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Draft Prospectus

The Effects of the War on Drugs on Healthcare Development and Outcomes in Latin America.

Statement of Problems

How does a moral panic around the consumption of what U.S. culture labeled as “illicit substances” cause a cascade effect that destabilizes countries and cause large-scale suffering? Is there truly a relationship between the two? How do the politics and policies of the largest global economy affect the day-to-day lives of the people living in the countries in its periphery? My thesis seeks to begin to understand these phenomena through the following research question: how has the war on drugs affected the Latin American healthcare development and outcomes? Given the towering complexity of such a question, I will specifically look at the Colombian department of Antioquia, whose capital is Medellín, after the 1991 constitution until the mid 2000s as well as Mexican border towns over the past decade. While these two cases cannot possibly encapsulate the entirety of the research question, they will allow insight into how U.S. drug policy affected healthcare in the past as well as how it continues to affect it in the present.

In a larger sense, this research question is an examination of the ways in which U.S. foreign policy often has unintended effects that extend beyond the target and goals of the original policy that was implemented. It may serve as a discussion around the important considerations that must be taken when constructing specific goals within foreign policy, and how we must think beyond the immediate effects those goals may have. The work required to understand the complex relationships between healthcare development, U.S. drug policy, and all of Latin America is far beyond the scale of a thesis and is more in line with decades of research; therefore, I will only develop this conversation by examining these two cases.

Theoretical Framework

The main theoretical frameworks that I will use are those in sociology and anthropology. Specifically, medical anthropology has major relevance to the study of this research question for its relationship to society and health. The sociological aspects will focus on theories relating to Karl Marx and Herbert Spencer to understand class relations and crime.

 Herbert Spencer was a philosopher from Britain and a social theorist of the 19th century. He pioneered the idea of “survival of the fittest” in a social context and believed that the ideas of evolution could pertain to sociological systems as well. His ideas have had significant contributions to ideas in criminology and social justice which are important to understanding how crime and incarceration play into the War on Drugs and possible effects it can have on healthcare outcomes.

Medical anthropology is a relatively new field that has grown into itself over the past century as it has evolved as a social science right alongside the natural science of medicine itself. The concept of medical anthropology and its attempts at understanding human interaction through a specifically health centered lens led to the development of a few key theoretical frameworks through which the field has operated by in some capacity since their conception.

One of the pioneers of medical anthropology and the father of one of the earliest medical anthropology frameworks (medicine as a social process) was William H. R. Rivers (1864-1922). Rivers was the first to push for the idea of medicine to be viewed as a social process and not just as a sterile science. Rivers put forth one of the early ideas of a diffusion of cultural traits that defined the idea of medicine as being intricately connected with the cultures in which it was practiced. This idea presents a framework within which I can argue that the cultural and societal contexts of Colombia and Mexico did not just affect the healthcare through injury and violence caused in its periphery, but rather directly through cultural diffusions. He believed “the practice of medicine is a social process, subject to the same laws, and to be studied by the same methods as other social processes” (Joralemon 2006).

One of the most influential medical anthropologists was Erwin Ackerknecht (1905-1988) who put forth the functional views of medicine framework. He believed that the relations between different social institutions acted in a similar way as the body does with each part contributing in some way to the continuation and function. While functionalism can allow a more nuanced discussion of the war on drugs as being an organic process rather than a static one, I will be cautious in not allowing it to become biologically deterministic or reductive. He also pointed out that social tension could be seen through how ideas about diseases were discussed and the reactions to them could help describe the culture of that society. He famously said, “what is disease is, in the last instance, not a biological fact but a decision of society,” showing how the rise of medical anthropology reflected the general idea that disease was more complex than previously given credit (Ackerknecht 1963). This idea applies not just to the war on drugs, but how the penal measures were defined along the lines of what chemicals were considered illicit vs. licit.

One of the newest ideas that is beginning to develop in medical anthropology is that of critical medical anthropology which has started to have serious implications in, for example, the US. It analyzes the affect that socioeconomic standing, wealth, power distribution, and labor divisions affects health care access and patterns. These more novel theories are supported by political economic writings and Marxist theory, although this field is gaining importance. A key author of this growing theory is Nancy Scheper-Hughes. In Scheper-Hughes work *Death Without Weeping: The Violence of Everday Life in Brazil,* she examines the effects of healthcare outcomes related to violent crime and how social determinants of health have a larger impact on outcomes than previously given credit (1992). Furthermore, I will be attempting to view Marxist theories of dialectical materialism not in the functions within a nation-state, but rather a transnational exchange with the U.S. acting as a consumer of surplus and the Colombian and Mexican cartels as the producers of sed surplus (in this case, the product being narcotics). Defining class struggle along these lines can hopefully give insight into the ways in which the narco-state was constructed in an international context, not a national vacuum.

