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Radical Remedies:

Women, Health, and the Micropolitics of Grassroots Organizing in Mexico

As states weaken and public health care deteriorates throughout the developing world, new spaces are opening for civil society groups to fill the gaps of declining health systems. In Mexico, popular health groups have responded to health care decline by building community clinics, establishing health promoter training programs, and opening natural medicine pharmacies. Lower- and working-class women are the primary participants in these groups that use a self-help approach to find practical solutions to local health care problems. However, little is known about participants' circumstances, motivations, or the ideals they embrace. Drawing from women's narratives, I explore the "micropolitics" of women's participation in local health groups. I examine their efforts to reclaim control over the health process as a metaphor for claiming control over their lives. Highlighting the "instrumental effects" of participants' medical encounters and healing relationships, this case illuminates some unintended consequences of health care decline.

Keywords: [gender, Mexico, health care, social movements]

I told you that I liked to drink alcohol a lot, and between then and now I have quit much of that. I was studying here when I started to change everything. I started to become a little more aware and I started to understand more, because you see people who are sick and it is like you start to put yourself in their place, and to say—yes, I have a lot to give. More than anything, I can help others.

Sofia is a middle-aged woman in Mexico who has dedicated herself to becoming a health promoter.¹ After struggling with a drinking problem and succumbing to what she defined as "severe depression" when her children moved out of the house, Sofia joined a popular health group where she pursued training in traditional and alternative medicine. Although she had to fight with her husband to be able to participate in the group, she is now an apprentice in its community clinic where her husband occasionally visits for a massage, acupuncture treatment, or herbal remedy.

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Sofia's story echoes many others that were relayed to me by the women I interviewed during my field research on community health organizing in Mexico. Women described how their participation in a health group has helped them develop a range of health care skills, decrease their isolation, develop a professional identity, and contribute to society. Participants also described how their work has created significant household struggles and required that they reconfigure their relationships with husbands, families, and neighbors.

The narratives I relate in this article describe the opportunities, challenges, and struggles that women experience as they immerse themselves in new social spaces opened through grassroots health associations.² Lower- and working-class women in Mexico are increasingly participating in popular health groups that provide members with health education, practical skills, and leadership roles. These groups facilitate women's expansion of their private role as household health managers to the public domain of community health organizing and health service provision. This is significant in a society where many lower-class women receive limited education and opportunities for professional development and public-sector participation.

Popular health groups in Mexico have emerged over the last three decades in response to the failures of the national health system to provide sufficient and accessible health care to marginalized communities. Macroeconomic and political trends since the late 1970s have propelled a massive restructuring of health services resulting in drastic cuts in public health services and a steep decline of health benefits (Laurell 2001). Despite efforts on the part of the Mexican government to increase the quality of public health services, an aging population and the growing burden of chronic illnesses have accelerated the deterioration of an underfunded health system. As the fundamental right to basic health care articulated in the Mexican Constitution has been eroded by neoliberal market-based reforms, responsibilities for health service provision have shifted from government agencies to NGOs and individuals. As a result, many community groups have organized around health care and looked to traditional medical practices, natural health resources, and global health discourses to devise solutions to local health problems.

In this article, I analyze the circumstances that bring women to participate in two grassroots groups that contribute to this movement in the central Mexican town of Zaragoza. These groups operate community clinics, health promoter training programs, and natural medicine pharmacies to make their alternatives accessible to the community. The majority of participants in these groups are women. I examine why women are participating in health groups, what their motivations are, and how their work contributes to new visions of health and well-being. I situate their participation within the context of socioeconomic and cultural factors that shape and often constrain lower- and working-class women's lives in central Mexico.

Women's health group participation highlights tensions between social structure and individual agency that emerge as women struggle to gain access to new social spaces. I draw from Finkler's (1994) theory of "life's lesions" to explore how gender ideologies, "unresolved contradictions," and adverse conditions create the circumstances that lead many women to the groups and how their participation and their collectivization of suffering helps to resolve, or at least manage "life's lesions." I also consider the extent to which participants see themselves as actors in

challenging traditional gender roles, reconfiguring household values, and removing medical hierarchies. Although the women I interviewed do not view their work as radically feminist or overtly activist-oriented in terms of agitating for social change, I suggest that their participation has the potential to alter gender relations and positively impact health and well-being. I draw from Gallin (2002) to describe how feminist consciousness raising can happen in subtle ways—talking, studying, applying alternative forms of health care, contributing community service—and how these practices can have the potential to transform women’s lives.

Through the lens of health group participation, I offer a reflection on the subtle processes of social change in Mexico. Sahlins (in Ortner 1984) argues that “change comes about when traditional patterns of relations . . . are deployed in relation to novel phenomena . . . which do not respond to those strategies in traditional ways” (p. 155). As health group participants extend their traditional roles as housewives and health managers to new public spaces, they confront traditional dichotomies and constraining social structures in new ways. Although women’s motivations to join groups are typically personal—healing their own or their children’s health problems, gaining greater control over the health care process, escaping the isolation of their domestic roles—the outcomes of their collective participation have the potential to be liberating.

Civil Society Responses to Health Care Decline

Although many scholars have theorized about women’s participation in Latin American social movements during the last few decades (i.e., Bose and Acosta-Belen 1995; Escobar and Alvarez 1992; Jaquette 1994; Molyneux 1985; Safa 1995; Stephen 1997), there is a dearth of information regarding the “micropolitics” of women’s grassroots health movements. For example, little is known about who is participating in grassroots organizations, the motivations of women for participating in health activities outside of state structures, the “lived experiences” of participants (Edelman 2001:309), or the “everyday life situations” (Lewis 1999:73) that support or prohibit their involvement in these groups (for exceptions see Ortiz Ortega et al. 1998; Ramirez-Valles 2003).

