



# Technical

## Discussions

Port-of-Spain  
Trinidad and Tobago  
October 1967



Provisional Agenda Item 20

CD17/DT/3 (Eng.)  
21 August 1967  
ORIGINAL: SPANISH

METHODS OF INCREASING HEALTH SERVICES COVERAGE IN RURAL AREAS

SOCIO-CULTURAL CHARACTERISTICS OF THE RURAL POPULATION IN LATIN AMERICA:  
THEIR INFLUENCE AND THEIR RELATIONSHIP WITH HEALTH

by

Dr. Héctor García Manzanedo, Anthropologist  
Berkeley, California, U.S.A.

SOCIO-CULTURAL CHARACTERISTICS OF THE RURAL POPULATION IN LATIN AMERICA:  
THEIR INFLUENCE AND THEIR RELATIONSHIP WITH HEALTH

INTRODUCTION

Both for historical reasons and as a result of economic, social and political factors, the rural population in Latin America has always outnumbered the urban population in all the countries, at times to an overwhelming degree. Only in the last few years has the urban population exceeded the rural population by a narrow margin in one or two countries. Urban communities, as a rule the capital and the chief towns of the various states or departments, have a type of social and political organization which distinguishes them sharply from rural populations. Even the demographic composition varies, and very frequently the Indian or Indian-half caste (mestizo) element lives mainly in the rural area.

The rural scene in Latin America is made up of a multitude of different social-cultural systems, and the existence of numerous cultural areas (communities of people living side by side and bound together by common social and cultural characteristics) sometimes in one and the same country, makes for behavior patterns, systems of ideas and beliefs, cultural values, and forms of institutional organization, which differ from those usually prevalent in urban communities.

The writer agrees with Lambert (p. 50) that generalizations concerning the sociological features of twenty different countries can be of only limited value. Latin America is made up of twenty nations each with its own particular character, and differing in each case in respect of their population and problems, not only in regard to health but in economic and social matters as well.

If we accept the definition of culture given by Foster, it is clear that the spectrum of cultures to be found in the countries of Latin America is extremely broad, and it is quite common for each of the rural communities to belong to a different culture from that of its neighbors within the same state, department or country. According to Foster (p. 11), culture is: "...the common, learned way of life shared by the members of a society, consisting of the totality of tools, techniques, social institutions, attitudes, beliefs, motivations, and systems of value known to the group." As far as Foster is concerned, the term society means people, whereas the term culture means the behavior of people.

In the following pages an attempt is made to present a general picture of certain characteristics of the population and the social and economic structure of the rural community, preparatory to a discussion of the health problems of the rural population in the light of its social and cultural characteristics. Emphasis is placed on the problems arising from

differences or outlook in regard to the causes of sickness, and the social barriers between the rural inhabitant and the urban professional worker.

THE RURAL POPULATION OF LATIN AMERICA:  
A TENTATIVE SKETCH

Composition of the population

Historically, the components of the population of Latin America are basically three: the aboriginal cultures of America; the results of European immigration at various periods; and a negro component, varying in size according to the country. In some countries the population is predominantly European in origin, and the culture is fairly homogeneous. In others, the proportion of Indo-Americans, in some instances constituting the bulk of the population, has helped to maintain and perpetuate certain ways of life, social structures and ideologies of Pre-Columbian origin which even today are very much alive (Lambert, p. 51).

The mestizos who are the product of the predominant Indian and European elements, form a segment of varying dimensions in the countries of Latin America. In some, such as Mexico, they make up the majority of the population; and they vary in the extent to which they absorb certain characteristics, or accept or reject certain patterns and ways of life common to their Indian or European forefathers. The mestizo is predominant in the rural population of Latin America.

As regards the characteristics of the indigenous Indian community, Vekemans and Segundo (p. 91), discussing the proportion which the Indian population bears to the total population of the Latin American countries, point out that in certain countries like Bolivia, Indians constitute 65 to 75 per cent, whereas in others, e.g. Costa Rica and the countries in the extreme south of the Continent, the proportion is virtually nil. In the development process, some of the main problems identified by the authors as originating from this high proportion of Indians are the following:

"The problem of integrating a large mass of Indians (or mestizos who are largely Indian) into the active civilized life of the country...";

"In the less civilized population groups, the lack of education and the primitive economic and social conditions maintain the physical maximum, and population increase is curbed only by the high child mortality rate...";

"The problem of cultural integration of a population the majority of whom are illiterate, where there are serious communication difficulties outside the cities." (Vekemans and Segundo, pp. 73-74).