Beyond the anthropological side, medical anthropology is closely tied to ethics and is often taught alongside the ideas of medical ethics. Medical anthropology and ethics both seek to answer similar questions, just in different ways. The popular ideas of medical ethics in terms of patient care are to respect the principles of healing (autonomy, beneficence, nonmaleficience, and justice) which were popularized by Beauchamp, Tom and James Childress. However, there has been contention around these principles due to their western centered “Americanized” idealism. These criticisms came from one of the newer influential experts in the field, Renée Fox. Fox criticizes the over connection of these principles to the idea of American individualism and justice that is not flexible enough to account for cultures other than western individual centered ones. It will be crucial to keep these critiques in mind when constructing my framework of analysis of healthcare success or failure as trying to define such an idea within the context of a western ideal of medicine can lead to misapplications when transposing it to another context, thus limiting the viability of my arugments.

 Medical anthropology is a field that is constantly changing as both the social understanding of medicine and medicine itself evolve together. The progression of societal views surrounding medical care, ethics, and practice will only continue, making medical anthropology a necessary companion to ensure that medicine is able to account for its unavoidable social aspect. This is crucial when considering the close ties that social factors have when discussing and examining relationships between healthcare outcomes and the prevalent factors effecting Colombia and Mexico.

 Finally, a discussion around healthcare, global health, and outcomes would not be complete without being able to discuss the reliability and validity of the data that has been and is currently being collected. There are profound limitations in the collective capacity of developing nations in regard to healthcare data, especially when looking at older statistics. To discuss the problems presented by the data and how to still obtain valid results that can support an argument, I will use the framework presented by Vincanne Adams in *Metrics: What Counts in Global Health*. This work will serve to bolster my arguments while, at the same time, still giving the important recognition to the problems presented.

Case Selection

The first will be Colombia. One of the examples in Colombia will focus on the effects on healthcare from Plan Colombia. Besides the financial and foreign aid supplied, the U.S. also pursued aggressive military aid, which involved large-scale aerial spraying operations to destroy large coca farms. By examining healthcare data in departments and towns where the majority of the spraying occurred from databases like the W.H.O. as well as data from the Colombian health ministry, I will look to answer questions like: what were the immediate effects on the surrounding hospitals?; were there outbreaks of chemical poisoning due to water contamination?; how did the local system respond to possible increased healthcare burdens?; And due to the displacement of these farmers across the country, how did cities respond to support the higher burden of healthcare? Furthermore, I will use historical analysis to try to understand the effects of early war on drugs efforts in Colombia before the 1991 constitutional rewrite. It will be difficult to attempt to use any type of statistical analysis from healthcare data before this period due to unreliable and unavailable data; therefore, the historical analysis and explanations will likely fall into my literature review section and background area. I will specifically be looking at the department of Antioquia, whose capital is Medellín. The Medellín cartel is one of the most notorious drug cartels in the world, rivaled in notoriety by only the Sinaloa cartel. It is a crucial zone of analysis for the war on drugs in Colombia and can serve as a proxy for the likely effects that would have been felt throughout the whole country of Colombia.

For the second case, I will use Mexico. Currently, Mexico has become a new nexus for cartel activity and violence is on the rise. I plan to reach out to medical schools on the U.S. Mexico border that do extensive outreach and volunteer work with border communities to attempt to understand the possible healthcare burdens that migrant communities are facing Furthermore, I will utilize the W.H.O and world bank to see how mortality related to non-accidental deaths have changed in Mexico in the past two decades as the main battle ground of war on drug related violence has shifted from Colombia to Mexico. I also plan to bring in a brief discussion on the healthcare implications that the Venezuelan migrant crisis that has relations to the war on drugs and how that is changing the healthcare landscape of Mexico, central America, and the U.S. Mexico border.

Hypothesis

 My hypothesis is that the war on drugs had significant impacts on healthcare development and outcomes in Colombia and Mexico by causing increased mortality from preventable and intentional deaths while also increasing capacity to handle the excess healthcare burden caused by the conflict. This hypothesis will be supported by the data, methods, and background that is discussed and collected. I expect this hypothesis to be true because of preliminary results gathered from healthcare statistics from the W.H.O. as well as the history of infrastructure development in the Antioquia region during the reign of the Medellín cartel.

Data and Methods

To better understand how the war on drugs has affected healthcare developments and outcomes in Colombia and Mexico, I will need to utilize a variety of methods. First, and most obviously, I will need to collect data on healthcare outcomes in both countries. Luckily, the W.H.O. and World Bank have extensive data on mortality rates, disease incidents, birthrates, violent crime deaths, and more; therefore, I can use this data to examine how incidents of violent crime have correlated (or not) with other key indicators of a country’s healthcare development. Indicators such as fetal and maternal mortality, tuberculosis rates, vaccination rates, and malnutrition can serve as adequate indicators of the level of care and effectiveness; therefore, I can utilize t-tests to check for any significance between these indicators and violent deaths. One of the issues with this specific method is that the healthcare data is, at best, semi-unreliable. Due to the nature of reporting and data collection in both Mexico and Colombia in the 20th century, there is a high probability that the data is not completely accurate; however, I believe the data is reliable enough to utilize for my research purposes since the W.H.O. believes it is reliable enough to keep published. There will also be certain years missing, so I will have to utilize projected values that follow a linear trend that I will calculate when needed.