This gap in scholarship is especially surprising given the growing concern among social scientists regarding the reduction of public-sector health spending throughout the developing world and the impact that neoliberal state reforms are having on health systems and women’s health and lives (i.e., Castro and Singer 2004; Doyal 2003; Foley 2001; Issacs and Solimano 1999; Laurell 2001). As research demonstrates, poor women in the developing world have borne the brunt of the deepening spiral into poverty that has accompanied global macroeconomic reforms over the last three decades (Sparr 1994). These women have had to take on a greater burden as deep cuts in household budgets and public services have increased their pressure as they administer households (Bakkar 1994). Poor women have also been the least likely to be able to afford private health services and fees associated with privatization within the public health sector (Standing 2002).

As states have weakened under neoliberal reforms and health services deteriorate throughout the developing world, civil society groups (i.e., nonprofit, NGOs, voluntary organizations) are stepping in to fill the gaps of declining health systems.

Local groups are advocating community-based approaches to health care to help meet the needs of rural and indigent populations that have been most affected by the decline of public health care (Jareg and Kaseje 1998). The deteriorated state of public health services has also created a need for women's community-based health services (Ewig 1999). Since the 1980s, women's groups have opened clinics to offer inexpensive, quality women-centered care. Many collectives focus on the use of alternative medicine because holistic health approaches have been viewed by feminists to be more attentive to gender, race, and class concerns and help to offset the systematic neglect of women's health (Bix 2003). Health centers have also been an important source of social support for women and an avenue through which they gain information and solidarity and focus on specific health objectives (Doyal 1995; Morgan 2002).

The popular health movement that I discuss responds to the failures of the Mexican government to provide sufficient health care for economically and geographically marginal populations. Although the 1970s brought about a significant expansion of primary health care facilities for rural populations in Mexico, the debt crisis of 1982 required that the government implement austerity measures that involved radically reducing health spending. At the same time, a profound demographic and epidemiological transition was occurring in the country resulting in new and significant problems that affected health care delivery. The limited availability and expense of high tech and long-term treatments, and their concentration in the largest (and most politically influential) cities and towns, resulted in great resource inequality for marginal social and geographic groups (Hunt 1995).

The peso devaluation crisis of 1994 required the largest International Monetary Fund (IMF) bailout in Mexican history, with the strings of structural adjustment attached.³ Mexico fell into its most serious depression since the 1930s, requiring a further reduction in social welfare programs to help pay off the growing debt. In response to its economic predicament, Mexico accepted the terms of state reform that accompanied neoliberal globalization as defined by international institutions such as the World Bank and the International Monetary Fund. These terms required that the Mexican government adopt market-oriented strategies to offset the contraction of public spending and to improve the nation's competitive position in the world market. As a result, the government has gradually reduced its direct responsibility for implementing social assistance programs for the poor and has required that individuals and communities bridge the growing gap between the state and market (Laurell 2001; Schneider 2007; for detailed consideration of the decline of government health care provision in Mexico, see Schneider 2006).

Responding to this "call to service" and seeking to address the growing health care gaps in their communities, health groups have emerged through neighborhood associations, local churches, and NGOs.

The groups I observed employ strategies for "self- and community empowerment"—to help meet the needs of underserved populations and to encourage women's engagement in health promotion activities—draw from Paulo Freire's work on education and consciousness raising among the poor, and advocate breaking the ties of domination between doctors and patients (Napolitano 2002:105). They draw from local and global healing traditions that are inexpensive and perceived to be efficacious in addressing basic health problems (for detailed discussion

on health group discourse and practice, see Schneider 2006). Throughout the country, these groups are targeting the health needs of underserved communities.

Popular Health Groups in Zarragoza

In Zarragoza two popular medicine groups have taken root since the 1990s—the Women’s Health Committee (“Health Committee”) and the Parochial Dispensary (“Dispensary”). These groups run community clinics, natural pharmacies, and health promoter training programs to make health care alternatives accessible to community residents. They charge for clinical services on a sliding scale, and the Health Committee offers scholarships for their health courses. Trained health promoters take leadership positions in the clinics, which are funded by in-kind services. The majority of students and members are women.

The Health Committee is a civil association dedicated to the “sustainable development of rural and urban communities in Morelos.” It was initiated in 1999 in a working-class neighborhood by two women involved in development work who had the vision of training other women to become health promoters. With a small amount of seed money from the Mexican government, the women initiated a series of courses focused on nutrition; traditional Mexican herbalism; and preventing, diagnosing, and treating common illnesses. When the money ran out, the group organized itself into a collective and began charging a small fee for women to take classes on a range of alternative health modalities.

The Health Committee opened a community clinic in the La Rosa neighborhood community center where health promoters offer alternative health services such as nutrition; herbal and massage therapy; acupuncture; Reiki; and reflexology on a sliding scale. Women who are involved with the effort continually take classes and contribute to the cooperative work of running the clinic and a natural pharmacy. Although the group focuses on making health care alternatives accessible to all members of society, it also explicitly seeks to empower women in the process.

