

CONTINUITY AND CHANGE:  
THE *MEXICANA* EXPERIENCE WITH HEALTH AND HEALING

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## ABSTRACT

This thesis outlines the *Mexicana* experience with health and healing in Iowa and Mexico. As the Mexican population continues to grow in Iowa, disparities in the health field are becoming more problematic. Understanding differences in practices of and beliefs about health and healing through open communication provide the tools necessary to mitigate disparate health conditions. An in-depth look at *curanderos*, *hueseros*, *parteras*, and other healers is used to better understand cultural conceptions of health and healing as it persists in Iowa.

Qualitative methods were employed to gain an understanding of health and healing among participants in this study. Twenty-three interviews with *Mexicanas* living in Iowa were conducted in addition to field notes taken on a traditional healing study tour and other group exchanges to Mexico.

How people come to view health is indicative of their own cultural norms, values, practices, and beliefs. When trying to adapt to a culture different than one's own, there are often misunderstandings on both the dominant and the subordinate sides. The goal of this thesis was to provide data needed to communicate these differences in perspective on health and healing between Mexicans and Iowans so that together they can develop strategies that will improve conditions in the health field.

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## CHAPTER I

### Introduction

Experiencing radical population shifts over the last decade and a half, Iowa is now developing the necessary framework to best adapt to its new and growing populations. Since 1990, Iowa's Hispanic population has grown 220% (US Census, 2004). A majority of this growth is due to an influx of *Mexicanos*, currently the largest immigrant segment of Iowa's economy. Health practitioners throughout the United States, and in Iowa have recognized increasing health disparities among these new Iowans. Health disparities are defined by the National Institute of Health (NIH, 2005) as "differences in the incidence, prevalence, mortality, burden of disease, and other adverse health conditions that occur among specific population groups." Understanding the Mexican experience with health and healing will help to address the necessary means to mitigate disparities in the health field.

It has been verified by a number of accounts that "Hispanics bear a disproportionate burden of disease, injury, death, and disability when compared with non-Hispanic whites, the largest racial/ethnic population in the United States" (NIH, 2005; Global Health Corp [GHC], 2005; US Center for Disease Control and Prevention [CDC], 2004). The CDC (2004) claims that factors contributing to disparate conditions include, but are not limited to, socioeconomic status, lifestyle behaviors, social environment, and lack of access to preventative health care. In contrast, Borrayo (2003) believes that Mexicans are not utilizing health care in the United States because they have certain beliefs and practices that differ from most Americans. Furthermore a study conducted in

Iowa and Nebraska by the Iowa/Nebraska Primary Care Association (IA/NEPCA 2003: 4-6) has indicated that trust, accessibility, language barriers, cultural incompetence, and a lack of utilization of the health services available to individuals contribute to these conditions.

In addition to exploring multiple identified factors contributing to health disparities, this thesis will attempt to define the *Mexicana* experience with health and healing in Iowa. According to the World Health Organization (2001), 80 percent of the world's total population uses traditional health practices as a source of health care. As the United States continues to face demographic changes due to the steady influx of immigrants, it is possible that the lack of understanding these different concepts of health and healing are contributing to health disparities. Disparities are defined by the National Institute of Health (2005) as “differences in the incidence, prevalence, mortality, burden of disease, and other adverse health conditions that occur among specific population groups.”

According to Janzen (2002: 134), “the crisis of illness is socially defined and structured.” This shows the importance of understanding health practices and beliefs of this population to promote health that is culturally inclusive and accessible to all populations residing in Iowa. Prior research, literature, and personal experience will be used to illustrate why *Mexicanos* have had difficulty adjusting to health care in the United States. Therefore an in-depth look at traditional practices and beliefs of health and healing among *Mexicanas* as well as the perceived effectiveness of modes of healing specific to Mexico will be given. The proceeding reading will address what can be taken

from understanding the *Mexicano* experience with health and healing to mitigate disparities in the health field.

### Theoretical Background

In pursuit of promoting culturally inclusive and accessible health care, this project explores Jurgen Habermas's communicative action theory in addition to his system and social integration theories. Jurgen Habermas is a critical theorist. He analyzes our social world by looking at what it is and compares that with what it could be. In turn, this provides individuals with a theoretical perspective aimed at change. As change in the United States has a tendency to be incremental at best, this perspective provides us with a good starting point to address the changes needed to understand cultural differences in the health field.

According to Habermas (1990: 133), communication plays a key role in action oriented at reaching understanding. As the goal of this paper is to collectively understand existing barriers faced by *Mexicanos* to utilize health care in Iowa, the communication of the health beliefs and practices unique to Mexican culture is essential. In this particular study, I gained this understanding through interviews with *Mexicanas* residing in Iowa in addition to notes taken in the field in Mexico. The intent is that this data can be used as a tool to educate individuals on health care utilization with the effect of decreased disparate conditions.

Communicative action precedes social and system integration, the next step needed to adapt our lifeworlds to changing conditions (Habermas, 1990). The lifeworld according to Habermas is:

The transcendental site where speaker and hearer meet, where they reciprocally raise claims that their utterances fit the world and where they can criticize and confirm those validity claims, settle their disagreements, and arrive at agreements (Ritzer, 2004: 530).

Habermas (1990) implies that communication not only can but should be used as a tool in developing understanding and reaching agreements on unresolved issues. Applied to the existing conditions in the health field, this approach guides us through the steps necessary to understand why disparate conditions exist and how to remediate disparate conditions.

Habermas bases much of his theory on the rationalization of the lifeworld. The lifeworld is broken down into “culture, society, and personality” (Ritzer, 2004: 530). The process of rationalizing one’s lifeworld incorporates these three “worlds” which in turn become a product of the collaboration of those worlds. As culture and society continue to change we must also change. This requires us to reformulate prior assumptions regarding our lifeworld and its operability. In this state we also need to be open to understanding new ways in which others existing in our lifeworld come to view their lifeworld. One of the ways in which this is achieved is through the rationalization of communicative action. This process involves “a wide range of unspoken presuppositions about mutual understanding that must exist and must be mutually understood for communication to take place” (Ritzer, 2004: 530). We must leave our presuppositions behind in order to establish any sort of agreement or understanding as to why, in this case, disparate health care conditions persist.

Habermas further regards communicative action as:

Not only a process of reaching understanding...actors are at the same time taking part in interactions through which they develop, confirm, and renew their memberships in social groups and their own identities. Communicative actions

are not only the processes of interpretation in which cultural knowledge is “tested against the world;” they are at the same time processes of social integration and of socialization (Habermas, 1988: 139 and Wallace, 1999: 175).

While remaining aware of the processes of communicative action, we must also develop the ability to decipher the differences between normatively achieved and communicatively achieved consensus. Normatively achieved consensus is the understanding gained through experience and exposure to different elements of one’s lifeworld (Ritzer, 2004). Communicatively achieved consensus is the understanding that evolves out of free and open communication with the part of our lifeworld we are trying to understand (Ritzer, 2004). The importance of communicatively achieved consensus is stressed due to the insufficient understanding gained from normatively achieved consensus. Our focus of achievement should be aimed at reaching a communicatively achieved consensus.

Current studies demonstrate the lack of communicatively achieved consensus in the health field. Many of the overlying issues in preventing individuals from seeking care lie in trust, accessibility, language barriers, cultural incompetence, and a lack of utilization in the health services available to individuals (IA/NEPCA, 2003: 4-6). These factors represent a portion of the barriers faced by immigrant populations but do not look at the internal forces that may contribute to this problem. If we are able to understand these factors, we will reach a more developed understanding of *Mexicano*’s perspectives, preferences, practices, and beliefs on health and healing.

Assuming we are able to reach a communicative consensus on barriers creating disparities, we will be able to perform the next step, system integration. To reach a state

in which we are able to integrate the immigrant populations in the health field as practiced in Iowa, we will need to educate individuals on how this “system” operates.

*System integration* is focally concerned with the system and the way in which it is integrated through external control over individual decisions that are not subjectively coordinated. Those who adopt this perspective see society as a self-regulating system...but this prohibits them from really getting at the structural patterns that can be understood only hermeneutically from the internal perspective of members of the lifeworld (Ritzer, 2004: 531).

Recognizing that there is a hermeneutic understanding of most systems is extremely important in addressing this problem. Hermeneutic is described as an understanding, in this case of a health system that only those who partake in creating it understand its working. Furthermore, Borrayo (2003) believes that Mexicans are not utilizing health care in the United States because they have certain beliefs and practices that differ from most Americans. A combination of theory and research is proposed to study these practices together. Undisclosed hermeneutic knowledge and culturally sanctioned practices and beliefs contribute to one’s overall ability or inability to access health care in the United States. Providing newcomers with introductory information on how to access health care could help resolve the former dilemma, and communication and education on cultural health practices and beliefs could contribute to resolution of the latter dilemma.

Developing the ability to exercise communicative action in the health setting is theoretically a good step to take in the pursuit of understanding and later integrating Iowa’s new populations. As it will take some time to achieve this, it is now necessary to pass on hermeneutic knowledge regarding the types of health care available in Iowa and how people can access them. At this point, more research needs to be done on this topic before we are able to fully immerse ourselves in this process. If enough action-oriented

research is done in this area, and change through the implementation of education (hermeneutic and cultural) is legitimized, change will inevitably begin to take form.

### Literature Review

The literature available on health disparities regarding the Mexican population is vast. It covers topics from specific health problems to traditional beliefs and practices. This indicates that this is a serious, growing concern for individuals and organizations throughout the country. Although I cannot cover all aspects that literature provides relevant to this topic, I will explore why health disparities persist among *Mexicanos* in the United States, traditional health practices and beliefs unique to Mexico, the use of traditional healers in Mexico, the effectiveness of traditional healing in Mexico, and implications for the integration of traditional and formal health care. I hope that the literature reviewed in the following section will prove to be useful in assessing alternative modes of health care and in identifying the disparities the Hispanic population experiences in the United States.

### Why Health Disparities Persist

The way in which one views health is derivative of the beliefs and practices unique to his or her culture of origin. An individual who comes to the United States from another country may have difficulty understanding and/or adapting to health care as it is practiced in the United States. Many of the individuals who migrate to the United States come from countries with very different views and understandings of health and health practices.

One reason health disparities exist for *Mexicanas* in the United States is that they have their own deeply rooted cultural practices and beliefs which impacts their understanding of how health care is used in Iowa. Many socio-cultural anthropologists believe that these ideas and beliefs lie in the “cultural consciousness about them, and the ways society organizes that knowledge and related behavior” (Janzen, 2002: 26), making this task of conjoining groups with different understandings about the ways of the world all the more difficult.

“When two populations with different cultures are united, the subordinate culture is generally integrated into the patterns of behavior and cultural norms of the dominant group” (Nigenda, 2004: 416). This is part of the process of acculturation. Acculturation is a process that takes time and ideal circumstances to achieve. Individuals have to be willing and able to let go of certain beliefs, attitudes, and values when trying to become a part of a new culture (Borrayo, 2003), something both the newcomers and the dominant group need to strive to achieve throughout the integration process. Concurrently they need to be provided with economic tools and resources to achieve acculturation. This is an area that Mexican subgroups in the United States have struggled with since their arrival in the 1800’s.

According to Williams (1977) *Mexicanos* have been oppressed in the United States since they began migration in the 1800’s, and are still today treated as “economic assets”. This infers so long as the economy is in need of immigrant workers the United States will continue to enable legal and illegal migration. However, as they can be easily replaced they are not treated justly. This is and has been evident through their treatment

in the workplace, unavailability of resources and rights, and difficulties faced in the educational setting (Grey, 1997). These conditions do vary according to socio-economic and legal status. If an individual happens to be undocumented, he or she enters a state of perpetual status immobility, further exemplifying areas of injustices through unequal treatment, inaccessibility, and a lack of security (Grey, 2002, 1999, 1997; Grey and Woodrick 2005). This is becoming more problematic as there is a need for employees in fields such as meatpacking and agriculture that are refused by many Americans and filled largely by Hispanics.

Kleinman and Desjarlais further note,

social suffering...brings into a single space an assemblage of human problems that have their origins and consequences in the devastating injustices that social force inflicts on human experience. Social suffering results from what political, economic, and institutional power does to people, and, reciprocally, from how these forms of power themselves influence responses to social problems...similarly, to say that poverty is the major risk factor for ill health and death is only another way of saying that health is a social indicator and indeed a social process (Janzen, 2002: 105-106).

This infers that how one is situated economically and how a society integrates new populations are determinants of the social and economic progress or stagnation experienced among populations which in turn affect their over all mental and physical health.

Studies further indicate the difficulties that will be faced if health disparities are not mitigated. The US Center for Disease Control and Prevention (CDC, 2004) states, "if Hispanics experience poorer health status, this expected demographic change will magnify the adverse economic, social, and health impact of such disparities in the US."

This, in turn, will negatively affect our capitalist system as a whole, providing further reason to work with the Hispanic population in hopes of gaining preventative knowledge.

In pursuit of bringing about change it is important to recognize that many individuals of Mexican descent naturally cling to their traditional practices and beliefs as a means to reduce the sense of inferiority they may feel due to the aforementioned conditions (Williams, 1977). Additionally, as they continually face barriers in becoming a part of a larger system, the degree to which they pursue integration significantly decreases. The relationships that are established between *Mexicanos* and the larger society remain at arms length.

In 2001, Hispanics under the age of 75 experienced 18 percent more strokes than non-Hispanic whites (CDC, 2003), 62 percent more cases of chronic liver disease and cirrhosis, 41 percent more cases of diabetes, 168 percent more cases of HIV, and 128 percent higher homicide rates. In 2000 (CDC, 2003), when compared to non-Hispanic whites, male Hispanics were 11 percent more likely to be overweight and female Hispanics were 26 percent more likely to be overweight. According to the Merriam-Webster dictionary (2006) overweight is defined as exceeding expected, normal, or proper weight; especially exceeding the bodily weight normal for one's age, height, and build. Obese is defined as excessively fat in which male Hispanics were 7 percent more likely to be obese and female Hispanics were 32 percent more likely to be obese than non-Hispanic whites. If we choose not to enact change to address such disparities, we will fail to provide Iowans with the economic security and health care that should be at the very minimum, accessible.

It is no small task bringing two cultures together. If education and awareness of cultural differences regarding health practices and beliefs are not spread, the core of Iowa's economic system may suffer. Yehieli and Grey (2005) explain the importance of increasing cultural competence as a tool in decreasing health disparities. They further explain,

Providing culturally competent care means that one is sensitive to cultural differences between various patients; understands the influence of these differences on health status and can modify programs to meet the specific needs of diverse clients (2005).

This may enable the bridging of the two cultures as well as addressing the specific needs of *Mexicanos*.

#### Traditional Practices and Beliefs Unique to Mexico

According to the Division of Health Systems and Services Development technical project report in Latin America and the Caribbean (2001), traditional health practices in Mexico are widespread today. Understanding what these practices are and how and when they are used will aid in achieving an understanding of the problems *Mexicanos* are facing in Iowa. It will also contribute to our understanding of how to help the acculturation process become less arduous and more effective for all parties involved. Janzen (2002: 81) states, "health concepts are historically particular, embedded in environments, and social and ideological contexts. This is true not only of classical traditions, but of biomedicine, a tradition of medicine that uses science to legitimize its findings, its measures, and its definitions of disease and cure."

