DOCUMENT RESUME

ED 115 431 RC 008 887

AUTHOR Simoni, Joseph J.; Ball, Richard A.
TITLE The Diffusion of Health Information: Medicine Hucksters Can Teach Us Something.
PUB DATE Aug 75
NOTE 28p.; Paper presented at the Annual Meeting of the Rural Sociological Society (San Francisco, Calif., August 21-24, 1975)

EDRS PRICE MF-$0.76 HC-$1.95 Plus Postage
DESCRIPTORS Communication (Thought Transfer); Credibility; Diffusion; Health Needs; *Information Dissemination; *Medical Treatment; *Mexicans; Role Perception; *Rural Population; *Salesmanship
IDENTIFIERS *Mexico

ABSTRACT

During 1974, the role and effectiveness of the Mexican medicine huckster were examined within the context of a specified information diffusion process. Seventy-five hucksters were observed at work in three states of Mexico (Oaxaca, Michoacan, and Mexico) and in the Federal District (Mexico City area). Twenty-five sales pitches were recorded and 100 (31 males and 69 females) clients were interviewed. Clients were members of the lower stratum of the Mexican social structure, characterized by low income, poor housing, and little education. Of the 100 respondents, 54 were over 45 years of age, 51 lived in rural areas, 49 resided in small towns, and 87 had resided in the same location for 11 years or more. Names and addresses of clients were obtained by promising to deliver free samples of medicine to the homes of people who made a purchase. Some findings were: although all the medicines bought by clients interviewed were medicinally worthless (as verified by hucksters themselves), 78 of the respondents reported that the medicines had been effective (11 believed them to be ineffective and 11 were undecided); 87 expressed confidence in the hucksters--57 because they told the truth, 6 because hucksters explained well, and 7 because the medicines were not expensive; and all gave the medicine huckster the highest composite ranking of 10 potential sources of health information. (NQ)

The Diffusion of Health Information:

Medicine Hucksters Can Teach Us Something

A paper prepared for presentation at the annual meeting of the Rural Sociological Society; August 21-24, 1975

Joseph J. Simoni & Richard A. Ball
Dept. of Soc/Anthro
West Virginia University

Introduction

Many of the problems of social planning in developing societies can be traced to biased assumptions. There has been a particular affinity for premises which would permit centralized, bureaucratically organized operations. Myrdal (1972) has pointed out that such planning has been essentially economic planning and that the failure of the strategies can be traced to the fact that they neglect important social and psychological considerations. Michael (1973:74) has stressed that variables such as attitudes toward expertise, authority and hierarchy, population characteristics, historical experiences and levels of aspiration and expectation should be taken into account.

The diffusion of health information is one of the most acute problems facing developing societies. One of the more difficult aspects of this problem has been the identification of channels which are not only effective for the communication of health information but which are also influential in encouraging actual adoption of health care practices based on acquired understanding. Some of the more "obvious" channels have proved to be of little value while other channels which were initially denigrated and sanctioned negatively as "improper" channels for such communications have subsequently proven useful.

A close examination of the communication problem outlined above reveals once again one of the most serious and persistent defects of the bureaucratically organized planning process--the denial of feedback. Effective communication is a two-way street. In the absence of force, the ability of the source to influence the recipient will depend to a considerable extent

upon the sensitivity of the source to cues provided by the recipient. The problem here is that centralized, bureaucratic agencies are relatively insensitive to feedback from clients and correspondingly incapable of discovering and adopting more effective influence strategies. It is possible for such organizations to structure themselves so as to reduce avoidance or distortion of feedback, but clarification of the social psychological mechanisms involved depends upon comparative work (Michael, 1973: 269). Our intention is to contribute to the necessary empirical base by examination of an ubiquitous, effective, but socially invisible source of health information in many developing societies--the medicine huckster. The huckster is able not only to convince his clients to try new and untested products, but to pay for the privilege. We suggest that attention should be paid to the huckster's persuasion techniques, and that similar communication strategies might be employed as part of community health programs in developing societies. These suggestions are based upon data gathered during an intensive study of the Mexican medicine huckster and his clients.

Medicine hucksters have been operating in Mexico for more than three-quarters of a century. In Mexico, the earliest predecessor for today's medicine huckster was the traveling salesman who, around the middle of the 19th century, would trade medicinal herbs for tallow. Toward the end of the Century, a Polish Jew by the name of Meraulyock immigrated to Mexico. He set up in marketplaces and streets with little traffic and proclaimed the merits of medicines which were for the large part colored water or harmless powders. From "Meraulyock" came today's popular label for the medicine huckster, "Merolico."

