Section VIII
Health & Access to Care

Executive Summary

- Overall the indigenous access health care at very low rates; however women access care at higher rates than men do.
- Factors that account for this low rate of access include systemic barriers like lack of insurance, high costs, transportation difficulties, long waits, and undocumented status plus cultural barriers such as language and unfamiliarity with U.S. medical culture.
- The indigenous are averse to the way modern medicine is practiced. They possess a different worldview regarding disease, health and healing, which leads them to avoid care (until the condition is extreme), and is also an obstacle to compliance.
- When possible they seek care in Mexico as well as from traditional healers who operate outside of the formal medical establishment in California.
- Women, who are the most likely to seek care in California for childbirth and delivery services, present a new and time-consuming challenge. Many providers lack sufficient familiarity with this population to make the appropriate adaptations.
- Providers, who strive to deliver culturally-appropriate care, struggle with a lack of qualified interpreters, staff shortages and an overall lack of resources.
- The extremely crowded and sub-standard conditions in which the indigenous live increase the risks for poor nutrition, infectious diseases, delayed development in children, and domestic violence.
- Women and men both suffer from depression: in women it can be related to cultural isolation following childbirth; among unaccompanied men it can be linked to loneliness due to separation from their families.
- The inferior social status of indigenous women, combined with culturally-sanctioned early age of marriage and childbearing and low levels of education, endanger women's health and place them at high risk for physical abuse.

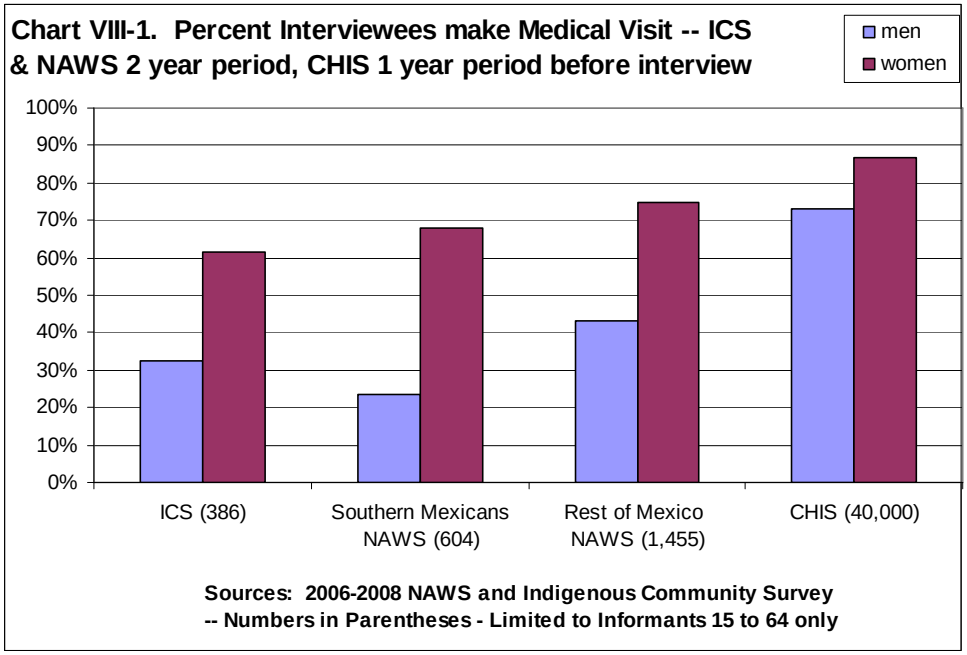
VIII-1 Overview: Low Access to Care

Indigenous farmworkers access medical care far below the rate of the general population, and even lower than other Mexican-origin farmworkers. In this section we examine these rates, for both men and women, and ponder the reasons that account for this extremely low rate of access.[1]

As indicated in Chart VIII-1 below, there are stark gender disparities in accessing medical care. In all four comparisons women visit a doctor more than men. The disparity between men and women is far more pronounced for farmworkers (using both

[1] For previous work on access to care among the indigenous see Bade, 1994 (Sweatshops, Sacrifice and Surgery)

NAWS and the ICS) than it is for the general population (CHIS).[2] In the two measures of the indigenous population, the ICS and southern Mexicans in the NAWS, the women go to the doctor at twice the rate of men or more. If we compare farmworkers with the general population, the disparities for men are much greater than for women. In the general population, 73% of men make a medical visit, while the three farmworker male rates vary from 24% to 43%. The variation for women is much less. In the general population, 86% of women make a medical visit. For farmworker women, the rate varies from 62% to 75%.



Leaving the general population aside, Chart VIII-1 also shows stark disparities within the farmworker population. Namely, there are differences between the indigenous and other (mestizo) farmworkers, especially for the men. The comparison in the NAWS indicates that 24% of indigenous men (southern Mexicans) make doctor visits, while 43% of the mestizo men (rest of Mexico) make visits. For the indigenous and mestizo women the rates are much closer: 68% for the indigenous women (southern Mexicans) and 75% for the mestizo women (Rest of Mexico).

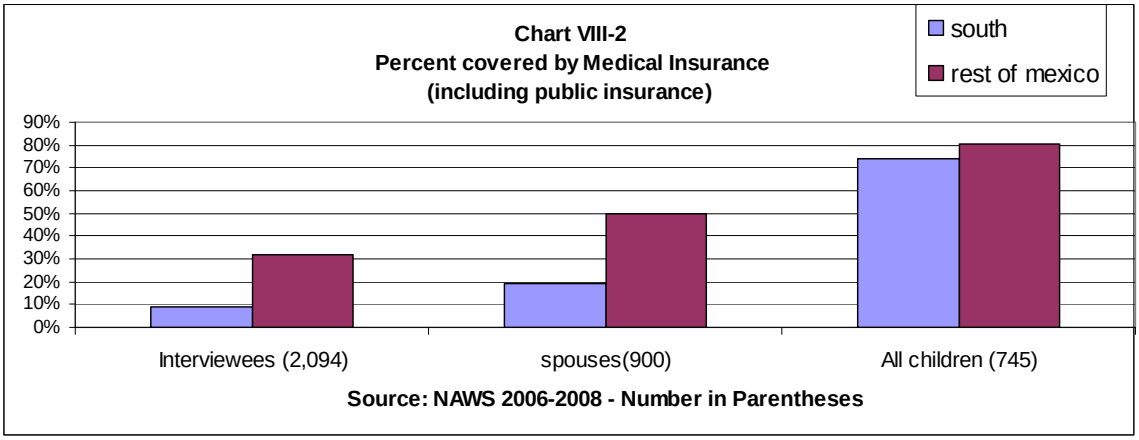
[2] We used three sources: our Indigenous Community Survey (ICS), the U.S. Department of Labor's National Agricultural Workers' Survey (NAWS), and the California Health Interview Survey (CHIS). Our rates refer to percentage of individuals who visited a medical provider one or more times. CHIS asks for one year back, the ICS and the NAWS ask for two years back. Therefore, if asked for a one year period, the rates for farmworkers would be even lower than reported here. See Section IV for explanation of using southern Mexicans as a proxy for the indigenous.

VIII-2 Factors that account for low access

What accounts for this disparity in access to care between the indigenous, mestizos and the general population? We first cite the systemic barriers to access and then the cultural ones. The reason most often cited is the high cost of care and lack of medical insurance.