Mexico's principal therapeutic specialties consist of traditional midwives (*parteras*), herbalists (*herbalistas*), bone-setters (*hueseros*), and spiritual healers (*curanderos/prayers*) (World Health Organization, 1995). Other types of healers found in Mexico are: snake healers (*culebreros*), shamans, and massagers/kneaders (*sobadores*) (DHDDS, 2001). Each type of healer performs tasks specific to his or her area of expertise. *Parteras* assist women throughout their pregnancy and deliver babies, *herbalistas* use combinations of herbs to treat ailments and illnesses, *hueseros* reset bones, and *curanderos* assist individuals with mental and emotional insight and how to attempt to restore balance in their lives (WHO, 1995). Together these four types of healers assist many individuals throughout Mexico. They are the peacemakers and maintainers of many aspects of this society.

In addition to living with a great deal of respect from the members of their communities, traditional healers in Mexico also deal with their fair share of individuals whom are skeptical of their practices. Because Mexico does not regulate traditional medicine and healers lack licenses, their practices can be de-legitimized (DHSSD, 2001). Numerous physicians look at traditional medicine with "condescending indifference if not outright contempt" (Lipp, 1996: 112) resulting in problems with respect by the modern population to their indigenous culture. *Curanderos* sometimes lack the freedom to practice, and all healers are presented with difficulties legally and financially, at times making it difficult to maintain a viable business.

One reason these issues prevail is because of how healing practices are learned. Most healers in Mexico gain their knowledge through the personal transmission of

knowledge outside of the biomedical realm. Knowledge is passed on in an informal setting between mentor and follower and through experience, in turn helping individuals develop their status in the healing world (Hsu, 1999). Due to the differences in learning and the amount of time it takes for individuals to begin practicing, many individuals in the biomedical world have difficulty understanding the legitimacy of these practices.

There are a number of issues that resonate between healers and biomedical professionals in Mexico (WHO, 1995). There are few existing relationships of support or mutual respect between *curanderismo* and biomedicine. One of the few institutions in Mexico that has a program for traditional healing is the National Indian Institute (DHSSD, 1999). This institute provides training in both types of healing and stresses the importance of holistic health. Other places to study traditional medicine are in healer's homes, in mixed clinics, in caves, in hills, and in homes of the sick. Practices and the beliefs used for healing are largely passed down by word of mouth. Additional transmissions of knowledge regarding traditional practices, however, occur through practice, observation, workshops, and dreams (DHSSD, 1999: 2-22). As it remains difficult for some doctors to believe that healers are a legitimate source of care, this adds further tension between the traditional and formal modes of health in Mexico.

Further consideration of the legitimacy of healing involves how healers diagnose illnesses and disease. This is generally done through spirit communication. Healers use dreams, listen to one's pulse, toss corn, take hallucinogenic substances such as mushrooms or peyote, and read eggs as a way to decipher what illness or disease a patient has contracted (DHSSD, 1999). As much of the healing is considered primary care

(WHO, 1995) and deals largely with spiritually and culturally understood ailments, these methods are quite appropriate and hold significant status in treating ethnospecific ailments.

Another difference between these practices and biomedicine involve the resources utilized. A healer uses resources such as: incense, colored candles, ritual alcohol and ritual drugs such as mushrooms, and peyote. Tobacco, colored and white flowers are also used in addition to Catholic figures or images, mystic or religious figures or images, special herbs, cloths, animals (live, dried, or in alcohol) such as hens, chickens, cats, pigs, turtles, snails, or snakes, various beverages, and stuffed squash which “call the spirit” (DHSSD, 1999). The connection between traditional medicine and religion also vary by location and ethnicity.

Lipp (1996: 14) contests that “the prevailing scientific view is that all disease is caused on a molecular level.” He further argues that medicinal plants, unlike chemical drugs “work on a higher physiological level,” making them more versatile as they can be combined in numerous ways and taken in numerous forms. Plants are used to eliminate symptoms and pains ranging from earaches and toothaches to those expressed in cancer or AIDS. Herbalists generally consider the healing process to rely upon the psychological will and well being of individuals emphasizing the body and self-healing. This is increasingly accepted by biomedicine. The effectiveness of the cures relies largely on individual confidence in the medicines and healers. This can also be said with cases of patients in hospitals given chemical drugs (Lipp, 1996). Werner (2003) further

stresses the power of belief in its ability to make people well or sick, especially those sicknesses caused by the mind.

The process of using plants to call the spirits and bring about visions in addition to the beliefs going into this form of diagnosis and treatment, become more complex. Plants that “evoke a profoundly religious experience when ingested have been termed entheogens: that which gives rise to the God within us” (Lipp, 1996: 120). A few of these plants popular among healers and used ceremonially are peyote, ayahuasca, and mushrooms. According to the Huichol, a native group in Mexico, peyote helps to assimilate the heart and soul and enables individuals to receive wisdom (Lipp, 1996). Peyote, ayahuasca, and mushrooms have been used in numerous indigenous ceremonies around the world. Sacred mushrooms are “primarily taken by the Mesoamerican peoples in cases of intractable illness, but also to learn the whereabouts of any lost or stolen articles, or to resolve problems and conflicts” (Lipp, 1996: 126). Ayahuasca is said to take individuals seeking spiritual healing on a journey revealing aspects of evolution and their true selves (Harner, 1980). Ayahuasca comes from the jungle vine *banisteriopsis caapi*, (Grof, 1988). The usage, preparation time, and rituals that go hand in hand with either of these plants, can be simple or complex, taking hours or days. Additionally, the uses of these plants vary by region and ethnicity, and in the case that they are taken for the purpose of healing are largely connected to spirituality. The results of the “trips” or journeys undergone while using the plants can be so profound they are life changing or in contrast, have no long-term affects. Shamans are also known as spiritual healers in Mexico and often use peyote or ayahuasca to help evoke visions among their seekers.

Kearney (1979: 23) furthers our understanding of the types of beliefs held by spiritual healers noting “spiritual healers invariably pronounce that the cause of the ailment is due to the intrusion into the invalid of some alien spirit or force,” therefore individuals often go to spiritual healers to seek “alleviation of ethnospecific syndromes.” This understanding by healer and patient enables the healer to identify the “malignant influence” in turn reducing “ambiguity and anxiety” within the patient.

The belief in the healer plays an instrumental role in the patients’ ability to be healed. The does often transcend beyond the healer into patient’s faith in God, as God is responsible for the healer’s ability to heal (Kearney, 1979). The healer, God, and the patient often work together to heal individuals. In Hsu’s (1999: 61) ethnography on Chinese medicine, she explained that, “as a healer he knew that he was successful only if his client felt cured.” It is believed that the spiritualist enters into a medium, or a meeting place in which they have established a working relationship with the spirit. The medium is in a possession trance while the spirit is operating. Aside from mouthing verbal instruction given to them by the spirit the spiritualist does not act (Kearney, 1979).

Kiev (1968) details the adamant usage of healers. He claims those living in Mexico who choose healers over other sources of health care do so because of their strong convictions. Kiev (1968) explains the deep religious connections rooted in *curanderismo*. Individuals were taught that God was punishing them when their health was not good. People were told tales of the *brujas* (evil spirits), the devil, and ghosts at very early in life as they began to develop their core belief systems. This was used as a form of social control. People lived in fear that if they misbehaved or did something

outside of cultural norms they would be punished with poor health (Kiev, 1968). Thus, these beliefs keep the believers behavior in line with that of the larger society, which they believed prevented them from being sick with illness and disease.

The information covered in this section contributes to our understanding of healers in Mexico, their practices and beliefs, and successes and struggles. Examining beliefs and practices of *Mexicanos* assist in developing insight as to how *Mexicanos* are situated today. Traditional health practices and beliefs in Mexico are deeply rooted in their culture. The connections made among health, religion, and spirituality are important to consider when evaluating which course of action to take and which type of healer to seek. A study conducted by the Iowa/Nebraska Primary Health Care Survey (2003) identified that one of the more significant factors contributing to immigrant populations distrusting/disliking their doctors was that the doctors did not understand their cultural practices and beliefs, a consideration to hold when conducting research on this topic.

### The Use of Traditional Healers in Mexico

Healers in Mexico are used for ethnospecific illnesses and ailments. These include: “*susto* (fright), *empacho* (constipation and stomach pains), *aire* (coldness), *caida de mollera* (fallen fontanel; soft spots on a babies head), *espinilla* (childhood illness of clammy skin), *mal de ojo* (evil eye), *mal puesto* (hex; a curse), and *latido* (stomach cramps)” (Bade, 2004: 229). Many of these illnesses are easily treated with herbal remedies and other spiritual practices used to bring balance back into individuals lives.

Many of these illnesses also evolve from traditional beliefs that have been passed down for centuries.

*Susto* is a condition recognized by many regions of the Spanish-speaking world (Rubel, 1977). It consists of complex beliefs about the spirits and the soul. “In Hispanic America, as elsewhere, these souls may leave the body during sleep, particularly when the individual is dreaming” (Rubel, 1977: 121) and is therefore associated with soul loss. *Susto* can be result of a number of things in individual lives, but situations evoking *susto* vary by ethnicity (indigenous and non-indigenous) and the specific beliefs known by that particular sub-group. This particular illness is generally evoked in

[social situations which victims perceive as stressful...intra-cultural and intra-societal in nature...and are product of the interaction between three open systems, each linked with others. The three systems in question are an individual’s state of health, his personality system, and the social system of which he is a member (Rubel, 1977: 126-127)].

Often western physicians are not equipped to help individuals with these complaints, so these patients seek out healers and shamans who have “healing rites” for these culturally specific health conditions.

Traditional healers are more closely associated with women than men as their health needs extend into child bearing. Traditional birth attendants (TBAs) are an essential aspect of Mexican society and culture (Camey, 1996). A study conducted by the National Survey of Fertility and Health in Mexico (1996) found that TBAs were involved in 45 percent of the live births in communities with fewer than 2500 inhabitants and 24 percent in larger communities.

Economic accessibility plays a significant role in the usage of TBAs. One third of the women with “high” socio-economic status visit TBAs, while nearly two-thirds of middle and low socio-economic status seek care from TBAs (Camey, 1996). Sixty percent of all women visit a TBA at least once during the prenatal stage of pregnancy, and of them, 48 percent also visit their physician. Of this same group, 12 percent chose visit the TBA exclusively. Women with high socio-economic status have a 32 percent higher probability than those of lower status of visiting a physician. Of the individuals who go to TBAs, 73.7 percent do so on at least three occasions during their pregnancy. Women of all socio-economic status levels seek the services of TBAs because “they share a common culture, an empathetic code on the human reproduction experience and because of the perception and the ‘collective *imaginario*’ the population has about the role of the TBA and that of the physician” (Camey, 1996: 205).

Those who do seek care from both the physician and the TBA do so for logical reasons. Visiting both enables the woman to “integrate both practices: the more conceptually expanded and inclusive one of the TBA, and the more technically oriented one of the physician on whom reliance is probably tied to the ability to deal with obstetric complications or symptoms” (Camey, 1996: 205). Many women are also fearful of the birthing process because of many cultural taboos and myths. TBAs in turn offer them calming advice and discourage them from going to the “hospital if necessary” (Camey, pp. 206). Two-thirds of the TBA assisted deliveries are done in TBA’s homes and the other third are done in the birthing women’s homes.

*Mexicanas* receive the least preventative health care of women of any other ethnicity residing in the United States (CDC, 2004). Attention to their culturally-based roles and expectations in individual lives thus becomes necessary (Borrayo, 2003: 198). According to Gonzalez-Romos (2004: 13), “much more research will need to be done to find best practices in the field of cultural competence and best practices for the education of healthcare professionals.”

### The Effectiveness of Traditional Healing as a Source of Primary Health Care

Testing the efficacy of practices exerted by traditional healers can be quite difficult as this requires guidelines specific to these forms of practices in order to accurately measure their effectiveness. Attempts have been made to test or weigh the effectiveness of such practices around the world. The World Health Organization (WHO, 2000) was able to develop specific guidelines specific to known forms of healing that they later applied to the research and evaluation of traditional medicine.

Traditional medicine is defined by the WHO as:

The sum total of the knowledge, skills and practices based on the theories, beliefs and experiences indigenous to different cultures, whether explicable or not, used in the maintenance of health, as well as in the prevention, diagnosis, improvement or treatment of physical and mental illnesses. The terms complementary/alternative/non-conventional medicine are used interchangeably with traditional medicine in some countries (WHO, 2000: 01).

In Mexico, there are two distinctly different types of traditional healing. These consist of those who use herbal medicine and those who use traditional procedure-based therapies (WHO, 2000).

Both types of healing have their positive and negative affects on individuals and the community. Data collected by the WHO (1995: 81) indicated that “Traditional practitioners play an important role in promoting primary health care services in communities, identifying critical cases early, and referring them to clinics and hospitals.” They additionally serve a key role in the overall maintenance and well being of individuals and the community.

### Implications for Future Integration

As disparate health conditions continue to take form in the United States, integration of traditional and formal practices has its implication for progress in this area.

German Estrada Navarro (2003: ch.8 sec.35) claims:

The traditional medical practitioner still constitutes a formidable resource as carrier of traditional knowledge, and is often the only person to whom patients can direct themselves for the cure of these diseases. The incorporation of the traditional medical practitioner in health programs and campaigns is an important fact in reducing mortality among women and children in indigenous areas, and should be recognized as an important part of indigenous peoples’ social capital. The current poor quality of health services and limited number of trained health personnel, combined with their patronizing attitudes towards traditional medical knowledge and practices, inhibit the diffusion of western empirical scientific knowledge and better medical practices.

At this point we know that traditional health practices exist around the world and serve an essential role to health in a number of societies. Literature also shows that traditional health practices are still widespread today.

Although disparate conditions create angst between formal practitioners and traditional healers, many healers and practitioners recognize the need for the integration of these practices. They just need time to work out the most efficient and effective way

to achieve integration. At this point, many healers refer their patients to the hospital when they feel that they can no longer be of assistance to the individuals. Some doctors acknowledge and respect them for this and their ability to maintain peace in many communities through spiritual healing. A formal staff member who attended a training session in Cuetzalan put on by a hospital to train traditional healers in certain aspects related to their fields in health competency said, “traditional practitioners make a spiritual cleansing to make safe the individual, family, and the community” (WHO, 1995: 74). Other staff members agreed that it would be wise of Mexico to integrate traditional health practitioners into its health system.

It is necessary for integration to extend beyond that of traditional and formal health care into institution and community interaction. An initiative by CEAMISH (Centro de Educacion Ambiental E Investigacion Sierra de Huautla) University in Cuernavaca, Morelos demonstrates further possibilities of integration through shared knowledge in the health field. In some parts of rural Mexico, access to medical doctors and/or traditional healers is impossible because of transportation issues. CEAMISH (2005) researchers therefore looked at alternative ways to feasibly reduce disparate conditions among the rural populations residing in Morelos. They developed a program that is still in motion with the goal of making the people in the community self-sufficient but able to rely on the institution for support. Initially workshops were given in 16 rural communities to teach people about the use and preparation of medicinal plants. The idea is that each family will end up with a “plant pharmacy” in their homes readily accessible to treat primary illnesses. Currently CEAMISH investigators are working with 135

participants in seven different communities in the state of Morelos, Mexico. They remain in contact with selected individuals from each community once a week and are hoping that in time the people will use, continue to use, and pass down the information that they have learned so the next generation will be able to rely on the plants also.

Alternative health models combine a number of diagnostic and therapeutic practices that originate in different parts of the globe. However, the use of these practices is “recognized as a part of the process of a search for legitimacy and is often a symbol of resistance to acculturation the struggle to resist globalization”. (Nigenda, 2004: 417). As we continue to educate ourselves on this issue we are able to see that previously held assumptions and beliefs about other’s practices and beliefs are not always accurate. At this point work needs to be done to resolve issues that may exist between formal and traditional health practitioners so that the health of all can be ensured.

