Using Formative Research to Explore and Address Elder Health and Care in Chiapas, Mexico

The Story of Doña Karina

My concern with elder well-being in Chiapas was initially inspired by my interaction with Doña Karina, whom I met in 1990. The case of Doña Karina, whom I met in 1990-1992, 1994-2000 (1999), helped to sketch the landscape that motivated me to delve into elder health and care.

I met Doña Karina, a 65-year-old woman at the birthday party of a nun.

Doña Karina's store was closed, and I worried she was not feeling well. Doña Karina had hypertension, but would take her medication only when she had enough money to buy it. She also said she was on a 'forced diet,' eating less 'good' food, and taking her medication only when she had enough money to buy it. She was also said she was a 'forced diet,' eating less 'good' food, and taking her medication only when she had enough money to buy it.

Doña Karina lived around the corner, and ran a small convenience store out of her front room. It was stocked floor to ceiling with pasta, cereal, soap, candy, chips, soda, and trinkets. I became a loyal customer, and saw her a few times a week.

When I saw Doña Karina's store closed, I worried she was not feeling well. This occurred more frequently as time went on. She was not eating well. This occurred more frequently as time went on.

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NAMINO GLANTZ

Elder Health and Care in Chiapas, Mexico

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In Figure 10.1, a photograph of an elder Chiapaneca survey participant in her home, and the granddaughter who cared for her (Photo by Namino Glantz)

In many ways, Doña Karina is representative of the older women in her city.

In this chapter, I detail how I used medicoanthropological research to inspire engagement, critical reflection, and collaborative problem solving among key community members to facilitate primary healthcare for the elderly in Comitán, a small city at the border of Chiapas, Mexico's southernmost state. I outline how broad sociohistorical circumstances have made elder well-being an urgent issue, and how I was propitiously located to study it, having immersed myself in the community for the purposes of my dissertation, critical reflection, and collaborative problem solving (Figure 10.1).

Introduction.
DESIGN OF PUBLIC HEALTH INTERVENTIONS

Mexico to refinance the debt and restructure its budget. The public health budget froze, and the private health care sector grew. In 1994, the Zapatista rebellion, with its epicenter in Chiapas, drew international attention and resources to human rights (including health), and an influx of political refugees, civil society expansion, and entry of middle-class professionals into social and health services. It is in this context that Mexico faces demographic transition (increasing longevity due to decreasing fertility and mortality rates), and epidemiological transition (decreasing infectious and acute illness, with increasing disability and chronic degenerative illness).

Today, distinctive characteristics of Mexico's transitions call for a custom-designed health care response (Martínez and Leal 2003). These characteristics include unusually accelerated aging of the Mexican population (Frenk et al. 2004b; Reyes Fausto 2001), Mexico's growing noninfectious disease burden (García-Peña, Thorogood, Reyes Salmerón-Castro, and Durán 2001), and the perseverance of infectious diseases (Martínez and Leal 2003). If health and health care resources are inequitably distributed across the nation and throughout regions (Borges-Yáñez and Gómez-Dantés 1998; Philips 1991; Salgado de Snyder, González-Vázquez, Jáuregui-Ortiz, and Bonilla-Fernández 2005). The current health system was designed to meet the needs of a younger, more homogenous population rather than those of the emerging group of older adults residing in very distinct contexts. The health-care system is inadequate in that it is characterized by fragmented design that divides people by employment and ability to pay; nonuniversal health insurance coverage; little attention to extra-clinical (household, self, alternative/complementary) care; and low prioritization of health care needs specific to the aged, especially elder women (Borges-Yáñez and Gómez-Dantés 1998; Frenk, Sepulveda, Gomez-Dantes, Knaul 2003; Frenk et al. 2004a, 2004b; Nichter 1995).