VIII-2.1 Lack of insurance

As can be observed in Chart VIII-2 below, the rate of insurance coverage for indigenous adults is incredibly low. Only 9% of the southern Mexican interviewees were covered, 19% of their spouses and 74% of their generally U.S.-born children. These rates for adult Southerners are lower than for adult farmworkers from the rest of Mexico but almost the same for children. The indigenous children (like the mestizo children), most of whom were born here and are below the poverty line, qualify for publicly-sponsored health care.



VIII-2.2 Other factors affecting low access

While affordability and lack of insurance are certainly important factors, they are far from the only ones. In hundreds of interviews over the course of more than two years, our research team repeatedly encountered a population *averse* to medicine as practiced in this country, reluctant to seek care except as a last resort, not trusting of the providers they encountered, and often confused or angered by the treatment they did receive.

We argue that any effort to improve access to health care for the indigenous, in addition to addressing matters of affordability, must also understand the reasons underlying the mistrust and avoidance we encountered, and seek innovative and creative ways to meet the health care needs of this hard-to-reach population. The discussion that follows is an attempt to begin that process.

For now, we turn to what we learned listening to indigenous informants, as well as to outreach workers and health providers, about the factors that help account for the low

rates of medical care among the indigenous. These include systemic difficulties such as lack of legal residence, transportation problems, long waits and poor treatment at clinics, and cultural-linguistic barriers that include fear of Cesarean sections, and preference for medical treatment in Mexico.

VIII-2.3 Transportation

As noted in Section VI-1, only around fifty percent of indigenous households own cars or trucks, and among newer arrivals up to eighty percent can be without their own means of transportation. Women, who are the ones most likely to seek health care, can be left isolated with any means of getting to a health care center. Proximity to health care services varies greatly by region and those in walking distance of a clinic are the fortunate minority.[3] In the Central Valley, where settlements are dispersed and distances considerable, having a car often determines whether one obtains medical care. The only transportation available in some isolated areas are expensive "independent" taxi/car services.[4]

A particularly dire situation exists for the tomato and strawberry pickers who live in makeshift shelters in the canyons of San Diego's north county in close proximity to upscale suburban neighborhoods. These canyon residents suffer from a not uncommon double disadvantage: no legal papers and no vehicles apart from bicycles. As one interviewee described the situation, "We have to put up with snakes, *la migra* and thieves... If we get sick we just have to live with it or go to Tijuana... Sometimes people are able to buy [medicine] in a drugstore."[5]

Even where public transportation might exist, learning to use it can present an almost insurmountable obstacle for indigenous women who have little formal education, speak no Spanish and are struggling to cope with the shock of transition from a small, remote village in southern Mexico to an intense and confusing urban America of the 21st century. Our study has identified a number of newer networks whose members arrived in the U.S. without prior experience traveling and working outside their homelands in Mexico. If this trend continues, there will likely be increasing numbers of indigenous who arrive without basic coping skills. An activist in Santa Maria, California, described a Mixtec woman she knew who was terrified of using the bus, and noted that "many of these women come directly from their villages and can't learn from one day to the next how to function in a modern society. Those who've migrated elsewhere in Mexico are better able to handle the transition to the U.S."[6]

VIII-2.4 Long waits, inconvenient hours and humiliating treatment

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[3] For further discussion of the transportation barrier for the indigenous see Bade, 1994 and 2000

[4] In the case of a patient in Huron needing to get to a clinic in Fresno, the cost was $60.

[5] Interview done by Rick Mines, December, 2008

[6] In Section II we note that the indigenous in the networks we studied are coming directly to the United States more often now instead of living for a time at the border.

Even for the few with health insurance through their employer, or eligible for some form of public assistance, the delay between making an appointment and getting to see the provider is an exasperating experience. "It can take 2-3 months and by then you're dead," complained a 69-year old former Mixtec farmworker in Santa Maria. For him it was better to go to Mexico, pay out of pocket and be seen right away.

Taking time off work and spending it in the waiting room is another disincentive. Time is literally money, and hours spent away from the fields and in a clinic places financial burdens on these low wage workers. Only a few clinics offer evening hours.

The treatment received at the hands of rude receptionists is another frequent complaint. While many indigenous men are able to make themselves understood in Spanish, simply having a Spanish-speaking person on hand is no guarantee of decent service. Indeed, mestizo staff often perpetuate the discrimination that is widespread in Mexico. One community activist in the North Coast area is convinced that indigenous people are singled out for poorer service: "We're less important for them and so they keep you waiting for 2-3 hours." Elsewhere in California, indigenous informants independently reported having to endure long waits and condescending treatment by clinic staff. A Mixtec-speaking man in San Diego recalled an encounter at a local community clinic where he had been asked to bring his daughter for an x-ray. He was made to wait several hours by a receptionist who pretended not to speak any Spanish. When he finally got angry she suddenly shifted into fluent Spanish.

In Fresno an accomplished mother of four who speaks several variants of Mixtec, and has worked for a number of years as an interpreter at local clinics, described how "there is no respect for the patient; they gesture at them, make faces and yell at them."

Indigenous Community Survey data shows that in those communities with a longer presence in the United States, people are more likely to seek help from the health care system. However the numbers reveal little about the quality of care or patient satisfaction. The following is an account as told to one of our researchers by a 48 year old man from San Miguel Cuevas about a terrifying episode in Fresno:

> The man was in the hospital for two or three days and the doctors told him he had either cancer or AIDS. The man was really frightened. His problem was that he was vomiting blood. He wasn't allowed visitors because they said he was highly contagious. While he was in the hospital a nurse came by and threw a bag at him, and this behavior by the nurse left him really scared. When he opened the bag he saw that it was food. He felt even sadder because they were treating him like a poor dog. After two days they told him there was nothing wrong with him, and that maybe it was something he'd eaten. The man said it took him a long time to recover from the trauma of the way they had given

him the news. He never saw the nurse's face, only her hair. She was blond." [7]

To be treated with respect and dignity is, of course, valued by everyone, but no more so than by indigenous communities where great store is placed on politeness, formality and courtesy. Careless comments can easily cause deep offence, or even trauma. Mixtec women in Ventura reported feeling humiliated by the clinic's interpreters who remarked that they were "good for producing babies but not for looking after them," and that they got sick because their homes were "like pig sties." Affording their patients respect costs nothing but earns considerable goodwill, while a failure to do so drives patients away. Indeed the word gets around, leading to avoidance of a given clinic or provider. A 48-year old Triqui man who has worked for years picking lettuce and broccoli in the Salinas Valley is typical of many men who see no point in even trying to seek health care when, as he put it, "They treat us worse than dogs." Conversely, a provider who establishes rapport with his or her patients gains a reputation for giving good care and the word quickly spreads. Even care-averse men will travel a considerable distance to be seen by someone they feel is trustworthy, albeit only as a last resort. Such is the case with "*La Doctora*" as they refer to the Physician's Assistant at a small rural clinic in western Sonoma County. This woman, who does not speak their language and who admits to only rudimentary Spanish, is nevertheless greatly appreciated by Mixtec and Zapotec men who work in the vineyards and dairies of the North Coast.

Nor is the poor treatment confined to front-line personnel.[8] In the Central Valley region an advocate expressed deep frustration at the attitude of agencies in her area where the indigenous are regarded as "low status." She likened it to "pulling teeth" to get clinic administrators and social service providers to make use of indigenous interpreters already available in the area, and lamented the overall resistance to providing culturally-competent services.