It is apparent that “traditional medicine forms an integral part of the health care delivery system” (WHO, 2001). The movement for the integration of these forms of health care has already begun. According to the WHO (2001: 60), “the authorities in Mexico are working on creating a license for this.” Additionally,

There are already, a series of projects designed to create regionally based health centers as well as hospitals where both modern as well as traditional medicine would be practiced. This organizational movement among traditional practitioners – started publicly in Chiapas over a decade ago. It has culminated with the creation of over 57 organizations, representing over 30 different indigenous groups and 18 states of the republic, which delivered in 1992, the first National Plan for Indigenous Traditional Medicine. (Navarro, 2003: ch.8 sec. 37).

The future of health around the world is looking promising: if individuals and organizations continue to research and work towards change that can improve upon disparate conditions, things can only improve.

Hospitals that designate areas for traditional healers have to be aware of the setting in which they practice. Gonzales-Romos (2004: 10) wrote, “we need to consider not only the quality of our services, but also where we physically situate services, thus helping to make them more physically accessible...seeking care in more naturalistic settings, such as through primary care centers, makes sense for many Hispanics, given the close association between the body and the mind in the culture” (Gonzales-Romos, 2004: 10).

The importance of learning the specific health needs and perspectives of the Hispanic population in Iowa is a necessary first step towards integration. This can be done through direct communication with the Hispanic population residing in Iowa. In areas around the world in which integration of traditional and formal health has taken form, conditions continually improve for the physicians, traditional healers, and patients. This has been accomplished through the open communication of hospital staff and traditional healers and through additional training in the areas of their specialty.

### Methods

I used a qualitative research approach in this study. I chose this method because it gets at the meaning and understanding of the population studied. This proved essential for the success of this study in identifying underlying issues, attitudes, and beliefs of the participants. Communicatively achieved consensus regarding the complexities of health

is one of my main objectives with the completion of this study I believe we are one step closer to achieving this. Qualitative research and analysis is interpretive in nature. It is not created to make vague generalizations about populations, rather, to look at the true meaning as it stands among the people being studied, individually, as no two people's experiences are the same. It is used to give a voice to the group being studied enabling us to understand their perspective of the social worlds which they live (Long, 2000).

As I strive to incorporate interpretative sociology into this study, I use grounded theory. Grounded theory as defined by Corbin and Strauss (1992: 273) is a general methodology that is used to develop theory grounded in data systematically gathered and analyzed. Theory evolves during actual research and it does this through "the continuous interplay between analyses and data collection" (Berg, 2004). Furthermore, a "qualitative approach is generally more used in theory generation, while a quantitative approach should be reserved for use in theory testing" (Long, 2000: 7). This makes the qualitative approach even more applicable to this study as theory generated throughout this study to induce change will later be used to mitigate current disparities among *Mexicanos* in Iowa.

### Participants

My intent was to gain a deeper understanding of *Mexicana* perspectives on health and healing in Iowa. I anticipated that understanding one another's lifeworlds would lead to possible solutions to the current problem of disparate conditions for *Mexicanas* in the health field. The participants in this study consist of *Mexicanas* residing in the state of Iowa, in addition to doctors, healers, and lay people residing in Mexico throughout different regions of the country.

I used the snowballing sampling method (Berg, 2004) to develop my sampling frame, which consists of those who were willing to participate in the study voluntarily. The initial contacts used to locate participants were developed using the convenience method. I work for an organization that has previously established contacts with a number of *Mexicanas* living in Iowa. The organization agreed to share contact information with me that led me to other social service agencies in the community as sources of participants. After the initial contacts were established, I relied on the women I interviewed to lead me to other potential participants. My goal was to attain 20 semi-structured interviews with women in this sub-group, and I attained 23. As my Spanish is not fluent, I relied on paid interpreters. Of the 23 interviews, 7 were conducted in English and the rest were conducted in Spanish with the aid of interpreters.

The data collected in Mexico was a culmination of information gathered over multiple visits to Mexico. There were no specific criteria for these particular participants as the data collected in this setting is used as preliminary data. The preliminary data is an assemblage of field notes. In taking field notes, I recorded information I found to be pertinent to health and healing, while in the field. The notes are additionally dated and have specific descriptions of the location and setting in which they were recorded. The names of the individuals spoken to and the specific locations that were documented in the notes were not used, as there was no exchange of consent in the field. I use pseudo names to protect participants' confidentiality.

I looked at personal beliefs and ideas the participants had on “alternative and formal” health practices to better understand their perceptions of health in the United

States in general and Iowa in particular. This study represents a micro unit of analysis. Inductive reasoning was utilized to get at meaning attributed to both forms of health practices. The two interpreters and I administered semi-structured interviews.

After identifying the overarching themes in this study, I created an index scale to measure these themes (Berg, 2004). This scale enabled me to indicate the degree to which revealed concepts existed and had meaning to the participants in the study. This, in turn, added to my ability to better understand *Mexicanas'* standpoints and perspectives on health and healing.

### Data Collection

I used two forms of data collection throughout this study, preliminary/background data and interviews. The preliminary and background data enabled me to form a deeper understanding of conditions in Mexico that were essential in developing an understanding of *Mexicanas'* perceptions on health and healing in Iowa

Preliminary Data. The field notes used for this study consisted of data collected in Mexico. I chose to use this information for the purpose of comparative analysis and to better understand the degree to which traditional values and beliefs are preserved over time throughout the process of migration. My field notes consist of those notes taken on prior study tours to Mexico. These notes make up the ethnographic portion of my study. Taking and analyzing these field notes proved essential to the studies overall understanding and comprehension of health and healing according to *Mexicanos*.

Interviewing. The data gathering technique I used in this qualitative research project was semistandardized interviews. A semistandardized interview as defined by

Berg (2004: 81) “involves the implementation of a number of predetermined questions and special topics.” I felt that this was the best method to use in conducting the interviews because it allowed for the implementation of new questions and removal of others. I feel having the ability to “go with flow” is essential to the progression of the interviews. Additionally, I prefer to do overt research because it is more interactive in its approach than other methods and it is easier to get at underlying meaning if you have participants whom are willingly sharing information.

In preparation for my interviews I conducted a pilot interview. After the pilot interview I was able to reformulate my questions and make them more suitable to get at the subject matter I was striving to obtain. I followed the steps asserted by Lofland and Lofland (1995: 84-85) in introducing the study to the participants. I assured them of confidentiality and anonymity, and that they need not answer any questions they feel uncomfortable with. A few of the women opted to not answer some of the questions when talking about *curanderismo*. I also told the participants to feel free to interrupt at any time.

While delivering the interviews I took the stance of interviewing as a choreographer. This approach enabled me to be involved in the dialogue while at the same time directing where it went. I maintained a “self-aware and reflective manner.” (Berg, 2004: 103) I chose this approach because it is important to be self-conscious of ones behavior in reaction to the participant’s behavior so biases were not to take form in the discussion.

## Data Analysis Plan

I took notes during each of the interviews. After each interview was completed, I typed up my notes and added information about the interviewees' disposition when talking about specific topics in addition to the environmental factors present in the women's homes I went to, to conduct the interviews. After each interview was transcribed, I used content analysis as the form of data analysis. This type of analysis enabled me to develop a "special understanding of the participants and how these individuals interpret their social worlds" (Berg, 2004).

Additionally, latent content analysis (Berg, 2004: 269-271) was used to allow me to interpret the data by looking in-depth at the meaning conveyed by the participants in the study. This was beneficial in identifying overlying themes across the interviews. It also contributed to developing the meaning and context constructed through what the participants were trying to portray.

After studying the transcriptions, and establishing the strongest themes, I began to saturate categories and then code the data. This was done systematically and inductively, leading me to the true focus of this study. I then compiled all of the information from my data into groups according to each of the determined categories or themes, and began filtering through the information. This helped me to identify the strongest themes as revealed in the data and the true perspectives of the members constituting this study. I then compiled selected quotes pertaining to these themes, and used them to express the most relevant information for this study.

After completing all of the aforementioned tasks, I was able to begin to write up my report. Throughout the report, I have incorporated theory and ideas from the literature review to further clarify the information being disclosed.

### Discussion

I propose this research be used as a tool to mitigate health disparities. I looked at proposed barriers causing health disparities to develop the tools necessary to locate where change needs to take place. Specifically, I detail the *Mexicana* experience with health and healing in both the United States and Mexico. Literature, theory, and personal experience provided the framework necessary to formulate the questionnaire developed and used in this study. Additionally literature has shown us that change, at this point, is necessary. I believe this research will provide Iowa with the tools and understanding necessary to take action on the situation unique to this state. There are obvious problems that will arise if integration is to take form, but if we do not enact change, the problems that we are currently facing will only worsen.

If understanding and communication is to take place and sessions are held for traditional healers to gain knowledge on what steps to take in case of emergency, and/or rooms were provided for traditional healers in the hospital (and there currently are some), any of these things would significantly decrease the mortality rates and emergency situations that exist in the health field. The WHO (1995) took on a project in which each of the aforementioned areas, and conditions significantly improved for the healers (as they gained more status and respect among their people), doctors (emergency care situations decrease) and patients (their overall health and health conditions were better

attended to). As disparate conditions in Iowa's health field continue to exist, any of the aforementioned methods, if implemented, would potentially improve conditions for *Mexicanos*, and our health care professionals.

At this point, a lot more research is still needed on this topic to enact any sort of change. For one, we need to find out if this is something *Mexicanos* really wants to see in the United States, if they would access care if it were accessible, and if their beliefs and practices, through the integration process have remained consistent with those in their home country.

## CHAPTER II

### Background Data

There are numerous health practices and beliefs that differ from those of the United States. Although many beliefs and ideas about health overlap from individual to individual and culture to culture, the cultural environment in which one grows up significantly affects his or her perspective on multiple aspects of life. The background data presented in this section will describe aspects of Mexican life in Mexico which give rise to perspectives that prevail with and throughout the process of migration.

While traveling throughout Mexico and Ecuador, I was able to engage in conversation about health and healing, observe healers work, and participate in practices used for preventative health care and healing. This experience challenged my former perspective as to how and why people view health the way that they do. The first study tour I made to Mexico was in March of 2004. Since then, I have visited Mexico on three other occasions from one-week periods to two-month periods, both alone and as part of various study groups. Throughout this time, I was able to gain perspectives of many individuals on multiple facets of life and develop a new awareness of Mexico's deeply rooted health practices and beliefs.

It is important to note that there are many differences in belief and practice among Mexicans based upon the region and their culture. Although many beliefs and practices coincide at many points, similar to the religions of our world, no two individual perceptions are the same on health, healing, and the practices needed to achieve and maintain health. There are disparities in beliefs among medical doctors, *curanderos*,

*parteras, sobadores, hueseros* and shamans. The healers themselves tend to have very different beliefs about their own practices compared to those of other healing practices under the same “umbrella” or with similar end goals for the patients, in addition to those healers who practice healing in different forms. Medical doctors in Mexico, however, tend to have the same working understanding of biomedicine from one doctor to the next, unlike other practicing healers explored in this study. This disparity exists because biomedical knowledge is acquired in a formal educational setting whereas other healers gain their knowledge informally from one practitioner to another, orally, or experientially.

Practitioners and healers both aid in the health and healing of individuals in Mexico. Although in practice and theory perspectives differ between practitioners, both healers and biomedical doctors have found ways to accept one another and their needed and necessary contributions to the overall health of individuals within their society.

### Why Health Disparities Persist

The data collected in this study explore the rationale as to why *Mexicanos* do not seek preventative health care. This is due in part to how health care is sought out in Mexico. This became evident while traveling in Mexico and in talking with women living in Iowa. Economic status, where they sit spatially (urban or rural), and personal belief systems determine the type of health care sought and the steps individuals take to get healthy. In the rural parts of Mexico, the likelihood of people being self-doctoring or seeking assistance from *curanderos* or *hueseros* exceeds that when compared to the

people living in urban areas. Although there are clinics in most rural areas in which an intern/doctor is assigned to go for one year upon completion of his or her formal M.D. training, they are often closed, under staffed, and work with limited resources. This often forces individuals to take things into their own hands and seek care from a village herbalist or *curandero* and when necessary, take the bus that stops in their village once a week to town to collect medicine from the pharmacy or stop and visit a doctor.

*Curanderos*, friends, family, and other healers additionally offer advice as to which medicines to use for any specific type of illness or ailment. Some of these behaviors have crossed the border with the migration of *Mexicanos*. Not only are they able to access *curanderos* situated in different parts of the state, they often seek the advice of family and friends and use their own knowledge to help to treat different sicknesses as they occur. This in turn affects the likelihood of these individuals seeing a medical doctor shortly after simple illnesses arise. This is simply a different way to go about health care than that most people in Iowa are used to.

Many *Mexicanos* are undocumented, do not speak English, and are unaware of the different services available to them. Having *curanderos* and other healers available to them ensures them that if they need help before going to the emergency room they are able to get some assistance with their health needs. Because many individuals are undocumented, they are also living in dire economic circumstances in which money gained is money spent on things necessary to live. Although health is essential to life, individuals know that seeking health care, especially for a minor illness or ailment takes money that they don't have which may turn them to seek alternative means of care.

## Traditional Health Practices and Beliefs in Iowa and Mexico

During this research, it became evident that healing is “alive and well” in the state of Iowa. Individuals living in Iowa have access to numerous types of healers ranging from spiritualists, shamanistic healers, hex removers for the African American community, and bone-setters, massagers, and *curanderos* for the Mexican community (Field notes, 2005).

It appears that for the Mexican community *curanderos*, massagers, and bonesetters are often sought out of economic necessity. This is not to say that the economically sound do not seek out treatment from these healers. They do so less frequently, and for different ailments than their counterparts in Iowa. It appears that when individuals do not feel that they have adequate funds to go to a clinic or a hospital, they will seek the care of a healer to perform one of many different treatments on them. In Mexico, however, the situation is a bit different. Individuals again seek treatment from healers because it is more economical, but at the same time, a lot of individuals in Mexico seem to have a much stronger belief in the work of these healers and seem more likely to get more severe cases of ethnospecific illness.

Curanderismo. *Curanderos* are alive and well in Mexico. You can find them in their homes and on the streets performing everything from *limpia* (cleanings) to mending broken hearts and relieving people of primary ailments and illnesses with a combination of herbal remedies and massage. *Curanderos* help relieve emotional syndromes such as

heartbreak, *nervios* (anxiety/depression), *mal de ojo* (evil eye), insomnia, and *susto* (fright).

Healers use various routines and/or rituals based upon their own particular belief systems, which are incorporated into their practices. Some *curanderos* employ ritualistic *limpias* and “read” eggs to help diagnose and identify where symptoms are coming from. After the *limpiando* is performed the patient is generally relieved of the ailment that had been preventing him or her from partaking in certain aspects of everyday life. All *curanderos* do not believe in the spiritual aspect of healing and therefore do not take part in these types of ritualistic healing practices. Some *curanderos* only believe in using herbal remedies and massage to relieve individuals of primary ailments in addition to providing homeopathic treatments for individuals with cancer and other terminal illnesses. Additionally most healers offer advice to those seeking healing in other forms. As practices do vastly differ among *curanderos* any of the aforementioned techniques of healing can be used together or not at all depending upon the particular *curanderos* belief system.