### Rural population and urban population

There are likewise differences in the ratio between rural population and urban population in all the Latin American countries. The countries of the cone-shaped southern tip of the Continent have the largest urban populations; between 66 and 81 per cent in Chile, Argentina and Uruguay. These are followed closely by Venezuela, with lower proportions in Cuba and Mexico. In other countries, the rural population still constitutes more than half the inhabitants of the country - in the Central American republics the rural population varies between 63 and 75 per cent. In the remaining countries of Latin America, the difference between the rural and the urban population is less marked, the rural being slightly higher (Vekemans and Segundo, page 91, data as of 1960). At all events it is evident that the rural population in Latin America is a factor of the utmost importance in general development programs, and more specifically in health programs.

### The rural community

The rural community and its population distribution likewise have noteworthy characteristics. Thousands of small groups of people, whose main source of livelihood is tilling the land, gathering the fruits of the earth, rearing domestic animals, and very frequently a combination of all these activities, maintain traditional patterns of settlement similar to those which have prevailed over the centuries, or else have adopted the patterns introduced by the European conquerors. Thus we speak of "dispersed communities" and of "compact" or "concentrated" communities. In the former case, the group is made up of smaller units, consisting of one or more families, living at times a considerable distance apart. The family occupies the center of the land it exploits, its boundaries being the property of its neighbors.

The pattern of settlement of the "compact" or "concentrated" community is different again - less Indian and more mestizo; the dwellings stand side by side, and the various communal services, as well as commercial, political and religious centers, are located in the middle of the community.

The agricultural land surrounds the community, and the inhabitants go from the communal center to their place of work. Between these two extreme forms of settlement we find a variety of other types, and of course, each one of them has advantages and drawbacks from the point of view of health, social and economic life.

Throughout the world, the inhabitants of the rural environment, as a general rule agricultural workers, have living patterns and face problems very similar to those of their counterparts in other countries (Foster, p.45). Moreover, certain socio-cultural and psychological features recur frequently in the literature on the rural groups in Latin America. Aguirre Beltrán (pp. 129-130) mentions factors characteristic of the economy of the Indian community, including the following:

The tools used are simple. The use of complicated appliances is unknown;

There are no proper roads;

Rudimentary division of labor; it is often based solely on sex;

The level of productivity is low, the productive unit being small (almost invariably the family);

The dependent status of women and children is unsatisfactory;

The level of capitalization of the productive unit is extremely small, and possessions are scanty;

Enterprises in search of new demand are non-existent;

Control of capital goods is of a peculiar type, frequently with conspicuous consumption;

Employer-employee relationships are non-existent;

The system of distribution of production is complicated.

These and other factors explain the low purchasing power of the rural inhabitant in Latin America, whether he is an Indian peasant or a mestizo.

The rural inhabitant is not self-sufficient in the strict sense of the word. He produces much of what he requires to live on, and at times also for barter and trading. But he relies on the city or small-town market to spend his surplus earnings and to satisfy other needs. Frequently his dealings with the townspeople lead him to distrust them, and his relationship with the town-dweller is seldom marked by a sense of equality and trust.

In the eyes of the peasant, the town is not only a center for the exchange of goods; but it is the center where decisions are taken and orders are issued affecting the life of the individual and the community. The individual rarely has any control over such decisions. Thus it is hardly surprising that the rural inhabitant fears and distrusts what the town has to offer him.

Nor is the rural community an enclave where the individual can feel secure and safeguarded against threats from outside. Foster (pp. 52-53) points out that peasant economy is essentially non-productive. The resources available are as a rule strictly limited. The sharing out of resources in the community is such that if one is seen to get ahead, it is assumed that this must have been achieved at the expense of the others. In self-defense, the individual who prospers must transform his newly acquired possessions

into a form which is beneficial to the entire community. The system of religious contributions on a considerable scale is sometimes the solution for this conspicuous and dangerous prosperity.

