ON AUGUST 31, 1942, two Kaqchikel Maya men from the rural highland town of San Juan Comalapa, Alberto Cali Cuzal and Cipriano Chovix Chali, traveled some seventy kilometers to Guatemala City. They hoped to access free expert healthcare at the publicly-funded General Hospital. Since neither spoke Spanish, they carried letters written by a scribe who explained their symptoms. Work and even relaxation had become excruciating for both because of pain in the abdomen (Cuzal) and lung (Chali). Chali could barely eat and suffered headaches. He had consulted a doctor in the department capital of Chimaltenango, but reported that medication “had no effect on him.” Now, both men appealed to leading authorities of scientific medicine in Guatemala. “I urgently beg [you] . . . to present me with a cure or an indication of what I should do to end my suffering,” Cuzal implored the hospital director.

There is no archival evidence of what response or treatment Chali and Cuzal received. But the letters’ existence suggests that the hospital deemed them valuable enough to save, so the Kaqchikel men likely got, at the very least, some form of attention. The social interactions they had in the hospital, as well as their own notions of illness and healing, would have shaped their decisions around whether to pursue whatever potential cures may have been recommended to them.

Indígenas (indigenous people) across Latin America commonly consulted diverse practitioners while pursuing healthcare, whose hybrid forms included scientific, indigenous, Afro-descendant, folk, traditional, and other medicines. By the time Chali and Cuzal travelled to the hospital, they probably would have already consulted indigenous curanderos (traditional healers), whom the Guatemalan government tended to portray, with both condescension and racism, as retrograde. But indígenas were also embracing modernity,
understood as a set of technological, social, and cultural changes catalyzed by capitalism and science. And they consulted doctors in urban hospitals enough to suggest they were ready to claim their rights to healthcare, even though they faced considerable obstacles along the way.

Some two thousand kilometers to the southeast, in Ecuador, Andean indígenas were up against similar challenges. A few years later, in June of 1945, the regional director for the north-central highlands of Ecuador, Dr. Enrique Garcés, travelled from Quito to Otavalo, a busy market town with a strong indigenous presence, to deliver a speech about typhus in Kichwa. His trip, part of a larger public health effort to disseminate information about disease, diet, and hygiene to rural indígenas, built on a legacy of communication between politically active indígenas in the region and colonial and national governments. It was also in keeping with a pattern in which, again and again, Ecuadorian government and health officials showed more respect to indígenas and their health practices than did their Guatemalan counterparts.

The differences in indigenous healthcare in each country were shaped, in part, by difference in government. Guatemala was a dictatorship. Since the 1871 Liberal Revolution, it had been ruled largely by caudillos whose administrations dispossessed indigenous land and conscripted indigenous labor to expand Guatemala’s agro-export economy. A functional legal system notwithstanding, a general disinterest in hearing from anyone who was not at the top of the hierarchy permeated Guatemalan political and social life, and meant that indigenous participation in public health initiatives was more or less foreclosed. Ecuador, on the other hand—while still authoritarian—had at least a semblance of representative governance, and it often encouraged indigenous participation in civic life. Although few indígenas could vote, they held a moderate demographic influence, comprising 25 to 40 percent of the population in the early to mid-twentieth century, and a burgeoning indigenous movement in the 1930s and 1940s led to increasing autonomy. Indígenas seldom threatened political power, but the government encouraged Ecuadorian medical professionals to approach them with cultural sensitivity, which helped make for better results in their healthcare.

Yet a close reading of Garcés’s speech reminds us that in Ecuador, too, racism endured. “In your language . . . I come again to teach you how you should live and how you can guard against this illness that is in your land,” he said. “You call it fever, we know it as Typhus,” the speech continued, suggesting that these differences were not just in perception, but in expertise: the indigenous audience might “call” the disease by its symptom, but scientists
“know” about the facts. He blamed the disease’s spread on indigenous lifestyles, asserting that “everywhere people live untidy [and in] grubby [surroundings] they contract it and die.”10 Subtly and explicitly, Garcés advanced medical science and discounted indigenous healing. By distinguishing taxonomies that fit state-sanctioned scientific medicine, he minimized indigenous knowledge.

During the first half of the twentieth century, encounters like these between indigenous Ecuadorians and Guatemalans and medical professionals took place in greater numbers than ever before. And they were enabled by desires for both humanitarianism and social control.11 The Rockefeller Foundation (RF), then one of the most significant international public health organizations, was working to mitigate disease and improve public health in both countries until the late 1940s, when it shifted its focus primarily to agricultural development.12 Healthy workers were good for US companies relying on local labor. For their part, Ecuadorian and Guatemalan officials, too, wanted to solve real health problems, from plagues to infant mortality. Yet they also railed against—and even penalized—indigenous modes of healing and well-being. During early-twentieth-century nation-building periods, for example, officials in Guatemala and Ecuador outlawed indigenous bathing and funerary rituals, respectively, for fear they spread deadly germs. These longstanding practices were part of dynamic, holistic approaches to health that took into account an individual’s psychological, emotional, and physical well-being.13 Attacking them meant attacking indigenous worldviews, histories, sense of place, and communities.