In my experience, practicing *curanderos* do know their “limitations” when aiding a sick individual and when symptoms or illnesses are beyond their immediate frame of reference or knowledge. At this point, they usually refer their patients to biomedical doctors. Although there are discrepancies between the approaches of healing among *curanderos*, they are generally sought out for aide regarding the same types of illness and/or disease. Some common illnesses *curanderos* treat are *susto* (fright), *nervios* (depression), insomnia, in addition to basic colds, the flu, diarrhea, diabetes, cancers

(including lung, breast, ovarian, and cervical), leukemia, and kidney stones among others (Traditional Study Tour, June, 2005)

Depending upon “what” the particular *curandero* is known for, determines the types of clients that seek his or her treatment. One such treatment is a standard “cleaning”. A cleaning is a process of healing performed by a *curandero* to provide the patient with an emotional “clean slate” so to speak. This work is generally used to rid individuals of curses and/or emotional distress. At any rate, I was able to both experience a basic cleaning performed on me in a small village in Michoacan, Mexico and observe a similar ritual in a village in Morelos, Mexico. The process in which each of the *curanderas* engaged had many similarities and differences. I paid the *curandera* that performed my cleaning 150 pesos, about 15 US dollars and the participant whose cleaning I observed was given for free as a part of a study tour. There were interpreters present at both cleanings and they both took place in the homes of the *curandera*.

My experience being cleaned and advised differed from that of the rest of the group. I, along with the help of an interpreter, Nora Rodriguez-Kurtovic, sought out a *curandera* in a small village in which we were staying. After locating where she lived we stopped by her home at least four times before we were able to catch her, and when we finally did, we had to wait in line for about an hour while she was attending to other patients. A family that was sitting next to us waiting for the help of this particular *curandera* had traveled from another state to come and see her. This led us to believe that we were about to meet a well-known and respected *curandera*.

After entering the healers' home I asked her for a cleansing. She first gave a wooden crucifix and asked me to hold it facing away from me in my left hand with my arm bent so that it was raised parallel with my shoulders. In the other hand I held an egg of which I picked out myself from a carton of thirty-six. I was facing the *curandera* and she began to communicate with the spirit world in a dialect that was only partially identifiable according to the interpreter—that which was understood by the interpreter was then passed on to me. Simultaneously she was holding a palm leaf in her hand and began to sweep my entire body from head to toe as if she was wiping away bad energy. The language, which was identifiable, consisted of her asking the spirits or saints to rid me of spells, curses, and/or ailments.

This process lasted about ten minutes. After this was complete she proceeded to dip her hand in water and put it on my forehead more or less blessing me in the name of the father, son, and Holy Spirit—the Catholic way. She then took the cross and egg from me, cracked the egg into a bowl and began to read it. My particular egg happened to have a stone owl on the inside that meant that two people had put curses on me—not because they hated me, but out of envy. I was then, according to her, absolved of their “works” and ready to enjoy the rest of my stay in Mexico.

The healing I was able to observe in Morelos was a bit different. It was a shorter process, performed in front of an audience and with different tools. In this particular session a candle, a coin of ten pesos, a glass of water, and an egg from a chicken were needed. Similarly, the *curandera* swept over the seeker's body with a leaf while speaking rapidly in a monotone voice. One difference was that this seeker was sitting in a chair

throughout the entire process holding nothing, whereas I was standing holding the egg and a cross. She swept over the seeker's body for about five minutes before requesting the egg, which she then threw behind us so it would break and she could read the yolk. This egg broke too soon and she wasn't able to get a proper reading in order to diagnose the seeker. She then called one of her nieces to fetch the glass of water and she retreated into the house to read the second egg. The diagnosis that this seeker received was almost identical to the one I received. She had a curse put on her out of envy, but only one, not two.

This visits to the *curandera* for the purpose of cleanings assured me that the use of *curanderismo* is alive and well in Mexico today. People travel long distances to be worked upon by particular healers as it not only gives people peace of mind on possible unresolved issues, it helps people to feel secure, better about their lives in general, and helps to maintain peace and harmony within their society and within the community.

Hueseros (bonesetters). Bonesetters in some sense resemble chiropractors in the United States. But they do general cracking and massage in addition to other treatments not used by chiropractors in the states. The bonesetter, like all other alternative forms of health care is received out of the healer's home. As time goes on names are built for the individual healer because of their gifts through new business from all over the state, sometimes even into other states. He, like the others was a very gentle and soft-spoken man helping the people with and without money, which is another thing that presumably aids in the status that is carried with the name. Bonesetters are selected to become healers through recognition of a gift that they hold in addition to the people's belief in the

possibility that they hold the gift. In the small town Villachuato, Michoacan, Mexico, individuals residing throughout the country visit the healers. As this practice has withstood the test of time in Mexico and is accepted and utilized regularly by the people, it is no wonder that it continues to grow. Bonesetters are generally “chosen” healers.

The particular bonesetter I visited in Mexico had actually given treatments both in Iowa and in Mexico. He treats numerous individuals with massage and bone cracking. People seek his treatment when they have strain in their backs because he has the power to release the pain; he cracks necks and moves them around, uses herbs as muscle relaxers, works on swollen joints, and gives massages. He incorporates, as many health healers do, numerous techniques to treat any particular problem his patients are dealing with; generally lighting incense at the beginning of the treatment and providing the patient with some form of herbal tea and sometimes pills, determined by the illness or ailment needing treatment. He got started in the business of bone setting because someone recognized his gift. When he was young, people would come to him from the fields and have him bite them on the top of their hands. His bite hit the nerves in the workers hands and relieved them of pain. This was not common among lay people, so the field workers continued returning to him. It is tradition in Mexico that if one has the gift it will be the first-born boy in the family. At this point in life his future was decided for him.

He also had an opportunity to live in the states for a time in which people from Mexico frequented him regularly. There were times when there would be an entire line of people at his door extending out into his yard waiting for treatment from him. He

would even get visitors from Minnesota even though he didn't know any of them. All of the people who worked in plants in the surrounding areas would come after their 2:00 shifts into early hours of the morning. He worked Saturdays and Sundays for no money, or maybe he would get around \$10 for five hours of work depending on if people had money to give for donations for his help. This goes back to well known ideology among healers that if they have been blessed with a gift to help people they should help people freely. This habit is exercised throughout the world. He was able to spend 13 months in Iowa before returning to Mexico. In both Mexico and Iowa, he would refer his patients to the doctor if he felt he was unable to treat the illness/ailment that needed treatment.

Parteras (Traditional Birth Attendants aka TBA's). *Parteras* are the midwives of Mexican society. They both deliver babies and aide women throughout their pregnancy with any difficulties they may incur. The Mexican government has begun to mandate that all *parteras* be trained in different aspects of obstetrics and birth. They are also learning how and when to refer patients to hospitals when there are complications outside their knowledge.

Village Injectors. Village injectors are self-taught injectors for villages throughout Mexico. They generally go to the pharmacy and buy mass quantities of medicines used by doctors. The woman I spoke to told me that people go to her because they like the way she injects. She injects in the muscle in the back. She learned how to do this after her father was in an accident and she had to learn to care for him. She began practicing on an orange with the supervision of a friend who was familiar with the process. Her sister was also able to learn how to do this. She also mentioned that people

come and buy the medicine from her because it is cheaper. After visiting the clinic and finding out what they need, they go to her and simply tell her what they want. If they need an injection she gives it to them on the spot. Many people whom have traveled to the states remember visiting her as children. She used to travel throughout town giving people injections and at one point in her life was able to train with traditional birthing attendants. Village injectors are used in Mexico because they are easily accessible, they have the medicines necessary to treat an array of sicknesses, and they provide cheaper care than most clinics and hospitals.

Farmacia. Pharmacies in Mexico run over-the-counter businesses. Therefore individuals are not required to visit a doctor to get a prescription before purchasing most medicine. Many pharmacists also assist individuals that come into their shops in finding the appropriate medicine that they need for the specific illness or ailment they are experiencing. Additionally they help people diagnose their sickness or ailment and then inform them of the proper medicines to take to aide them back to health. This being the case, in addition to many individuals' self-diagnostic tendencies, they are able to seek the advice and assistance of pharmacists, friends, and family before they are ready or willing to go to the doctor.

Tiendas. There are numerous *tiendas* located throughout Mexico that are filled with candles, soaps, incense, herbs, and other resources to aid their patients in healing themselves with emotional issues they are working through. Some examples of resources sought in a tienda are those that help to mend a broken heart, hold a relationship together, block bad energy and/or works, and limitless other issues. The owner of these stores

offer advice as to what assortment of items the individual needs to buy for any issue they are trying to resolve. After the customer decides what items to buy, the owners prepare the items with a ritual and then give it to their customer with a list of instructions on how to use the item or items bought for maximum success in resolving their issue.

Medical System in Mexico. The Healthcare system in Mexico is called *Sistema Nacional de Salud* or *Sector Salud*. It is broken down into 3 different levels:

Level 1: Attention / Prevention

*Casa de Salud*, which is a basic package of healthcare services, provided most of the time by a leader in the community who is trained by nurses as a first responder.

*Centros de Salud*, which are clinics located in small rural communities that provide basic medical services like health education, immunizations, pregnancies and small wounds.

Level 2: Hospitals

Regional and private hospitals that have family practice, gynecology, pediatrics, in addition to performing general surgery and internal medicine.

Level 3: Specialists

Federal and private hospitals that have Otolaryngology, Orthopedics, Oncology, Neurology, Radiology, Cardiology, Urology and other specialty departments.

In Mexico people are automatically enrolled in the *Seguro Social* (medical insurance ran by the government) by their employees who process all the paperwork. Every month the employees get a deduction (7%) out of their paycheck according to their salary to have access to this medical insurance. The medicine prescribed by the *Instituto Mexicano del Seguro Social* (IMSS), ISSSTE, and the *Centro de Salud* is free and they

have their own pharmacy inside their hospital or clinic. An example is: If a doctor from this institution prescribed a patient to take Bactrim for three months, the pharmacy (*farmacia*) will provide the meds all at the same time (over-the-counter). Patients can only get medicine prescribed by a doctor at the *Seguro*, ISSSTE or the *Centro de Salud* pharmacy. Their medication is not sold in any other local pharmacy.

The National Health Program of Mexico created “*Seguro Popular de Salud*” (Popular Health Insurance). This program provides access to healthcare to those families within the poverty level who spend one third of their income in getting medical attention. Their goal is to reduce the medical expenses by offering an Insurance package for a monthly or yearly fee that is based on their income. This Insurance covers family practice, medication fees, preventive physical exams, Lab, ER, referrals to see a specialist and is accepted in every government hospital or clinic.

## CHAPTER III

### Data Analysis and Write-Up

The twenty-three *Mexicanas* who participated in this study come from middle and low class families both here and in Mexico. Most of the women interviewed in their homes were living in apartments with sometimes two four people families separated by a sheet. About one third of the women were currently working while others were attending colleges and Universities or unemployed. I met the women both in public places and in their homes; whichever was more convenient for them. The longest any of the women had lived in the United States was 19 years and the shortest amount of time was 1 year. A little under half of the women spoke English in some capacity and there were about one fourth who spoke fluently.

The ages of the participants range between 19 and 64. The women came from numerous states throughout Mexico: seven from Michoacan, four from Jalisco, three from Coahuila, four from Tlaxcala, and three from Morelos. These women have been living either transnationally or have stayed in the states. Transnational villages “emerge when a large number of people from a small bounded sending community enact their lives across borders” (Levitt, 2001: 213). The median number of years spent in the states ranged between 11 and 15. The education attained among these women was from anywhere under the 4<sup>th</sup> grade to seven whom had a BA (Bachelors Degree) or an AA (Associates Degree). Two thirds of the participants were living in what by American standards would constitute poverty. The other third of the respondents were doing quite well and seemed to be very well adjusted to life here. A majority of the participants were

Catholic; however there were five participants who were non-Catholic Christians and four who were not practicing any religion. Those who were practicing their chosen religion seemed to be adamant followers of their religion and religious beliefs seemed to affect their willingness to talk about *curanderismo*. The non-Catholic Christians were the most reserved on this issue.

Most of the women were extremely eager to share their stories and experiences on health and healing. Some were a bit more reserved. All in all, there was an eagerness to help in any way possible to improve upon the current situation in the health field. Although a lot of the women were unfamiliar with a lot of the issues that had come up in literature regarding barriers such as not trusting their doctors, they helped to define areas within health and healing that they saw as problematic.

A lot can be taken from what the women in this study had to say. Their stories of both health and healing reveal the complexity of the role mind/body duality plays in health in so many countries throughout the world. Their stories show the struggle families have to go through in moving to a new country and adjusting to a new culture as documented and undocumented immigrants. In bringing together the voices of these *Mexicanas* living in Iowa, a deeper understanding of the difficulties encountered in the health field has been gained.

This chapter will provide insight in the unique situation *Mexicanas* in Iowa find themselves with regards to their experiences with health and healing. It will open with an overview of the participants understanding of health, go into detail about cultural differences in health ideology as expressed through the different modes of healing used

and believed in among *Mexicanas*. Furthermore, it will explore the experiences women have had both here and in Mexico in the health setting, provide clarity as to why preventative care seems to be a major disparity between Mexicans and Americans, explore possible misconceptions regarding this issue, and provide suggestions as to where studies can go in the future to look more effectively at health disparity issues among immigrant populations in the future.

### Defining Health

Health according to the WHO, “is a state of complete physical, mental, and social well-being, and not merely the absence of disease or infirmity.” Perceiving, diagnosing, and treating health are however, learned processes; culturally particular, embedded in history, and passed on with new generations (Janzen,2003). Transcending borders, these learned processes, representing cultural norms and values, remain close to the hearts of people. *Mexicanas* exhibit their unwavering bond to their own culturally specific understandings of health and healing while beginning a new life or enduring a life in Iowa. The attitudes and beliefs that evolve out of these shared norms and values then shape their behavior and understanding with regards to health.

*Mexicanas* see health as fundamental to life. They recognize that health extends beyond the physical into the mental and have their own particular codes which are used to maintain and restore their good health. Many *Mexicanos* living in Iowa came from humble backgrounds in hopes of economic advancement. Coming from a country in which doctors are not always accessible, *Mexicanos* have been exposed to, utilized, and learned many health maintenance strategies, practices, and methods of healing that differ

from the biomedical approach to health that most Americans know. The ailment or injury experienced is indicative of what type of assistance is sought (self-diagnosis/treatment, visit to healer, visit to doctor) to help the patient restore health. Other factors that contribute to the type of care sought are: educational background, religious beliefs, cultural capital, and personal experience. The methods applied to health and healing will be discussed throughout the remainder of this chapter.

In response to the question, “What is health to you?” the responses given all expressed the well being of both the mental and physical. Mental health was expressed as their emotional well-being or the well being of their souls, while the physical related to how their bodies were feeling. Emotionally, *Mexicanas* differ from most Iowans because they are continually trying to understand and adapt to a new society, they experience homesickness in different ways, and a sense of detachment from family, friends, and a culture that understands emotional and physical conditions differently than established Anglo residents do in Iowa. The level to which *Mexicanos* experience any of the aforementioned are largely determined by their legal status, where they are situated economically, and the number of years in which they have resided in a foreign country.

A common belief shared among many *Mexicanas* is the power the mind has over ones body and overall health. They see the well being of the mind as instrumental in maintaining and restoring health both physically and mentally. Additionally many believe that believing in the healer or doctor’s and their own ability to heal in addition to having faith in God (many experienced healing miracles which they attributed to

summoning God to heal in group prayer over persons), are essential to maintaining and restoring their own and other's health.

Although *Mexicanas* understand health similar to most Americans, how they go about healing, maintaining, and diagnosing health differs greatly. *Mexicanas* are in a continual state of adaptation and re-adaptation throughout the migratory experience and as many are on the lower end of the economic spectrum and do not have access to the same resources many Iowans have, many of the health practices and beliefs that were learned in Mexico have prevailed in Iowa. In part this can be attributed to the types of jobs many *Mexicanos* fill (the meatpacking industry or field work), the high number of undocumented immigrants, and the inadequate integration of this population in Iowa (Grey, 1997).