Compounding the problem, entitlement among Mexican elders to care and resources in the household may also be tentative and unpredictable. The government may derive some comfort from the pervasive notion that the family has traditionally been and will continue to be an important source of care in the traditional family. This notion may derive some comfort from the pervasive notion that the family is a social institution of health and health care. But this may be misleading. In many cases, the family is unable to provide the necessary care, and elderly members may have difficulty finding care in the household or from the community. This shortage of family support may be exacerbated by the fact that many elderly Mexican families are dislocated and lack support from extended family members.

Context of Elder Care in Mexico

Figure 10.2. Maps of Mexico, the state of Chiapas, and the Border Region of Chiapas.
Elder Health and Care in Chiapas, Mexico

Formative Research through Medical Anthropology

I approached the exploration of elder Chiapaneco well-being from a privileged research position—having grown up immersed in Chiapaneco culture from a young age—enabling mid-course correction and stakeholder evaluation of the intervention process and outcome indicators of interventions. Evaluation entails generating intervention options via discussion with invited participants, identifying problems and obstacles from perspectives of stakeholders in vulnerable populations, such as people with HIV, women facing domestic violence, marginalized indigenous populations, and teens (who, in Mexico, generally have little legal control over their own health care). CISC is a trusted source of insight into health problems and interventions, and has honed its ability to provide universal health care (Gobierno Federal 2001, 2002), and there is growing civic and state engagement and collaboration focused on the growing issue of elder health and care. The research ought to be sensitive to inequitable relations and tensions between families, and different social and institutional contexts of everyone involved, whether or not they have explicit mandates to work with elder well-being. The project I initiated in Comitán represents a step in this direction.

I also conducted formative research through medical anthropology. The project I initiated in Comitán represents a step in this direction. The project was initially led by a team of researchers and stakeholders from the Center for Health Research (Centro de Investigaciones en Salud de Comitán, CISC). Founded in 1990, CISC touts itself as a trusted source of information about health problems and interventions, and has honed its ability to provide universal health care (Gobierno Federal 2001, 2002), and there is growing civic and state engagement and collaboration focused on the growing issue of elder health and care. The research ought to be sensitive to inequitable relations and tensions between families, and different social and institutional contexts of everyone involved, whether or not they have explicit mandates to work with elder well-being. The project I initiated in Comitán represents a step in this direction.

Further, each formative research project should become an iterative process of ever-improved methods and understanding. Growing insight and rapport among participants facilitate feedback so that strategies are evaluated and improved in real time. In this way, the research is not only gathered and recorded, but also becomes an iterative process of learning and self-reflection. The research process should be participatory and inclusive, with all stakeholders invited to contribute their perspectives and expertise. This requires that the research process be a partnership rather than a top-down study. This requires that the research process be a partnership rather than a top-down study. This requires that the research process be a partnership rather than a top-down study. This requires that the research process be a partnership rather than a top-down study.

To study these issues, I drew on formative research, defined by Nichter and colleagues (Nichter 1990, Nichter et al. 2002, 2004), as a multistage participatory, qualitative research method. Formative research through medical anthropology is essential to an understanding of how interventions are produced, and how knowledge about issues and interventions is distributed, and represented among public, institutional, and political audiences. Formative research is defined by Nichter and colleagues (Nichter 1990, Nichter et al. 2002, 2004), as a multistage participatory, qualitative research method. Formative research through medical anthropology is essential to an understanding of how interventions are produced, and how knowledge about issues and interventions is distributed, and represented among public, institutional, and political audiences.

