of recognizing that getting ill is a social occurrence,

SALUD COLECTIVA, Buenos Aires, 7(1):73-86, January - April, 2011

so that any preventive measure or treatment must take into account the relationships hierarchy and subordination among different groups of the population (31). If, to the contrary, the differential characteristics that ethnic minority groups demonstrate in the health-disease-care process are considered to be erroneous attitudes and beliefs that need to be corrected, excessive importance is given to the socio-cultural context as an isolated determinant at a single level of analysis and not as a result of multiple and complex interactions. The exclusion of these groups from the benefits of modern medical technology is thus justified. According to Sen (32), from the hegemonic occidental perspective, many concepts are taken for granted. It is almost never presumed that because a person belongs to the dominant ethnic group, that person will inevitably think according to the general beliefs of his or her respective groups. However, when observing other cultures, such as those of Africa or Asia, the social limits imposed are conceived as common to the population and therefore able to be generalized. The same happens in the case of Mexican indigenous groups.

The *Seguro Popular*, which theoretically ensures universal access to health, including free medications, is far from offering health care equivalent to the service provided by social security institutions to their beneficiaries (33,34). With regard to medications, a study conducted by Garrido *et al*. in 2006 states that there are difficulties in the total coverage of prescription drugs at health clinics. This difficulty becomes more evident in public hospitals: according to the authors, only 44% of the beneficiaries affiliated to the *Seguro Popular* had all their prescription drugs supplied. This percentage drops to 18.5% in non-affiliated people. The authors conclude that that the drug policy must be reviewed because the high amount of low cost prescriptions in health clinics come at the expense of higher cost but more effective drugs within hospitals (35).

In the populations of marginalized rural areas like those that participated in this study, the situation is even more complicated. In addition to the model of medical attention provided by the health services, this part of the population has biological, social and economic disadvantages in comparison with the non-indigenous population, thus resulting in a serious problem of social exclusion.

With regard to communicable diseases, an early diagnosis becomes important, and not only for an individual and his or her family group. A good epidemiological surveillance system ensures the timely interruption of the chain of disease transmission, thus contributing to treatment and limiting complications or even death due to a delayed diagnosis. If the population does not use the health care services and chooses instead other options, it will result in the worsening of the problem of diseases requiring early attention in the primary care system and for which programs with regulated guidelines are already in operation. The perception of the population of the mountain region regarding rural health clinics is that they do not have the proper infrastructure to meet their health care demands. This situation is shared by all the people in the poorest states of the country (20,36). A study carried out by Linares and Lopez (20) showed that the poorest states — mainly located in the central and southern parts of the country — exhibit the greatest limitations in access and use of health services, which is reflected in the percentages of people receiving primary care services for the first time.

Given that primary care is the principal source for reporting morbidity, when the early warning system fails and thus impedes specific epidemiological measures from being taken, it is likely that the rate of diseases which are currently under control will increase. This situation will particularly affect those diseases that are subject to special attention within the national epidemiological surveillance system (37), such as vaccine-preventable diseases, tuberculosis and breast cancer, among others.

In conclusion, indigenous men and women are social agents who actively interact with institutions and, in this particular case, with health services. It is necessary to listen to their voices in order to implement in practice what has already been planned (14,26,37) and to design strategies consistent with people's real life conditions, through the joint effort of institutions and the population. This is a way for the

SALUD COLECTIVA, Buenos Aires, 7(1):73-86, January - April, 2011

population to approach health services with the certainty of finding quality primary care and, when necessary, to integrate the second and third levels of medical care to address complications and to limit secondary long-term effects related to the disease.

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END NOTES

a. The research study led to a previous work entitled *"Pobreza, género y etnicidad. La tuberculosis pulmonar en una zona indígena de alta marginación en el estado de Veracruz"* (22), which contains information on the first stage of the study. It is focused on care options available for chronic cough and the response of health services in initiating the diagnostic protocol for pulmonary tuberculosis. At the end of the text, the reasons for not consulting about a cough at institutional health services are briefly explained. In this article, the information contained in the survey, the interviews with people suffering from cough, and the workshops and conversations carried out with different social actors of the mountain region are analyzed. The discussion focuses on experiences of inhabitants of the mountain region with the use of institutional health services, without considering aspects of the pulmonary tuberculosis program in operation.

b. The social gap index provides a comparative view of the conditions in a locality, municipality and state, according to the social deficiencies. This index helps to identify the areas with the greatest social marginalization within a state, municipality or locality; among these areas are found indigenous municipalities. The index considers the proportion of households having access to basic services such as piped water, drainage, toilets and electricity as well as schooling and health care service eligibility indicators (23).

c. In order to define a locality with an indigenous population, the INEGI indicator on the population in indigenous homes was used (24). The municipal presidents were subsequently asked to indicate, according to their perception, what the dominant ethnic group was (Nahua, Popoluca, mestizo) in each locality. This enabled triangulation of the information from the INEGI.

d. Information compiled from death certificates for the years 2003-2007, from statistical archives at the municipalities of Mecayapan, Pajapan, Soteapan and Tatahuicapan, from the General Civil Registry Office, Government of State of Veracruz, Mexico.