#### Contrasts in Care and Treatment across Borders

Due to the vast number of differences in care and treatment between the United States and Mexico, it is not unexpected that *Mexicanas* do not understand, have not adapted to, and therefore do not seek care and treatment the same way that many Americans do. Knowledge gained about when to go to the doctor, how to access and use health care what health care options are available and which social service programs are available, are culturally specific and learned over time. Therefore, to address any difficulties that may be encountered in any of these instances, a look at the differences in care and treatment is needed so they become identifiable. The differences discussed for the purpose of this research cover differences in patient/doctor relationships, the intake/outpatient procedures, the strength and availability of medication, the different

health care options available, and the difficulties incurred for *Mexicanas*—both documented and undocumented—in attempting to meet their health care needs.

Medical care in the formal setting is done differently between the United States and Mexico. In Mexico, it is much more feasible for Mexican doctors to engage in building personal relationships with their patients as they are not regulated by the clock as they are in the United States. In the United States, insurance companies run hospitals, pushing doctors to see the maximum number of patients possible in any particular allotment of time. This puts serious restraints on doctors' ability to build strong relationships with their patients, although occasionally they are able to work this in.

Furthermore, specific doctors with whom *Mexicanos* have personal relationships and with whom they feel comfortable discussing medical issues are the doctors they generally seek. Unfortunately, many *Mexicanas* living in Iowa do not feel that they have had the opportunity to build these kinds of relationships with doctors here. Gina claimed that if she had the opportunity to talk to the doctors here,

I would tell the doctors to always look at the person or make us aware of the time we have with them because we are not conscious about that because in Mexico you can spend one hour with the doctor just talking. Here it feels like I'm going through a drive-thru.

Unfortunately, for all, this cannot be changed so long as the The United Statesn health system remains as it currently is. Educators can however share these issues with *Mexicanas* so that they understand it is rather a difference in how each system is run rather than the doctor's unwillingness to donate their time to their patients. In time, with new understandings gained, new attitudes on this issue should take form.

A further issue that repeatedly evolved throughout the interviews was the paperwork that has to be filled in before the doctors see them. In the United States you are required to provide insurance information at most hospitals and given questionnaires with a series of personal questions on it. This proves to dissuade numerous *Mexicanas* from seeking treatment because they do not have legal documentation or insurance, and many do not know English. Fortunately there are a number of social service programs available for low-income families. If knowledge on whom to consult regarding this issue is shared with *Mexicanas*, the likelihood of more families seeking treatment at an earlier stage of illness could significantly increase.

In Mexico it is sometimes necessary to pay for your care up front, and depending on the level of care you are seeking—private, public, government, or specialist—you are required to bring all of the supplies that the doctors and nurses need to work on you—from needles to toilet paper—in order to get the attention you need. Giselle shared drawbacks to this type of intake procedure,

The medical care here is better because everyone can be seen here...and no matter what they treat you...for the treatment in Mexico you have to pay up front which determines the type of care you will receive and everything else.

Patients are additionally able to make payments on the care and treatment they received after their visit in the United States, which many women agreed to be a positive aspect of the American system. While Jalisce contended, “I know a lot of people who seek care here because you can make payments here instead of having to pay up front,” Esmeralda, whom happened to be undocumented, mentioned how it can work in their favor because it is easy to “disappear” and never have to pay the bill. This is due to the use of

pseudonyms and faulty addresses that undocumented immigrants provide so as to not disclose any information that could prove to be harmful to them—a situation that is yet to be resolved in Iowa.

The Mexican and American systems also differ in how they prescribe treatment for illness. As patients can buy most anything over the counter in Mexico, coming to the states, they have to go to the doctor to get prescriptions for medicine. This of course has its positive and negative implications. On the one hand, patients know that they are getting the treatment that they need for their specific illness, and on the other, they have to spend that extra money and visit a doctor to get a prescription which proves problematic for many low-income families. This is a classic catch-22.

Maria saw the positive side of having to go through a doctor to get her medication,

Here, if my son is sick I can't just go and buy medicine...there are laws that prevent us from doing that...but in Mexico, there have been cases where you go to buy and it poisons you, so it's good to go to the doctor. Anyways, I am very reserved because I don't want to speak with just anyone about my health. I don't take pills just because someone says. I want to see what the doctor says.

While Maria was able to see the positive aspect of these differences, most expressed a certain level of economic frustration on the issue. Economically, many immigrants are struggling. As each dollar then becomes accounted for just to “get-by” or make “ends-meet” for the month, it becomes strenuous to find means to reallocate incomes and find money to use on health. This being the case, many *Mexicanos* get their medication shipped to them from Mexico so they can avoid going to the doctor, another aspect of their self-doctoring tendencies. Additionally, according to the interviewees,

medication given in Mexico is much stronger than the medication given here. Immediate relief from excruciating pain has its strong points. Giselle explained,

If you go here with simple illness the doctor's don't give you medicine but in Mexico you go, and straight away they'll give you medicine. And the medicine they give you in Mexico is stronger. I don't know if it's a belief I have or if it's how it is. The doctors in Mexico will give you penicillin, and if that isn't strong enough they give you Iloisone which is even stronger.

Susanne agreed but expanded a bit further,

Medical treatment is different from here to there, but it's also the same. They still give pills and the same treatments...but the dosage here in the states is lower because they give you little by little and in Mexico they give the strongest medication right away.

Not only does this contribute to *Mexicanos* interest in calling home for medication, it prevents them further still from sometimes seeking much needed treatment. As many *Mexicanas* feel extremely in touch with their bodies and believe they have accrued the knowledge necessary over the years to self-diagnose, this isn't all that surprising, and generally proves to work. Unfortunately there are many diseases, viruses, and illnesses that do not produce signs and symptoms can be easily overlooked when constantly taking ones health into their own hands.

A similarity between Mexico and the United States is the vast types of healers available to aide one to health both mentally and physically. In addition to having formal practitioners *curanderos* and *hueseros* are available in Iowa, although more sparse than in Mexico. Nevertheless, these healers are available and utilized extensively among *Mexicanos* living in Iowa. As economic resources and knowledge on the American system do not appear by osmosis, the availability of healers enables those whom have little money to be cared for in addition to providing *Mexicanos* with someone to treat

culturally specific illnesses and ailments unknown in biomedicine. Seeking the treatment of nearby healers when encountering a culturally specific illnesses or out of economic necessity are common practices in Iowa. According to Maria, an American living transnationally,

People really don't have the option of going to a doctor, so, the last resort is going to a healer instead. Doctors do a lot of blood work and x-rays, so it's very expensive. If I were to be over in Mexico and go to the way of thinking that has been taught, I would believe that the healer can heal. The people would rather go to a healer than a doctor because they are very poor...if there was free doctor, there would be a long line.

She continued talking about her experiences in utilizing healers,

My back is hurting a lot and I don't have the economic resources to go to the doctor so I go to a healer. Only here in the states, not in Mexico...I was sick during the first months of the year—there was a very sharp pain in my neck...I woke up and I was sick so I went to the clinic on Saturday, the only one open, and the doctor asked me a lot questions. The doctor thought it was a muscle problem or a nerve in my neck so he gave me very strong medicine. I thought if it's a pain in my neck, the massager could heal me. The day after, I went and I was healed, so I believe he healed me. The massager graduated from a school and has a technique where he massages until you are healed. He works out of his home in Marshalltown...the massager was explaining to my husband that if they don't know how to work with nerves, they can make it worse. He has a lot of people going to visit there...you can't trust anyone you know...I wouldn't go unless he was recommended to me.

Most healers working in the United States treat their patients on the basis of receiving money only if the patient has it. They generally make their living from donations. Utilized in both Mexico, and the United States, one could conclude that healers serve an essential role to the health of many *Mexicanos* living in Iowa, and that in and of itself, adds to further to healers' legitimacy.

The final issues that will be discussed in this section are the difficulties that are incurred because of existing barriers of documentation, work, and language. When

risking one hard life for a chance at another hard life, the future can sometimes seem quite grim.

There are many issues that arise with the lack of documentation among immigrant newcomers. Most of the individuals that come to the United States illegally have less education, fill the most dangerous and stressful jobs, and at the end of the day, have no rights or resources to assist them with any of their needs. This is problematic as the United States economy is in need of these immigrant workers—both documented and undocumented—to fill the jobs that Americans are not taking (Grey, 2002). Eva enlightens us with the simplicity of this issue: “It’s very simple, what other group in the United States is going to work those jobs...aside from the Hispanics, you will not find another cultural group to do work in the field...” She continued explaining the difficulties that arise when working for a company that treats you as an economic asset and her brother piped in:

If you work in any company and go to the doctor they send you to another one. There are differences. The company doctor will tell you, you can work and the other doctor will say no you can’t work. You come to the US to work, that’s the main purpose here. And then you get injured and the boss says if you don’t work you get fired...and then I start thinking about my family and my bills and what will happen if I don’t work...where are you going to get money if you get fired. What am I going to do? There is an old saying in Mexico, *hasta que cuerpo aguante*—until your body can’t take it, you do it.

Which is what most Hispanics do, leaving them with ill health and added mental stress.

It is beneficial for the United States capitalist economy to continue enabling undocumented workers to work here. “Immigration itself does not lower workers’ wages. But competition and division between groups of workers does. If one section of the workforce can be exploited without any legal recourse, it’s easier for the bosses to

lower all workers' living standards" (Selfa, 2003). Although this may prove beneficial for employers, by not providing rights in exchange for work, it is additionally perpetuating the high costs of health insurance. As many of the undocumented workers fill the most dangerous jobs and often get hurt on the job, they are forced to go to the emergency room for health care. Furthermore, when doing this, as they are unable to disclose any personal information for fear that they will be deported. These cases then get written off and the taxpayers end up footing the bill for them, as Esmeralda had hinted at before.

She continued, "What can I do? I'm always between these four walls. I would feel healthy if I could get work. I came from bad to worse." Because Esmeralda doesn't have legal papers to work here, her spirits have been very low for quite some time. She cannot seem to find peace. Although she considers her body to be healthy, she cannot travel back and forth between here and Mexico and therefore experiences significant amounts of emotional distress. She said the "only thing that can make my spirits healthy is if I could find papers."

It becomes obvious that not having legal documents or insurance significantly contributes to the ill health and disproportionate burden to disease, death, and injury, at both the physical and mental level (Chavez, 1992). I repeatedly heard statements like, "When you come here from Mexico, you usually come with good health and it starts deteriorating after you get here" or "when I lived in Mexico I was never sick and didn't get sick until coming here." Although this could be due to the fact that humans generally get sick as they get older, the Hispanic population continues to experience disparities in

treatment in the workplace which transcends to their physical and mental well-being as reported by the NIH, CDC, GHC, and other leading health organizations in the United States.

As it is unrealistic to change the system to more equally and adequately serve the populations that are serving us, we need to look to other means to attempt to decrease these disparities. As awareness spreads among Iowans and they continue to be open to understanding the story of the *Mexicano* the hope is that in time, they will sympathize with them, recognize that they are contributing to our economy, and ensure them of the same rights that everyone else gets as a citizen or visitor of this country. Additionally as they do fill many of the high-risk jobs, it would be ideal to mandate that the employers of these companies provide health insurance to all of their employees regardless of immigration status.

The final barrier, recognized by both scholars and *Mexicanos* is the language barrier (Iowa/Nebraska Primary Care Association, 2003). Language came up in almost every interview conducted with women who did not speak much English. In some instances the women were able to take care of this problem on their own as they had children born here who were able to go and interpret for them in emergency situations. Simultaneously, there were instances when because there was no interpreter available at the hospital or clinic, women and children had to suffer unnecessarily. Eva spoke of such a case, "I know of a case when my friend went to People's with a toothache and she was pregnant but because there was no interpreter and she was pregnant she had to go home without any help and cried for two days in pain."

Another issue language presented was in making appointments over the telephone. As many of the women spoke little or no English, fear and discouragement arose preventing *Mexicanas* from actually making the call. The same response was given over and over when the question of barriers came up, “the language is a problem here. They should have more people who can speak Spanish.” Additionally a sense of fear comes over one when they know that they need help but cannot communicate that. “Language is the biggest problem and that creates fear...I have someone who comes with me and interprets though, so it works out.” Fortunately this is a problem that can and should take care of itself as the community continues to grow and the children coming from Spanish speaking backgrounds continue to learn English. If there are enough bilingual people within the community we can also look to volunteers as a means to reduce the severity of this issue. To Elsie the situation went like this:

With me, it’s different because I understand the language and it’s hard when you’re interpreting because you try to convey what the problem is. Many doctors get impatient with interpreting and very few doctors speak Spanish here. And it’s very important to convey those messages.

Alicia agreed, noting,

I went to People’s and the experience was ok because I had an interpreter...it wasn’t easy though, because I felt that the interpretation services weren’t the best....somehow what I was saying was not being conveyed to the doctor. It went from me giving long sentences to being rephrased in few words. I don’t know...if they didn’t know what they were doing, I guess they wouldn’t have them there.

Even with an interpreter the experience of going to get medical treatment may not be the best. Being that this is one of the major factors that *Mexicanas* face in the formal medical setting, it seems that solutions to this problem are not out of reach. Not only are volunteers an option, we can start to integrate Spanish medical terminology into nurse

training or make a bilingual reference sheet easily accessible in hospitals and clinics that are frequented by different immigrant populations.

Although there are many contrasts in health ideology between Mexicans and Americans, there are many similarities. It is important to note that ideology plays a significant role in one's behavior, choices, and understanding of health and through addressing these differences of solutions to any of the aforementioned issues will evolve (Yehieli, 2005). The differences in care and treatment as depicted here outline both the positive and negative aspects to how Iowa is currently integrating and adjusting to its changing populations. As cultures come together it is essential for the dominant group to provide the resources necessary for other groups to not only learn and understand how to access, but to utilize the options available to them. It is also evident that just because individuals cross borders, they do not let go of their practices and beliefs about health and healing (Levitt, 2001). It is necessary to address the need of *curanderos* and *hueseros* in Iowa, to meet culturally sensitive needs of this population which practitioners of this country are not able to do.

### Sensitivity in the Health Care Setting

*Mexicanas* claim to be more sensitive than American women regarding encounters in the health care setting. Privacy of the body, the gender of the doctor, and the number of people caring for *Mexicanas* either deter or promote these women's visits to the doctor. The younger the woman, the less likely she is to seek care from medical doctors for female issues. Also, the level of comfortableness experienced by *Mexicanas* in the health care setting is derivative of the women's stances on each of these issues.

Many *Mexicanas* see privacy of the body as more precious to them than American women. The body in Mexican culture is understood as something to respect and not to be seen until after a woman is married. Practiced in Mexico, women do not visit the gynecologist or allow medical doctors to see their body uncovered until after they have been married. This is a major contrast between cultures. American women are taught to start seeing gynecologists at the age of 18 regardless of marital status, and if they are in need of care, they generally feel comfortable with doctors. Verified throughout the interviews, difficulties are then encountered among *Mexicanas* in the health care setting with female health issues.

Furthermore, the gender of the doctor plays a significant role in the level of comfortableness *Mexicanas* have in visiting the doctor. Many women expressed how they felt much more comfortable with female doctors than male. One woman even said, “I’d rather die before going” when discussing the possibility of being seen by a male doctor. Obviously gender of the doctor can hold a lot of weight for some women’s willingness to seek care, although for some it holds much more weight than it does for others. Others who had been seen by male doctors explained the reservations that they had about sharing information with the doctor that he should know, but they felt uncomfortable talking about because of his gender. The general rationale for this was that women understand women best, making the environment more conducive to explaining the extent of an illness or ailment and feeling comfortable with the doctor examining them.