### The rural family

The family structure constitutes a bulwark in the shelter of which the individual can feel secure, since the family is the basic economic, social and educational unit in the rural environment. Property systems everywhere tend to recognize the right of the individual to work and earn the resources he needs for his own subsistence and that of his family. From an early age, the members of the family carry out tasks appropriate to their capacity, so that the entire family contributes to the family income. In the rural family social interaction with other members of the family group is found in its most widespread and regular form.

Patterns of authority follow a strict order of sex and age, and especially in large families where two or more generations live together, the more senior members, the "Gerontes", have unquestioned authority (Aguirre Beltrán, p. 188). The individual serves his apprenticeship rubbing shoulders with parents, uncles, grandparents, and persons of his own generation, brothers and cousins. Where there is a school in the locality, the acquisition of skills is incidental to the whole process of acquiring the culture in the family environment.

Perhaps because of this, the individual endeavors to create a family type of relationship with members of the community with whom he is not bound by ties of kinship. Under the auspices of the Catholic religion, the system of godparents has gone beyond the limits of mere ritual and has become a formal system of artificial parenthood, with privileges and duties recognized on both sides. On occasions, as I have observed in certain regions of Mexico and Central America, the peasant tries to establish similiar relationships with townspeople with whom he has various types of business to transact. This may be a self-defense device set up by the individual to safeguard himself in his dealings with the town-dweller.

### Innovation and the rural environment

Economic and social factors such as we have described above are of great importance in determining the attitude adopted generally by the individual in the rural environment towards anything which implies the adoption of new patterns of behavior. As editor of one of the most valuable collections of casebook studies on the introduction of technological change in rural areas, Spicer makes it quite clear that similar situations exist the whole world over (see References at the end of this paper).

Factors of a cultural type related more specifically to the spheres of health and sickness must also be taken into consideration. While resistance to the adoption of methods and techniques which differ from the traditional ones in, say, agriculture, may be due to the narrow margin of

security enjoyed by the peasant and his fears that any change in techniques may be for the worse, in the case of measures designed to protect and restore health, the conflict is broader and goes deeper.

Because of the nature of the culture regarded as a system, the cultural notions of health and sickness generally are bound up with values of an ethical, moral and religious type. Whereas modern medicine is the outcome of scientific research of an experimental type, the principles of traditional medicine (indigenous or popular) are as a rule based on notions of cause and effect. The survival of traditional concepts of Indian culture, as well as of ideas and practices introduced by Europeans during the colonial period, is associated with the use - in some of the more advanced communities - of analgesics, antipiretics, antibiotics and other forms of self-medication.

A publication put out by the Chilean National Health Service makes the following statement: "The attitudes of the various groups towards health and sickness are undoubtedly determined by the traditional culture; there are groups which consider themselves the custodians of an empirical learning and hence help to maintain beliefs, superstitions and medical practices which are not particularly helpful for the health programs, but which cannot be underestimated by the doctors and the technicians concerned with these matters" (p. 31, the underlining is the author's).

#### HEALTH PROBLEMS FROM THE SOCIO-CULTURAL VIEWPOINT

Some of the most important health problems in the rural environment in Latin America are bound up with factors which suggest the following groupings:

1. Problems connected with the natural environment and their assessment in cultural terms;
2. Problems connected with the prevalence of traditional ideas about health and sickness;
3. Problems of the interpretation of sickness in terms of magic; and
4. Problems arising out of the sense of social barriers.

1. Problems connected with the natural environment and their assessment in cultural terms. Water plays a vital part in the survival of the individual. An abundant supply of water within easy reach of the human dwelling is a necessity not only for health programs but also for the individual himself. As far as the health officer is concerned, water must be free from contamination and from suspended matters injurious to health. As far as the individual is concerned, water must be pleasant in taste and appearance. This is all the assurance he needs. But there may be cultural prejudices

against boiled water: in Peru, for example, boiled water is sometimes regarded as harmful (Wellin, p. 78); in Tehuantepec, Mexico, boiled water is drunk by women in childbirth, and hence is considered an unmanly drink. The protection of springs or fountains may be a matter of concern both to the peasant and to the health officer, but whereas the latter thinks in terms of cement hoods and wall-linings, the reaction of the peasant is to set up a cross to ensure divine protection.