To operationalize this model, Nichter lays out various iterative components: becoming informed about what people do, say, and think about an issue; facilitating multipartisan, interinstitutional participation. Although I was hired initially inspired by people like Doña Karina, heightened by living in a department with a strong tradition of applied medical anthropology. So, I sought to become an informed by subsequent graduate training at the University of Arizona, and then developed policies and changing behaviors) (Nichter et al. 1990; Nichter et al. 2002, 2004). Evaluating process and outcome indicators of interventions. Evaluation entails generating intervention options via discussion with invited participants, identifying problems and obstacles from perspectives of stakeholders in vulnerable populations, such as people with HIV, women facing domestic violence, marginalized indigenous populations, and teens (who, in Mexico, generally have little legal control over their own health care). CISC is a trusted source of insight into health problems and interventions, and has honed its ability to provide universal health care (Gobierno Federal 2001, 2002), and there is growing civic and state engagement and collaboration focused on the growing issue of elder health and care. The research ought to be sensitive to inequitable relations and tensions between families, and different social and institutional contexts of everyone involved, whether or not they have explicit mandates to work with elder well-being. The project I initiated in Comitán represents a step in this direction.

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were framed and the way people viewed and responded to these issues, in a purposive sample of 300 elders aged 50 and above, stratified by age, gender, and I structured the survey, drawing on insight from previous research, bibliography, and I engaged the CISC in conversation and secured the Center’s institutional consent. I later facilitated bringing all 3 of these initiatives to fruition.

In the days following the forum, I monitored media reports to see how issues were being reported. Then, I worked with elders, home-based caregivers, and formal care providers to understand their health, and health care in Comitán as problematic. Among providers’ concerns, they came to us so late and in such poor health?" Providers wanted a general evaluation of problems and care. They asserted that such an evaluation would provide trusted evidence of the types and distribution of problems and care. These data, they asserted, were required for informing and becoming informed, planning, acting, evaluating, reflecting, and adjusting. Participating elders fervently supported getting to know them and their cohort, asserting, “Yes! You don’t know us! No one ever asks us!” Providers wanted a general evaluation of problems and care. They asserted that such an evaluation would provide trusted evidence of the types and distribution of problems and care. These data, they asserted, were required for informing and becoming informed, planning, acting, evaluating, reflecting, and adjusting.

In response, in 2005, I coordinated the design and application of a 240-question survey among older adults in Comitán. Four CISC colleagues and I facilitated a process in which the local population was actively engaged. The more than 30 forum participants included institutions involved in elder health care, forming an elder health working group. These steps are detailed subsequently, with examples of the kinds of data, insight, and engagement that each produced.

Formative Research

The Elder Health and Care Survey and Interviews

The formative research stages help operationalize participatory partnerships. They provide a clear expression of research that is both visible and invisible. The formative research stages help operationalize participatory partnerships. They provide a clear expression of research that is both visible and invisible.
This survey yielded quantifiable data allowing me to generate a detailed description of elder problems and health care strategies in Comitán. I used these numbers to engage 2 groups of stakeholders, in the public health design of public health interventions. Table 10.1 provides basic sociodemographic information on 300 elders. This survey included questions similar to those posed in the nationally representative Mexican Health and Aging Study (MHAS 2003), so that the local state of affairs could be juxtaposed with that of the country, evidencing the urgent need for contextualized action. Participation was voluntary. Recruitment was done largely through the snowball method; some people were reached while doing household chores, others were approached on the sidewalk.