Like the Health Committee, the Parochial Dispensary is a civil association dedicated to improving the living standards of the poor. The group works in a space donated by the parochial church. It runs a health promoter training program and a community clinic. The effort began in 1990 when a women’s group within the parochial church began visiting sick members of their congregation to distribute Communion. They eventually began to teach these members about nutrition and natural healing practices. After inviting an acupuncturist to help expand the program, the group established classes on herbalism, acupuncture, and Chinese medical philosophy. Their training program is now a formal, three-year, 135-hour curriculum focused on natural and alternative medicine. The clinic offers services in acupuncture, homeopathy, polarity therapy, massage, yoga, chiropractics, naturism, and herbalism. The group’s central goal is to help the poor by providing inexpensive health services and education.

Methods

I conducted participant observations with the Health Committee and Parochial Dispensary from February to November 2003 while living in Zarragoza, an urbanizing

town of 40,000 in the central Mexican state of Morelos. During the research period, I enrolled as a student in both of the groups' health training programs and established relationships with members through my direct participation. I participated in the groups' weekly classes, activities, meetings, and events. I also observed each of their community clinics one day a week. Through daily field notes, I recorded observations and informal conversations with group members during the research period.

At the time of my research, there were 32 students enrolled in the Health Committee and Dispensary's health program. All but six members were women and the majority belonged to the lower and working classes. Students who study at the schools may pay upward of \$12 a month to take classes, although the Health Committee offers scholarships. Although the cost of classes is not prohibitive for most working-class women, it does exclude those from the lowest social classes. The opportunity to take classes and work in the clinic is unique for many women as they typically have limited education and experience significant household constraints in pursuing endeavors in the public arena.

I conducted an ethnographic questionnaire (Schensul et al. 1999) with 18 of the students who agreed to participate in the study. I gathered demographic and health history information as well as data pertaining to their participation with other community groups, experience with alternative medicine, and application of health care practices in the household and community. I conducted in-depth interviews with an additional ten members who were most active with the groups to learn about their health histories, family and work situations, the factors that led them to participate in health groups, and their experiences as health promoters. These interviews lasted from two to eight hours (and were sometimes conducted during multiple sessions). They were tape recorded and transcribed. The median age of the health group members I interviewed is 45 years. Seventy-three percent have less than high school education and over half have no more than elementary school education.

I also draw from 30 in-depth interviews that I conducted as part of my larger study with women in two working-class neighborhoods in Zarragoza who were not participants of health groups. I selected these interviewees from 100 residents with whom I administered a 16-question survey regarding local health care perspectives. This sample was asked to elaborate on specific issues that were brought up during the survey interview as well as their perspectives on health care, gender relations, work, community participation, and other social issues. These interviews lasted from one to four hours and were tape-recorded and transcribed. Over half (60 percent) of this sample were between 25 and 44 years of age, and 33 percent were between 45 and 64 years old. Ninety-three percent had less than high school education, and the majority (90 percent) worked in the home and generated extra income through petty sales. I utilize these interviews below to help contextualize the lives of working-class women in Zarragoza.

Women's Lives, Women's Roles

Poor Mexican women have been most significantly affected by the long-lasting impacts of the economic crises of the 1980s and 1990s. As elsewhere in the developing world, increasing numbers of Mexican women had to look for income-generating

work, more women than men became unemployed, working conditions for women deteriorated, and women became poorer (Sparr 1994). Yet Mexican women are often excluded from the formal labor market and they commonly lack the support system that would enable them to take formal jobs. They most often take informal jobs that allow them to combine domestic responsibilities with income-generating work. Their jobs are generally low paying and limited to traditional female roles like domestic work and food preparation.

The increased entry of women into the labor market has made job seeking more competitive, and it is increasingly difficult for women to find employment (Ortiz Ortega et al. 1998). Ageism and sexism often combine to limit women's options outside of the home. I was told repeatedly by the women I interviewed that once a woman turns 30, her chances of getting hired for a job become quite limited. Job opportunities are also constrained by unequally distributed educational opportunities. Because lower- and working-class women often marry at a young age and begin their reproductive cycles early, education is often curtailed after secondary school. It is common that husbands expect women to stay at home and attend to their caretaking roles. Although men have the freedom to move about freely, women often experience isolation in the household. Sexual double standards also sanction men to have multiple partners. Although affairs may be a mark of status and a source of self-esteem for men, they often siphon off scarce household resources (Finkler 1994). Even if women are able to generate income through informal work, most economic resources tend to be filtered through men, leaving women with little power to change their circumstances.

Finkler (1994) suggests that the most problematic shift for Mexican women since industrialization has been the devaluation of unpaid household work, children, and their role as reproducers. Although women's role in the household was once esteemed, increasing value is placed on individual accomplishments through profession or workplace. Finkler (1994) argues that "women are losing an important source of self-esteem as reproducers and nurturers of children without having attained any new avenues for gaining self-worth and a sense of meaning in their lives" (1994:35). Furthermore, as nuclear families become more common, women are losing the support they once had from female members of extended families.

The interviews I conducted with working-class women in Zarragoza illuminated the particular challenges they face. Their narratives repeated themes of abandonment and abuse at a young age and often in their married life, a parent's or partner's struggle with alcoholism, early marriage to get out of unhappy households, heavy workloads inside and outside of the household, and feelings of isolation and entrapment within the house. These problems were often coupled with a lack of power in the household and, in most cases, economic strain. Many men in Zarragoza migrate to the United States in search of work leaving women to take care of the children in their absence. Some of the men are gone for two or three years whereas others never return; some men send back remittances whereas others start new families "over there."