Racist thought shaped the public health initiatives in both countries.14 With nineteenth- and early-twentieth-century citizenship in Latin America reserved for those who elites deemed capable of participating in civic life—urban, cosmopolitan Hispanic citizens—indígenas and their healing practices tended to be relegated to society’s margins.15 In Guatemala, a relatively united oligarchy exploited indígenas singlemindedly, and eugenicists demanded indigenous assimilation. Convinced indígenas and their culture undermined the nation’s march toward progress, economic and political elites coercively extracted indigenous labor and dispossessed indigenous land. Ecuador followed eugenicist thinking as well, but framed its efforts as attempts to improve a national (rather than solely indigenous) race. In contrast to Guatemala, Ecuadorian officials did not demand assimilation and sometimes corrected for such overreach, which facilitated conditions whereby indígenas could embrace public health and health care initiatives without
fear of surrendering their ethnicity. Moreover, divisions among political and economic elites in Ecuador created openings in which indígenas could advance their agendas and mitigate some of the structural racism they faced. RF representatives acted in kind, advancing notions about indígenas in Guatemala that often mirrored racist thought there, but seldom denigrating indígenas in Ecuador where they enjoyed greater respect.

Yet influence acted in multiple directions, such that—during an epoch of intense nationalism and modernization—indígenas and their healers shaped the evolution of healthcare and public health programs in both countries. With their consistent and robust demand for curanderos, indígenas ensured medical science never monopolized healthcare in either country. In turn, indigenous midwives who taught their natal care techniques and knowledge to interested doctors injected indigenous expertise into gynecological care. Even when their states did not recognize them as citizens, indigenous men and women claimed medical citizenship, the right to public health initiatives and healthcare. And while medical science became increasingly powerful and orthodox, it did not fully edge out the knowledges and remedies on offer—among empíricos (who learned through experience rather than formal medical training), curanderos and indígenas. The contact, conflict, and collaboration of the era led to new forms of syncretism, too.

**RACE RELATIONS, RACIALIZATION, AND INDIGENEITY**

Unlike other Latin American nations such as Costa Rica, Chile, and Argentina, postcolonial Guatemala and Ecuador both had and continue to have large indigenous populations. Mexico and Peru also had significant indigenous populations, but as colonial hubs and postcolonial capitalist centers of modernization, they attracted numerous foreign entrepreneurs, diplomats, interlopers, and later, attention from historians. In contrast, Guatemala and Ecuador saw less in-migration and, with notable exceptions, have been less extensively chronicled. As importantly, Ecuador and Guatemala represent different, albeit sometimes overlapping, elite approaches to indigeneity which both shaped and were shaped by the history of public health. Taken together, they can help us elucidate connections between imperialism, public health, state and non-state actors, and constructions of race and racism.
Recognizing that ethnic identities are created, contested, and reinvented, for the purposes of this study, the term “indigena” hews closely to its use in archival documents, from which it is difficult to know how scribes and observers defined indigeneity. Most likely clothing, language, footwear (or a lack thereof), diet, and other outward ethnic markers served to distinguish indigenous from nonindigenous people (contravening postmodern scholars’ discouragement of defining indigenous people by discrete cultural, traditional, linguistic, or historical traits). Archival materials shed little light on how actors came to define indígenas and even less on how indígenas defined themselves. While the 1896 Ecuadorian constitution referred to natives as the “indigenous race” (raza indígena) the 1906 constitution referred to them as the “Indian race” (raza india). When scribes denote ethnicity explicitly, I identify people as such. Elsewhere I attempt to ascertain ethnicity, being transparent about how fraught that process is. While my focus is on indígenas living in rural highland communities, there is broad variety within that category: Guatemala is home to more than twenty different Maya linguistic groups; in Ecuador, regional differences distinguish Kichwa speakers in the Andes mountains, various Amazonian tribes, and a few indigenous groups along the coast.

In both Ecuador and Guatemala, indígenas occupy similar places in racial hierarchies shaped by conquest, colonization, and slavery. Although the racial order has varied over time, its broad contours have remained consistent: lighter-skinned citizens have enjoyed more social, political, economic, and political privileges than their darker-skinned counterparts. In Ecuador, whites have persisted atop the social structure followed by blanco-mestizos (white mixed-race people), indígenas, and Afro-Ecuadorians. Africans, forced into slavery to labor in gold mines and later plantations, were most populous in the Guayas, Manabi, Esmeraldas, and the Chota valley, and remained at the bottom of the social ladder even after the new nation abolished slavery in 1822. Writing in the 1930s, the Guayaquileño journalist and poet Rodrigo Chávez (1908–81) considered “los negros” inferior to indígenas. No wonder, then, that some Afro-Ecuadorians identified themselves as “blancos.”