The final issue that arose for *Mexicanas* in the health setting had to do with the number of doctors, nurses, and/or interns in the examination room. As most *Mexicanas* claimed to be private people, many agreed that the more people in the examination room, the less comfortable they are. If, however, a woman does have to have a male doctor, they prefer that one female be in the examining room observing.

The issues of privacy that transcend into the health care setting are not unique to *Mexicanas*. It is however, important to be aware that these issues do exist, and can be easily monitored to make the health care experience for *Mexicanas* in Iowa more approachable and comfortable. Sharing this knowledge with health care practitioners in Iowa could prove to make the health care experience faster, easier, and more conducive to health and healing for both health care practitioners and *Mexicanas*.

#### Experience in the Health Care Setting

Studies suggest that trust and accessibility are two of the strongest factors that prevent individuals of Hispanic descent from seeking preventative health care (Iowa/Nebraska Primary Care Association, 2003). Talking with *Mexicanas* in Iowa, I learned that although accessibility proved to be a problem for some, the lack of trust refers to the system rather than the doctors. Almost all of the women in this study sincerely trusted their doctors and in their ability to heal them. Rather, a few women had issues with differences in the systems between Mexico and the United States, and this was largely due to misunderstanding different aspects of the American system bringing about feelings of distrust.

Many *Mexicanas* agree that “you have everything here and with sacrifices over there you don’t.” They recognize, respect, and appreciate that “the service is better over here.” *Mexicanas* interviewed in this study rarely complained about the type of care or treatment they received from their doctors. They seem to appreciate the professionalism and resources available here in addition to feeling that the doctors here are fully capable of meeting their health needs. As biomedicine is currently a universally recognized and respected, our task of bringing cultures together in the health realm should not be that difficult—perhaps that is because it has more to do with the economy and system rather than cultural health practices and beliefs.

Newcomers in Iowa may have limited knowledge about how different aspects of society are run. For example, a newcomer may have difficulty knowing how to go about making an appointment to see a doctor or finding an accessible doctor. As the systems between Mexico and the United States differ, this has been slightly challenging for some, although most have found ways around it. Jeanette explained, “I learned how to get health attention from my sister-in-law...because at first when you come here you don’t belong and you don’t know what to do.” Lupe had a similar experience upon her arrival, “when I first got here I started living with my sister whom had already lived here so she knew the system and was able to help me. There are a lot of times when people come here and ask us to help them get appointments.”

Fortunately, the “not knowing” has not played too significant a role in the prevention of receiving treatment as *Mexicanos* have developed networks in which they share knowledge with one another. *Mexicanos* are resourceful and look to one another

for help in times of need as they have come to understand they cannot count on the native Iowans to assist them through the necessary procedures. Forming groups within their communities in which they help one another figure out how to “make it” in Iowa has been necessary for their survival here. A useful resource to make accessible in hospitals and clinics would be a guidebook introducing the different systems to the reader in their language and specific English terminology for specific tasks such as making appointments when interpreters are unavailable.

### Experiences with Healing in Mexico and the United States

Healers come with migration and are available in areas where there is a demand for them. Their locations are generally situated where there is a concentration of individuals with similar cultural backgrounds and health practices and beliefs. As the Mexican community in Iowa is growing, people are able to access *curanderos*, *hueseros*, and *sobadores* in both Des Moines and Marshalltown, Iowa. Participants in this study sought the attention of healers in both locations and suggested both healers live off of donations their patients provide for them. This idea parallels the belief that healers have been given a gift and should offer it freely and they will in turn be taken care of. Furthermore, many undocumented immigrants are unaware of the different social services available to them through public health clinics and turn to utilizing healers for ethnospecific illnesses, and as a source of primary health care.

Discussing people’s general feelings about and experiences with healers varied from case to case. It is obvious that there is a demand for healers in this culture as well as in Mexican culture. It is also obvious that there are a different set of cultural ideals

and beliefs that come with new groups migrating to the United States. The perspectives people had on *curanderismo* varied greatly. The use of healers varied by religious beliefs, educational background, experience with *curanderismo* and other healing practices, immigration status, and how they are situated economically. Of the women I interviewed, these four areas significantly affected, but did not determine, their use and beliefs of and in *curanderismo*. Each factor held its own varied weight according to the respondent. The responses given with regards to healing will be grouped into three categories: the unsure, the religious, and the experienced.

The Unsure. There were numerous responses given that displayed uncertainty, neutrality, or confusion about healers and their practices and legitimacy in both Mexico and the United States. This was mainly due to the lack of formal training that the healers possessed. Additionally the women who responded this way were of higher socio-economic standing than others and had minimal direct experience with *curanderos*. While discussing the difficulties many immigrants from Mexico have in receiving any sort of health care including primary health care, it became clear that of the possible options for *Mexicano*'s primary health care needs, healers were their main source. This is true of the portion of the population that lack access to clinics and hospitals because of the lack of money, insurance, or papers. While deliberating possible alternate options of seeking health care, Elsie thought aloud,

It would be best to find means where the people could go that was low-cost or a no cost clinic or someone that speaks their language. You also have to teach people where you would explain, in their language what is important and explaining the importance of preventative care but it needs to be within their financial means and have the ability for them to feel comfortable. That's why many people go to Peoples...you really have to find someone you can trust and

that will take care of you. A lot of people do worry about status though, because it's a fear...and at least they [*curanderos*] are within the peoples reach...at least access and money wise...and if they use different treatments like herbs, they aren't as expensive...and there are people who trust them completely.

Although like many of the women, Elsie expressed a level of uncertainty about *curanderismo* she was able to recognize the legitimacy they hold among *Mexicanos* in addition to the essential role-played and service given to *Mexicanos* both here and in Mexico.

Jalisse who comes from a middle class background, agreed, but took a different stance on the issue, "well, they are out there and they mean right, but they don't have a formal education." Although Jalisse claimed, "I've never been to one...I haven't because if I'm sick, I think I have to go to the doctor" she in some way retracted that statement explaining,

At the beginning I didn't believe in any of this...but I have a cousin who is a teacher and a lawyer and she believes in them. At the beginning it was only a game for me...but one time, I went with her to serve as a companion with her and they read my cards and told me many things that no one else knew...so I left and believed a little because they told me about things in the future and four or five years later, they started happening.

She did however recognize that without a formal education, "it's dangerous...a *huesero* can set something, and as they haven't had formal training for it, it could be bad."

Although evident that the lack of formal training hindered some women from seeking the services of healers, they were able to recognize their worth and even need in society.

These women were among the few who evaluated this topic, religious views aside.

The Religious. Religion played the most significant role in individual perspective on healing. Elsie, a devout Catholic, discussed an issue that many individuals have in

determining the legitimacy of *curanderismo* and other methods of healing that are commonly used in Mexico:

It has more to do with superstition or that...hmm...I think it's a contradiction to the church because you're believing in that a person has power...and many people that live in rural areas have to use them because they can't find a doctor or anything, and you can trade, and get help with a chicken or a goat or something...it's supernatural, believing that people have powers...and thus, use they use statues or images. I wouldn't doubt that they have some type of religion but it's used (as a tool) to convince people that they have this gift and can then heal people.

She continued,

If I didn't have any way to get to a doctor, I probably would use them...well, you have to do what you have to do to get better. Anyways, I know a lot of people believe in the herbs so a lot of people try that...you just try to go through the cheapest way possible before you hit the doctor or the emergency room, you know.

Esmeralda felt the same way for quite some time in her life, "if I'm sick I'm going to the doctor or the church. I will never go with a spiritualist or witch doctor."

Esmeralda further noted, "medical doctors will know the diagnosis, *curandero*'s just give you herbs and never actually figure out what your problem is...although they are very respectful and try to find out the problem." Angela laughed when I asked her if she believed in healers, "I just believe in God...and through the doctor God will give me the right medication. I have never gone to them and I don't want to. Primary health care I can just do at home" she retorted further validating that religious ideology plays a significant role in how one responds to and/or feels about healers.

There were discrepancies in responses according to religious background as previously mentioned. Catholics were more likely to be open to talking about

*curanderismo* and other healers while non-Catholic Christians had tendency to withdraw from the conversation shortly after the mention of *curanderismo*.

The Experienced. The experiences women have had with healers are quite different between Iowa and Mexico. In Iowa *Mexicanos* tend to visit healers for primary health care needs, massage, and advice about herbs. Standard cleanings and other basic healing procedures for simple ethnospecific emotional and physical issues are also practiced among the healers in Iowa. The complexity and severity of problems that are dealt with in Mexico proved to significantly decrease with migration to Iowa. This will be shown through the differences in experiences first that happened in Iowa and second, in Mexico.

Esmeralda talked briefly about her experiences using healers both in the United States and Mexico:

I was sick the year I came to the United States, and here, you can't stay home when you're sick...I brought my homeopathic medicine with me, but I didn't use that until after I went to a big hospital and no one could find a cure for me. Then I went to a homeopathic doctor and found a cure. Six months after using the herbs, I was better.

The homeopathic doctor she visited told her that she had fatigue because she was doing too much, an illness commonly treated by healers. Her sister had a similar experience and sought the treatment of a healer for blisters she had on her hands and feet. She first went to the dermatologist to seek help and they weren't able to help her. She then went to a healer who told her to, "gather garlic, lemon, salt, and alcohol...she then rubbed her skin with garlic and then the lemon. After that she poured salt over the blisters and cleaned it off with alcohol. It went away."

Esmeralda further informed me of what she learned in Mexico, “they say you can cure on your own and you can make cream that will heal you with your own body.” This was later elaborated on and was to mean that if you believe that you are creating cream physically by willing it to happen and then rub it on your body, you will be cured.

Esmeralda did not stand alone on this issue. Throughout the interviews conducted for this study many stories were told in which demonstrated the power the mind has over the body.

Bianca spoke of an ailment the biomedical doctor wasn't able to heal, but the *curandero* was:

Yeah, I've been to a *curandero* to find information about what herbs to take or drink and sometimes he makes it for me. First I will go to the doctor and he said we have to take away my uterus because I had cysts on it and then I went to a *curandero* and he told me to take four teas for seven days and then go back to the doctor and have him run the tests again.

After returning to the doctor, the doctor was no longer able to see the cysts on Bianca's uterus. However one chooses to believe these individuals have been healed and/or absolved of affliction, be it mental or physical, there is no denying that unexplainable phenomena of healing and dying, which are often associated with the spiritual world, have and continue to happen throughout the world (Janzen, 2002).

Jan explained the need of the mind and body to work together. She said that “to a point people can heal themselves and to another point you can make yourselves sick with voodoo curses and stuff like that...after that, they have to go see a healer before they are healed.”

Cause and affect play different roles in different people's lives depending on their belief systems. Giselle has visited the *curandero* in Iowa for many different types of healings:

There was lady who used to be a healer in town...Señora Ambrosia...she helped with *empacho*—that happens when your baby doesn't want to eat—she makes a chocolate recipe to help. If you are scared or wake up in the middle of the night, it's because you have *susto* [and] she helps with that too. If you lay down she does a sweep over your entire body. You have to be relaxed. Then she yells in your ear three times and you are ok. I went to her because I couldn't sleep.

Giselle and her children have accessed healers in Iowa. There was an instance when wasps attacked her son. After the attack, he began waking up in the middle of the night so Giselle decided to take him to see Señora Ambrosia. After the visit, he no longer had problems sleeping through the night.

Bianca explained some more complex issues that healers assist with: “if you fall down on the floor and your body aches or you have pain in your second uterus, or if you just don't feel well...the healers can cure just about anything.” Although, similar to many *Mexicanas*, Bianca currently believes in healers, this was not always the case. She explained what brought on her conversion:

My oldest son woke up one day with a humongous lump in the middle of his forehead, so big it was stretching his eyes...we rushed him to see the doctor and they decided that he was going to have to have surgery. I took him to a *curandera* after that to have her pray for him...she gave him a *limpia* (cleaning) and read an egg to figure out what was going wrong with him. The egg had a red marble on the inside...and that's when I started believing that people can wish you bad and put spells on you and stuff. The next day it went away and the doctors couldn't explain what had happened...anyways, now I believe. My husband, however, still doesn't.

Although the incidence and prevalence of ethnospecific illness experienced in Iowa is significantly less than in Mexico, the beliefs of and about these illnesses remain. In part this is due to experiences had in Mexico that resulted in the widespread awareness that

there are “evil people everywhere who will try to cause you harm,” meaning regardless of where one is situated in the world, he or she is susceptible to ill will.

Jeanette recalled a situation she had with a healer in Mexico.

In Mexico, when I first got married...when I went to sleep...I would feel like a spirit came over me and it would make it so I couldn't talk. The healer told me that the spirit wanted my money or the baby...and my baby died the day after it was born. We didn't have any money to give the healer and at first we didn't pay much attention to what he said and didn't go back...until after the baby died...then I went back and had a cleaning.

Jeanette felt better after she had a cleaning. She regretted not listening to the *curandero* by returning to him for help before her baby was due. Although she did not admit it directly, she inferred that if she had sought the needed care by the *curandero* at an earlier point in time, her baby might have survived.

Healers can do many things for many different types of illness and ailments anywhere in the world. Many of the acts performed by *curanderos* can be viewed as miracles or as gifts of healers being passed on, depending on who is interpreting the healing. The procedures of diagnosis and treatment vary according to preference in practice, the problem that needs relief, and the healer and seekers willingness to cooperate and be open to being healed and finding the correct means of doing so.

Diane shared her story, which involved much more complex issues than did any of the problems reported in Iowa:

I have used healers in Mexico...it was when I was working and had to use the services of a spiritualist because my husband left for the states and I hadn't heard from him for two years. I was very content with *Instituto Mexicano del Seguro Social* (IMSS) and I always went to the hospital, but emotionally I sought out the attention of the *espiritualista* and fortunately it worked and I was able to move on with my life and take care of my six kids at that time...actually I had two problems, the first one I started feeling ill...this happened when my first kids

were two and three. At that point I couldn't walk and we traveled all the way to Michoacan (from Mexico City) to see a *curandero*. My mother was the one who reached out to me and took me...and it worked. Some people did some "work" on me and I got to that point where I couldn't walk...I felt that I was near the end.

Diane, like Giselle, did not believe in healers before having her own experiences with them. She reiterated and continued with her story,

I didn't believe in *curanderos* but I was so sick that my mother took the initiative to get me to the *curandero* since I couldn't get out of the house. For about two months the *curandero* was praying for me and so when I went to him I told him I didn't believe...and he said you have to believe and he told me that he wasn't the bad guy and wanted to help. He also told me that he believed in God and Jesus and the Virgin Mary, and the power of prayer. He did a *limpia* (cleaning) on me and after about eight months, I could walk again...My father-in-law took me to Michoacan a couple of times after the first treatment and he started getting frustrated and asked the *curandero* why it wasn't working. He used the example of putting nails into a tree and taking them out a year later. He said that you can take them out of the tree but it takes a while for the tree itself to heal. The same is true of your daughter-in-law, he said.

It was after Diane experienced her first healing when she became a believer. Her mother was a strong believer and initiated Diane's first experience with healing. Diane's brother also used *curanderos* to help reverse a "work" that had been put on him. As Diane's narrative continues more aspects of *curanderismo* as practiced in Mexico are revealed.