Medicine hucksters are picturesque personalities with a gift of gab, ingenious, witty and skillful in the use of synonyms. Their products run

the gamit from virility stimulants to pomades for calluses, to cure-all syrups. They serve as a source of inspiration for comedians and other comics, and it is both fascinating and laughable to hear them jabber with their characteristic rhythm, their language mixed with technical and popular terms.

But there is also a serious side. Although all the medicines bought by clients interviewed during the course of this study were medicinally worthless (as verified by hucksters themselves), 78 of 100 respondents reported that the medicines had been effective (eleven believed them to be ineffective and eleven more were undecided). Eighty-seven respondents expressed confidence in the hucksters, 57 because they cured them, 17 because they told the truth, 6 because hucksters explained well, and 7 because the medicines were not expensive. The 100 respondents also gave the medicine huckster the highest composite ranking of ten potential sources of health information. He was ranked first in terms of "credibility," first again in terms of "usefulness," and second only to the family in terms of "similarity" ("thinks like you").

Methodology

We will examine the role and effectiveness of the huckster within the context of a specified process of information diffusion. The process may be defined as: "1) acceptance, 2) over time, 3) of some specific item--an idea or practice, 4) by individuals, groups or other adopting units, linked 5) to specific channels of communication, 6) by a social structure and 7) to a given system of values or culture" (Katz, et.al., 1963: 40). This definition has the merit of clear focus upon the important constituents of the total process.

All the data presented here were collected during 1974. Hucksters were observed at work in three different states of Mexico, (Oaxaca, Michoacan, and Mexico) and in the Federal District (Mexico City area). With their cooperation, sales pitches were recorded and interviews with their clients were obtained. Hucksters also served as key informants; a few volunteered their life histories.

Names and addresses of clients were obtained by promising to deliver free samples of medicine to the homes of people who made a purchase. This procedure was employed in eight sales situations on different days with the cooperation of five different hucksters. One hundred fifty-seven clients were identified, and 100 of them were interviewed. The remaining 57 clients were not interviewed for one of the following reasons: 1) interviewers could not locate the addresses, 2) they were not home when interviewers called on them, 3) their locations were judged too difficult to reach because of the lack of transportation or the potential danger to interviewers, 4) one client refused to cooperate.

Adopting Units and the Social Structure

The final sample of clients included 31 males and 69 females. Fifty-four of the respondents were over 45 years of age. Fifty-one of them lived in rural areas, and the other 49 resided in small towns; 87 had resided in the same location for eleven or more years. Educational levels were low, 79 having completed three years of schooling or less, 11 having completed primary school, and only three having gone beyond primary school. It is clear from these data and supplementary observations of housing and household goods that the clients of hucksters are drawn almost entirely from the ranks of the poor. Following the definition of diffusion presented above, we can identify the adopting units, individual

clients in this case, as members of the lower stratum of the Mexican social structure, characterized by low income, poor housing and little education.

The Culture

Turning to the matter of culture and the importance of a given system of values, we focus on the subcultural system of the Mexican poor, a "culture of poverty." This subculture has been adequately described by Lewis (1974) as including: 1) a structure, rationale and defense mechanisms without which the poor could hardly carry on, 2) an adaptation and a reaction of the poor to their marginal positions in a class-stratified society, 3) attempts at local solutions for problems not met by existing institutions and agencies because people are not eligible for them, can't afford them, or are suspicious of them. That the medicine huckster represents an attempt at a local solution will be substantiated below. As Lewis (1961) earlier stated, the poor in Mexico are unable to afford doctors, who are used only in dire emergencies, and they are suspicious of hospitals "where one goes only to die"; they rely upon herbs or other home remedies, and upon local curers and midwives. A "culture of poverty," then, the subculture of the Mexican poor, is a dynamic factor which affects participation of the poor in the larger national culture. As a subculture, it possess its own modalities and distinctive social psychological consequences for its members.

Initial movement of the poor in the direction of any health care service is influenced by two interacting sets of factors, physical symptoms (e.g., aches and pains) and social psychological contingencies. We are uncertain as to whether physical symptoms are more common among the huckster's clients than among friends and neighbors who do not patronize the huckster. Although the possible psychosomatic nature of the

complaints complicates research here, the question is important for a complete understanding of the latent functions of the huckster, and can be answered in time.