VIII-2.5 Cultural-linguistic barriers

The ability to communicate is critical in the physician-patient encounter. One of the physician's first steps in caring for a patient is obtaining an accurate history. A practitioner places great importance on this step, and uses his or her powers of listening, together with the physical examination and, if needed, tests to arrive at a diagnosis and a decision regarding treatment. The inability of patient and doctor to understand each other erects a barrier from the outset, heightening the risk of misdiagnosis, inappropriate treatment and non-compliance by the patient. For a western-trained physician the challenge of treating an indigenous patient goes beyond simple translation barriers. Elizabeth Gomez is a trained medical interpreter who works at the Oxnard Clinic. Ms. Gomez, who is trilingual in English, Spanish and her native Mixtec, explains that there are often no words in Mixtec for numerous medical conditions such as asthma, tuberculosis, anemia and diabetes. She must also improvise language to explain to parents

[7] Information gathered by interviewer Anna García.

[8] For further discussion of behavior toward the indigenous by medical personnel see Bade, 2004, 2005

why their children need to be vaccinated, why they may be at high risk for lead poisoning, or should be tested for anemia.[9] As for women's health, there are often no terms in Mixtec for certain body parts, particularly those relating to the reproductive system. It is even difficult to explain a procedure such as a cervical exam, or a concept such as contraception. Ms. Gomez says that it takes her considerable time and tact to put a woman at ease and establish trust. The problems are the same in Mexico. She knows of no culturally-sensitive medical care for the indigenous in Mexico, nor any effort there to educate or inform patients about their prescribed treatment. She points out that no vocabulary has been developed in the home country to bridge the divide between biomedical and traditional approaches to healing.

VIII-2.6 Fear of Cesarean sections

During our research, an illustrative example of the communication gap emerged on the subject of Cesarean sections. Repeatedly, indigenous women we interviewed expressed their distress at having their babies delivered by C-section. At first, we wondered if indigenous women were being subjected to this procedure at a rate higher than other groups. While we are unable to answer that question quantitatively,[10] probing the matter did shed light on a subject where poor communication across the cultural-linguistic divide has created an arena rife with misunderstanding. In fact, some indigenous activists believed it was yet another conspiracy against the indigenous: by performing C-sections on defenseless indigenous women, the hospitals, in their opinion, could extract additional money from the government, since they believed that reimbursement for C-sections would be higher than for vaginal births.[11]

Probing the issue was not an easy matter, given the reticence about discussing reproductive matters, especially in the presence of a male interpreter, as well as the reluctance to complain or appear ungrateful for free care. Finally, one of our Mixtec interpreters, after sufficient trust was established, reported that women were very angry, that they felt they were being forced against their will to have C-sections, and that they believe they're being assigned incompetent doctors who don't know how to deliver babies and thus resort to performing C-sections. He concluded the litany of complaints with a question and a plea: "They want to know *why* they are always told they have to have a C-section?" Interestingly, it was our interpreter's wife who stepped forward to shed light on the matter.

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[9] Alarm over lead poisoning in mestizo and indigenous children has been growing in recent years. Sources of contamination include exposure to lead paint in sub-standard housing as well as folk remedies, foods and candies imported from Mexico. For an account of research into an outbreak of lead poisoning among Oaxacan children and pregnant women living in the Central Coast, see Handley, et al, May, 2007. pp. 900-906. For an account of how lead-contaminated food items from Oaxaca are inadvertently transported to California, see Handley and Grieshop, 2007, pp. 1205-1206.
http://ije.oxfordjournals.org/cgi/content/full/36/6/1205

[10] Administrative data is not collected for the indigenous as a distinct group.

[11] From the perspective of traditional medicine, a Zapotec midwife told community workers that when doctors practice Cesareans, they cut not only the skin and layers of muscles and fat, but also the different layers of energy that our body has, so after that, the women need to seek treatment from a traditional healer to help them heal and recover. (Personal Communication with Nayamín Martinez, December, 2009).

The interpreter's wife, whom we will call Francisca, has been working as a Mixtec interpreter for more than five years at a local clinic. Francisca explained that there are several reasons why indigenous women might have to have a C-section. First, because they only come to the clinic at the end of their pregnancy. Since they are not accustomed to prenatal care in Oaxaca, they "just wait 'till it's time for the baby to be born." According to clinical regulations, this automatically puts them in a high-risk category, increasing their chances for a C-section. Francisca believes this is an important area needing attention: there should be outreach to pregnant indigenous women explaining the importance of prenatal visits. These kinds of outreach efforts for farmworkers do exist in her area, but they're only conducted in Spanish and thus they fail to reach the many Mixtec women who don't understand Spanish.[12]

A woman also might receive a C-section for the seemingly obvious reason that she's already had one before. When Francisca is called in to interpret, she is able to explain that there's a risk of complications, including the possibility that the previous sutures might burst, a fact the women had not understood. There are educators at the clinic that are supposed to explain this, but when things get busy they may not have the time or remember to bring Francisca in to interpret. She also suspects that the doctors don't realize that the Mixtec women they are attending simply don't understand what is happening to them. In spite of the years Francisca has worked at the clinic, she is still not clear how the facility is organized nor does she have the confidence to approach anyone in authority to voice her concerns

Francisca's account also prompted discussion of a related matter that had been bothering her husband: he knew of two Mixtec women who had stayed away from the clinic and given birth at home. Now they were finding themselves unable to obtain birth certificates or documentation for their infants. He offered this as another example of what happens when Mixtec girls arrive not knowing anything about how things are done in this country, and he longed for a program to educate indigenous girls and women about pregnancy and childbirth.

Nearly three hundred miles away, a resident working the emergency room of a county hospital provided a physician's perspective, confirming and expanding on much of what Francisca told us. This doctor has gone to considerable lengths to learn about Oaxaca's indigenous peoples, with the intention of providing care in a culturally-sensitive manner. But communicating with indigenous patients in the hospital setting, even with an interpreter on hand, presents even well-intentioned physicians with huge challenges. He told of Mixtec women who have been picking strawberries along the Central Coast as follow-the-crop migrants, with little or no prenatal care, arriving at the hospital ER ready to deliver:

[12] One Family Nurse Practitioner in Ventura County, who serves many Mixtec patients, has collected data from her own practice demonstrating that culturally appropriate care does lead to earlier dates of entry into prenatal care for pregnant Mixtec women.

> They may be higher risk but it's difficult to explain that they may need a C-section; they're very resistant to having a C-section. Often there's a perception that if the doctor is no good, they'll get a C-section. There's not a good understanding of C-sections and they see it as 'the worst thing that can happen.'

By law, hospitals are required to provide care in a language the patient can understand, but when situations arise outside of normal hours, and the on-staff interpreter is not available, they may turn to a telephone interpretation service. This at least puts the hospital in legal compliance, the resident explained, but it's seldom satisfactory. When a woman is in labor they need to conduct regular vaginal checks given the complications than can and do arise, however the women are "very fearful of male providers and they don't understand the procedures and it's hard to explain things to them."

Even outside of the intensity of the Emergency Room, language can raise a barrier to appropriate care. A Mixtec woman who works as an interpreter in Fresno expressed her concerns: "I don't think they prescribe the right medicine for what we have because they don't understand what we're saying." One of our Mixtec informants in the Watsonville area, and an activist within his community, reported that people complain that the doctors don't give people very much information. The same informant also wondered about the extent to which the indigenous themselves bore part of the responsibility. From personal experience he knew that doctors and nurses tried to explain things, such as how to take the medicine being prescribed. He went on to speculate that a cultural behavior may be at work here, noting that the indigenous, when asked a question, instead of admitting they didn't understand, or requesting clarification, simply answer "*si*" to all questions, in order to avoid an impolite "*no*." And so perhaps the doctors simply assumed they had understood.