High rates of male migration are creating an increasing number of female-headed households. Although these women may have more freedom to leave the house, they typically lose this power as soon as their husbands return. They also must work harder to supplement remittances, which may not be consistent. Like other

lower- and working-class women, this does not leave them much time or energy to engage in activities like studying alternative medicine with a health group. Yet despite the odds, economic limitations, and cultural obstacles, some women do manage to pursue group membership.

Why Do Women Participate in Zarragoza Health Groups?

Participants' narratives suggest that there are a myriad of reasons why they are motivated to become involved in a health group. On a social level, many women are searching for a purpose or vocation, experiencing tremendous isolation in their home, and seeking greater economic independence. These women also share dissatisfaction with allopathic medicine, an interest in gaining skills to help resolve their or their children's health problems, and a general sense of disempowerment vis-à-vis government biomedical services. All of the women I interviewed feel a connection with the therapeutic approach advocated by the Health Committee and Parochial Dispensary. Below, I highlight the most prominent factors that have brought Zarragoza women to participate with a health association, while taking into consideration the "material and ideological webs" (Finkler 1994) that constrict their mobility.

Health Problems and the Search for Control

Women's concerns for resolving their own health problems and those of their families are central to their decisions to participate in health groups. Most of the women I interviewed linked their involvement in a health group with health concerns. Many describe being drawn to a health group because of personal health problems ranging from depression to migraine headaches to diabetes. For example, Juana, a member of the Health Committee, began studying with the group when she was ill with what she describes as a "filthy nervous system" [*tenía el sistema nervioso hecho un asco*]. She explained that when she began to study with the group, she couldn't walk without holding onto the walls. Her blood pressure was high and she experienced constant dizziness and diarrhea. Yet she says that this changed once she began working with the Health Committee. As she explained, "When I went to study, one of my teachers started to give me herbal recipes and—look at me! Now I am making them myself."

At the time that Alicia learned about the Dispensary, she was suffering from severe health problems. She said that she had bled for 40 days after her last son was delivered by Cesarean section. Her doctors told her that she had cysts in the womb and needed a hysterectomy or she would die of cancer. However, Alicia did not trust her doctor's diagnosis after a series of previous misdiagnoses.

Alicia encountered a neighbor who told her about the Parochial Dispensary and recommended a therapist named Raul who worked with acupuncture and herbs. When she saw Raul, she was told that she was "one degree away from having diabetes." As Alicia recalls:

I had irregularities of pressure, high blood pressure and then low blood pressure and then I fell into a depression. He (Raul) told me that I also had

an inflamed liver. During this time I was obese, 100 kilograms. He told me the obesity was a serious problem. I had constant vaginal bleeding and he told me they were provoked by cysts, but more because of the obesity. The obesity was giving me all of these problems—blood pressure, depression, borderline diabetes—and I was having strong anemia.

Raul put Alicia on a papaya diet for 15 days and she lost 25 kilograms. Along with recommending natural therapies, he told her to keep going to her doctor. When she returned to the clinic, the ultrasound revealed that she no longer had cysts. As Alicia recalls:

This was the last time I went to the IMSS (clinic). I never returned and this was when I began using only natural medicine. Raul asked me, “Do you want to learn how to cure yourself?” “Yes,” I said. “Good,” he replied, “on Friday we are going to begin classes.” I had never been so happy.

The majority of the women I interviewed also said that their participation stemmed from an interest in helping their children. For example, Anna, Lety, and Monica (all participants in the Health Committee) felt drawn to natural medicine because their children suffered from acute asthma and the medical resources were not available at their public clinics to address their needs. Anna described how the clinic never had oxygen or an ambulance available when her daughter had asthma attacks. She began looking for ways to prevent the attacks. Monica described her frustrations with public health facilities when her son had asthma attacks and explained, “This is where my restlessness began to search for some other alternatives.” Almost all of the women’s stories about their children’s medical crises communicate a sense of powerlessness in public health institutions and a distrust of doctors.

These types of frustrations often lead women to search for alternatives to biomedicine, and they are eager to gain knowledge and control over the health care process. By participating in a training program, they learn how to effectively use natural treatments like herbs, nutrition, and homeopathic remedies. For example, when Vicenta began studying with the Parochial Dispensary, one of the therapists made a homeopathic treatment for her son’s “weak lungs” and then taught Vicenta how to make the treatment herself. Vicenta later began to treat herself for migraines with homeopathic remedies. This type of empowerment represents a major shift for women who were previously dependent on and disempowered by their clinical encounters with biomedical professionals.

The women who participate in the Health Committee and Parochial Dispensary gain a network of health practitioners whom they can call on in times of need. Miguel, a therapist at the Parochial Dispensary, has been an especially important resource for each of the women in this sample, who, at one time or another, has called on his services. For example, Juana believes that Miguel’s remedies have helped her daughter improve in her struggle with cervical cancer, although she is receiving treatment at the hospital as well. The women I interviewed share a sense that the remedies promoted by the health groups can be efficacious if used correctly, but they do not use them to the exclusion of biomedicine.

Many of these women have experienced acute anxiety about their and their children's health problems. Their dependence on public health care adds another layer to this anxiety. It is possible that the health provider network and training they receive help decrease this anxiety. For example, I observed how Health Committee members used each other as their first point of contact during a nonacute illness episode. Not only would they provide each other with instructions on what to do or which remedies to take during illness episodes, but they would also accompany each other to a clinic or hospital if necessary. This was most important for women like Vicenta, whose husbands were in the United States and who had little other social support outside of Health Committee participants. Having a support network (akin to Janzen's [1978] kin therapy managing group) to call on in the case of an illness appeared to be an important aspect of health group membership.