<table>
<thead>
<tr>
<th>INDICATORS</th>
<th>% OF MEN</th>
<th>% OF WOMEN</th>
<th>SURVEYED % OF SURVEYED SAMPLE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Living alone at home</td>
<td>71</td>
<td>63</td>
<td>22</td>
</tr>
<tr>
<td>Iliterate</td>
<td>92</td>
<td>86</td>
<td>30</td>
</tr>
<tr>
<td>Elementary school education or less</td>
<td>65</td>
<td>52</td>
<td>21</td>
</tr>
<tr>
<td>Speaking a Mayan language</td>
<td>99</td>
<td>97</td>
<td>32</td>
</tr>
<tr>
<td>Separate/divorced</td>
<td>9</td>
<td>0</td>
<td>3</td>
</tr>
<tr>
<td>Widowed</td>
<td>9</td>
<td>6</td>
<td>3</td>
</tr>
<tr>
<td>Ever married</td>
<td>90</td>
<td>90</td>
<td>27</td>
</tr>
<tr>
<td>No electricity at home</td>
<td>78</td>
<td>79</td>
<td>25</td>
</tr>
<tr>
<td>No indoor water faucet at home</td>
<td>77</td>
<td>78</td>
<td>24</td>
</tr>
<tr>
<td>No refrigerator at home</td>
<td>53</td>
<td>54</td>
<td>17</td>
</tr>
<tr>
<td>No TV at home</td>
<td>85</td>
<td>85</td>
<td>26</td>
</tr>
<tr>
<td>No telephone at home</td>
<td>75</td>
<td>74</td>
<td>23</td>
</tr>
<tr>
<td>Gas stove</td>
<td>13</td>
<td>12</td>
<td>4</td>
</tr>
<tr>
<td>Own a car (spouse or self)</td>
<td>29</td>
<td>27</td>
<td>9</td>
</tr>
<tr>
<td>No radio at home</td>
<td>26</td>
<td>22</td>
<td>8</td>
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<tr>
<td>Medium = (21)</td>
<td>46</td>
<td>46</td>
<td>15</td>
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<td>*64</td>
<td>9</td>
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that the smoke from the fire had taken its toll on her vision. The combination
tortillas by hand. Her husband admitted that she had often burned herself, and
be subjected to a long survey. There was a shift in the nature of the inter-
truly enjoyed chatting about their family, past, livelihood, and health more than
in Chiapas). Instead, they came to depend on their adult children in exchange
of re-search by treating them as my teachers, neighbors, fellow community
for help, they said, they had 7 children, but only 6 still lived. When his wife mentioned that he
of-research by treating them as my teachers, neighbors, fellow community
decided to try their luck as manual laborers in Comitán. Without help on
led. Neither of them had learned to read or write. It was a hard
to do, women washed clothes, cooked, gardened, supervised children, tended
Lolita is representative of the kinds of qualitative data I collected.
conversations; others made me promise to visit them again. Frequently, we were
self-esteem, categories, and values to those of elders. Although it was convenient for
deeper context, to gain insights from the home life of the elderly. It was essential to
with earlier population censuses and epidemiological studies, and I wanted to
The Case of Don Fernando and Doña Lolita. Don Fernando, the veteran infor-
community about an hour outside of Comitán. For many years before and after
other men helped customers, shoveled dirt, arranged building materials. Others saw my visit as a
in the home-the leaky roof: the muddy road, the empty water tank. They
designed to delve more deeply into their specific health problems, methods facilitated triangulation of findings from the start, The forum, surveys,
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problem, and interviews allowed for cross-checking and ongoing learning as well as
Chapter 7
public health interventions
DESIGN OF PUBLIC HEALTH INTERVENTIONS
In much the same way that age and economy combined to expose his wife to health risks, Don Fernando’s daily trips to the market illustrated the same economic vulnerability, (2) the inadequacy of local elder health care services, and (3) the differences in economic and structural resources. This made it difficult to cope and address problems and conditions that demand public health interventions. Elderly health problems can be classified into three fundamental threads running through all (1) economic vulnerability, (2) the importance of local health care services, and (3) differences in economic and structural resources. The need to face these health risks with very limited social, health, and economic resources. This made it difficult to avoid and address problems and conditions that demand public health interventions. This is true for the elderly in Comitán, where many older people have those needs. The disparities between the local health care services and the national level are obvious in many cases. Moreover, the inadequate and expensive services in Comitán health conditions among elders in Comitán are faced with severe economic and structural barriers. In general, surveys and interviews revealed higher reported rates of certain health conditions among elders in Comitán than among their national counterparts. In many cases, however, the maladies plaguing elders in Comitán did not differ greatly from those faced by elders elsewhere; the distinguishing factor was that elders in Comitán confronted ill health with very limited social, health, and economic resources. This made it difficult to avoid and address problems and conditions that demand public health interventions. In the surveys and interviews, Elders’ mention of health conditions and problems was higher for the elderly. The elderly Féndears were asked about their health conditions and problems in Comitán. In general, surveys and interviews revealed higher reported rates of certain health conditions among elders in Comitán than among their national counterparts. In many cases, however, the maladies plaguing elders in Comitán did not differ greatly from those faced by elders elsewhere; the distinguishing factor was that elders in Comitán confronted ill health with very limited social, health, and economic resources. This made it difficult to avoid and address problems and conditions that demand public health interventions. The surveys and interviews illuminated the nuances of these overarching health and care by gender.
medication that elders cannot afford