What is clear is that the subculture of poverty involves a "value stretch" (Rodman, 1967; Rosenstock, 1969:188) which allows a tolerance for a wider range of chronic, subclinical ailments than would be accepted by middle class Mexicans. Although Della Fave (1974) is correct in his assertion that the value stretch allows members of the subculture of poverty to maintain the scale of preferences of the larger society while extending the variation which will be tolerated, he is incorrect in his argument that the tolerance is so radically extended that expectation will never exceed it. The error is obvious in the case of health problems. The poor prefer to be in good health, but will tolerate more ill health than would be acceptable to the middle class (Mechanic, 1969:193). Greater tolerance is conditioned, for example, by observation of higher death rates and lower life expectancies. However, despite limited income and restricted opportunity for medical care, tolerance does not extend to the point of expecting nothing. Beyond a certain level of physical symptoms and/or anxiety arousal, expectations will produce health care seeking behavior. Consideration of such behavior should take into account both the objective factor of physical disturbance and the subjective factor of anxiety (Kosa and Robertson, 1969:64). Behavior may be directed at one or both of these factors.

An important aspect of anxiety reducing behavior is the tendency of the poor to prefer interpersonal communication and personable social interaction within a local social milieu (Levin and Taube, 1970). The evidence is that in most of the industrially underdeveloped areas, interpersonal

sources of communication are considered to be the most important communication channels for providing both information and influence in the process of innovation diffusion (Rogers and Svenning, 1969; Liu and Duff, 1972). Lay referral systems are important here, deriving their potency from the fact that they are subsystems which are integrated into the local social milieu, and from their capacity to frame messages in a personable manner. Lay systems allow the individual to feel a part of the ongoing social interaction rather than to experience self as a marginal and somewhat alienated "case."

The relationship of the health care establishment (doctors, hospitals, clinics) to this subculture is another major force influencing the direction of individuals seeking health-care information. There is evidence that the health care establishment does not relish contact with the poor. Working with the poor is "dirty work" which is threatening to important status distinctions, particularly in societies with a tradition of class lines. As a "client-centered" bureaucracy, the establishment actually tends to neglect those in greatest need (Levin and Tuabe, 1970), partly because of limited readiness to deal with them and partly because the seriousness of the problems challenges organizational effectiveness, especially as measured by quantitative criteria. Dealing with anxiety related problems of health care is especially difficult and is relatively unrewarding if those with the problems have limited resources to exchange. With many clients residing in rural areas without available transporation, the problems are further compounded. Given the limited readiness to deal with them at all, factors of cost and convenience tend to foreclose the possibility of seeking out these potential clients.

The potential for various forms of contact between the health-care establishment and the poor is affected by alternatives available to the establishment. A very attractive alternative is the centralized health-care pattern in which the client comes for the care, puts personal health entirely in the hands of the medical specialist and accepts the fact that "objective" treatment will proceed according to a routine in which the convenience of the bureaucracy is paramount. This mode of organization has many advantages of status and convenience for practitoners and tends to be defended by a definition of the problem which is based upon selective perception and which provides a convenient justification for the lack of contact.

Nor is the prospective client likely to initiate contact with the establishment. Social psychological readiness is limited by experiences with the establishment which have alienated the poor from it and by perceptions of the establishment as being both impersonal and bureaucratic. Higher costs and a perceived absence of focus on illness related anxiety also discourage the individual.

Acceptance

Before considering client acceptance of the medicine huckster and his products, we must emphasize that different health-care sources do not represent mutually exclusive options. The major options in Mexico are spiritualistic mediums, witches, doctors, druggists, empiricas, local curers, herb vendors and hucksters. Evidence (Fabrega and Silver, 1973) indicates that they are probably followed concomitantly and during the course of an illness a patient may be involved with several of them at once. However, the same evidence also suggests that clients will remain relatively loyal

to a single practitioner as long as they judge him to be helpful or useful. Our own data indicate that huckster partonage is not a one-shot phenomenon. Of the 100 clients sampled, 81 had purchased medicine from hucksters more than once; one-third had purchased ten or more times. Furthermore, the data shown in Table 1 certainly indicate considerable confidence in the huckster and belief in his usefulness. Our data do not support the argument that hucksters only appear effective because so many curious people will try anything once. How can we account, then, for this evidence which suggests that the medicine huckster has managed to gain institutionalized acceptance of himself and his new "health care" products?

The very existence of the huckster depends upon one of the major social insitutions of Latin America, the marketplace. The atmosphere of the marketplace appears to be quite important to his success. Of 100 clients of hucksters, 76 reported themselves to feel "protected" and "content" in this familiar milieu, while 75 agreed that they felt "safe"; 78 felt that they were "tranquil" and 63 felt "comfortable" there. Most hucksters follow one of the regional market circuits, moving from town to town on respective market days.