BIBLIOGRAPHIC REFERENCES

1. Secretaría de Salud. Programa de Acción: Salud y Nutrición para los Pueblos Indígenas [Internet]. México DF: Secretaría de Salud; 2001 [cited 5 jul 2007]. Available from: http://www.salud.gob.mx/docprog/estrategia_2/salud_y_nutricion.pdf

2. Székely M. Veinte años de desigualdad en México. México DF: Secretaría de Desarrollo Social; 2005. (Cuadernos de Desarrollo Humano, 20).

3. Consejo Nacional de Población. Índices de marginación, 2005. México: CONAPO; 2006.

4. Naciones Unidas. Common Country Assessment. CCA México 2006 [Internet]. Sistema de Naciones Unidas en México [cited 16 abr 2008]. Available from: http://www.undg.org/docs/7625/CCA_Final.pdf

5. Borja-Vega C, Lunde T, García Moreno V. Economic opportunities for indigenous peoples in Latin America in Mexico [Internet]. Banco Mundial. Economic opportunities for indigenous peoples in Latin America. 2007 [cited 10 mar 2010]. Available from: http://siteresources.worldbank.org/EDUCATION/Resources/278200-1169235401815/Mexico.pdf

6. Instituto Nacional de Estadística y Geografía. Perfil sociodemográfico de la población que habla lengua indígena. México DF: INEGI; 2009.

7. Organización para la Cooperación y el Desarrollo Económico. List of OECD Member countries. Ratification of the Convention on the OECD [Internet]. OECD [cited 6 nov 2010]. Available from: http://www.oecd.org/document/58/0,3343,en_2649_201185_1889402_1_1_1_1,00.html

8. García López JE. Grado de acceso geográfico a los servicios de salud [Internet]. La situación demográfica de México 2008. México: Consejo Nacional de Población [cited 6 nov 2009]. Available from: http://www.conapo.gob.mx/publicaciones/sdm/sdm2008/02.pdf

9. Organización Mundial de la Salud. Decenio Internacional de las Poblaciones Indígenas del Mundo. 55a Asamblea Mundial de la Salud [Internet] Organización Mundial de la Salud. A55/35; 18 abr 2002 [cited 20 abr 2009]. Available from: http://apps.who.int/gb/archive/pdf_files/WHA55/sa5535.pdf

10. Rojas R. Programa Salud de los Pueblos Indígenas de las Américas. Plan de Acción 2005-2007. [Internet]. Organización Panamericana de la Salud [cited 20 abr 2009]. Available from: http://www.cdi.gob.mx/participacion/dlupe/programa_salud_indigenas_OMS.pdf

11. Organización Panamericana de la Salud. Salud en las Américas 2007. Volumen I-Regional. Washington: OPS; 2007. (Publicación científica y técnica No. 622).

12. Comisión Económica para América Latina. Panorama social de América Latina 2008 [Internet]. Santiago de Chile: Naciones Unidas: 2009 [cited 6 jun 2009]. Available from: http://www.eclac.org/publicaciones/xml/2/34732/PSE2008_Versioncompleta.PDF

13. Secretaría de Salud. Dirección General de Información en Salud. 2005. Estadísticas de mortalidad en México: muertes registradas en el año 2003. Salud Pública de México. 47(2):171-178.

14. Secretaría de Salud. Plan Nacional de Salud 2007-2012. Por un México sano, construyendo alianzas para vivir mejor [Internet]. México DF: Secretaría de Salud; 2007 [cited 14 ene 2010]. Available from: http://portal.salud.gob.mx/descargas/pdf/pns_version_completa.pdf

15. Gómez-Arias RD, Nolasco Bonmatí A, Pereyra-Zamora P, Arias-Valencia S, Rodríguez-Ospina FL, Aguirre DC. Diseño y análisis comparativo de un inventario de indicadores de mortalidad evitable adaptado a las condiciones sanitarias de Colombia. Revista Panamericana de Salud Pública. 2009;26(5):385-397.

16. Organización Mundial de la Salud. Atención Primaria de Salud. Informe de la Conferencia Internacional sobre Atención Primaria de Salud. Alma-Ata, URSS, 6-12 de septiembre de 1978. [Internet] Ginebra: OMS; 1978 [cited 14 ene 2010]. Available from: http://whqlibdoc.who.int/publications/9243541358.pdf

17. Organización Mundial de la Salud. Informe sobre la salud en el mundo 2008. La atención primaria de salud, más necesaria que nunca. Ginebra: OMS; 2008.

18. Ugalde A, Homedes N. La descentralización de los servicios de salud: de la teoría a la práctica. Salud Colectiva. 2008;4(1):31-56.