The resident at the county hospital concurred that most of his colleagues don't have an effective connection to the indigenous population, and so while he believes that his colleagues genuinely strive to provide good, culturally-sensitive care, they simply don't know how. For example, "They think Mixtec women are very stoic and don't want pain medication because they don't speak up. It's a pattern they fall into," he says, "and they just assume all sorts of things."

Many physicians simply rely on the patient to bring in a friend, a relative or even a child to interpret. Often it can be a male relative and, again, with the extreme sensitivity around the female body, this raises barriers to effective communication and care.

The cultural-linguistic barrier, though daunting, is not insurmountable. In the downtown Oxnard branch of the Clinicas del Camino Real, they employ a process of "relay" interpretation: on staff is a female Mixtec-Spanish speaker who interprets between the patient and a bilingual Spanish-English health assistant who then interprets for the English-only health provider. Tending a Mixtec-only patient does take more time, but one OB/GYN Nurse Practitioner, who speaks only English, has found the extra effort

worthwhile. She reports that her Mixtec patients are attentive, compliant, and return for their follow-up appointments on time.

VIII-2.7 Seeking medical treatment in Mexico

Many of the indigenous we interviewed opt for the trouble and expense of seeking care in Mexico. The reasons given are multiple: because costs are a fraction of those in California, they don't have to deal with confusing paperwork, they can pay out of pocket for immediate attention, and medicine is practiced more to their liking. Those living throughout the southern half of the state reported travelling for medical and dental treatment in Tijuana, as well as to purchase medicine. The same was true even for people living further afield. People in the Central Valley, in the Fresno-Madera, Tulare and Bakersfield regions all reported going to Tijuana for medical attention and medicine, as did people living on the Central Coast in the Ventura, Santa Maria, Salinas and Watsonville regions. While proximity to the border and having legal U.S. residence obviously facilitate this cross-border care-seeking, even those without documents reported risking the trip to obtain medical treatment that they deemed affordable and effective.

A 36-year old Triqui farmworker who lives in a men's group house in Greenfield put it this way: "When they get seriously ill, they go to Mexico and afterwards they brave the border to get back. Few use the medical services here."

Elsewhere on the Central Coast a community worker who is familiar with navigating the U.S. system and has health insurance through his job reported that even he prefers to go to Mexico for care:

> Here they give you an appointment that's a long way off and it's expensive; even if you have insurance it's cheaper and faster there. And for dental care, they want to charge me $5,000 for some dental work here, and my insurance won't cover it, while in Mexico they will charge me 2,000 pesos (about $160) to replace a molar.

For some, obtaining care in Mexico has become a way to supplement U.S. insurance coverage by paying out-of-pocket in Tijuana when their Medicare coverage is insufficient. Others who are unable to travel to Mexico entrust friends or relatives to purchase their medicine for them, including injections, so they can self-medicate.

VIII-2.8 Public health care for the indigenous in Mexico

While the above discussion highlights the appeal of seeking medical care in Mexico for those who are willing and able to pay out of pocket, it should not be concluded that health care for the indigenous population is superior in Mexico. Far from it. Mexico's

government-run health care system has serious deficits when it comes to meeting the needs of its indigenous peoples at all levels: institutional, cultural and interpersonal. Therefore, it's not surprising that the same aversion to accessing health care in California also exists towards using the Mexican government's own health care service. Repeatedly our researchers found that in Mexico public health care for the indigenous was inferior to that found in California. Interviewees reported great difficulty obtaining appointments, extremely long waits and degrading treatment by providers in Mexico who look down on people who don't speak Spanish well.

In Tijuana, with its sizeable indigenous population, there is no interpretation service in the hospitals and clinics, unlike in California where some services do exist. Those who don't speak Spanish must bring along a friend or relative in order to understand what the receptionists, nurses and doctors are saying. Past efforts to provide indigenous interpreters have been sporadic and underfunded, with interpreters quitting when they were not paid.[13]

While the Mexican government has set up clinics in areas of high poverty, accessing care can prove a time-consuming and frustrating experience. In Colonia Cañón Buena Vista, a farmworker settlement just south of Ensenada in Baja California, people described lining up at the clinic door at 4:00 a.m. so as to obtain an appointment chit at 8:00 a.m. when the clinic opened. When there are more people than chits, the unlucky ones have to try again another day. Those who have transportation, and can afford it, seek private doctors in nearby towns.

Nor are medical services better for the indigenous in their regions of origin. Our research team visited the remote village of Jicayán de Tovar, a village of about 1,000 in eastern Guerrero. We learned that the government had recently built a clinic in the village, however the clinic had neither medicine, supplies nor staff. In the past a doctor would occasionally visit the village, but it had been six months since they had seen or heard of him. People in need of urgent attention drive three or more hours over rugged dirt roads in this mountainous region to reach medical care. One man described what happened to his daughter-in-law when she required an operation. He managed to get her to town to a doctor who charged him 2,500 U.S. dollars for the surgery and subsequently was demanding 50 dollars for each monthly follow-up visit. The man had to borrow the money and now relies on relatives working in California to pay off the debt.

Some of the less remote villages we visited did have clinics with a doctor in residence. However, mistrust of the biomedical approach and the inability to communicate kept people away. One Oaxacan village of just under a thousand had a clean, well-maintained clinic with a doctor available Monday through Friday. The doctor spoke only Spanish while nearly two thirds of the local population spoke only Mixtec. The clinic had a nurse (from a nearby town) who could interpret, yet in spite of her presence, villagers preferred their traditional healers and midwives. Nor did pregnant women come

[13] Matilda Laura Velasco Ortíz, Professor, Department of Cultural Studies, Colegio de la Frontera Norte (COLEF), Tijuana. Personal communication, May 11, 2008.

for prenatal care, despite efforts to reach out to them.[14] Over the previous year, this physician recorded fifteen births in the village, of which twelve were home deliveries. Only in extreme situations, when all else fails and the situation is dire, do women come to the clinic or go to the hospital in the nearest town. A similar preference for home delivery was reported by a doctor assigned to a community of about 5,700 where 90% of the women give birth at home with local midwives. The doctor in this area expressed deep frustration over this custom: there's a high birth rate in his area, lots of pregnancy complications and local women die every year in childbirth.[15]

At a hospital in western Oaxaca, where 80% of the patients are Mixtec-speakers, the medical director lamented having no one on staff who spoke the local language. Nor did the hospital have a kitchen to prepare food for inpatients. Instead patients rely on their families for meals, or the hospital staff goes out seeking food donations from local merchants to feed the patients. The hospital director repeated the oft-heard comment that patients only come as a last resort. First they try household remedies, go to pharmacies or turn to traditional healers. When they arrive at the hospital it is often late in the illness or pregnancy and it is difficult to help them, especially given the language barrier. Furthermore, there are long waits, up to three months, to see a specialist. Even well-intentioned Mexican physicians find it difficult to provide long-term or preventive care when most patients only come when they are very sick and then don't return for follow up visits.

The observations of a U.S.-trained physician who recently traveled to Oaxaca echoed our findings. He saw considerable mistrust between indigenous patients and physicians, noting that the physicians are usually on short-term assignments and don't speak the local language.[16] In the city of Oaxaca, where he followed a pediatrician, there were no interpreters and instead family members were relied upon for interpretation from the indigenous language to Spanish. He noted that in Mexico, unlike the U.S., there is no law requiring that care be available in a person's own language. Nevertheless, there are some innovative efforts underway to improve the quality of care in some indigenous communities. He visited one such government-funded program in San Juan Ñumí, outside of the city of Tlaxiaco in western Oaxaca. There, an herbalist from the

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[14] This does not mean that they did not receive prenatal care from traditional midwives.