Imagine for a moment the scene in an open-air marketplace in Mexico. You weave your way through the throngs of people, looking from side to side, watching and listening to vendors selling fruits, vegetables, other perishables and nonperishables such as cloth, pottery and laundry detergent. A low voiced "Comprame marchante--buy from me, merchant" or "Que lleva, marchante--what will you buy, merchant?" is a typical verbal approach. Commonly, goods are lifted into the air and waved gently to attract your attention. Proceeding further along, you come upon a crowd listening to someone. You move in closer to look and listen. This is part of what you might hear:

[Table 1 About Here]

Table 1

Ranking of Ten Sources of Health Information
by One-Hundred Clients of Medicine Hucksters

	Huck-ster	M.D.	Nurse	Drug-gist	Mid-wife	Neigh-bor	Family	Radio	T.V.	News-paper
COMPETENCE:	5	1	3	2	8	10	9	3	6	6
Knows About Health	4	1	3	2	5	10	8	6	7	9
Educated	5	1	3	4	9	10	8	2	7	6
Intelligent	5	1	4	3	9	10	8	2	7	6
CREDIBILITY:	1	3	4	5	6	10	1	6	9	8
Honest	2	5	4	3	6	9	1	7	10	8
Can Ask With Confidence	3	2	4	6	5	10	1	7	8	9
Responsbile	2	1	3	7	9	10	5	6	8	4
USEFULNESS:	1	3	4	2	6	10	5	7	9	8
Helps	2	6	5	4	3	10	1	7	9	8
Gives Important Information.	1	4	5	3	8	10	9	6	7	2
Explains Well	1	5	7	2	9	10	8	3	6	4
Cures	3	1	2	4	5	8	6	7	9	10
Accessible	1	6	4	2	5	9	3	8	7	10
Gives Attention	4	1	3	2	5	10	6	7	9	8
SIMILARITY:	2	7	5	4	3	9	1	6	8	10
Thinks Like You	2	7	5	4	3	9	1	6	8	10
COMPOSITE RANK:	1	3	4	2	7	10	4	6	8	8

> Have you been treating yourself for stomach, lung, kidney or nervous disease, and have failed to find a cure? Chances are your trouble is in your heart. Place your finger on your pulse and see if your heart beats regularly and steadily. If there is a single skipping or irregularity of beats, your heart is weak or diseased, and there is no telling how soon it will stop beating altogether. If you have heart disease you are in grave danger. You may die any minute--anywhere. Shortness of breath, tenderness, numbness or pain in left side, arm or under the shoulder blade; fainting spells, dizziness; hungry or weak spells; nightmares; choking sensation in throat; cold hands and feet; swelling of the feet or ankles--one of the surest signs; if you have any of these symptoms, don't waste any time! Get these heart tablets at once! They will restore your health and strength.

Approximately 75 hucksters were observed in action, and 25 sales pitches were recorded. It is important to examine the sales pitch closely, for this is one of the keys to the acceptance of the huckster. A content analysis reveals six major categories of communication. First, (category #1) the huckster will call attention to types of people who tend to have health problems, usually including pregnant women, women who are nursing, people who work more than eight hours per day, women who wash and iron, people who don't understand sicknesses, people with parasites or with kidney problems, people who wear no shoes and contact hook worm, people without easy access to water for washing, people who suffer from bad nutrition, people who suffer from susto (evil eye), and people who take too much aspirin, Novarina, or Alka-Seltzer. Such a list will likely cover almost everyone listening. Next (category #2) there is a vivid descrption of the courses which illnesses run, often with the use of visual aids, such as anatomical charts, bottles full of tape worms, and pictures of malformed children. Then (category #3) there is a description of the source of a cure for those troubles, the huckster himself. Credibility is enhanced through references to medical doctors and the phrase,

"as the doctor says," through claims of having been taught medicine by experts and often through purporting to be a representative of the laboratories which allegedly produce the medicine. There is attempted identification with God by the frequent use of phrases such as "in the name of our Lord," pretension of cosmopolitanism through references to discussion with people in other towns and cities, and display of expertise in specialty arts such as ventriloquism. There is even sometimes a folksy method of identification of himself as another Mexican who understands the personal problems of those listening. Finally, there is a display of credentials such as licenses or "validated" permits to work.

The sales pitch will also include a description of the product (category #4) with claims that the medicine is advertised on the radio, that it is derived from plants and herbs, has nutritional value in addition to curative power, and that its full powers have not yet been appreciated by the medical establishment. Demonstration of the powers of the medicine frequently involves the "prueba de la sangre." The audience may even be told that they can personally verify the medicinal powers of the product by, for example, witnessing dead parasites in their excrement. The huckster will often sample the medicine himself and allow buyers to select their own bottles or packages so that none might suspect switching.