Meanwhile, through organizing, protesting, and negotiating for their rights, indígenas enjoyed some social mobility and political influence, and by 1929, literate women had won the right to vote. Ecuadorian racism was mitigated by elites’ confidence that they would not cede control to indígenas, who comprised a minority of the population. But the combination of literacy requirements and the structural racism working against equal access to
education prevented most indígenas in Ecuador from being able to vote until 1979.\textsuperscript{25} For their part, blanco-mestizos identified with both their European and indigenous ancestors, while coastal Montuvios who embraced their indigenous, African, and European heritage sometimes were identified as “indios”—a term that was a racial slur in Guatemala, but associated with little denigration in Ecuador.\textsuperscript{26} Overall, Ecuadorian racial diversity was complex, sometimes contested, and not entirely fixed. For example, the father of social medicine in Ecuador, Eugenio Espejo (1747–95), has been portrayed as both one of the nation’s greatest indígenas and the most “celebrated Afro-Ecuadorian.”\textsuperscript{27} His father was indigenous, while his mother was of mixed African and European heritage—known, in the terminology of the time, as a mulatta.

In Guatemala, Criollos (Creoles, self-proclaimed pure-blooded Spanish descendants) stood atop the social ladder followed by mestizos (of mixed indigenous and Spanish heritage), ladinos (Europeanized, nonindigenous people), and Afro-Guatemalans. A few entrepreneurial indigenous elites notwithstanding, indígenas and Afro-Guatemalans, including Garífunas (an African-Arawak population), were on the bottom rungs. Though hostility arose between indígenas, Africans, and mulattos, intermarriage between them was not uncommon: mestizaje, or racial mixing, happened both biologically and culturally. For example, indigenous women were said to have been attracted to African slaves because their physical and social mobility was not as restricted as that of indigenous men.\textsuperscript{28}

Yet beginning in the late nineteenth century and in contrast to the more fluid set of identities available in Ecuador, Guatemalan Liberals sought to establish a racial binary with censuses that separated the population into being either indígenas or ladinos. Mestizos populated the nation, but not the censuses. During the first part of the twentieth century, the offspring of German immigrants and Q’eqchi’ Maya women were referred to as la raza mejorada (the improved race).\textsuperscript{29} And while indígenas comprised the majority of the population—some 65 percent in 1921—\textsuperscript{30} they had little access to wealth and authority. Those who shed their indigenous markers, like language and clothing, could adopt a ladino identity and hope for the spoils that came with it. But many indígenas remained steadfast in their claims of ethnicity and citizenship.\textsuperscript{32} Writing to the ruthless dictator Manuel Estrada Cabrera (1898–1920) in 1918, a rural indígena identified himself both as a member of the “indigenous race and citizen of the nation.”\textsuperscript{33} As in Ecuador, however, the full rights of citizenship were restricted to those who could pass
literacy tests, which remained in effect until 1945 for indigenous men and 1965 for indigenous women.34 Tainted by such racist disempowerment, public health campaigns often failed to engage, let alone serve, indígenas. Three-quarters of the population of Guatemala was rural (and nearly 70 percent worked in agriculture), but medical professionals were concentrated in cities.35 Ecuador similarly struggled to provide public health and health care services in rural indigenous areas. Physicians generally cared for a more cosmopolitan elite section of the population, who purchased medications at farmacias instead of informal botiquines where poor and working class people were attended.36 When elites fell ill, private doctors shielded them from the deprivations and indignities of hospital care and public health campaigns.37 By the 1910s, Central American elites enjoyed medical attention and sanitation measures such as screens and piped water that reduced their likelihood of contracting diseases.38 The concatenations of poverty, racism, and geography that undermined health and convalescence meant that poor, rural indígenas had some of the worst public health indicators in both countries.

**The Shifting Terrain of Science, Healing, Race, and Place**

Medical science never has been settled terrain. In the early twentieth century, the curative powers of orthodox medicine were often limited, and university-trained doctors struggled to prove they were more competent than Mesoamerican and Andean healers.39 Antibacterial medicines and antibiotics only began to appear in the late 1930s and mid-1940s, respectively. Most vaccines were developed in the second half of the twentieth century, and thereafter, scientific medicine saved millions of lives. In the early part of the twentieth century, however, scientific medicine was often ineffective and some practices—particularly when applied aggressively—harmed the ill. In those instances, indigenous medicine was preferable. In particularly egregious cases, as when US and Guatemalan doctors injected Guatemalan subjects with syphilis and gonorrhea, scientific medicine actively sought to harm patients.40 Considered against such brutality, indigenous healers were less of a threat to individual and collective health than medical professionals. Whether considering curanderos, comadronas (midwives), physicians, or
other providers, my aim is to understand what the meaning, value, and efficacy of their practices reveal about race, class, gender, and politics.