Reasonably comfortable and adequate living quarters, giving protection against the inclemencies of the weather are another of the primary concerns of sanitation programs. Tough and durable materials, windows providing light and ventilation, and watertight flooring are important aspects of any program for improved housing. But even if the cost of a dwelling possessing such amenities was not as a rule beyond the economic resources of the rural inhabitants, other factors of a cultural kind have to be considered. The dwelling house is of only relative importance for the individual, since his life and that of practically all the members of the family is spent mainly outside. Even the wife as a rule prefers to wash the clothes in the open rather than inside the house. Light and ventilation are notions of less importance than cosiness and a sense of security. For the peasant, a window may seem to invite curiosity, or still worse, aggression by persons hostile to the family. Or again, a window may be regarded as a danger to the virtue of the women-folk.

Environmental Sanitation programs are much concerned with air purity and air pollution. According to the notions which prevail in rural Latin America, air is connected with very definite beliefs about sickness. The effect of cold air is regarded as the cause of pains, ailments, and even various types of paralysis. A draft is regarded as a potential danger to health: a child caught in a draft while feeding at the breast may catch the deadly disease of "alferecía" (Kelly, García and Gárate, p. 90).

2. Problems connected with the prevalence of traditional ideas about health and sickness. As a matter of convenience, only those factors will be considered which appear to be most widespread in the rural areas of Latin America.

The traditional concepts of "cold" and "hot" were introduced into the Americas by the European conquerors in the XVI century, having spread through Europe along with others originating in ancient Greece. The theory of "humors" in connection with sickness is related to these notions. According to this theory, the effects of a certain type of food or bodily condition, or the effect of a "cold" element (regardless of its actual temperature) on another "hot" element, are what cause disease. As a general rule, the mother of the family tries to balance the diet not in terms of proteins, calories or vitamins, but in terms of "cold", "hot", and "cordial" or "fresh". Mexicans living at the present time in California have applied the same terms to cola drinks and vitamin capsules.



The effect of factors associated with "cold", such as drinking fresh water, standing in a cold draft, or being drenched with rain when the body is "hot", is regarded as responsible for ailments of greater or lesser gravity. Treatment is in line with these ideas, its purpose being to restore the balance of the body, which is generally speaking the basis of health.

With regard to problems of the expectant mother judged in cultural terms, certain phenomena may be regarded as characteristic of some of the more important of these problems. An idea which has been widespread throughout Latin America at various times is that an eclipse has a noxious effect on the fetus inside the womb. It is believed that the result of such exposure may be hare lip, or a deformity of an arm or leg. The most generally recognized means of protection against this is for the pregnant woman to carry steel articles - keys, scissors, etc. - round her waist.

"Craving" is another concept related to pregnancy, the importance given to the satisfaction of a strong desire for certain food as a means of ensuring the health of the unborn child (Kelly, García and Gárate, p. 106) varying with the group. Both these concepts illustrate the existence of beliefs and ideas of a cultural type but at the same time they give evidence of a concern to ensure the present well-being of the mother and the future health of the child - which are likewise principles of maternal and child health.

Another phenomenon affecting the future of the unborn child is what happens to the umbilical cord when it is severed. Particularly among Indians in Latin America, what is done with the umbilical differs according to the sex of the child. In a case of a male child, who in adult life will be mainly employed in the open air, working in the fields or in the forest, the umbilical cord is tied to a tree-top or is buried in the land. In the case of a female child, the cord is buried in one corner of the house, or underneath the stove, as a guarantee that her future life will be that of a housewife. This concern for what happens to the umbilical cord has no parallel in our own culture, which tends to emphasize different factors as means of ensuring future health.

No less marked is the difference between the principles underlying behavior based on cultural traditions and those of modern medicine. Yet the purpose of both is the same, namely, to ensure a normal pregnancy and a straightforward confinement, with a future for the child conforming to the norms and practices applicable to each and every member of the community.