The fifth category of communication consists of solution related details and includes an emphasis on the fact that no diet is required while taking the medicine, that the medicine is to be taken orally rather than through injections, that getting the same medicine elsewhere would be difficult, that the curative period should be relatively short, that his presentation is promotion oriented not sales oriented, and that there is a guarantee. The sixth category involves audience learning and knowing.

There is a constant stress upon the importance of seeing, knowing, and learning by the audience. There is a careful demonstration of how to prepare the cure, an explanation of dosages, and an explanation of the manner in which the cure actually works in the body. There may also be a detailed explanation of the specialty art (e.g., ventriloquism) which has been displayed as a technique developed to attract and hold an audience.

As Menzel (1960) has pointed out, the adoption of health care behavior depends upon factors of communicability, risk, and pervasiveness of appeal to a specific social category. Communications between hucksters and clients take place within the well established social setting of the marketplace and tend to be personable in nature. These factors and the relative "credibility," "usefulness" and perceived "similarity" (Table 1) attributed to hucksters by their clients enhance communicability.

The huckster's handling of the risk factor is particularly effective. There is evidence that the poor are predisposed to strategies which tend to minimize risks rather than to those which tend to maximize gains, especially under conditions of anxiety (Ball, 1968). For example, to get less than what might be preferred but at low cost is usually a more appealing exhcange than to pay much more than one can begin to afford for the best of treatment--especially when there is no complete guarantee that it will succeed either. The sales pitch stresses the way in which risks are minimized by the "fact" that no change in eating habits is necessary (convenience risk), that injections would not be needed (pain risk) that curative periods would be short (risk of emotional investment), that one might be unable to obtain the medicine elsewhere (procurement risk) and that the product could be obtained at low cost and with a guarantee only because of the promotional campaign (financial risk).

As to pervasiveness of appeal, it is clear that the sales pitch tends to gain the attention of the audience partly by accenting the relationship between poverty and health problems, a relationship which is not so vigorously stressed by the mass media or the health authorities. There is also a recognition of the anxiety resulting from inadequate knowledge about health care and inadequate resources for obtaining such care. Katz, et.al. (1973) have emphasized the extent to which mass media are unsuited for dealing with personal problems such as this and the immense salience of personal contact in such cases. The huckster provides such a contact, and he apparently provides one solution to the twin problems of knowledge and resources. Our hypothesis is that the sales pitch satisfies to some extent a personal cognitive urge to know about health problems and to learn through personal contact and through direct visual observation. This would explain the fact that the presentations of the huckster become obviously more successful when the anatomical charts and other paraphenalia are highlighted. Arensberg and Neihoff (1971:93) have stressed the communicative power of the demonstration as follows:

> The villagers of the world, as well as the urban poor, are pragmatic people. Indeed, they have had to become so to survive. Nevertheless, the solid core of pragmatism is skepticism. The very practical person has to see how results are obtained before he can believe their value. This is the basis for demonstration, or the technique of showing in a pragmatic fashion the advantages of a new idea or practice. It is the most direct communication possible.

The huckster, then, shows extreme sensitivity to operative social psychological factors. He presents himself as a link to scientific medicine and emphasizes the need to learn and know about illness. Furthermore, the items which he sells cost relatively little compared to the costs of "scientific" cures form other sources (physicians, druggists, empiricas). By exploiting the social psychological readiness of the potential client

the huckster becomes a crucial and necessary intervening variable between perceived problem and related action, a "trigger" (Rosenstock, 1969:178) for health behavior.

Time

As is indicated directly above, the pervasiveness of the huckster's appeal is dependent to an appreciable degree upon the social psychological readiness of the potential client. Focus on the time dimension alerts us to the idea that social psychological readiness is not necessarily a constant, and that various sources of health care information and influence may vary in their effect depending upon the point in time in which they are introduced.

Fortunately for those concerned with the introduction of new health care ideas, recent research indicates that the poor of Latin America are in the process of a gradual preference switch from folk medicine to scientific medicine (Schendel, 1968; Rivera, 1973). These findings make sense in the light of other research which indicates that the mass media in developing areas have served to create social climates favoarable to the diffusion of innovation (Rogers and Shoemaker, 1971)--in this case the acceptance of scientific medicine. The huckster, at this point, appears to represent a bridge. His lines to the traditional patterns of communication and his connections with what are perceived as "scientific" products are both valued, and enhance his role as a diffusion and change agent.