[15] Reliable data for maternal mortality rates (MMR) in Oaxaca are hard to come by. By some estimates, an indigenous woman is nearly ten times more likely to die in childbirth in Mexico than a woman in the United States. Some MMR estimates:

Mexico (2000-2007):	62
Indigenous in Mexico (2003):	124+
United States (2005):	13

See: United Nations Commission on Human Rights: Indigenous Issues (2003), p. 16: "The risk of dying in childbirth is more than twice as high for an indigenous woman as for a non-indigenous woman." According to UNICEF, the MMR for Mexico (2000-2007) was 62. http://www.unicef.org/infobycountry/mexico_statistics.html). In the United States, whose MMR is considered high compared to other industrialized countries, the MMR in 2005 was 13 (see: http://www.medicalnewstoday.com/articles/80743.php)

[16] Many of the "doctors" in the rural villages are interns (*practicantes*) with limited clinical experience.

community, a "*médico tradicional*," was paired with a western-style doctor and together they were succeeding in providing more effective care.

This dual-system approach is, unfortunately, the exception. As Leoncio Vázquez, an indigenous activist in Fresno noted, "Encounters with the medical system in Mexico are not very positive and so they're already pre-disposed to avoid modern medical settings."[17]

VIII-2.9 Undocumented status

Our researchers did not inquire about a person's immigration status. Nevertheless, it was clear that our interviewees were acutely aware of anti-immigrant sentiment in the United States. Some believed they were not entitled to care in this country and others expressed the fear of approaching any institutional setting lest it put them at risk of deportation. An outreach worker on the North Coast who helps men gain access to medical treatment explained that simply registering them to see a health worker raises alarm bells since they fear the paperwork might be passed along to others and used to deport them.

For those who do not speak English or Spanish, the isolation and paranoia can be extreme, especially during an emergency when they are unable to understand what is happening. A Mixtec farmworker described his experience on the morning of September 11, 2001. Shortly after he and his companions began picking strawberries, the crew leader called them all over, told them the country was at war and sent them home, warning them to stay indoors. The farmworker remembered how rumors flew, including that Mexico had attacked the United States and that their lives were in danger. He spent the next two days huddled indoors, terrified and unable to learn what was happening since he could not understand the news on Spanish language radio or television.

VIII-3 Indigenous Perspectives: disease, health & healing

VIII-3.1 A different worldview

An indigenous person's belief system and understanding of his or her relationship to nature, society, the spirit world, and to the cosmos, all play important roles in notions of disease, health and healing. A key feature of this worldview is the importance of maintaining equilibrium between the various forces at work in the world. One of the most frequently expressed needs for balance is between the duality of "hot" and "cold" (concepts which do not necessarily refer to temperature). A detailed treatment of this subject is beyond the scope of this report, however a brief discussion can shed light on the important differences between the indigenous and the western biomedical approaches to health matters, and help us understand why indigenous patients often avoid medical

[17] Leoncio Vásquez, Interim Director, FIOB, Fresno, speaking on "Indigenous Peer-to-Peer Conference Call" facilitated by Adam Sharma, Farmworker Health Services, Inc., Oakland, CA. June 26, 2008. For more information see www.farmworkerhealth.org

treatment that they find offensive, and why non-compliance is often an issue.[18] The following excerpts are taken from a recent treatise on Mexico's indigenous communities by Federico Navarrete Linares, a renowned Mexican scholar who specializes in Mesoamerican studies.[19] The translation is ours.

> While each indigenous society may have its own worldview, linked to its particular language, history and natural environment, these worldviews share much in common. For example, nearly all indigenous peoples believe that the world has elements, or forces, that are either hot or cold. Hot elements are associated with the sun, the sky, the masculine, order, light and life. Cold elements are associated with the moon, the earth, the feminine, disorder, darkness and death. Although hot elements are considered superior to cold elements, it does not follow that the former are good and the latter are bad, since both are necessary for life. Plant growth, for example, requires the heat and light of the sun, but also depends on the cold forces of earth and death [decomposition]. While males possess a greater quantity of hot elements, they also require cold elements to maintain health; women in the same way need hot elements. Similarly, there are hot diseases that cause an excess of heat in the body, and cold diseases that lead to excessive temperature loss. What's important, according to the indigenous worldview, is the balance between these opposing forces. Equilibrium is necessary for human health, for social tranquility and wellbeing, and it's important in the wider sense as well, to ensure that plants grow and life continues.
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> ...In the indigenous worldview nature is not separate from society. This means that what occurs in one realm has consequences in another: a social conflict can impact the rest of the cosmos; hunting a wild animal without permission from the owner of the forest can bring harm; taking water from a spring without offerings and gifts to its guardian spirit can cause the spring to dry up.
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> ...The territory an indigenous community inhabits is inseparable from the group's identity and survival; it is not seen simply as a resource to be used and exploited.

Navarrete goes on to describe how indigenous healing practices depend on an intimate knowledge of the environment and of local plants and animals. The healer makes use of his or her knowledge of the pharmaceutical properties of plants, as well as knowing their hot and cold attributes. For example, plants that are classified as hot are used to treat

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[18] An interesting presentation of indigenous health care attitudes is found in a DVD prepared by Bonnie Bade, see Bade, 2008.

[19] Navarrete Linares, 2008, pp. 78-85. For his description of the relationship between the indigenous worldview and health Navarrete cites Alfredo López Austin's *Cuerpo humano e idiología. Las concepciones de los antiguos nahuas*, UNAM-Instituto de Investigaciones Antropológicas, 1980.

illnesses that are caused by an excess of cold elements. In the indigenous worldview health is a condition that is achieved by balancing hot and cold elements in the body, as well as balancing the several souls each person carries within with the external forces that interact with these souls. As Navarrete describes it:

> There are illnesses such as "susto" (literally: fright) that result when one of the person's internal souls leaves the body as a result of a shock. When someone who is suffering from this condition goes to a modern doctor, it is of no help to tell the patient that such a thing doesn't exist or that the idea of *susto* is false from the perspective of modern medicine. The person is genuinely suffering and could even die from his/her condition.[20]

A concept such as *susto* can seem completely alien to a biomedical practitioner. However, thinking of it as a post-traumatic stress disorder (PTSD) can begin to build a bridge between the indigenous and the modern worldviews. Just as PTSD has a significant psychological and cultural component, so too does *susto*, and its effective treatment requires the intervention of a qualified practitioner:

> In this light, traditional healers are extremely important in the community as they share the patient's worldview and can prescribe the appropriate treatments for many ailments using medicinal plants, prayer, ceremonies and other forms of diagnosis to ascertain, for example, where the person's soul went as a result of *susto* and how to bring it back into the body.[21]

When a Mixtec woman who works as a medical interpreter in Fresno was asked about the hot-cold concept of illness causation, she explained: "When it's cold you need to avoid "cold" foods such as rice. When it's hot you should avoid foods such as mango." When asked if medical personnel in the local hospital were aware of these sorts of things, the Mixtec interpreter replied that they simply don't discuss this with the doctor.[22]

VIII-3.2 Use of traditional healers in California

Throughout California there's a web of Mexican traditional healers practicing their healing arts discretely and below the radar of official institutions. They can be *yerberos* (herbalists), *sobadores* (massage specialists), *hueseros* (manipulators similar to chiropractors), *curanderos* (spiritual healers), or some combination thereof. In the San Joaquin Valley, in San Diego, along the coast in Ventura County, Santa Maria, the

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[20] Navarrete Linares, 2008, p. 83.