There are substantial differences between what might be called the concept of an avenging Deity and modern epidemiology. In many Indian communities, and to a certain extent in isolated mestizo communities, the outbreak of an epidemic is explained as the consequence of transgression against the moral and spiritual rules, and chastisement inflicted by the Divinity in retribution (Paul, p. 128, 140; Holland, p. 123). Occasionally the blame is

attached to local happenings - incest, adultery or the use of "supernatural" powers, etc. It frequently happens that members of the group who are themselves regarded as experts in the treatment of diseases become the chief means of transmitting the epidemic, e.g., through parasites of contaminated objects carried on their person, spreading the infection among the families of the community or the communities in the region.

3. Problems of the interpretation of sickness in terms of magic.

It would be a considerable undertaking to analyze the different notions of sickness considered as deriving from the effect or use of supernatural powers. We need only mention the prevalence almost everywhere of notions such as the so-called "evil eye", "magic spells", or their regional variants in which Afro-American cultural features likewise occur.

A careful if brief analysis is called for of the part played by the practitioner of traditional medicine and his importance in the persistence or disappearance of such ideas. The first question is whether he is a person who sincerely believes he is endowed with curative powers or whether he is a charlatan.

Obviously, there are individuals who claim to know and to have mastered the traditional principles governing the diagnosis and treatment of the type of ailment referred to above. In many cases they are persons who sincerely believe that they are endowed with special powers enabling them to restore their patients to health. They enjoy prestige, respect and deference of the part of the rest of the community, and unfortunately in many places they are the only authority to which the community can turn for help in tackling its sickness problems. The healer, known variously as "curandero", "zajorin" or "rezador", is in many instances economically speaking just an ordinary member of the community, one who works in the fields or in the forest, and in payment for his services receives the gratitude of his patients and a small token "fee". As a member of his own cultural group he is in a position to pinpoint the patient's disorder in accordance with the principles of traditional medicine. The very fact of giving a name to a problem would seem to make it easier to solve.

In contrast with this type of healer, the charlatan or quack doctor is a person who generally practices the art of deception and subterfuge, frequently using devices designed to awaken fear and amazement in his clients. He charges very high fees for his trouble, either in cash or in kind.

In both instances, the importance of these persons is not lost on the public health personnel. In the first place, from the cultural point of view, both manipulate phenomena which the culture itself recognizes, whether the ailments are induced by the effect of known causes, or result from the action of supernatural powers. The professional medical man is at a disadvantage in this respect, since he is unaware of the existence of many such ideas. Healers and medical practitioners are on a different footing in relation to the community - the former belong to the group, speak its language, and its

concepts are their stock-in-trade. The latter, on the other hand, are outside the group and they work with different types of concepts.

Secondly, from the social point of view, as a general rule the doctor visiting a rural area comes from the city, where he has grown up and received his training. The healer is born and bred within the group itself and is well known - and very often highly acceptable - to the members of the community. Thirdly, from the economic point of view, it is difficult for a doctor, unless he is sponsored by an official or private agency, to compete with the healer as regards the price of the services he performs. Exception must be made here in respect of many quacks, who sometimes charge exorbitant fees for their ministrations. It might be worth mentioning at this point - although it has nothing to do with the traditional concept of magic as the source of sickness - that the three types of factors mentioned above could well be the fundamental reason for the large proportion of childbirths attended by empirical midwives in rural areas.

Referring to magic as a cause of sickness, Cravioto et al. state optimistically that "... while historically and sociologically it can be argued that in communities where magic prevails the principle of contradiction does not apply, and that experience, far from removing their belief in magic, serves rather to support it, it seems logical that reeducation programs should start out from this knowledge and plans must be made to induce the communities to accept contradiction as a fundamental means of modifying the subject matter of knowledge, with a view to speeding up the differentiation between magic and science" (p. 142).

4. Problems arising out of the sense of social barriers. It may be thought that the role of the healer gives him a prestige within the community not unlike that of the specialist in our own society. But there are likewise differences in the way in which the average member of the rural community regards the public health officer. This is bound up with factors such as:

- a. The origin of the officer, who as a rule comes from the town;
- b. His social and economic position in relation to that of the rural inhabitant;
- c. His position as a representative of modern western culture; and
- d. His position as a member of the regional or national power structure.

Because of his origin, the professional worker is regarded by the rural community as belonging to a different and often hostile system namely that of the town. The doctor and nurse form part of this environment which the rural inhabitant fears and distrusts. A traditional and not infrequently justified fear is that of being sent to a hospital, an institution regarded

with the utmost suspicion as being a place where people die separated from their kith and kin and in the hands of strangers. Doctor and nurse are identified with the institution and are regarded as part and parcel of the system.