            Second, I will look at how USAID and other health related NGOs funding has changed over time in Colombia and Mexico. These bodies of aid will help to understand how U.S. and international interest in helping support these countries during times of crisis caused by the war on drugs has changed over time. Furthermore, one of the points of my thesis is to discuss how, at least it seems, the nexus of the war on drugs has shifted from Colombia following the partial success of PLAN Colombia into Mexico where we are currently seeing increased violence and narco activity. Additionally, my examining this shift in aid can also help support a claim that is materializing through my research about how there is a growing public health crisis forming at the U.S. border due to the legacy of war on drug related policies.

            I will also be utilizing historiography to discuss the histories that led to the conditions that allowed the war on drugs to concentrate first in Colombia and then Mexico. I plan to analyze governmental documents from the U.S., Colombia, and Mexico (such as PLAN Colombia, Documents on plans for the war on drugs, and other related items), the political and social histories of the countries, and the inciting events that allowed the emergence of narco-states. By utilizing historiography, I will be able to discuss the impacts of the war on drugs pre-1990. Specifically, I am mentioning this timeline because before this period data related to health outcomes, healthcare distribution and accessibility, mortality statistics, and prevalence of narco activity are much more difficult to come by and far less reliable.

            I will also investigate free clinics and hospitals concentrated in Antioquia, Colombia, and the Mexico-U.S. border to see if any of them were founded by or have monetary ties to cartels or guerrilla groups. It is well known that Pablo Escobar helped develop infrastructure in and around Medellín to allow easier transportation of cocaine and illicit goods; however, I want to gain further insight into understanding who may have been involved in the development of particular clinics, hospitals and other medical facilities to see if there were external interests or relations. I will also be looking for organizations that help treat PTSD and mental health related disorders to see if the trauma caused by the violence from the war on drugs had an effect on the growth and development of that aspect of healthcare. Finally, I want to look at when certain healthcare facilities were founded in departments that had the highest level of war on drug related activity compared to those with lower activity to see if there was an increase in founding new healthcare centers in these areas with higher narco activity compared to those with lower activity.

            Finally, I want to analyze spending reports from Colombia, Mexico, and the U.S. to understand how the war on drugs financially impacted these countries. The reasoning behind examining this is because if there was an increase in spending on, say, military and related war expenses and a decrease in healthcare spending, that is a clear effect on development and capacity. The opposite may also be true, it could be possible that the increased levels of violence and death prompts a response to increase healthcare spending to try to deal with the new burdens on the healthcare systems.

Limitations

 The most pressing limitations that I will face is access to reliable data from the specific towns and departments I plan to analyze. While healthcare data on entire countries is readily available through the W.H.O and the World Bank, it does not offer data by town or department/state. This will make it difficult for me to say with 100% confidence that the healthcare statistics I will be using are representative of those locations instead of other areas in the country contributing to the outcomes more than others. Furthermore, while the data does go back into the 50s, it has years that do not have data and the data is reported by the country itself, not collected directly by the W.H.O., so issues with reliability come into play. Furthermore, issues with gathering reliable statistics, especially in rural areas, means that the number reported during these periods are likely much less than the reality. As discussed previously, Adams’s “Metrics: What Counts in Global Health” will be one of key works used to support my discussion of the data reliability. It will help me both explain the limitation, while also being able to still argue that the results produced from the sources, I will utilize will still be usable. Furthermore, the data collection on hospitals in the Antioquia region and clinics in border regions will help to corroborate the data used and display that it is still applicable.

Chapter Outlines

1. Introduction
	1. Introduction of the topic will be accomplished by discussing the problems posed by the war on drugs in an international context. It will also be the section where I give a brief background on the genesis of the war on drugs in the U.S.
2. Literature review and background
	1. This section I will introduce my key theoretical frameworks that will be used to analyze and discuss my research topic. After discussing the frameworks, I will go into depth on the implementation of U.S. foreign drug policy in Colombia and Mexico as well as the implications it has had on healthcare.
3. Methods and data
	1. It will be in this section that I elaborate on my methods and data as well as the results from my analysis. The contextualization of these results will be concentrated in the subsequent two chapters and broadened to my overarching research question in the discussion.
4. Colombia, Medellín, and Antioquia
	1. This chapter will discuss the background for the Colombian war on drugs as well as how the results from my methods and data support or reject my hypothesis in the Colombian case study. It will specifically be discussing the department of Antioquia, with a special attention to Medellín and its surrounding area.
5. Mexico, the border, and the current day
	1. This chapter will discuss the background for the Mexican war on drugs as well as how the results from my methods and data support or reject my hypothesis in the Mexican case study. It will specifically be discussing the U.S.-Mexico border with particular attention to border towns and the healthcare implications within the Mexican population as well as the migrant populations.
6. Discussion
	1. As discussed in the prospectus, these two cases serve to discuss the broader issue with the war on drugs’ effects on the healthcare development and outcomes in all of Latin America. I will use this section to generalize my results to the broader context of that issue while also utilizing the space to discuss contemporary healthcare issues facing Latin America.

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