My brother had a similar experience to me, before me and the *curandero* said that he was going to show him the people that have done the "work" on him. He had a big silver bucket, like the kind we wash clothes in, and filled it with charcoal and lit it on fire. Through the flames we could see images of the people...it was his girlfriend and her mother. I didn't want to believe that because I thought it was evil. When it was my turn he saw three people on my husband's side of the family and he said the "work" would be reversed. I told him no, I don't wish anything bad for anyone...and that I thought he didn't do that kind of work...and he said, "I don't, God does"...they will turn into God-fearing individuals after this. The only one that was affected was my sister-in-law who got really sick. The fire is only lit on the first visit. It can't be done more than once. The people that did the "work" on me did not wish me well because they envied me because

after having six kids, my body didn't change. They also envied me because they think I am pretty. They used to talk about how nice my body was to me and then they would touch my belly. They tried to put a pregnancy on me because they wanted me to get pregnant and the baby to die or be unhealthy. After that, the pain started from my lower belly into my leg. So, I went to the *sobadore* (massager) a couple of times and it didn't work. I moved to the states and things were better. The next time I went back to Mexico, it came back, the pain. So I went to the doctor through IMSS and he couldn't figure out what was wrong with me so my son suggested I go to a card reader. So I went, and asked her for a massage and she said that that wasn't what I needed—someone did a “work” on me—and then she did the cards and showed me and then she gave me some teas and a shot. She told me to take them to the states with me. As soon as I got here, it's ironic, I felt better because I was away from that family. I don't like to talk about this because the church always tells us it's wrong and I don't want the people to laugh at me.

Diane continued sharing about how her “situation” has significantly improved since moving to the United States, “I don't have as many problems here as in Mexico. It has to do with family issues because they are the one's bringing harm to me. Every time I go to Mexico something bad happens to me. I never have a good experience there.” She was content with the belief that, “the people that put works on others never get better after the work is reversed.” She also mentioned “a doctor cannot see or cure these things. People used to laugh at me because what I did, but now they see that I got better.”

Diane's narrative is a good example of how and why a lot of these healing practices are still used and strongly believed. The experience she had with the “work” resembles some African voodoo practices that have been thoroughly studied by numerous anthropologists. Most of these narratives bring to light the power belief has in both healing and causing or maintaining illness (Janzen, 2002) demonstrating the extent to which the mind has influence over the body.

The WHO (2001) asserts that 80 percent of the world's population use traditional healing practices. Many people believe in these practices while many do not. It is evident through the cases shared here that *curanderismo* and other forms of healing work for numerous people. These stories also demonstrate the need for healers in Iowa to continue to maintain and assist many *Mexicanos* with primary health care needs and ethnospecific illness and ailments. Among other methods *Mexicanos* employ to meet their health needs, working with healers can be viewed as preventative health care method and a legitimate means of restoring both physical and mental health.

#### A New Understanding of Preventative Health Care

Preventative health care can have different meanings to different people. Based upon the data collected, the conclusion has been made that *Mexicanos* means of preventative health care lie in their self-diagnosis and treatment in addition to other means of healing. In Mexico knowledge on herbal remedies is extensive and has been around as long as the people. Even second generation *Mexicanas* living in the states today have a tendency to self-diagnose and self-treat. Self-doctoring in this instance refers to the ability to assess one's illness and then use home remedies to help alleviate any symptoms they may be experienced. This is a part of Mexican socio-cultural behavior. Additionally, numerous other preventative health measures have been passed on orally.

Many *Mexicanas* learn growing up, to diagnose and treat themselves for many health issues rather than seeking the care of a doctor. It was common to hear statements like, "I don't remember ever being to the doctor. My grandmother knew how to take care

of us...she knew how to heal us and what to do.” The same individuals who made comments such as this had knowledge of remedies of their own to apply to different illnesses. In this section insight will be given to the many different types of remedies used to prevent and alleviate primary illness, which in turn increases our understanding of fundamental codes grounded in Mexican culture. *Mexicanos* get the “least preventative health care of any other minority group” in the United States according to the CDC (2004). According to the *Mexicanas* who participated in the interviews, they are taking the necessary steps of precaution in treating themselves until it proves ineffective,

I wait until I’m really really ill—I don’t know why...because people in Mexico tend to self-prescribe—including me...so I try that and if it doesn’t work or gets worse, I go to the doctor...but we know what to use, and in Mexico you can get medicine over-the-counter without a prescription.

Not only are the ladies aware of multiple herbal remedies and ways to balance their humors (hot and cold elements in Chinese medicine), when applying either of those methods, if unsuccessful, they are just as easily able to access the pharmacy where they can buy most any drug with the assistance of the pharmacist. Although policy in the United States is different when it comes to over-the-counter drugs, many still apply other methods to reduce symptoms before spending money “unnecessarily” on a visit to the doctor. According to Estella,

It depends on the health issue. With my stomach I don’t take medicine or go to the doctor...I just try to meditate or something to make it better. I don’t have health insurance...if I did I would go. I was never raised to need insurance and I go back to Mexico anyways...because it’s cheaper for different doctors there.

Angela felt the same way,

I generally go to the hospital...but only when I feel really sick. In Mexico I had never been with a doctor or to the hospital...it was wait wait wait...I only take my kids now when they have asthma, otherwise in my family, I usually try to take care of it with herbs and teas. If it's a cold I usually try to give medicine from a pharmacy otherwise, if it's their stomach I try to massage it. If it's *empacho*, when you eat something and get bloated and then try to eat again and it doesn't agree with you, we go.

Another approach to healing is self-diagnosis through the help of books or the internet. Annesse does research and tries to figure out what the symptoms are so she can be informed as to what step to take to improve upon her condition.

Usually my first thing is not to go to the doctor...I try tea, and resting, and if I don't get better after about two weeks, I go to the doctor. I don't have health insurance and even if I did, I was taught by my dad, mind over body, so I try to meditate. It's different with my younger brothers and sisters...but he says you can overcome your illness because you can and you do have the power to do it.

It's not that the women are opposed to visiting the hospital; it is just that they have learned other ways of dealing with sickness for simple survival matters both in Mexico and in the United States. Suzie never really visits the hospital herself as she generally tries to use teas and/or herbal supplements, the support and prayers of her family, and religious leaders as a means to restore her health. She said that *curanderos* were not her thing. "I'll just call my parents and ask them to pray for me," she declared matter-of-factly. They simply make do with what they have and utilize available knowledge on multiple facets of life in order to "make it." Jeanette lasted an entire year without going to the doctor after coming to the United States,

Growing up I had to go to the doctor only if I got really sick. If I feel sick, I take my own teas or whatever until I can't get better, then I go to the doctor...usually after about a week. If I were in Mexico I would go to the doctor after eight days of feeling sick, but here it took me over a year with my ovary because I don't have insurance or money...it's not like in Mexico.

If one's own knowledge and treatments to alleviate symptoms of illness prove ineffective and the individual does not have medical insurance, they start asking around for advice as to what to do to get healthy. Maria explained,

A while ago I was sick and didn't go to the doctor. I had terminal headaches and I was talking to other people about it and they told me of another person who was also suffering from the same thing who got better after she started to exercise...so I learned from example and changed my diet and it must have been right because I no longer suffer from chronic headaches. I don't go to the doctor because I don't have medical insurance.

Human nature teaches people to learn how to survive as best they can under any given circumstances. People have endlessly had to work around barriers that keep them down in many different facets of life. When something is not available, you find other means to survive. With regards to health, home remedies and advice to treat or prevent different illnesses have been a part of Mexican culture for centuries and have acted as a tool of survival for many. As their economic situation in the United States is not always sound, they do the only thing they know how to keep healthy. Louise said she waits so long to go to the doctor because she has failed to think about the consequences of not seeking care. She added, referring to *Mexicanos*, "it is always about the money...and you aren't sure or people don't have documents. Anyways, my mother would always wait forever before taking us to the hospital." She continued,

I went through a period when my ears hurt a lot because of *aire*. Almost always with the ears and throat. I went for two weeks with an infection because I thought it would go away. I didn't go to the doctor quickly. Then I went to People's and got medicine and it got better. Now, if I'm not better in three days and it's really bad I will go and get some medication.

This is to say going to the doctor is an option most do not opt to take as their first choice of restoring their health. As a learned process, it is not expected that this situation will change as new immigrants are continually coming to Iowa, and they have developed methods of primary care that are available within the means available to them in both the United States and Mexico.

Bianca, who is from a small *pueblo* in Michoacan shared some of her home remedies:

I make three mixtures myself. There are some remedies that you don't use with kids...for example, if there are stomach problems I make peppermint tea....and if my son swallows gum for example, and it doesn't come out in his stool...I take one tablespoon of Crisco, boil it, and cover it with chocolate and give it to him.

Angela additionally had a few treatments of her own that seemed better in theory to her than in affect:

For my stomach my mother actually brought me some stuff...*nopalinas*...like cactus stuff and she would put it in my drinks...it was based on natural stuff but I have a difficult time keeping up with it...because I didn't even know if it was working and it just pissed me off.

Nadia explained,

I use herbs and I know how to use them because my grandmother taught me. *Manzanilla* is used for a stomachache and *Rada* is also used for stomach pain. I generally wait two or three days if not more...depending on how sick I feel before going to the doctor. For my kids, I seek care immediately, but for me, I try to help myself before going to the doctor.

Although *Mexicanas* in Iowa self-diagnose and treat themselves for multiple types of illness, they do not always pass these methods on to their children. Elsie, informed me of some of her own behaviors when she gets ill and how that differs from the treatment her children receive:

If it's something like a cold you take over the counter medicine. I know my body well enough now to know when I can take over the counter medicine and when I need to go to the doctor. I get my physical every year and make sure my kids do too. I always make sure, ever since they were babies. She continued...I guess when a person experiences chronic pain and over-the-counter medicines aren't working...although it depends on the individual and how they were brought up...you rely on common sense. You pray also. Faith plays a role in it.

In Cecil's case she uses a combination of methods to deal with her children's illnesses and ailments that differ from her own.

I wait until I can't handle it anymore...but for my kids, when they are sick, I take them right away. I use teas for myself but the kids don't like them. *Sofucado* is when you are having inflammation problems with your stomach. I use *Yerba Buena* and *Manzanilla* a lot. My grandmother knows how to use herbs, but I don't know because it hasn't happened to me...but when babies get sick with inflamed bellies they take some of their saliva and heat it up and then rub it on their bellies and it heals.

Although a lot of treatment and care taken among *Mexicanas* is well thought out and affective in the end, there is a cluster of careless individuals who ignore their health problems and let themselves go. This of course, is not unique to *Mexicanos*. Jan grunted referring to her disappointment in some of her friends' health behavior. "They are self-doctoring and when they start getting better they stop caring for themselves." She continued,

My sister-in-law went to the doctor and he found a lump in her breast and he wanted to remove it. She didn't go back to the doctor for two years after that and it grew into a big-ass lump. It just pisses me off.

Although these are imperfect solutions to problems to some medical problems, *Mexicanas* are attempting to take it in their own hands to restore and maintain their health. If nothing more, their efforts have proven to be psychologically affective—the first step to better health according to many *Mexicanas*. Additionally, herbs and other treatments used are easily accessible. Not only are *Mexicanas* aware of common herbs to treat primary illnesses, in Iowa they have access to “stones which they bathe with and if the water turns black the spell or curse is removed....we also have all the tea here that people come in and use for all sorts of illness and affliction from cramps and abortion to a common cold,” according to Jan. Both minor and complicated health issues can be taken care of right in the home. Other advice offered to prevent different ailments and maintain the balance of the humors, were given:

You have to put cold foods in your body when you have inflammation. We were taught not to eat cold food while on our periods...things like avocado or lemon...or you will get a belly that won't leave you because you will be bloated and it won't go away when you get older.

You can't use anything cold which helps your skin to be less flaccid...It's really bad to add cold because you swell. When you are pregnant your body is open and when birthing wide-open...so adding cold is bad.

You can't eat pork if you're taking medicine and can't shower after eating.

In Mexico you can't take a shower until one week after giving birth. You also can't eat cold foods. I had a lot of milk in Mexico but when I came here I didn't follow the “no-cold-food” regime after giving birth and I didn't have any milk in my breasts...I was completely dry. They use a lot of different remedies for producing milk and they didn't work for me here,

While discussing certain precautions women take during their periods, Giselle clarified that because many American women eat cold foods while on their period and don't take

care of their bodies after pregnancy. “Many American women blow up...it’s all about your diet and taking care of your body.”

This study has led me to believe that preventative care for *Mexicanas* means something quite different than it does for most Americans. It means survival. It means utilizing knowledge and resources available—and all of within one’s means. There are many ways to “see to” the needs of ones health without necessarily going to the doctor. If affordable, accessible, and available, visiting the doctor would be ideal for *Mexicanas*, but it does not seem to be for most. Although health should be an innate right for all of humanity, this is not the case and people learn to make-do with whatever they have. Given this reality, people worldwide have resorted to other means of seeing to their health needs that have proven and continue to be effective.

*Mexicanos* tendency to self-doctor evolved out of Mexican society centuries ago. Often successful, this means of preventative health care serves its purpose; it is not however, effective for everything. There are multiple illnesses that invade the body without showing any physical signs or symptoms. Providing education, materials and health screening for *Mexicanos* in Iowa’s community would enable them to not only be aware of such illnesses but to identify their risk for any these illnesses.

## CHAPTER IV

### Discussion & Summary

Questions regarding disparities among the Latino population persist today. There have been numerous studies in addition to funds allocated for studies to help identify the different barriers preventing Hispanic's from getting the health care they need (NIH, CDC, Iowa/Nebraska Primary Care Association). These studies continue to produce explanations as to why disparities do exist in the health field and possible suggestions as to how to go about alleviating them or decreasing current barriers faced by newcomer populations and other minority groups. Some of the most common explanations for disparities in the health field are: the lack of medical insurance, language barrier, lack of knowledge and accessibility to health care as a newcomer, the lack of cultural competency, and culturally specific practices and beliefs (Iowa/Nebraska Primary Care Association, 2003). While each of these factors do play a role in individual lives in their perspectives on health and healing, they play a minimal role in the perpetuation of disparities in the health field.

Ultimately, to see statistical improvement on Hispanic health disparities, radical change from the governmental level is necessary to alter where and how *Mexicanos* are situated economically in addition to providing them with rights and mandating that employers provide health insurance for both documented and undocumented immigrants. Unfortunately, change in the United States is incremental at best so we must look to other means of mitigating health disparities in Iowa.

Understanding the *Mexicana* experience with health and healing in both Iowa and Mexico has ensured the first step in reaching a communicatively achieved consensus between *Mexicanos* and Iowans regarding health issues, is in progress. Multiple recognizable factors affecting *Mexicanas*' experience with health have been identified. From these, we are able to begin suggesting possible solutions to strengthen relationships between *Mexicanos* and Iowans, adjust to new ideas, better integrate this population into Iowa's health field, and implement change at the meso and micro level.

A large proportion of Mexican immigrants—documented and undocumented—as well as many Americans, do not have health insurance. Fortunately, *Mexicanos* have utilized their own knowledge and resources to care for themselves at the primary or preventative level. They are also familiar with and utilize local health clinics in which they are able to get the care and financial assistance they need to stay as healthy as our system enables people without health insurance to be. Providing them with additional resources will improve this condition further. However, it becomes a greater issue as Hispanics are doing the same thing as everyone else living in poverty yet statistically bear a disproportionate burden to disease, death, and injury, as reported by the WHO (2001) and the CDC (2004). This is because:

- (1) the types of jobs that the Hispanic population are filling are more strenuous and dangerous than other lower-end jobs that exist in this society (Grey, 1999), and

(2) statistically, the Mexicans have much higher concentrations of individuals in these jobs proportionately than do any other subgroup in America. Statistics therefore reflect these numbers.

Reflecting upon the *Mexicano* experience with health and healing a number of feasible suggestions have been provided to better integrate this population into the health field in Iowa. Furthermore, we can now recognize that *Mexicano* cultural health ideology exists in Iowa. Maintaining their cultural ideology contributes to the preservation of Mexican culture and assists *Mexicanos* with their primary and ethnospecific health needs. The preventative health methods and healers who have followed Mexicans to the United States are currently essential to the overall health and well being of *Mexicanos* in Iowa. This is evident as *curanderos* and other healers service this community in Iowa on ethnospecific illnesses that Iowan health practitioners have not been trained to treat.