Almost throughout Latin America, the medical practitioner, like the professional worker in other branches of science, belongs to the highest economic and social stratum of society. The peasant regards such professional workers as representatives of the traditional upper class in the country, i.e. of the same ilk as the big landowner or local boss, and as far as he is concerned the social gap between them is unbridgeable.

The public health team represents a professional sub-culture. In its relations with the rural inhabitants social barriers such as origin and social and economic position combine with cultural barriers to lessen the chances of establishing communication not only in terms of language but also because of the differences in cultural background. The telluric, magical world of the Indian peasant differs from the pragmatic, rational world of the professional public health worker. In the rural community certain problems are solved on the basis of processions and supplications, penitence and resignation. Such passivity is altogether different from the outlook of the professional worker, who is prepared to attack the problems boldly, armed with the weapons of modern technology.

Finally, mention must also be made of the attitude of the individual in the rural community towards the representatives of the power structure, among whom he includes the public health personnel. The literature on the subject frequently gives evidence of an attitude of rejection, lack of confidence, or fear, in relation to nurses and doctors connected with health programs. This is a reflection of a similar outlook produced by past experiences with representatives of the power structure. Foster (p. 126) and Aguirre Beltrán (p. 209) among others refer to this outlook and the obvious consequence is that public health programs are not accepted and allowed to flourish in the rural area without a struggle. Past experience with rent collectors, police, militia, excise officers etc., color the attitude of the individual towards other representatives of the regional or national authorities - including health personnel.

At various times and in various regions there has been strong resistance to measures designed to protect the population. Rural communities have energetically rejected smallpox vaccination or insecticide spraying teams, regarding them as a threat to personal security. Even today there are cities in the United States where entire communities are opposed to the fluoridation of drinking water. Thus quite frequently the idea that public health officers are influential members of the national or regional power structure arouses misgivings and fears on the part of the rural inhabitant, and his consciousness of the social barrier separating him from them leads him to shy away from the relationship or to reject the program.

## CONCLUSIONS

In the foregoing pages mention has been made of certain social and cultural characteristics of Latin America whose influence on health may be regarded as of great importance, and some account has been given of the composition of the rural population and its social and cultural organization patterns. Factors such as illiteracy or geographic isolation have been left aside, since such matters are felt to be bound up rather with programs of national development.

A number of conclusions are suggested, chiefly for the purpose of emphasizing once again aspects of the public health administration already incorporated in the programs undertaken by certain countries. Some of the ideas put forward below suggest not so much a new approach to the planning of programs as a more efficient use of the human resources available in the rural community. Finally, some suggestions are made as to the possibility of replacing habits and behavior patterns among the population by others which seem more likely to make for promotion of health, while modifying in the process certain habits and behavior patterns of the part of the public health personnel as well.

1. The public health administration already recognizes the desirability of using specialists in the social sciences - anthropologists, sociologists, and psychologists - in public health programs. As a general rule, experts in these fields have been called upon for research, advisory services and teaching duties. It frequently happens that the professional and technical interests of such personnel are in conflict, owing to the discrepancy between the technical requirements of the public health administration and the professional approach of the social science specialist. Professional workers in both public health and in the social sciences, must endeavor to establish better means of communication by a mutual understanding of areas and problems. The social science specialist may prove to be more effective, since his efforts are calculated to bridge in the most satisfactory manner possible the gap between the features of the culture of the rural population and the targets and objectives of the public health programs.
2. The problem not infrequently arises of a lack of experienced specialist personnel in the social sciences to study social and cultural problems connected with health programs. Generally speaking sufficient incentives have not been offered for the training of such personnel to induce them to make a career in public health. An attempt should be made to hold out to persons specializing in this field opportunities similar to those available to professional workers in other branches of public health, e.g. physicians, epidemiologists, engineers, dentists, etc.