Women's concerns about the cost of biomedical treatments, side effects of synthetic medicines, lack of quality health care, and poor treatment at public clinics were central themes of their narratives. Ortiz Ortega et al.'s (1998) study in Mexico also found that neighborhood groups allowed women to discuss their private-sphere health concerns as well as the "constraints imposed on these strategies and efforts by public-sphere reality, namely the unreliability of state institutions or the imperiousness of health officials" (p. 146). As groups draw from traditional and alternative medical practices like Mexican herbalism, massage, and homeopathy, women learn to apply self-help solutions to the problems they don't feel are sufficiently remedied in biomedical institutions.

Empty Nest and the Search for a Purpose

Many of the women I interviewed explicitly linked their participation in a health group to their search for a purpose, particularly after their children left the home. These searches took on different forms. For example, Belinda learned about the Parochial Dispensary through one of her daughter's friends who told her about their nutrition classes. Belinda was intrigued because of her interest in health and because of her growing sense of isolation in the home. Two of her children had recently married and left the house, and the third was busy in high school. Because Belinda had dedicated her life to raising her children, she became depressed and did not have any social or intellectual outlets. She explains: "More than anything I started going to the Parochial Dispensary because I wasn't going out at all. When I started to go there, it was like an escape, an outing. It was something that was important to me and it interested me a lot and I kept going for two years."

Although Belinda experienced depression and isolation when her children grew up, Juana described the freedom she experienced when she gained time to dedicate to herself. When Juana learned that classes were being offered by the Health Committee in her neighborhood, she eagerly joined and has been working with the group ever since. Yet she struggles with the fact that she is 54 and is just beginning to find her purpose. As she reflected:

Sometimes I get desperate. I think it is too late. So I question God, "Why hasn't this happened until now?" But, I also think that it was the best moment for this. God allowed me to rise and do this. I was not well

prepared before, so I probably would have not done this in the right way. I think this is the right time, after I raised my grandchildren.

Sofia, a Parochial Dispensary participant, also found the group during a time in which her life was changing dramatically. She suffered from a severe bout of depression that came on slowly as her four children grew up and left the house. She recalled, “In this depression I began to feel that I was not useful, that life was not giving me anything. And you begin to believe this is true.”

Sofia was drinking at the time. As her depression deepened, she eventually stayed in bed and did not leave her house. During this time, one of her friends injured herself and asked Sofia to take her to the Dispensary. After watching her friend recover, Sofia became intrigued with the clinic. She eventually sought help for her allergies and asthma that she says was brought on by “excessive allopathic medicine.” Eventually, she enrolled in the school and began recovering from her drinking. She explained how things started changing for her:

At first you start doing it for yourself, changing your nutrition, and everything starts to change—your mentality, your lifestyle. For example, when I started to take homeopathic medicine—I told you that I liked to drink alcohol a lot, and between then and now I have quit much of that. I was studying here when I started to change everything. I started to become a little more aware and I started to understand more, because you see people who are sick and it is like you start to put yourself in their place, and to say—yes, I have a lot to give. More than anything, I can help others.

This comment suggests that one important aspect of women’s participation relates to their need to feel as if they are contributing to society. Regardless of education or income, the women I interviewed share an interest in helping others, particularly people living in rural communities who have limited access to formal medical services. As Anna, a Health Committee member, explained, “If we here in the county seat don’t have the necessary medical services that we need, then they [people living in rural communities] have fewer. At times they die because of scorpion bites, from diarrhea or vomiting. They die from curable illnesses. Here we are training women, and we hope that they become trainers as well.”

A community service approach is central to the work of health groups. Students at the health schools are taught that one of their primary roles as health promoters is to help others who are in need. This discourse appears to be incorporated into women’s own narratives about how they should serve the community. For example, Sofia explained that, rather than opening her own clinic in her home, she would rather work in “far away” communities where “almost no information arrives.” Similarly, Juana explained that she has dreams of moving to a rural community where she can work as a health promoter. She said:

It is not important if it is a community far away from here—that is what I would most like, to go to an indigenous region where there are no doctors, where you can honestly serve. That is what I want, and I don’t know where I

will go, but as soon as I find it I know that it will fulfill me, not economically but as a human being.

Despite their own economic struggles, these women want to bring their services to poor indigenous communities. At the same time that they want to serve the poor, many participants also hope to generate income from their work. As Belinda's case suggests, women often see the opportunity to make money as a means to decrease their dependence on their husbands, and sometimes even to leave them. On numerous occasions, Belinda arrived at the Dispensary in tears from the frustration that she felt in being belittled by her husband on account of her lack of education. She believed that earning an income could offer her the option to leave, but she was ultimately unsuccessful in selling her remedies.

Although Belinda's case is typical in that most participants generate very little income from their health-related work, many do try. In fact, over half of the 18 students I surveyed offer clinical consultations in their home, in a clinic, or in the homes of patients, and many make and sell herbal remedies. For many women, earning even the smallest amount of money can be significant. As Gallin (2002) suggests, when poor women achieve a small cache of earnings, they may gain a minimum space for control over their lives and a measure of self-respect. With this economic boost, women may also gain greater bargaining power over "male prerogatives embedded in the conjugal relationship" (2002:69). Although the extent to which women are motivated by economics to participate in health groups may be related directly to their specific household situation, my interviews suggest that an interest in income does not initially bring them to health groups. The more salient issues have to do with their search for a purpose, need for greater control over health care, and as I discuss below, their social isolation.