[21] Navarrete Linares, 2008

[22] For a popular yet perceptive and highly readable discussion of Mexican ethno-specific conditions such as *susto, empacho, mal de ojo,* and others, see Avila and Parker, 1999. Avila is a psychiatric RN whose own experience with Mexican folk healing allows her to bridge the divide between the western biomedical approach and traditional knowledge systems. Another important source is the dissertation by Dr. Bonnie Bade for University of California at Riverside entitled: "Sweatbaths, Sacrifice, and Surgery: The Practice of Transnational Health Care by Mixtec Families in California," 1994

Salinas Valley, and the North Coast, people spoke of knowing traditional healers and of seeking them out for a variety of ailments. The treatments are familiar and non-threatening, cheaper and often the outcomes are positive. One family we interviewed in Watsonville wished to take a sick child to Mexico, but since the journey was not possible, instead they drove three hours to Santa Maria to seek the services of a traditional healer and reported that the child recovered.

A farmworker living on a quiet suburban street in a farm town on the Central Coast described a neighbor of his as a *sobador* who saw a steady stream of people entering his home, from seven in the morning till seven at night. This *sobador*, as do other indigenous healers we learned of, charges on a sliding scale: five, ten or fifteen dollars, whatever people can afford.[23]

Yet in spite of the many traditional healers serving the indigenous community in California, respondents feel there is a shortage of this kind of care. Numerous individuals we interviewed expressed frustration at not having access to a traditional healer or to familiar medicinal plants. Also missing is access to a sweat bath, or *baño de vapor*. Besides the therapeutic value of the heat and the medical herbs, sweat baths play an important role in re-establishing a spiritual connection to the earth, a connection deemed essential for health. Women in particular miss having access to sweat baths following childbirth, as discussed below.

VIII-3.3 Perinatal care

Indigenous women, and the activists who work with them, report a dislike, mistrust and a profound fear of the way pregnancy and childbirth are managed in the biomedical setting. Given that perinatal care is currently the most frequent encounter between the indigenous and the modern medical system, the attitudes we encountered offer valuable insights into beliefs and behaviors. While the gynecological and obstetric care indigenous women receive in California is likely to result in far higher rates of maternal and child survival when compared to Mexico, women generally did not express appreciation for the care they received, highlighting an arena of cultural collision.

As noted earlier, indigenous women avoid prenatal care and only arrive at the clinic or hospital when they're ready to deliver. Certainly prenatal care from the biomedical system is not something they are accustomed to in Mexico, yet women give a variety of other reasons for avoiding it in California. Activists and culturally-attuned practitioners who work with indigenous women shared the following:

- "They don't go for prenatal care so as not to lose a day's work. To go to the clinic means losing a whole day. They have to arrange child care for

[23] For a journalistic account, including a short video, of a Oaxacan traditional healer working in Madera, California, see: Sack, 2008

the youngest, walk to the bus stop, take the bus downtown, wait for their appointment, and then come back again. Some communities have very bad bus service. Many women work up to a few days before the baby is born, some even up to the day they deliver."

- "We've found that nearly all the women are anemic during pregnancy. They don't want to take vitamins because the say it will cause the baby to grow too large and result in their being given a C-section."
- Pregnant women have concerns that are not addressed by western medicine: they are very worried about how their *nervios* and *coraje* will affect the baby; even second generation young women hold to these beliefs even though they grew up in the U.S.[24]
- Women will seek out a *sobador* (massage specialist) to relieve stress and physical discomfort related to pregnancy; it's inexpensive, convenient and comforting.
- The contrast between the indigenous and the medical approaches to childbirth is like "heaven and earth" according to one Mixtec health outreach worker in Fresno. She explains that indigenous women traditionally think of this time as a happy occasion; pre- and post-partum practices include hot herbal teas and massages. "But here it's all about machines. Of course they're going to be alarmed!" It begins during prenatal care with the need for blood tests and the ultrasound. And during labor: "Traditionally only certain foods are consumed, and nothing cold like ice chips should be taken. Yet when indigenous women request a sip of water, they are offered ice-chips." And then, following birth, "They want you to bathe! They even want you to get off the bed and walk by yourself to the bathroom."
- Following childbirth, Mixtec women in their home communities undergo a carefully-prescribed regimen of sweat baths, under the supervision of other experienced women, and they include the use of medicinal herbs, all to aid recovery and help re-establish the body's equilibrium. The lack of access to sweat baths on this side of the border can contribute to the women's profound sense of isolation and post-partum depression. [25]

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[24] These ethno-specific conditions, loosely translated as "nerves" and "anger," reveal a concern that strong emotions and heightened stress can have negative consequences for the fetus, and hence the desire to maintain emotional equilibrium during pregnancy. While biomedical practitioners might interpret the avoidance of prenatal care as a failure to understand the importance of maternal health during pregnancy, worries about the effects of *nervios* and *coraje* reveal indigenous women attuned to the connections between their own health and that of their baby, but they express their concerns from within their own worldview.

[25] Respondents lamented the inability to set up sweat baths, either because they live in apartment complexes or they feared neighbors would complain and local authorities intervene if they tried building the necessary fire pit in their backyards. We did hear reports of people who were able to set up sweat baths on their property, including a traditional healer in the Central Valley who lives outside of town and maintains a low profile. For a first-hand account of a sweat bath experience, see "Alive and Well: Generating Alternatives to Biomedical Health Care by Mixtec Migrant Families in California" by Bonnie Bade in Fox and Rivera-Salgado, 2004.

VIII-3.4 Coping with illness

Given the lack of insurance, the high cost of care, the many barriers to access, the preference for self-medication and traditional treatment, people tend to seek biomedical care only as a last resort. Following are the steps people follow when coping with illness, as described to our researchers:

1) Start with a traditional tea or home remedy at the onset. Those unfamiliar with the appropriate remedy will seek advice from relatives and neighbors. Failing that, and if one is available, they will seek advice from a salesperson at a *Botánica*--a store selling herbs and traditional remedies.
2) Next, people will seek out Mexican medicines they know or have used in the past. These might be available at a local Mexican grocery story or at a flea market. People either request the medicine by name or describe their symptoms and ask the salesperson for a recommendation. Shop keepers and flea market vendors become their de facto pharmacists.
3) If these efforts fail to provide relief, the next step is to visit the local Western-style pharmacy to purchase an over-the-counter medication recommended by a friend, neighbor, family member, or something the person has used before.
4) If a traditional healer is available, the person may seek treatment in exchange for a small fee.
5) Finally, after all avenues have been exhausted and the condition has worsened, they go to the clinic or emergency room.

As a Central Valley outreach worker commented: going to a doctor at an early stage is likely to require a series of tests which indigenous farmworkers view as an expensive waste of time. Those who have been to doctors in Mexico prefer examinations that don't involve "a bunch of machines" and instead lead to a quick diagnosis and prescription. Since prescriptions are often antibiotics, some would just as soon skip the doctor visit and move straight to self-medication. Antibiotics can be had at local flea markets or from someone who purchased them in Tijuana. Injections are prized as a quick way to get results and many people are able to inject themselves or know someone who can do the injecting.