3. The actual organization of the community frequently exhibits features or patterns which make it possible to use the structures of the community itself for the purposes of the program. In this respect, as in many others, a basic knowledge of the cultural characteristics of the population will make for a realistic type of planning, geared to the needs of the community and even making use of patterns peculiar to the community itself in matters such as the participation of key individuals in the planning phases, the diffusion of information, the formation of groups of volunteers, and the awakening of a keen interest on the part of the population to ensure the success of "their" program.
4. The public health programs in rural areas may find support through the utilization of auxiliary workers from the local communities - the training of men and women to carry out specific functions such as assisting in the preparation of censuses and health surveys, working as interpreters and translators, acting as liaison between the program and the families making up the community, and participating in the activities of clinics and health centers, according to their degree of skill. In the State of California in the United States, health auxiliaries have proved very helpful in health programs directed towards the migrant agricultural population, mainly of Mexican origin, and the present author has compiled a special glossary of technical and popular health terms for the use of migrants, in Spanish and English which is issued by the Health Department of the State of California.
5. Emphasis has frequently been placed on the need for knowledge of the social and cultural characteristics of the rural population in the planning phase of health programs. Once again it may be well to mention this point and its importance for the personnel who will have to carry out the program. Adequate knowledge of the local culture, free from prejudice and based on a sincere desire to understand the guiding principles underlying the conduct of the individual in the rural group, is fundamental for the establishment of better relations between the program personnel and the members of the community. Similarly, public health personnel must recognize that certain habits and patterns of behavior which are perfectly logical and make sense to them may not be similarly comprehensible to the peasant dealing with a health service and puzzled by the administrative maze of case histories, medical check-ups, or the whereabouts of the auxiliary diagnosis services. The health program officer must therefore play a dual role

in relation to the community - first of all he must become acquainted with the features of its social organization and its cultural structure, and secondly he must inculcate patiently and politely, a knowledge of the organizational characteristics of the public health branches with which the individual must become acquainted. Unfortunate incidents calculated to drive the individual away from the health service in a resentful and antagonistic frame of mind must be prevented by a real understanding of the social and cultural differences existing in the Latin American countries.

REFERENCES

AGUIRRE BELTRAN, Gonzalo

Regiones de refugio. El desarrollo de la comunidad y el proceso dominical en Mestizo América. Instituto Indigenista Interamericano, Ediciones especiales: 46, México, 1967.

GRAVIOTO, J., L. Rivera, J. L. Pérez Navarrete, J. González, L. Vega, A. Vilchis, R. Arrieta y E. Santibáñez

Ensayo de sistematización del concepto de enfermedad transmisible. Boletín, Pan American Sanitary Bureau. Vol. LIII No. 2, August 1962, pp. 136-144.

FOSTER, George M.

Traditional Cultures: and the impact of technological change. Harper & Row, New York, 1962.

HOLLAND, William R.

Medicina maya en los altos de Chiapas, un estudio del cambio socio-cultural. Colección de Antropología Social, Instituto Nacional Indigenista, México, 1963.

KELLY, Isabel, Héctor García Manzanedo y Catalina Gárate de García

Santiago Tuxtla, Veracruz: Culture and health. Institute of Inter-American Affairs-Dirección de Estudios Experimentales, Secretaría de Salud y Asistencia, México, D. F., 1956 (mimeo).

LAMBERT, Jacques

Requirements for Rapid Economic and Social Development, the view of the historian and sociologist. In: Social Aspects of Economic Development in Latin America, UNESCO, 1963, Vol. I, pp. 50-66.

PAUL, Benjamin D. (Ed.)

Health, Culture and Community. Case studies of public reactions to health programs. Russell Sage Foundation, New York, 1955.

SERVICIO NACIONAL DE SALUD, CHILE

Conceptos de salud y enfermedad (Información técnica para profesionales), Sub-Departamento de Educación Sanitaria, Santiago, Chile, 1958.



SPICER, Edward H.

Human Problems in Technological Change. A casebook. Russell Sage Foundation, New York, 1952.

VEKEMANS, Rev. Roger, and J. L. Segundo

Essay of a Socio-Economic Typology of the Latin American Countries.  
In: Social Aspects of Economic Development in Latin America, UNESCO, 1963,  
Vol. I. pp. 67-93.

WELLIN, Edward

Water Boiling in a Peruvian Town. In: Paul, Benjamin D. (Ed.)  
Health, Culture and Community, etc. Russell Sage Foundation, New York,  
1955, pp. 71-103.