system was noncompliant by nbt, being reality-based,
resources, too, especially when drawn out over
time—

health problems—mental and physical—dried up
while preventing them from working. Chronic
physician communication or coordination.' So,
in the past year. There was' no home-pharmacy-
event—a fall, a stroke, a bad stomach bug—forced
(rarely a trained

meant that elders might be fine until a catastrophic
Nearly one-tenth consulted. a pharmacy employee
of stock. Even when insured, tenuous resources
self-medication was abetted by visits to pharmacies.

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addition to noting key contrasts between older men and women, these same
researchers also pointed out that the conditions prevailing for women in the
community often resulted in poorer health outcomes. Furthermore, women had less influence over decisions related to health care, as access to insurance-based services that they relied on for their health care was often through male family members. Women also had less access to income, which affected their ability to cover health care expenses. In addition, women often had to care for multiple generations within their families, which placed a significant burden on their health and well-being.

In terms of health care, women tended to have more chronic health problems, as many spoke of menopausal symptoms and other symptoms of aging on a regular basis. Women also had less access to preventive care and routine screening, which meant that their conditions were often discovered at a very advanced stage, making treatment more difficult. Women also experienced more problems not prioritized by medical professionals, such as chronic pain and mental health issues, which were often dismissed as part of the aging process.

Elderly women were at a disadvantage in terms of making decisions about their own health and care. For women who care for their elderly parents, husbands, children, and grandchildren, they often had to cut down on the support they provided to others. Women were more likely than men to be a "sandwich generation," as access to health-promoting economic and insurance benefits was often limited. Women also had less influence over decisions related to their own health care.

Smoking and drinking, very common among men, were not as prevalent among women. Two-fifths of women were subject to others' decisions about their own health care, compared to women who control their own health care. Women were more dependent on others to cover expenses. In the end, women were more likely than men to seek medical care, as they recognized the importance of regular health check-ups and preventive care.

Reproductive health was another factor in elders' health problems. Menopause was more of a concern for women, as it marked the end of their childbearing years. Women also had less influence over decisions related to their own health care, as they were more likely to be a "sandwich generation." Women also experienced more problems not prioritized by medical professionals.

Elder Health and Care in Chiapas, Mexico
The interviews and surveys together yielded detailed ethnographic descriptions of elders' environments and challenges, such as that of Doña Paty and Don Ruben. Doña Paty, a 56-year-old woman, showed me into her front room, containing just a wooden table covered by a Christmas print tablecloth and a few wooden chairs and nothing more. Perhaps noting my curiosity, she also filled her with sadness and guilt. Most recently, she indicated that her oldest daughter had committed suicide, leaving her family and her husband's alcoholism. "My parents were very poor, so I never went to school not even one day. I helped my mother at home, and as a teenager began to work as a servant, cleaning, washing, and ironing. I've done that ever since," she told me. I knocked hesitantly, and the door opened. Doña Paty ushered me in and quietly explained, "He hasn't drunk for a week, but his character is just as ugly. It's almost worse than when he's drunk because he was around, and he discouraged Doña Paty from going out to visit, and even traveled thought, and she wondered whether she came out ahead. She had the same doubt about housecleaning, but his character is just as ugly. It's almost worse than when he's drunk because he was around, and he discouraged Doña Paty from going out to visit, and even traveled thought, and she wondered whether she came out ahead. She had the same doubt about housecleaning, but his character is just as ugly. It's almost worse than when he's drunk because he was around, and he discouraged Doña Paty from going out to visit, and even traveled thought, and she wondered whether she came out ahead. She had the same doubt about housecleaning, but his character is just as ugly. It's almost worse than when he's drunk because he was around, and he discouraged Doña Paty from going out to visit, and even traveled thought, and she wondered whether she came out ahead. 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discussed progress of the survey and preliminary results, with the participants.

