SOCIOCULTURAL CHARACTERISTICS OF THE RURAL POPULATION IN LATIN AMERICA: THEIR INFLUENCE AND THEIR RELATIONSHIP TO HEALTH [1]

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The rural population's resistance to modern health measures is rooted in cultural notions of health and sickness that are bound up with values of an ethical, moral, and religious type. Physicians and health workers should not underestimate the importance of superstitions and empirical medical practices as obstacles to rural health programs.

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. Only in recent years has the urban population exceeded the rural population in several countries. Urban communities, as a rule the capital and the chief cities or towns of the various states or departments, have a type of social and political organization that distinguishes them sharply from the rural groups. Even the demographic composition varies, and very frequently the Indian or 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 that differ from those usually prevalent in urban communities.

The writer agrees with Lambert (*1*) that generalizations concerning the sociological features of 20 different countries can be of only limited value. Latin America is made up of 20 nations, each with its own particular character, and differing in each case in regard to both population and to health problems and economic and social conditions.

If we accept the definition of *culture* given by Foster (*2*), it is clear that the spectrum of cultures to be found in the Latin American countries 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, 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 char-

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acteristics of the population and the social and economic structure of the rural community, preparatory to a discussion of the health problems of rural areas. Emphasis is placed on the problems arising from differences in 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

The components of Latin America's population are basically three: the aboriginal cultures of America, the European immigrants, 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 inhabitants, 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 (*1*).

The mestizos, who are the product of the predominant Indian and European elements, form a segment of varying dimensions in the different countries. In some, such as Mexico, they make up the majority of the inhabitants; 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.

Vekemans and Segundo (*3*), in discussing the proportion which the Indian population bears to the total population of Latin America, 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 number is virtually nil. In the development process, some of the main problems identified by those 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 that maximum [of population growth] and population increase is curbed only by the high infant mortality rate. . . .
>
> The problem of the cultural integration of a population, the majority of whom are illiterate, where there are serious communication difficulties outside the cities.

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 inhabitants still make up more than half the total; in the Central American republics the rural population varies between 63 and 75 per cent. In the remaining countries, the difference between the rural and the urban population is less marked, the rural being slightly higher according to data for 1960 (*3*). 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 patterns of population distribution also 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 works, the 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 viewpoint of health and social and economic life.

In all parts of 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 (*2*). Moreover, certain sociocultural and psychological features recur frequently in the literature on the rural groups in Latin America. Aguirre Beltrán (*4*) mentions the following factors characteristic of the economy of the Indian community: the tools employed are simple, the use of complicated implements being unknown; there are no proper roads; the division of labor is rudimentary and 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 distinctive type, frequently with conspicuous consumption; employer-employee relationships are non-existent; and 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 Indian or 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 them is seldom marked by a sense of equality and trust.

In the eyes of the rural dweller, the city is not only a center for the exchange of goods; it is the place 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 city has to offer him.

Nor is the rural community an enclave where the individual can feel secure and safeguarded against threats from outside. Foster (*2*) 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 that 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 (*4*). 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 to 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 occasion, the rural dweller establishes similar 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 those described above are of great importance in determining the attitude adopted generally by the individual in the rural environment toward anything that 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 (*5*) makes it quite clear that similar situations exist the whole world over.

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 that differ from the traditional ones in, say, agriculture, may be due to the narrow margin of security enjoyed by the rural dweller 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, antipyretics, antibiotics, and other forms of self-medication.

A publication put out by the Chilean National Health Service (*6*) makes the following statement: "The attitudes of the various groups toward health and sickness are undoubtedly determined by the traditional culture; there are groups that consider themselves the custodians of an empirical *learn-*

ing and hence help to maintain beliefs, superstitions, and medical practices that are not particularly helpful for the health programs, but that cannot be underestimated by the doctors and the technicians concerned with these matters."

Health Problems from the Sociocultural Viewpoint

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

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

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 (*7*); 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 to both the rural dweller and the health officer, but whereas the latter thinks in terms of cement hoods and wall-linings, the reaction of the rural dweller is often 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 were not as a rule beyond the economic resources of the rural inhabitants, other factors of a cultural kind have to be considered. The house itself 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 coziness and a sense of security. A window may seem to invite curiosity or, still worse, aggression by persons hostile to the family.