It is also evident that culturally specific practices and beliefs, regardless of class and cultural background, are going to be retained so long as illness and ailments arise which contribute to these beliefs. For example, as long as I believe my prayers are being answered, I will continue to pray. As long as *Mexicanas* believe there are evil individuals that wish harm upon them, they will continue to utilize *curanderos*. This is an example of how beliefs and attitudes shape behavior. This does not, however, bear much weight on individual decisions to seek health care in a medical setting.

Although cultural practices and beliefs come with migration, these beliefs do not prevent *Mexicanas* from seeking care. It has been suggested that the lack of cultural knowledge on the practitioner's part is keeping *Mexicanos* from going to the hospital and

seeking care (Iowa/Nebraska Primary Care Association, 2003). On the contrary, healers in a biomedical setting are trained in biomedicine. This means they look at the body and its functionality objectively and apply diagnostics according to scientifically sound knowledge of the human body. As the human body is essentially the same across borders and medical practitioners are trained to heal people based upon different aspects of the human body, the two ideas, although related, have no direct affect upon one another. If we were to require medical practitioners to be trained on cultural competence, we would have to train them on every form of religion and healing practice world wide so in the end they could work on one human body that is just like another human body, which is unrealistic. It is however possible to improve upon conditions by informing them of simple strategies that can be used when working with *Mexicanos*.

Although preventative health care is incorporated into the *Mexicana* lifestyle, the need to integrate more health screening programs for illnesses that show no physical signs or symptoms is an essential aspect of preventative care that they are lacking. Concurrently, identifying the most common types of injury occurring in the industries in which many *Mexicanos* are employed and ways to aid themselves to heal could be beneficial. In turn, providing awareness on the steps to take to get adequate care and/or how one can care for oneself could significantly improve work-injury related issues and problems. As awareness increases, disparities decrease.

Additionally, as the health systems between Mexico and the United States are significantly different, developing an introductory guide to Iowa's health system, the social services available for both documented and undocumented immigrants, how to

access health care depending on status, and how to go about this if one does not speak English, could prove to be extremely useful for this community.

As language is a major barrier for individuals seeking health care a number of methods to decrease the severity of this issue are easily enacted. Communities can look to volunteers and provide incentives for them to donate time at hospitals and clinics. Spanish medical terminology can be implemented into nurse training, and a medical bilingual reference sheet can be made available at hospitals and clinics so, if interpreters are unavailable, care can still be given to individuals who are in need. To make the conditions run smoother still in hospitals and clinics, training health practitioners, or providing them with a guide on cultural sensitivity issues would assist in decreasing misunderstandings between doctors and patients.

Providing the Hispanic population with a Spanish-speaking, ask-a-nurse help line would also provide the community with accessible information about their health needs and provide them with instructions as to where to seek the care they need depending upon the illness or ailment which they are experiencing.

Although, if implemented, these suggestions will improve working conditions in the health field, the problem with disparities is never going to dissipate so long as we are unwilling to look at the core reasons for their existence in the first place. Although the identified “barriers” faced by *Mexicanos* in addition to other minority populations exist, if alleviated, will improve relations and conditions between Iowans and Mexicans, they will not significantly decrease disparities. Many of the suggested barriers are viable and there are ways to implement change that can aid in system integration. Furthermore, by

providing Iowans ways to relate to Mexicans, relationships will continue to build and Iowans—aiding a mutual integration understood and supported by both Mexicans living in Iowa and Iowans.

## BIBLIOGRAPHY

- Bade, Bonnie. 2004. "Alive and Well: Generating Alternatives to Biomedical Health Care by Mixtec Migrant Families in California." Presented at Indigenous Mexican Migrants in the US: Building Bridges between Researchers and Community Leaders, 2002. Santa Cruz, CA.
- Berg, Bruce. 2004. *Qualitative Research Methods for the Social Sciences*. Boston, MA: Pearson Education Inc.
- Borrayo, Evelinn, and Sharon Jenkins. 2003. "Feeling Frugal: Socioeconomic Status, Acculturation, and Cultural Health Beliefs Among Women of Mexican Descent." *Cultural Diversity and Ethnic Minority Psychology*. Vol. 9(2). Pps. 197-206.
- Camey, Xochitl, Cecilia Barrios, Xochitl Guerrero, Rosa Nunez-Urquiza, Dolores Hernandez, and Ana Glass. 1996. "Traditional Birth Attendants in Mexico: Advantages and Inadequacies of Care for Normal Deliveries." *Social Science Medicine*. Vol. 43(2). Pp.199-207.
- Centro de Educación Ambiental e Investigación Sierra De Huautla (CEAMISH). Col, Chamilpa, Cuernavaca, Morelos. Retrieved September 22, 2005 (<http://www.uaem.mx/posgrado/investigacion/ceamish.htm>).
- Chavez, Leo, Estevan flores, and Marta Lopez-Garza. 1992. 'Undocumented Latin American Immigrants and U.S. Health Services : An Approach to a Political Economy of Utilization.' *Medical Anthropology Quarterly*. Vol. 6. Pps. 6-26.
- Corbin, J. and Strauss. 1992. "Grounded Theory Methodology: An Overview." *Strategies of Inquiry*. Pps. 273-285.
- Division of Health Systems and Services Development. 1999. "Traditional Health Systems in Latin America and the Caribbean: Base Information; Technical Project Report." November. Washington, D.C. Pps. 0-22.
- Global Health Corps. 2005. University of Northern Iowa. Retrieved February 17, 2005 (<http://www.globalhealthcorps.org>).
- Gonzalez-Romos, Gladys. 2004. "An Overview of Health Disparities in the Hispanic Population". Culturally Competent Mental Health Care for New Hispanic Immigrants. New York University.

- Grey, Mark and Anne Woodrick. 2005. "Latinos Have Revitalized Our Community": Mexican Migration and Anglo Responses in Marshalltown, Iowa. In *New Destinations of Mexican Immigration in the United States: Community, Formation, Local Responses and InterGroup Relations*. Victor Zuniga and Ruben Hernandez-Leon, eds. New York: Russell Sage, pps. 133-154.
- Grey, Mark. 2002. *Welcoming New Iowans: A Guide for Managers and Supervisors. The Best Practices of Iowa Employers with Immigrants and Refugees in the Workplace*. University of Northern Iowa New Iowans Program.
- Grey, Mark. 1999. Immigrants, Migration and Worker Turnover at the Hog Pride Pork Packing Plant. *Human Organization* 58(1):16-27.
- Grey, Mark. 1997. Secondary Labor in the Meatpacking Industry: Demographic Change and Student Mobility in Rural Iowa Schools. *Journal of Research in Rural Education* 13(3):153-164.
- Grof, Stanislav. 1988. *The Adventure of Self Discovery: Dimensions of Consciousness and New Perspectives in Psychotherapy and Inner Exploration*. State University of New York Press.
- Habermas, Jurgen. 1990. *Moral Consciousness and Communicative Action*. MIT Press: Cambridge, MA.
- Harner, Michael. 1980. *The Way of the Shaman*. San Francisco, CA: Harper.
- Hsu, Elisabeth. 1999. *The Transmission of Chinese Medicine*. Cambridge Studies in Medical Anthropology, Cambridge University Press.
- Iowa/Nebraska Primary Care Association. 2003. "Survey and Analysis of Health Needs and Disparities of the Immigrant Population. Pps. 0-104.
- Janzen, John. 2002. *The Social Fabric of Health: An Introduction to Medical Anthropology*. McGraw-Hill Company.
- Kearney, Michael. 1979. "Spiritualist Healing in Mexico." *Culture and Curing: Anthropological Perspectives on Traditional Medical Beliefs and Practices*. University of Pittsburgh Press. Pps. 19-39.
- Kiev, Ari. 1968. *Curanderismo: Mexican-American Folk Psychiatry*. The Free Press: A Division of Macmillan Publishing Co., Inc.
- Levitt, Peggy. 2001. *The Transnational Villagers*. Berkeley and Los Angeles,

- California: University of California Press.
- Lipp, Frank. 1996. *Healing Herbs*. Hammersmith, London: Thorsons; Harper Collins Publishers Ltd.
- Lofland, John and Lyn Lofland. 1995. *Analyzing Social Settings: A Guide to Qualitative Observation and Analysis; 3<sup>rd</sup> ed.* Albany, NY: Wadsworth Publishing Co.
- Long, Rebecca, et. al. 2000. "The Qualitative versus Quantitative Research Debate: A Question of Metaphorical Assumptions?" *International Journal of Value-Based Management*. Vol. 13 (189-197).
- Merriam-Webster Dictionary. Retrieved January 15, 2006 (<http://www.m-w.com/>).
- National Institutes of Health: US Department of Health and Human Services. Retrieved February 20, 2005 (<http://www.nih.gov>).
- Navarro, German Estrada. 2003. "Profile of the Indigenous People of Mexico Chapter 8." *Mexico Magico: Everything you wanted to know about Mexico...but nobody told you*. Mexican Government Institutions (SEOESOL). GO2, SA de C.V.
- Nigenda, Gustavo, Enrique Cifuentes, and Warren Hill. 2004. "Knowledge and Practice of Traditional Medicine in Mexico: A Survey of Healthcare Practitioners." *International Journal of Occupational and Environmental Health*. Vol. 10. Pps. 416-420.
- Ritzer, George and Douglas Goodman. 2004. *Sociological Theory; 6<sup>th</sup> ed.* Boston, MA: McGraw Hill.
- Rubel, Arthour. 1977. "The Epidemiology of a Folk Illness: *Susto* in Hispanic America." *Culture, Disease, and Healing: Studies in Medical Anthropology*. New York: Macmillan Publishing Co.. Pp. 119-128.
- Selfa, Lance. 2003. "A Two-Faced Immigration Policy." *Socialist Worker Online*. Retrieved December 14, 2005 ([http://www.socialistworker.org/2003-2/474/474\\_09\\_Immigration.shtml](http://www.socialistworker.org/2003-2/474/474_09_Immigration.shtml)).
- US Census Bureau. 1990, 2000, and 2004. Washington D.C. Retrieved March 9, 2005 (<http://www.uscensus.gov>).
- US Center for Disease Control and Prevention. 2004. Retrieved March 9, 2005 ([www.cdc.gov](http://www.cdc.gov)).

- Wallace, Ruth, and Allison Wolfe. 1999. *Contemporary Sociological theory: Expanding the Classical Tradition, 5<sup>th</sup> ed.* Upper Saddle River, N.J.: Prentice Hall.
- Werner, David. 2003. *Where There Is No Doctor: A Village Health Care Handbook.* Berkeley, CA: the Hesperian Foundation.
- Williams, Charles Harrison. 1977. "Utilization of Persisting Cultural Values of Mexcian-Americans by Western Practitioners." *Traditional Healing: New Science or New Colonialism? Essays in Critique of Medical Anthropology.* New York: Conch Magazine Limited. Pps. 108-122.
- World Health Organization. 2001. "Legal Status of Traditional Medicine and Complementary/Alternative Medicine: A Worldwide Review." Washington D.C.
- World Health Organization. 1995 and 2000. Retrieved February 11, 2005 (<http://www.who.int/en/>).
- Yehieli, Michele and Mark A. Grey. 2005. *Health Matters: A Pocket Guide for Working with Diverse Cultures and Underserved Populations.* Boston: Intercultural Press.

## APPENDIX A: GLOSSARY

### General terminology

*Mexicano* refers to men or men and women from Mexico

*Mexicana* refers to women from Mexico

*Geijin* foreigner

*Pesos* form of money in Mexico

*Limiar/limpiando* the standard cleaning performed by *curanderos*

### Healers in Mexico

*Curandero(a)(ismo)* (o) male or female (a) female healers (ismo) the practice of traditional and/or indigenous healers in Mexico

*Husero* bone-setters

*Herbalisto* traditional medicinal herb specialist

*Partera* midwife or traditional birth attendant

*Sobradore* masseus

*Espirualista* spritual healer or guide

### Ethnospecific Illnesses

*Nervios* anxiety/depression

*Mal de Ojo* evil eye

*Empacho* stomach problems

*Aire* when a baby does not stop crying

*Sofucado* when you are having inflammation problems with your stomach

*Work* when someone puts a hex or curse on someone else

### Places

*Farmacia* pharmacy

*Pueblo* village or town

*Tienda* shop

### Herbs/Plants

*Manzanilla* chamomile tea

*Yerba Buena* spearmint tea

*Nopalinas* cactus

## APPENDIX B: INTERVIEW GUIDE

The goal of this project is to collect data from women of Mexican descent to better understand their perspectives on traditional and formal health care. I am primarily interested in your perspective of traditional and formal health care and if living transnationally has changed these perspectives. The data collected for this study will be used to educate health professionals on cultural health practices and beliefs unique to Mexico so they will better be able to address your needs. I traveled to Mexico this summer and was able to participate in a number of interviews given to traditional healers throughout Mexico in addition to visiting universities and attending classes on traditional healing.

### I. Demographics

- What name would you like to use?
- How old are you?
- Do you identify yourself as *Mexicano* or do you prefer to be called something else?
- How many years did you attend school?
- How many years have you lived in the United States?
- What town and state did you come from?
- Where in the United States have you lived?
- Are you married? How many children do you have?
- Are you comfortable talking about your immigration status?
- Are you currently employed?
- Are you a part of a church? Which church do you usually attend?

### II. Beliefs and Understandings

- When someone uses the word *salud* what do you think they mean?
- Do you use the word *salud* when you talk about yourself and your family?
- Is *salud* the word you use when you talk to your doctor?
- How do you know when you are healthy?
- How do you know when you have been healed?
- What kinds of words do you use to describe your body when you are not healed? Can you give me an example of when you were sick or lacked health and you healed? How long did it take?
- Can your body be well but your spirit sick?
- When you think about being healthy, how much has to do with your spirits?
- Have you ever had a time when your body would not heal because your spirits were not good?
- How much of the healing process do you think relies on the belief that the healer has the capability of healing? Does the weight put upon this differ between traditional healers and medical doctors?

- Have you ever used a *curandero*? *Partera*? Shaman? *Huesero*? *Espiritualista*? Can you give me an example of when you used these? What problem or ailment did you seek this treatment for?
- Do you have a doctor? How long have you been seeing this doctor?
- Have you ever been in the hospital? When? Where?
- Have you had surgery? When? Where?

### III. Practice

- What steps do you take to seek care when you are ill?
- Whom do you consult? Your mother? Friends? A religious leader?
- What are the illnesses/diseases that can best be treated with the knowledge and practices of medical doctors?
- What are the illnesses/diseases that can best be treated with the knowledge and practices of traditional healers?
- Have you used both traditional and formal health care/treatment in your lifetime?
- Have you ever used both traditional and western medicine at the same time and for the same condition?
- What led you to use traditional versus formal health care?
- What led you to use western medicine instead of traditional practices?
- Can you talk about your experiences in receiving treatment from a traditional healer? Medical doctor? How do they differ? How are they the same?
- What are the positive aspects of traditional healing? Negative?
- What are the positive aspects of formal health care? Negative?
- Is it easy to access traditional healers in this area? Do you feel comfortable doing this?
- What are the differences in access to folk healing between the United States and Mexico?

### IV. The affect of migration

- Has your perspective on healing changed in any ways since migrating to the United States? How about your children's perspectives?
- Where do you see the future of traditional healing in the United States? Mexico?
- Are you willing to help me meet traditional healers in this area?
- Is there anything else you would like to add?
- Do you have any questions for me?