Communication Channel

The medicine huckster, at this time, is a particularly effective communication channel for the diffusion of health information. Medicine hucksters provide information about health and health care to many poor (rural and

urban) Mexicans for whom adequate health care by professional standards represents a scarce commodity. During this study hucksters were observed to communicate with as many as 200 people and to sell to as many as 70 people in a period of 2 1/2 hours. In fact, it was observed that even those hucksters who seemed to be relatively less organized and polished in their presentations were somewhat effective in terms of sales. Medicine hucksters are elements of lay referral health care systems and their prestige as medical care practitioners depends heavily on their local community reputations. Medicine hucksters have become an "institutionalized group" (Znaniecki, 1945) within Mexican society. These manifest functions and statuses are at least covertly recognized by two major social groups, the health care establishment and the poor; and these social groups control these functions by positive and negative sanctioning. The establishment's posture allowing the huckster to work is a positive sanction, while the requirement of bribes and periodic hassling are negative sanctions. The poor, on the other hand, sanction the huckster's functions through their patronage or lack of patronage.

Given their ubiquitous presence and obvious effectiveness, we have been struck by the lack of attention paid to medicine hucksters as communicators of health information and as health care sources. Three major sources of information on health care in Mexico-Folk Practices in North Mexico (Kelly, 1965), Medicine in Mexico (Schendel, 1968), and Illness and Shamanistic Curing in Zinacantan (Fabrega and Silver, 1973)--do not even refer to the huckster. The initial response to a proposal for this study by Mexican health care adminsitrators and Mexican research personnel was laughter and a tendency to suggest that such people could not be taken seriously, certainly not as a target for research. When a staff reporter responsible for daily marketplace coverage for one of Mexico City's leading

newspaperswas asked about articles on medicine hucksters, he said he covered every aspect of marketplace life but had not done a story on the hucksters during his 5 1/2 months on the job. He added, "That's a good idea."

Our study of medicine hucksters lends further support to those who have argued for the identification and application of a type of communication channel not generally recognized in the literature concerned with the communication of health information. The traditional differentiation between mass media and interpersonal channels has left little room for consideration of other types of communication channels. Rogers and Shoemaker (1971), for example, fail to mention anything other than mass media and interpersonal sources in their otherwise comprehensive discussion of communication. The medicine huckster in Mexico represents a type of communication channel which should be labeled neither mass media nor interpersonal media. Like mass media channels, the huckster reaches a larger target population than interpersonal sources usually can. A huckster often will be communicating with audiences of 50 to 75 people. Again like mass media channels, the huckster works speedily, on the basis of a certain uniformity of message and serves an informative function. Yet, like interpersonal channels, the huckster is able to customize messages for specific audiences and has the advantage of being able to be intimate. He represents an example of communication generally but inappropriately subsumed under the label "interpersonal sources." Such channels can be more appropriately termed "local media" channels of communication (Lin and Burt, 1973; Menzel, 1971). To date, they have been relatively invisible. We suggest that intensive efforts be undertaken to identify local media channels and to enlist them in the diffusion of health information where possible.

Discussion

If we acknowledge the probability that subcultures of poverty will continue to exist in developing societies for the foreseeable future, then we must face the challenge of effectively communicating health care information and providing adequate health care for the rural and urban poor identified with these subcultures. Within many of these developing subcultures a transitional pattern is in evidence. People are seeking the benefits of scientific medicine while either continuing or ceasing to consult folk practitioners. Their preference, however, is for practitioners not only knowledgeable about scientific medicine, but also personable in manner and willing to encourage clients to learn and know about their health problems. Considering the seeming inability of the health care establishment and its traditional practitioners to provide such attention and care, the existence of surrogate health care professionals (paraprofessionals) is not only understandable, but necessary.

For community health programs, the potential of communications modeled upon the methods of the huckster is obvious. Medicine hucksters already play such a role in Mexican society, and it is safe to predict that practitioners very much like medicine hucksters play similar roles in other developing societies. Furthermore, during the course of our study, we learned that Mexican health authorities actually have employed hucksters to promote public health efforts, but that such employment has been confined to certain emergency situations.

Our data suggest that communications on the huckster model would not only be favored by the poor but should be especially effecitve in combining the advantages of mass media and interpersonal channels. The mass media characteristics would tend to develop and maintain social climates

favorable to the acceptance of new health care norms while the interpersonal channel characteristics would provide the person-to-person contact which is so critical in influencing the actual adoption of innovative behavior in industrially underdeveloped areas. Utilization of this "local media" form of communication would support and strengthen both mass media and interpersonal communication efforts directed at the same goals.