Environmental sanitation programs are much concerned with air purity and air pollution. According to the notions that sometimes 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* (*8*).

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 16th 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."

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.

Maternal and child health practices also show the influence of cultural factors. An idea that has been widespread in 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) around her waist. "Craving" is another concept related to pregnancy, and great importance is given to the satisfaction of a strong desire for certain food as a means of ensuring the health of the unborn child (*8*). 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 the case of a male child, who in adult life will be mainly working in the open air, 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, it 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 (*9, 10*). Occasionally the blame is attached to local happenings—incest, adultery, or the use of "supernatural" powers. 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 or contaminated objects carried on their person, spreading the infection among the families of the community or the communities in the region.

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.

Obviously, there are individuals who claim 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 on 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, zajorín,* 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 he 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.

The importance of these persons is not lost on the public health personnel. In the first place, from the cultural point of view, they manipulate phenomena which the culture itself recognizes: ailments that are induced by the effect of known causes, or that result from the action of supernatural powers. The professional physician is at a disadvantage in this respect, since he is unaware of the existence of many such ideas. Healers and physicians 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 are outside the group and work with different types of concepts.

Secondly, from the social point of view, as a general rule the physician 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 to the members of the community. Thirdly, from the economic point of view, it is difficult for a physician, 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 to 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.* (*11*) 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 the belief in magic, serves rather to support it, it seems logical that re-education 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."

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 city; (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 city. The physician 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 kin and in the hands of strangers. Physician and nurse are identified with the institution and are regarded as part and parcel of the system.

Almost everywhere in 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 rural dweller regards such professional workers as representatives of the traditional upper class in the country, 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 subculture. 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 in regard to differences in cultural background. The telluric, magical world of the Indian farmer differs from the pragmatic, rational world of the professional public health worker.

Finally, mention must also be made of the attitude of the individual in the rural community toward 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 physicians connected with health programs. This is a reflection of a similar outlook produced by past experiences with representatives of the power structure. Foster (*2*) and Aguirre Beltrán (*4*), among others, refer to this outlook; its 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, and excise officers color the attitude of the individual toward 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 that seem more likely to make for promotion of health, while modifying in the process certain habits and behavior patterns 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: physicians, epidemiologists, engineers, dentists, and others.

3. The actual organization of the community frequently exhibits features or patterns that 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, men and women trained 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 of Mexican origin have proved very helpful in health programs directed toward 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 State Health Department.

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 that are perfectly logical and make sense to them may not be similarly comprehensible to the rural dweller 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: he must familiarize

himself with the features of its social organization and its cultural structure, and he must inculcate patiently and courteously a knowledge of the organizational characteristics of the public health branches with which the individual must become acquainted. Unfortunate incidents bound 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 countries of Latin America.

Summary

A generalization is made of the social, cultural, and economic characteristics of the rural population in Latin America to serve as the basis for a study of health problems in rural areas, particularly as regards a different appreciation of the causes of diseases and the social distance between the rural dweller and the city professional.

In this attempt at making a generalization, the following factors were taken into account: population composition (indigenous group, European immigrants, Negro component); percentage of these components; percentage of urban and rural population in the various countries; patterns of population settlement, whether in dispersed or concentrated communities; purchasing power of the rural worker; his economic weakness and lack of security; poor distribution of wealth and resources; and, finally, the family as the basic economic, social, and educational unit of the sociocultural environment.

All these factors influence the attitude of the rural dweller and his acceptance of the concept and practice of modern medicine, which is the product of experimental scientific research, as opposed to traditional medicine (indigenous or popular), which is usually based on the principle of cause and effect. Apart from illiteracy and geographic isolation, the factors relating to health problems in rural areas fall under four main headings as follows: (1) those which relate to environment and its assessment in cultural terms; (2) those connected with the traditional ideas about health and sickness; (3) those which relate to an interpretation of sickness in terms of magic; and (4) those arising out of the sense of social barriers.

The conclusion reached is that health programs should make increased use of the human resources available in rural communities. It is suggested that the behavioral patterns and habits of the rural population should be changed to accept and promote health programs, and that such acceptance by rural communities will be facilitated by changes in the habits and attitudes of physicians and other public health personnel.

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