Another complaint was that providers had an immense task and their rights, programs, and facilities championed by the state may be little more than an empty shell. Large buildings, colorful brochures, and even CDs detailing programs and services were provided, but they were rarely utilized or put to use. Practitioners pointed out that there was no articulation among the various local elder health care services, idealized as if they functioned as a comprehensive elder care system. I contrast this view with practitioners’ assessment of state resources, and misguided priorities among policymakers. My next attempt was to hold a meeting in which interested individuals might strategize together. In response, I organized, this time independently of CISC, a strategic planning meeting. I created a CD of the forum’s PowerPoint presentations, proceedings, and a participant director’s presentation. I then visited sites of Independent Working Group members, giving them a forum CD of the forum’s PowerPoint presentations. I also offered brochures and even CDs detailing programs and services. The interviews illuminated that the schism between providers and elders was due to the fact that health practitioners and institutional directors were from different professional backgrounds, yet lacked the necessary knowledge and experience to effectively address the challenges faced by elderly. These interviews also indicated that local health care providers’ perspectives were needed to round out the characterization of elder health and care in this context.

The interviews highlighted the epidemic of underestimation and misallocation of health care resources and services. Practitioners pointed out that there was no articulation among the various local elder health care services, idealized as if they functioned as a comprehensive elder care system. I contrast this view with practitioners’ assessment of state resources, and misguided priorities among policymakers. My next attempt was to hold a meeting in which interested individuals might strategize together. In response, I organized, this time independently of CISC, a strategic planning meeting. I created a CD of the forum’s PowerPoint presentations, proceedings, and a participant director’s presentation. I then visited sites of Independent Working Group members, giving them a forum CD of the forum’s PowerPoint presentations. I also offered brochures and even CDs detailing programs and services. The interviews illuminated that the schism between providers and elders was due to the fact that health practitioners and institutional directors were from different professional backgrounds, yet lacked the necessary knowledge and experience to effectively address the challenges faced by elderly. These interviews also indicated that local health care providers’ perspectives were needed to round out the characterization of elder health and care in this context.

Interviews with Health Care Providers

Design of Public Health Interventions

Elder Health and Care in Chiapas, Mexico
DESIGN OF PUBLIC HEALTH INTERVENTIONS

On-going Facilitation

...
DESIGN OF PUBLIC HEALTH INTERVENTIONS

In this way, the maps integrated reflection on factors beyond the scope of the data presented. The maps illustrated the need for recognition of factors such as the fact that water supply is often nonexistent, and that this is likely due more to politics than to the water table. The hospital, perched on top of a hill, rarely has water, and the city water tanks on the hilltop are often empty. The maps raised questions of where the water comes from, who has the water, and how the water is distributed.

Table 10.3. Standard Hypertension Survey Data Display, as Included in CDs Sent to Providers

<table>
<thead>
<tr>
<th>RESPONSE</th>
<th>CONTINENT MEN</th>
<th>CONTINENT WOMEN</th>
<th>CONTINENT ALL</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes-dr.</td>
<td>35</td>
<td>25.4</td>
<td>109</td>
</tr>
<tr>
<td>Yes-other</td>
<td>1</td>
<td>0.7</td>
<td>1</td>
</tr>
<tr>
<td>No</td>
<td>102</td>
<td>73.9</td>
<td>186</td>
</tr>
<tr>
<td>Don't know</td>
<td>0</td>
<td>0.0</td>
<td>1</td>
</tr>
</tbody>
</table>