VIII-4 Provider Perspectives

VIII-4.1 A recent phenomenon

The appearance of Mexican indigenous patients in significant numbers caught the health care system off guard and unprepared. Prior to the mid-1990s few providers distinguished indigenous patients from other Mexican immigrants, or had any background knowledge or training in how to deliver culturally-appropriate care. A bilingual Family Nurse Practitioner at a community clinic in Oxnard reports only becoming aware of this distinct group around 1998, when she began to see patients who spoke little or no Spanish. Ten years later half of her patients are Mixtec, and she and her

colleagues have begun to see other indigenous groups including Zapotecs, Triquis and Amuzgos.

VIII-4.2 Provider-patient communication gap

Even with an interpreter available to assist, providers who deal directly with indigenous patients describe the difficulty of interacting with people with very low levels of education, with limited exposure to western medicine and technology, and who hold entirely different notions of disease, its causation and its treatment. Yet the challenges go beyond ones of language, terminology and worldviews. Women, who account for the majority of indigenous patients, have limited knowledge of their own bodies and reproductive systems, have no vocabulary for many internal body parts, are extremely reticent about discussing matters of sex and reproduction, and are fearful of being touched by male providers.

VIII-4.3 Reticence to speak up

Providers have noted that indigenous patients may not self-identify as indigenous or admit when they don't understand Spanish. Providers find it frustrating when their indigenous patients profess to understand when in fact they do not. This tendency not to admit being indigenous and to remain "invisible" has been attributed to the discrimination they have experienced in Mexico and in the U.S. at the hands of mestizos.[26]

VIII-4.4 Lack of suitable educational material

Activists and outreach workers lament the lack of health education materials suitable for a barely literate population. Particularly important are materials on contraception, the risks of teenage childbearing, information on prenatal care, and education about infant safety, given the dramatic differences between conditions in a remote village and those in modern urban America. Most pamphlets produced by agencies are aimed at readers with an 8th grade education, but organizations that serve the indigenous report that women, who are most of their clients, left school after the 4th or 5th grade, and many are not literate in any language. Pamphlets, even those featuring drawings and photos, have not proved effective, only the more time-consuming face-to-face communication has worked. Some groups believe that informative video programs (on health matters and parenting) could be effective and could be played as DVDs in waiting rooms. However the cost of this kind of effort has proved a constraint.

VIII-4.5 Time, staffing and budget constraints

Caring for indigenous patients present a number of challenges from the perspective of providers, chief among them the strain it puts on already-stretched resources. A clinic

[26] The Indigenous Community Survey found that among respondents who described a medical encounter for a serious condition, fifty-five percent said they had trouble understanding what was being said. (71 out of 128)

administrator noted that while an appointment with a Spanish-only patient can take around 25 minutes, it can take 30-45 minutes to see an indigenous patient. "There's a lot of hand holding required, it's a slow and time-consuming process," he said, noting the extra staff time required to deal with paperwork. Staff even have to take time to explain how to use public transportation so patients will return for follow up visits. The administrator described how this can cause his staff to fall behind and to lengthen the patient wait times. While a solution would be to increase staffing and interpretation services, there is a shortage of family practitioners in the U.S., and a lack of qualified interpreters. Additionally, these demands are coming at a time when clinics are facing severe budget cuts.

VIII-4.6 Hiring interpreters

Whereas several clinic administrators expressed a desire to hire more indigenous interpreters, they described the obstacles they encountered when the candidates possessed no documents or social security numbers. In one region, an administrator approached the Mexican Consulate, but found it was of little assistance, since it had no indigenous language resources or any connection to the indigenous immigrant community in its area. Administrators who have sought the help of indigenous organizations for assistance and guidance in hiring interpreters described the frustration at what appeared to be conflicting agendas at work, with favoritism for those associated with the indigenous organizations emerging when there was a possibility of employment. One health administrator likened working with indigenous leaders to the challenge of working with the Hmong refugee population, and spoke of the arduous and time-consuming effort to build bridges of understanding and trust across the cultural divide.

VIII-4.7 Legal issues

Providers have described the quandary they face when they encounter cultural practices that are illegal in the United States. In Section VIII-5.5 below we describe the legal problems that can emerge with underage teenage mothers, particularly where the father is a few years older and can be considered in violation of laws against statutory rape. Our research did not collect systematic information about polygamy, but one provider reported seeing multiple cases.

VIII-4.8 Male dominance

A number of providers express frustration at how indigenous men frequently insist on being present during a woman's medical visit, acting as interpreter and asserting control over provider-patient communication and decision-making. Women's inferior status in Mexico persists when they come to the United States. In many of the indigenous groups we encountered, women are expected to be submissive to men and not speak up for themselves. Women's lack of power, combined with linguistic isolation and minimal education, prevents them from assuming control of their own bodies and can keep them trapped in abusive relationships. Whereas perceptive providers would like to screen for domestic violence, they're reluctant to do so in the absence of culturally-appropriate

intervention services. (See Section VIII.5.6 below for additional discussion on domestic violence.)

VIII-4.9 Building bridges

Providers serving the indigenous agree on the need to establish relationships with the indigenous communities in order to improve communication and deliver quality care. However, developing those relationships can be difficult and time-consuming, even for sympathetic providers. With staffing shortages and budget cuts, primary care providers are stretched thin with heavy patient loads and lack the time to reach out and get to know the indigenous communities in their areas. Nevertheless, there are a few promising initiatives that are attempting to bridge the cultural divide in innovative ways.

VIII-5 Health concerns and needs

This discussion is drawn from interviews with key informants, including providers, community activists, members of the indigenous communities, as well as from field observations by our research team. As such it represents the views of individuals familiar with indigenous farmworkers in California. We have no data on the frequency of given health conditions, specific diseases or outcomes. Data is not kept for minority Mexican language groups by county health departments. As a result, we had no administrative information at our disposal to provide quantitative evidence of the disadvantages the indigenous face in California relative to other Mexican immigrants.

VIII-5.1 Extreme crowding

In Section VII-4 we described the extraordinarily high rate of crowding among indigenous farmworkers. Here we offer some first hand accounts of housing conditions encountered by our research team while conducting interviews. We then go on to describe some of the health implications of these conditions, as expressed by providers we interviewed.

As shown in Chart VII-5, the Watsonville and Salinas regions present the highest rates of crowding:

> In Watsonville (Pájaro and Lomas) and Salinas we began interviewing families who live in garages or in small rooms without a kitchen, without a bathroom, without heat and with a single bulb for lighting. These families had to ask permission to use the bathroom and the kitchen, and only according to a set schedule.
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> ...
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> We were struck by the lack of material possessions among the families from San Martín Peras. We met families who offered us the only plastic chair they possessed. In that

> house our interviewer had to conduct the interview while seated on a clothes basket and the interpreter sat on a plastic bucket. The family sat on the floor. On another occasion, we had to conduct the interview standing up because they didn't have a chair, nor a table, nor a bed to sit on.

In the crowded Ventura region, we observed the following:

> In Santa Paula and in Fillmore, in almost all the apartments where we conducted interviews we found several families or several single men living in the same apartment. The families rent a room and the single men rent space on the living room floor.
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> ...
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> When Marbella was initially interviewed she only noted her own family and two cousins living in the household. When we returned hoping to interview the cousins, we found that another couple and their children were moving into the house. We also learned that the two cousins were living in the garage.

In Santa Maria we encountered the following extreme situation:

> We interviewed a woman last night who lived in an ordinary-looking 1930s suburban house with a detached garage in back. She informed us that in addition to herself and her two young daughters there were another 38 people living at the address. There were 19 kids, 16 solo males (10 living in the garage), plus 6 women and only one bathroom. The men bathe in back with the garden hose. The woman told us she is looking for another place and hopes to move out soon.