Health Participation as a Social Outlet

The social interaction that members receive through their participation is an important aspect of their narratives, particularly for the Health Committee members. The La Rosa community center, where the Health Committee holds its meetings, offers a unique space for social interaction. For example, many of the classes in which I participated turned into discussion sessions or *minifiestas*. The women would bring food and spend half of the class time chatting and eating. Sometimes, class time would be spent discussing one woman's health issue or addressing an emotional problem that another woman was experiencing. Personal problems often became the focus of class discussion. For example, when one member broke down crying during a massage class, the instructor led the class through a workshop on treating emotional problems through massage. I observed that participants were open to shifting priorities during class, and they seemed to appreciate these learning opportunities.

In another Health Committee class, the instructor Alicia had an emotional breakdown that became the focus of the class. She had been experiencing significant anxiety about a patient who had come to see her weeks before with an acute kidney infection. When he arrived weeks later at the clinic to announce that he had improved, Alicia began weeping as she lay down to have a student practice a massage

on her. Juana took the lead in managing this crisis. She went to her house across the street and pulled out a special calming herbal concoction. She massaged Alicia's body with the remedy while the rest of the students stood around Alicia and held her hand. It took about two hours before Alicia recovered. When I spoke with her later about this crisis, she explained that she had let very intense emotions build up—not only about this patient but also about family struggles. She did not have an outlet to release these emotions until that moment. In Juana's analysis of the situation, Alicia's breakdown occurred at that time because she knew that she was in a safe environment.

Ortiz Ortega et al. suggest that one of the reasons grassroots groups play such an important role in the lives of Mexican women is that the family, whether extended or nuclear, “does not allow them the space to express their concerns easily” (1998:157). Often, women have no other avenue for expressing their concerns and group members may be their only outlet. As Belinda explained:

Before (I joined the group) I didn't leave for anything; I married, I had my kids, I raised them, and here I stayed. Now I have friendships that I didn't have when I lived shut away in here. I found friends and I like getting together with them. Before, there was nothing else in my world except my husband and my kids. That was my world.

During my research period, each Health Committee member openly shared at least one personal crisis when the women were together during clinical hours or classes. Regardless of the activity that was occurring, the other women would give their full attention to whoever had the problem. They would listen, provide a massage, and tell the woman that she was not alone. Massage serves an important purpose in that it provides a hands-on connection that is reassuring and soothing for the women in crisis. In essence, the group's gatherings often served as a therapeutic outlet for participants and a socially sanctioned space for women to socialize, learn, and heal one another.

Obstacles to Health Group Participation

Although women's participation in health groups offers them many positive benefits, participants also report that their involvement brings about unforeseen challenges. It was not uncommon for women to battle with their partners or suffer from the gossip of their neighbors because they chose to leave the house and “improve” themselves. Many women are confronted with their husbands' insecurities about their involvement in activities outside of the house. As Sofia explained:

For those of us who are here, it is because we have had to fight very hard with our partner or with our husband because it is not easy for them to accept this situation. It is not easy for them to say, “Yes my love, go and study.” No. They think that men will be here; they are going to be naked. This is the filth that fills their heads. They start to think that you are going there to see someone else. I left [the house] to find a space for myself because I like to feel tranquil and I like it here. In the house I feel bad, I get sick. They

see this and they ask, 'What do they give you there? What is going on there?' And you start to have these types of problems.

Juana shared perhaps the most intense frustrations of all of the women I interviewed because of her husband's disapproval of her participation. When she told him she was going to study herbalism with the Health Committee, he didn't speak to her for three months. He wanted her to attend to him "day and night without leaving the house." She said that he has never accepted her interest in medicine; no one in her family has been supportive of her work. Juana explained:

Men can't stand that a woman is bright and successful. If a woman accomplishes achievements in her life, men will get jealous of that. That's something that bothers them. Men say that they need you or they love you. Yes, they want you there at home. They even want you to be covered and hidden, so nobody would see you. That is something that women can't accept, because that is not what women deserve as human beings.

For Vicenta, this conflict was abated when her husband, Juan, left for the United States to find work, freeing her to pursue her interests. Vicenta "discovered" the Parochial Dispensary shortly after Juan departed to the United States. After Juan left, Vicenta felt alone because she knew few people in Zarragoza. She also felt deeply unfulfilled because she had nothing to replace her role as a wife. She noticed the Parochial Dispensary on an afternoon walk and became intrigued by what the group was doing. Two of the therapists working there encouraged her to join the program and study with them. Three years later Vicenta graduated from the program and became a clinic coordinator and the Dispensary treasurer. She eventually opened her own private clinic with a colleague in her apartment. In reflecting on her impetus to begin training with the group, Vicenta explained that when her husband left, she had the freedom to explore new things. Juan had never agreed that she work outside of the home. His departure opened up the space that she needed to explore this new opportunity.

Her case suggests that migration may open up spaces for women to more freely seize opportunities to develop their interests. When Vicenta's husband returned, she reported that he was gradually growing to appreciate what she was doing. Because she was beginning to have a steady clientele in her private clinic, she was able to carry her family through the transition of her husband's unemployment. Although it was at first difficult for him to accept that she was the breadwinner, he became more open as time passed.

Although a husband's migration to the United States might theoretically free women to participate in a health group, they might still encounter other obstacles. For example, Monica's husband migrated to the United States while she stayed behind to take care of their two sons. Her in-laws live across the street from the house she rents. They did not support her work, viewing it as "a waste of time." Their criticism of her participation had a significant impact on Monica's sense of freedom, even though her husband was abroad. Similarly, Sofia reported that her neighbors were judgmental when she left the house for long periods of time. She said

that the gossip of her neighbors left her unable to view herself as free and worthy of the opportunities presented to her.