Early-twentieth-century public health campaigns demonstrated the efficacy of laboratory-based medicine and the ability of state-sponsored scientific medicine to contain epidemics and cure debilitating diseases. Those efforts undoubtedly improved public health, but their agendas foreshortened healing alternatives. What’s more, these campaigns were shaped by, and helped perpetuate, racism. For example, as an understanding of miasma (that foul-smelling vapors from the air, water, or ground caused epidemics) gave way to germ theory, with its emphasis on vectors and infectious agents, doctors of medical science framed indígenas themselves, rather than the environment, as contagious threats.

Guatemalan and Ecuadorian authorities, intellectuals, and medical professionals also mobilized racist thought to promote their priorities by portray ing indigenous healing practices as retrograde and dangerous. Officials argued that elevating scientific medicine and suppressing indigenous and other unlicensed healing were crucial to modernization. They denigrated, and even outlawed, unlicensed healers. They attributed these decisions to the need to maintain public health concerns and continue modernization, but were less forthcoming about another goal: to defend the economic interests of doctors who had graduated with degrees in scientific medicine and whose competition included partially-trained nurses, midwives, pharmacists, and medical students as well as indigenous curers and empíricos. Yet campaigns to persecute unlicensed practitioners stalled in rural areas: medical professionals tended to prefer the cosmopolitanism and higher salaries cities offered, so authorities had to rely on the very empíricos they derided, and indeed criminalized in cities, to treat rural residents. Guatemalan and Ecuadorian officials who rejected indigenous customs as contagious threats often depended on indigenous interlocutors (some of whom were curanderos) to convince their communities that public health initiatives worked, and to encourage indigenous participation.

Public health campaigns may have advanced humanitarian goals, but they were also articulated in the interests of economic and political elites. In Guatemala and Ecuador, doctors, scientists, and authorities maintained a symbiotic relationship as scientific medicine and state rule emboldened each other. At a 1905 Guatemalan Medical School conference, the conveners noted, “The School of Medicine and Pharmacy owes its existence, progress, and development to the public powers.” Legislatures passed health codes and
governments constructed hospitals and clinics. Latin American nations established police forces to enforce public hygiene, sanitation, and health standards and to persecute unlicensed practitioners. Increasing surveillance and regulation that characterized public health empowered technocrats to monitor women, the poor, and particular ethnic groups (especially indígenas).

The poor and marginalized populations who were subject to such campaigns tacked between embracing and rejecting them. While national officials used disease as a rhetorical tool to validate domestic interventions, and local authorities unleashed it to stave off labor and other demands from their superiors, local denizens deployed it to attract government resources. The same epidemics that afforded authorities opportunities to intervene in local affairs sometimes emboldened locals who feigned illness to avoid compulsory labor. In May 1928, the Santiago Zamora mayor was unable to fulfill the Sacatepéquez governor’s request for three female tortilla makers because the town’s “population has been decimated . . . [by] malaria.” Malaria provided an opportunity for him to reassert his political power vis-à-vis the Guatemalan state.

Depending on how it affected discrete regions, the same disease meant different things to different people and thus was put to many uses. Whereas Guatemalan officials were more likely than their Ecuadorian counterparts to associate typhus and typhoid with indigeneity, RF representatives generally thought of typhus as a disease of war, poverty, and poor hygiene—the last two of which they associated with Guatemalan indígenas, who predominantly populated the highlands. In both countries, authorities sometimes conflated indigeneity, geography, and disease.

Perceptions of race and place influenced the fate of public health initiatives and responses to crises. By pointing to endemic typhus in the highlands and malaria epidemics in the lowlands, public health reports emphasized the geography of disease. In 1911, the Guatemalan Government and Justice Secretary reported typhus epidemics in the predominantly indigenous towns of Comalapa and Patzicía (2137 and 2135 meters above sea level respectively) and a malaria outbreak in San Jerónimo Baja Verapaz, a town that sits 940 meters above sea level. The highlands, drier and cooler, generally enjoyed better health than the lowlands in the early twentieth century. Two decades later geographical distributions of diseases continued to catch officials’ eyes. The 1933 Guatemalan Public Health annual report noted “typhus outbreaks in the [highland] departments of San Marcos, Quetzaltenango, and Chimaltenango and malaria epidemics in many towns on the northern and