19. López O, Blanco J. La polarización de la política de salud en México. Cadernos de Saúde Pública. 2001;17(1):43-54.

20. Linares Pérez N, López Arellano O. Los efectos de las transformaciones del sistema público de salud sobre la equidad en México, 1995-2002. Salud Colectiva. 2009;5(2):237-257.

21. Estados Unidos Mexicanos. Gobierno Federal. Desarrollo Integral. 3.2 Salud [Internet] Cuarto Informe de Gobierno, septiembre 2010 [cited 10 sep 2010]. Available from: http://www.informe.gob.mx/pdf/Informe_de_Gobierno/3_2.pdf

22. Montero Mendoza E. Los programas prioritarios de salud pública: el diagnóstico de la tuberculosis pulmonar en un área indígena de Veracruz, México. In: Peña Saint Martin F, León Parra B, coordinadoras. La medicina social en México III. Entre la tradición y la emergencia. México: Ediciones y Gráficos Eón, PROMEP-SEP, ALAMES-México, ENAH-INAH, Universidad Autónoma de Tamaulipas; 2010. p. 103-111.

23. Consejo Nacional de Evaluación de la Política de Desarrollo Social. Índices de rezago social. Población total, pobreza por ingresos, indicadores, índice y grado de rezago social, según entidad federativa, 2005 [Internet]. México: CONEVAL [cited 23 oct 2007] Available from: http://medusa.coneval.gob.mx/cmsconeval/rw/resource/Estados%20y%20Municipios1.xls?download=true

24. Instituto Nacional de Estadística, Geografía e Informática. II Conteo de población y vivienda

2005 [Internet]. México: INEGI; 2005 [cited 23 oct 2010]. Available from: http://www.inegi.org.mx/sistemas/consulta_resultados/iter2005.aspx?c=27436&s=est

25. Roldán JA, Ávila A, Chávez A, Alvarez M, Muñoz M, Shamah T. Regionalización de la situación nutricional en México. A través de un Índice de Riesgo Nutricional por Municipio. México: Instituto Nacional de Ciencias Médicas y Nutrición Salvador Zubirán; 2004.

26. Secretaría de Salud. Atención a la salud de los pueblos indígenas de México. Elementos generales para la construcción del programa de acción [Internet]. México DF: Secretaría de Salud [cited 26 ago 2010]. Available from: http://www.dgplades.salud.gob.mx/descargas/dmtdi/carpeta3/Programa_ASPI_Nov.pdf

27. Romero Hernández C. Creencias y consecuencias sociales de la tuberculosis pulmonar en dos comunidades indígenas del estado de Oaxaca: una aproximación cualitativa. Revista del Instituto Nacional de Enfermedades Respiratorias. 1999;12(4):235-241.

28. Lasker JN. Choosing among therapies: illness behaviour in the Ivory Coast. Social Science & Medicine. Part A: Medical Psychology & Medical Sociology. 1981;15(2):157-168.

29. Liefooghe R, Baliddawa JB, Kipruto EM, Vermeire C, Munyck AO. From their own perspective. A Kenyan community's perception of tuberculosis. Tropical Medicine and International Health. 1997;2(8):809-821.

30. Montero Mendoza E, Zapata Martelo E, Vázquez García V, Sánchez Pérez HJ. Tuberculosis en la Sierra Santa Marta, Veracruz: un análisis desde la perspectiva de género. Papeles de Población. 2001;7(29):225-245.

31. Nazroo JY. Genetic, cultural or socio-economic vulnerability? Explaining ethnic inequalities in health. In: Bartley M, Blane D, Davey Smith G, editors. The sociology health inequalities. Oxford: Blackwell Publisher; 1998. p. 151-170.

32. Sen A. La razón antes que la identidad. Letras Libres. 2000;2(23):12-18.

33. Tamez González S, Eibenschutz C. El Seguro Popular de Salud en México: pieza clave de la inequidad en Salud. Revista de Salud Pública. 2008;10(Supl 1):S133-S145.

34. López-Arellano O, Blanco Gil J. Caminos divergentes para la protección social en salud en México. Salud Colectiva. 2008;4(3):319-333.

35. Garrido-Latorre F, Hernández-Llamas H, Gómez-Dantés O. Surtimiento de recetas a los afiliados al Seguro Popular de Salud de México. Salud Pública de México. 2008;50(Supl 4):S429-S436.

36. Jaramillo CMC. La descentralización de la salud en México: avances y retrocesos. Revista Gerencia y Políticas de Salud. 2009;6(13):85-111.

37. Centro Nacional de Vigilancia Epidemiológica y Control de Enfermedades. Sistema Nacional de Vigilancia Epidemiológica [Internet]. México DF: Secretaría de Salud; 2010. [cited 10 sep 2010]. Available from: http://www.dgepi.salud.gob.mx/2010/plantilla/sinave_04.html

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