Several different application possibilities exist. One alternative is to train individuals in a huckster style of communication. This is possible. Although the difficulty of the task is appreciable, we know enough at this point to begin and should be able to develop some effectiveness with experience. Another alternative would involve the integration of selected huckster skills within the orthodox roles of change agents. A third alternative would involve retooling of already existing medicine hucksters with communication pitches concerning such topics as V.D., dental care, family planning and general hygiene (fruit peeling, handwashing, etc.). The advantage of this last-mentioned alternative is that medicine hucksters are institutionalized elements of local community social structures, and adaptation of their talents to the needs of community health programs would necessitate little or no change in existing patterns of social interaction on the local community level. As Merton (1959) has pointed out, local influentials fall into the categories of "cosmopolite" and "local". The first group consists of the important "gate keepers" of information who have contacts with the larger society, while the second group is made up of those strategically located in the sociometric network of the community itself. The medicine hucksters represent a unique type of local infuential in that they combine the attributes of both cosmopolites and locals; they thus offer potentially valuable linkages between the health care establishment and the poor.

Ryan (1969:156-7), in a discussion of the potential of various "change agents," writes as follows:

> The role of the professional, or the "change agent," is intermediate to and supporting of both informing and influencing functions in diffusion.... In the spread of opinion and ideology, the professional may range from the pastor of the local church to a party precinct captain. In the realm of less valuative diffusion, the range is perhaps as great, to include the advertising copy writer, the agricultural extention agent, and on occasion the Fuller brush man. Normally the idea of "change agent" is limited to one who personally bridges the organizational source of the diffusion item with the potential recipient, or at least the local influentials. Recent research would seem to indicate that effective operation of the professional arises when he is jointly viewed as "scientist" and personal associate. This influence seems also to be most effective in personalizing the gap between the massive impersonal media and the opinion leaders.

Several roles are possible for the medicine huckster as paraprofessional. He is well-equiped for the role of expeditor who can function as an "interpreter" between professionals and the target subculture, who can serve as a "negotiator" assisting the client in his interaction with the bureaucracy, and who's, assistance as "educator" and "helper" would be invaluable (Miller and Riessman, 1968:208). In terms of the "knowledge linking roles" described in Havelock's (1971) recent review of innovation techniques, the medicine huckster might be particularly effective as a "conveyor" who can transfer knowledge from scientists and physicians to health care consumers, and in the capacity of "knowledge builder and linker" who can operate with a dual orientation toward scientific soundness and situational usefulness. He would be in a position to provide help without the patronizing attitude which is so often cited as a factor leading to avoidance of formal health care facilities. As a "boundary spanner" (Michael, 1973:237-54), he could serve the increasingly important function as a "broker" between systems who can be effective not because he is independent but because he is located simultaneously within the boundaries of different systems.

We do not wish to minimize the problems involved in any attempt to employ medicine hucksters in such roles. The ethical issues are important, and they must be faced and resolved. The political aspects are touchy and must be handled with care. Certainly one must not overlook the pitfalls, some of which apply to the use of paraprofessionals generally:

> Frequently, professionals assume that nonprofessionals identify with the poor and possess great warmth and feeling for the neighborhood of their origin. While many nonprofessionals exhibit some of these characteristics, they simultaneously possess other characteristics.... They are particularly good at functioning and communicating on an informal level. While they know the hidden assumptions of the neighborhood, it should not be assumed that they are always going to be friendly, cooperative, "concerned", or any of the romantic myths about the poor. Moreover, there are many different "types" of nonprofessionals: some are earthy, some are tough, some are angry, some are surprisingly articulated, some are slick, clever wheeler-dealers, and nearly all are greatly concerned about their new roles and their relationship to professionals (Miller and Riessman, 1968:211).

Our interviews indicate that medicine hucksters themselves would be willing to try the new role. Many hucksters relish the idea of making a more positive contribution to community health programs in their country. They are now working in their present form because economic opportunity for them has been limited and medicine huckstering has proved to be a workable option for making a living. Given their life situations, they are simply applying their talents to what they can do best. They possess communication abilities which are sorely needed in community health programs, abilities which those concerned with the welfare of the poor cannot afford to ignore.

Although the potential of the medicine huckster as a source of health care information is clear, we are obviously not yet in a position to propose the specifics of organized implementation. Our intention has been to break ground for further work and to identify some

of the major questions which should be investiaged. Our data, although supplemented by other studies, is drawn from samples of hucksters and their clients. What proportion of poor Mexicans seek satisfaction of health needs through contact with medicine hucksters? What about those who do not; by what means do they seek satisfaction? How different are their attitudes? Do people who patronzie hucksters also go elsewhere? If so, what factors influence where they go? How much information from hucksters is actually consumed, and how long is it retained? How effective would medicine hucksters be communicating preventive health care information rather than providing cure-all solutions? The answers to such questions could guide attempts to employ the huckster in a different venture.