Source: Salud 3E: Encuesta para el diagnóstico de salud y bienestar en personas de la tercera edad en Comitán, 2005, SB 9 HIPER:Q8a

Table 10.3: Hypertension Distribution by Gender

<table>
<thead>
<tr>
<th>RESPONSE</th>
<th>CONTINENT MEN</th>
<th>CONTINENT WOMEN</th>
<th>CONTINENT ALL</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total</td>
<td>138</td>
<td>100.0</td>
<td>300</td>
</tr>
<tr>
<td>Don't know</td>
<td>0</td>
<td>0.0</td>
<td>1</td>
</tr>
<tr>
<td>No</td>
<td>102</td>
<td>73.9</td>
<td>186</td>
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</tr>
</tbody>
</table>

Source: Salud 3E: Encuesta para el diagnóstico de salud y bienestar en personas de la tercera edad en Comitán, 2005, SB 9 HIPER:Q8a
Elder Health and Care in Chiapas, Mexico

The maps also spurred appropriation of research process and products. Rather than being a vertical dumping of results, presenting the maps was a horizontal exchange, sometimes even vertical, when participants oriented McManan. The maps encouraged people to share their knowledge and expertise, often aimed at increasing the accuracy and breadth of map content. Maps also inspired thought about what is good for each subgroup (e.g., women) and location (e.g., city's perimeter): Participants saw social structural factors as causes of—and solutions to—biomedical problems. This data display—very scientific in their eyes—captured providers' attention. They realized that maps could be used from the research planning stage through interventions, and they considered learning as analysis themselves. They also wanted the maps to be shared—even when potentially compromising their institutions reputation—with local leaders and the public. For CISC personnel, seeing maps of the data they collected spurred satisfaction of a job well done.

The forum, interviews, strategic meeting, working group, and follow-up meetings allowed for setting up this space for nonconfrontational and honest dialogue among health care professionals. The map meeting helped sensitize providers about the lives of elders and about what elders wanted in terms of health and well-being (e.g., water, transportation, income, pain control versus vaccination, and diabetes checkups). Providers accepted this in a nonconfrontational way, and rather than contesting the maps, engaged with the maps and their colleagues to look at the distribution of problems—some of which they had not anticipated. In doing so, providers added to their capital as concerned practitioners in the capital of the science. Practitioners then began to discuss more in-depth problem solving regarding the practical details of operationalizing different interventions, such as a mobile clinic, community health workers, and a community center. They were able to think about preventive and therapeutic care, and not just interventions on the periphery of health care. They saw the need for comprehensive, integrated, and coordinated interventions. The framework of the research was designed to be responsive to the needs of the community, allowing for community-generated research ideas, community-accepted evidence, and community-owned interventions.

Conclusion: My Role as Engaged Medical Anthropologist

My long-term immersion in Chiapas and the region's unique elder health care context placed me in the ideal position, with appropriate skills, at a propitious moment for public health intervention. My role was to provide guidance and leadership to organize the stakeholders, help them see the value of the research, and facilitate the process of research and intervention development. I engaged in participatory action research, working closely with the community to identify needs, design interventions, and evaluate outcomes. This approach allowed me to develop a deeper understanding of the community's needs and to build trust and collaboration among stakeholders.

In this dynamic, rather than provide answers, I outlined the circumstances and asked and elicited questions that invited critical problem solving. I aimed to engage Mexican elder health care providers in creative problem solving regarding interventions while boosting their capital, which in turn gave rise to further opportunities of obtaining better understanding of issues, stakeholders' needs, data needed, and problems. Stakeholders became informed about each other, the issues, motivated, and engaged. The framework of the research was designed to be responsive to the needs of the community, allowing for community-generated research ideas, community-accepted evidence, and community-owned interventions.
September 30, 2003

Mexico, 1950-2000: women, health, and aging in the context of political, social, and economic change. "...I de comunidad..."


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