As these examples suggest, women's entry into health groups requires that they confront some barriers that have traditionally excluded them from the public sphere. They may even face consequences for transgressing traditional gender norms and expectations. As Anna explained, "There are social expectations, and women are still sealed within these." Vicenta goes as far as to suggest that these barriers are at the source of some women's illnesses. She explained:

One cause of illness is a lack of awareness or knowledge—and it is not poverty, because one can be very poor and eat beans and handmade corn tortillas, and the people are very healthy—but the ignorance of not learning to respect ourselves and love ourselves. This is what people don't understand and for this reason they get sick.

Vicenta's description of the source of women's sickness resembles Kaja Finkler's (1994) notion of "life's lesions." In her study of gender and morbidity in Mexico, Finkler articulates how disorder is produced in the body as a result of "perceived adversity, hostile social relations, stressful life events, unresolved contradictions that corrode one's existence, take hold of the body and carve impairments on it" (1994:16). These contradictions emerge when women are caught between the realities of everyday existence and prevailing cultural ideologies. Finkler suggests that sexual double standards, the experience that life is not as it "ought to be," and limitations on their freedoms contribute to women's domestic and material struggles and predispose them to non-life-threatening sickness at higher rates than men.

In health group participants' narratives, Zarragoza women described a range of health struggles that cannot be easily "cured" in the biomedical sense. Juana's "filthy nervous system," Alicia's "irregularities of pressure," and Sofia's "severe depression" seem to fit into the category of "life's lesions." Finkler argues that for life's lesions to be alleviated, the adverse circumstances and ideologies that contribute to women's struggles must be resolved. She suggests that one way in which this resolution may occur is if women immerse themselves in a movement or a public sphere activity that ideologically addresses the injustices that "corrode" their existence. Finkler's (1985) earlier work on a Mexican Spiritualist healing movement offers a salient example of how this might work; women's regular participation with a Spiritualist healing temple offered them the opportunity to transform their lives by being incorporated into a community of people who have suffered in similar ways. Finkler suggests that the transformative process of their incorporation into temples as functionaries and healers constitutes a powerful aspect of healing.

Arguably, women's participation in health groups contributes to this transformative process. Their incorporation into a community of women allows them to see that they are not alone in their struggles. Moreover, the support of other women helps them to build a sense of personhood. Ortiz Ortega et al. (1998) found that after a few years of participating in grassroots groups, some women felt they were entitled to work outside the home. In the case of Zarragoza groups, the health training that women receive helps to connect the private and public dimensions of their lives. Expanding their role from housewife to health promoter, these women gain

a foundation from which to build a new sense of identity and purpose. This was demonstrated in my ethnographic surveys. Although the majority of non-health group participants I interviewed referred to their profession as housewife (*ama de casa*), the majority of Health Committee and Dispensary students described themselves as “traditional and alternative medicine student,” or “health promoter.” They identified with their work to the extent that they located their profession in the public realm.

For women like Alicia who came to a group on account of an illness, the transition from sick role to healer is also important in creating a sense of personhood. Numerous women shared their delight at being able to tend to their children, heal themselves, make herbal and homeopathic remedies, and help their neighbors. In their role as health promoter, they could treat male patients thus subverting traditional gender roles. However, in the household, women often had to defend their work to their husbands. These elements of struggle and achievement—in the private and public domains—represent the complex wrestling required for women to reorder their relationships and lives and begin to resolve their life’s lesions.

Although women’s efforts to reclaim some control over the health care process may be viewed as a metaphor for reclaiming control over their lives, their work stops short of challenging the social frameworks that have created gender and social inequalities in the first place. Although group meetings may be “consciousness-raising platforms” (Ortiz Ortega et al. 1998) and clinics may be women-centered spaces, their collective concerns do not move participants to take action beyond negotiating personal relationships and contributing community service. As Ortiz Ortega et al. (1998) found in their Mexico study, grassroots women lack a critical gender perspective and thus far have “not been able to transform this personally validating experience of group participation into a collective exercise of entitlement . . . although respondents rely on strategies discovered in the group to try to improve their power position at home, most of them indicate that they are more willing to engage in collective action around community issues than to change gender arrangements” (p. 173).

Arguably, this health movement offers significant support for addressing individual health and provides a path toward reshaping gender relations and cultural frameworks that have limited women’s opportunities in Mexico. However, the movement appears to lack greater influence on macrolevel structures in large part because it is driven by low-income women with little political power. In theory, community participation, as a central component of community health and international development efforts, has the potential to challenge patterns of dominance. However, as scholars argue, participation is more likely to be a means through which existing power relations are entrenched and reproduced (Nuijten 2002; Smith 2002) as the acts of participation can easily conceal and reinforce oppressions and injustices (Cooke and Kothari 2001).

This irony of participation plays out in the work of health groups in numerous ways. By taking health care into their own hands, health groups, to some extent, absolve the government of its constitutional responsibility for providing sufficient health care to all of its members. Because these groups will care for the poor without being remunerated, they are ultimately accepting the new responsibilities that have been placed on them by the neoliberal agenda—without challenging the

underlying ideologies of inequality. By accepting their role as part of the new face of a flexible neoliberal state, these groups may be replicating, rather than rectifying, the structures of disempowerment that motivate their work in the first place.