BIBLIOGRAPHY

Arensberg, Conrad and Arthur Niehoff

1971 Introducing Social Change: A Manual for Community Development. Chicago: Aldine.

Ball, Richard A.

1968 A poverty case: the analgesic subculture of the Southern Appalachians. American Sociological Review 33:885-895.

Della Fave, L. Richard

1974 The culture of poverty revisited: a strategy for research. Social Problems 21:609-620.

Fabrega, Horacio Jr. and Daniel B. Silver

1973 Illness and Shamanistic Curing in Zinacantan. Stanford, California: Stanford University Press.

Havelock, Ronald

1971 Specialized knowledge linking models. In Planning for Innovation, Ronald Havelock, A. Cuskin, M. Frohman, M. Havelock, M. Hill and J. Huber. Ann Arbor. Institute for Social Research, Center for Research on Utilization of Scientific Knowledge.

Katz, Elihu, Martin L. Levin and Herbert Hamilton

1963 Traditions of research on the diffusion of innovation. American Sociological Review 28:237-252.

Katz, Elihu, Michael Gurevitch, and Hadassah Haas

1973 On the use of the mass media for important things. American Sociological Review, Vol. 38, 2:164-181.

Kelly, Isabel

1965 Folk practices in North Mexico. Austin: University of Texas Press.

Kosa, John and Leon S. Robertson

1969 Social aspects of health and illness. In Poverty and Health--A Sociological Analysis, John Kosa, Aaron Antonovsky, and Irving Kenneth Zola (eds.). Cambridge: Harvard University Press.

Levin, Jack and Gerald Taube

1970 Bureaucracy and the socially handicapped: a study of lower-status tenants in public housing. In Sociology and Social Research, Vol. 54, 2:209-219.

Lewis, Oscar

1961 The Children of Sanchez. New York: Vintage Books

1974 The culture of poverty. In Contemporary Cultures and Societies of Latin America (second edition) Dwight B. Heath (ed.) New York: Random House.

Lin, Nan and Ronald S. Burt

1973 Roles of Differential Information Channels in the Process of Innovation Diffusion. International Center for Social Research, Albany, New York.

Liu, William and Robert Duff

1972 The strength of weak ties. Public Opinion Quarterly, Vol. 36: 361-366.

Mechanic, David

1969 Illness and cure. In Poverty and Health--A Sociological Analysis. John Kosa, Aaron Antonovsky, and Irving Kenneth Zola (eds.) Cambridge: Harvard University Press.

Menzel, Herbert

1960 Innovation, integration and marginality. American Sociological Review 25:704-713.

1971 Quasi-mass communication: a neglected area. Public Opinion Quarterly, Vol. 35, 3:406-409.

Merton, Robert K.

1957 Social Theory and Social Structure. New York: Free Press.

Michael, Donald

1973 On Learning to Plan-and Planning to Learn. San Francisco: Jossey-Bass.

Miller, S.M. and Frank Riessman

1968 Social Class and Social Policy. New York: Basic Books.

Myrdal, Gunnar

1972 The World Poverty Problem. Encyclopedia Britianica World Book.

Rivera, Jorge

1973 Encuesta Nacional De Droguistas En Colombia--Análysis Del Papel Del Boticario En La Prestaction De Servicios De Salud. Asociación Colombiana De Facultades De Medicina, Bogota.

Rodman, Hyman

1963 The lower-class values stretch. Social Forces 42:205-215.

Rogers, Everett M. and L. Svenning

1969 Modernization Among Peasants: The Impact of Communication. New York: Holt, Rinehart and Winston.

Rogers, Everett M. and F. Shoemaker

1971 Communication of Innovations. New York: Free Press.

Rosenstock, Irwin M.

1969 Prevention of illness and maintenance of health. In Poverty and Health--A Sociological Analysis, John Kosa, Aaron Antonovsky, and Irving Kenneth Zola (eds.), Cambridge: Harvard University Press.

Ryan, Bryce

1969 Social and Cultural Change. New York: Ronald Press.

Schendel, Gordon

1968 Medicine in Mexico. Austin: University of Texas Press.

Znaniecki, Florian

1945 Social Organization and Institutions. In Twentieth Century Sociology, Georges Gurvitch and Wilbert E. Moore (eds.). New York: Philosophical Library.