New problems may emerge as groups willingly participate in the process whereby those “left behind” must create their own solutions to community-based problems. For example, health groups and lay health promoters may not be equipped to deal with the many serious health needs of their patients. Herbal remedies, homeopathy, and a false sense of security can deter patients from seeking the kind of urgent care they may need. Although health groups may address many of the social, cultural, and economic challenges their patients face, their work will not eliminate the need for high-quality biomedical care or greater equity in a broken health care system. Their work may have the consequence of absolving government accountability while attempting to mend individual lives.

Health groups also play into stereotypes long held by government officials about the type of health work that women are “expected to do” in the household and community. In fact, many Zarragoza health officials I interviewed shared the perception that women who participate in these groups are “practicing what they have always practiced—traditional medicine.” In other words, their work does not seem to directly challenge the dichotomies (i.e., public–private and biomedicine–traditional medicine) that have long relegated women to the private domain of household health. Although they may provide alternatives to biomedical care, they are not demanding that doctors approach their patients with more sensitivity or that the biomedical model be reexamined. Instead, they offer a parallel system that allows patients to circumvent biomedicine rather than lobby for changes. As the women in my study tackle important, immediate concerns, it appears that health group participation may help to massage and manage life’s lesions, but not necessarily resolve the forces that cause them pain.

Conclusion

The medical encounters that participants have with alternative healing traditions and the healing relationships that women develop through health groups may be important factors in facilitating a myriad of changes in their lives. As their stories demonstrate, some have given up drinking, turned to healthier lifestyles, overcome their depression and isolation, confronted their husbands, aired their grievances, and politicized the patriarchal domain of biomedicine. If women’s participation benefits their health and transforms their lives, then we can understand health groups to be radical in their potential to affect individual well-being.

If participants cannot relieve life’s lesions because they are not willing or able to change gender arrangements, they nonetheless appear to be building courage, solidarity, and even feminist consciousness. Scholars suggest that feminist consciousness is produced through women’s interaction in grassroots organizations, which begin as a response to “practical” gender issues (Ryan 2004). Jaquette (1994) writes that “Women in movements often speak of how their participation has changed their lives, expanded their awareness of the unjust structures of society, and given them new self-esteem—even when their involvement brings them into conflict with husbands, children, and other family members” (1994:225). As Safa (1995) argues,

women's collectivization of tasks helps to construct a new gender identity not only based on women's private responsibilities as mothers and wives but also based on their public rights as citizens. Participants of grassroots groups may begin to stake new claims regarding entitlement both within and outside of the home (Ortiz Ortega et al. 1998). These shifts are not to be underestimated as they can have significant implications for social change.

The women I interviewed did not describe themselves as "feminists" or their work as explicitly activist oriented. As Ortner (1984) suggests, "The idea that actors are always pressing claims, pursuing goals, advancing purposes, and the like may simply be an overly energetic (and overly political) view of how and why people act" (1984:51). Gallin (2002) argues that feminist consciousness raising happens in more subtle ways, rather than directly addressing unjust structures of society. In her case study of working-class women's chanting groups in Taiwan, Gallin (2002) suggests that talking itself constitutes a form of consciousness raising by bringing injustices to the social realm. She writes:

One woman's articulation of injustice brought to mind other injustices for the whole group. Individual problems became social problems. The shared knowledge created helped women develop critical perspectives on the world in which they lived. This shared knowledge politicized women, enabling them to resist power on the patriarchal terrain of daily life (p. 72).

Just as Taiwanese women are using chanting groups to develop "critical perspectives" on their world, so too are Mexican women taking advantage of new spaces opening up through health groups to reflect on their lives and pursue new forms of being and healing. As Ortner (1984) suggests, "Major social change does not for the most part come about as an *intended* consequence of action. Change is largely a by-product, an *unintended* consequence of action, however rational action may have been" (1984:157).

State decline under neoliberal reforms and the accompanying deterioration of health services have been the source of much scholarly ire in recent years (Castro and Singer 2004; Kim et al. 2000). One effect of state cutbacks has been the rise of civil society to fill in health care gaps. Although the "associational revolution" may be viewed as an unfortunate but necessary response to state decline, it has undoubtedly created new opportunities for local citizens, particularly women, to participate in reshaping society. Regardless of these opportunities however, health groups and their participants cannot fill in the gaps of a declining public health care system. Expecting that local groups pick up the pieces of a broken health care system is not only irresponsible on the part of governments, but it is also dangerous.

The women I met in Zarragoza made the choice to position themselves at the frontlines of the very problems that concerned them the most. The urgency of their work was understood as well as their limitations. Although they were clear that broader systemic changes needed to happen for health to be achievable for all, the path toward making these macrolevel changes was not in their view. The challenge, it seems, in moving forward, will be for government and civil society entities who are uncomfortably embraced in this neoliberal state to develop more flexible

partnerships. In formulating a new vision for health care, governments must be willing to draw from the creativity and insight produced by local community groups that understand the realities and complexities of the individuals and populations with which they work. Only if these groups are viewed as viable contributors to social, cultural, and health care reforms, can participants achieve their goals of addressing the most profound elements of suffering in their communities.

Notes

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1. I have assigned pseudonyms to all individuals discussed in this article to protect their anonymity. I have also renamed the health associations and the town in which this study was conducted.

2. I use the term *grassroots health associations* and *popular health groups* interchangeably to refer to neighborhood and community groups that have organized around health education and health service provision. These groups are largely self-sufficient and offer traditional and alternative health care services to community residents.

3. With the global economic crisis of the 1980s, structural adjustment programs (SAPs) were put into place to ensure that poorer nations repaid their debts to lending agencies like the World Bank.

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