And in the Bakersfield region:

> While in Taft I interviewed a woman and noted cockroaches moving about on the floor and on the wall behind her. No one mentioned them, nor made any complaints about the apartment. There are three couples living in the apartment. Two couples sleep in the bedroom upstairs and the third couple sleeps in the living room. The apartment is fairly new and appears to have working appliances and faucets. The bathroom is in a poor state of repair.
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> ...

> We realized there was fear we would discover how many people are living in a house, apartment, room or garage because people are afraid that if it's known, someone might come to evict them, i.e. the owner, the manager, the city or some other authority. We were able to speak with the owner of some apartments who told us that he's found up to 15 people living in a single apartment, but "for security and for their own good" he's established a rule of a maximum of 10 per apartment.

People gave a variety of reasons for enduring such crowded conditions, including the high cost of rent and the desire to save and send as much money as possible to their families in Mexico. Providers, for their part, expressed great concern over the health implications of poor housing conditions, including:

1) *Lead exposure:* they're seeing contamination in 4-5 year old children who are living in garages.[27]

2) *Infectious diseases:* a Family Nurse Practitioner in Ventura reports that RSV (Respiratory Syncytial Virus Infection) is a serious bronchial infection in young children. It sweeps through the community every winter and is exacerbated by close living conditions. A local pediatrician estimates that Ventura County has several hundred cases each year that are serious enough to require medical attention, including some 50 hospitalizations. Of these, some of the children are so sick that they must be transferred to the pediatric intensive care unit in Santa Barbara where they are intubated. The practitioner notes that RSV affects poor and crowded communities disproportionately. She describes it as a close-contact disease similar to tuberculosis and fears that one day TB will spread in a similar way through the community.

3) *Epidemiological risk:* the same provider noted that this is a non-immunized population; if someone gets measles, a very serious disease in adults, it can spread through the entire population.

4) *Poor nutrition:* from November through January[28] there's no work and people are under considerable pressure to pay the rent and so they cut back on food; one outreach worker reported seeing families that were only eating eggs and beans. Other observers have noted a high consumption of junk food, candy and soft drinks.

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[27] See footnote 129 for other suspected sources of lead contamination.

[28] In the ICS, this time period was identified by a majority of informants in response to a direct question asking for the period of no work.

5) *Food preparation & storage*: under crowded conditions it is difficult to gain access to the kitchen, which limits the ability to prepare healthy food; food storage space is restricted when several families share one refrigerator.

6) *Reliance on unhealthy processed foods:* packaged and highly processed foods are more convenient to store and consume in highly crowded situations; additionally they are a cheaper form of calories and are favored by children who are accustomed to seeing advertisements on TV.

7) Sanitation: plumbing systems are not designed to handle the large number of people sharing the same facilities. One physician described seeing a lot of skin problems in children, attributing it to poor hygiene.

8) Delayed childhood development: several providers, all working independently and at separate facilities, report seeing large numbers of indigenous children with delayed speech and delayed overall development, even when no other medical problems are present. They attribute it to a lack of infant stimulation. They speculate that in crowded and substandard living situations infants are not placed on the floor and suffer from a lack of "tummy time." Due to a lack of space, children are not able to benefit from the important crawling phase of development, and without physical-muscular stimulation they fail to develop muscle tone. Also, with both parents away working, babies are often left in the care of older women and, with too many children to look after, nutrition is poor and infants are kept restrained for long periods of time.

9) *Family Separation:* Crowding has led neighbors and others to call Child Protective Services; this results in encounters that are frightening and confusing for indigenous parents who are at risk of losing custody of their children. Agency personnel, lacking interpreters and resources to deal with the indigenous population, also find these situations extremely frustrating and difficult to resolve in a humane manner.

10) *Domestic violence (DV):* providers in many of the regions believe DV is exacerbated by multiple families living in the same unit.

VIII-5.2 Isolation and depression among women

Frontline providers, including nurses, outreach workers and community activists, report that post-partum depression is a serious condition among indigenous women. As a Mixtec interpreter on the Central Coast described it:

> Women will cry by themselves; they don't want to breast feed, or they don't want to stay with their partner; they just want to withdraw. I think it's because they're away from their village,

they're alone and can't drive. They're often not close to a park, the husband is away and there's no transportation.

Another provider noted that the absence of traditional sweat baths and supportive communal rituals adds to the women's linguistic and cultural isolation, coming at a time when they're already emotionally vulnerable. Many of the mothers are also quite young (see section VIII-5.5 on teenage pregnancy below).

A clinic administrator on the Central Coast acknowledged that depression is a huge problem and that in 2007 they began screening pregnant women. They've provided some mental health counseling, using interpreters as intermediaries, and he estimates that they were able to prevent at least ten suicides over the previous year.

A Family Nurse Practitioner in Ventura agreed that post partum depression is a serious problem that deserves more attention. In her practice they attempt to address it in Well Baby classes where groups of eight mothers gather to meet with two outreach workers. They believe that the group setting is a culturally appropriate approach with indigenous women, instead of attempting individual mental health therapy.

In the Central Valley a community activist also agreed that post partum depression is a problem, but noted that the local health care agencies in the area make no effort to identify or address the problem.

VIII-5.3 Mental health problems among men

Since indigenous men seldom approach clinics for help, it has been outreach workers who have noticed the problem of depression among these men who are lonely and far from home. An unhealthy syndrome can take hold among men living on their own, be it in encampments, in crowded apartments, in garages or sheds. They miss their families, they have unhealthy diets, there is a lack of recreation and exercise, and many turn to alcohol and drug use. Their physical and mental health suffers and they can find themselves spiraling out of control. A Mixtec outreach worker in San Diego reports seeing mental health problems among the men living in the canyons. He described the men as profoundly sad and overcome with feelings of inferiority and impotence.

This sense of despair was echoed by an outreach worker at the other end of the state, on the North Coast. He observes that newly-arrived indigenous men find it difficult to adapt, are easily exploited, and when they fail to achieve the goals they had set for themselves in coming here, the stress combined with little news from family leads to depression. They start hanging out and drinking with friends, and their descent into alcoholism begins.

Activists report that alcohol consumption is resulting in multiple problems for the indigenous community. They point out that alcohol consumption is culturally sanctioned, especially during fiestas, where binge drinking is common. However, there is also considerable drinking during the week as well, yet consuming beer is not really viewed as "drinking." Outreach workers note that driving while intoxicated is a serious problem

resulting in DUI arrests, in auto accidents and in serious injury. One of our interpreters informed us that Mixtec men in his area see nothing wrong with driving while intoxicated, even with women and children in the vehicle. He and other indigenous activists believe there is an urgent need for education and outreach around this matter, especially since the men are used to drinking and driving in Mexico where it is not censured.

Another condition afflicting indigenous farmworkers may be PTSD, or Post Traumatic Stress Disorder. A mestizo outreach worker who comes into daily contact with Zapotec men searching for work, describes cases of severely traumatized men who are still suffering from the violence and abuse they experienced while crossing the border. It is affecting their daily lives and the outreach worker believes they urgently need someone to talk to about it. However, there are no Zapotec interpreters in the area.

VIII-5.4 HIV/AIDS

While our study did not gather information on these conditions, interviews with providers and outreach workers revealed that there is considerable fear and misinformation regarding the disease, together with a strong resistance to the use of condoms.

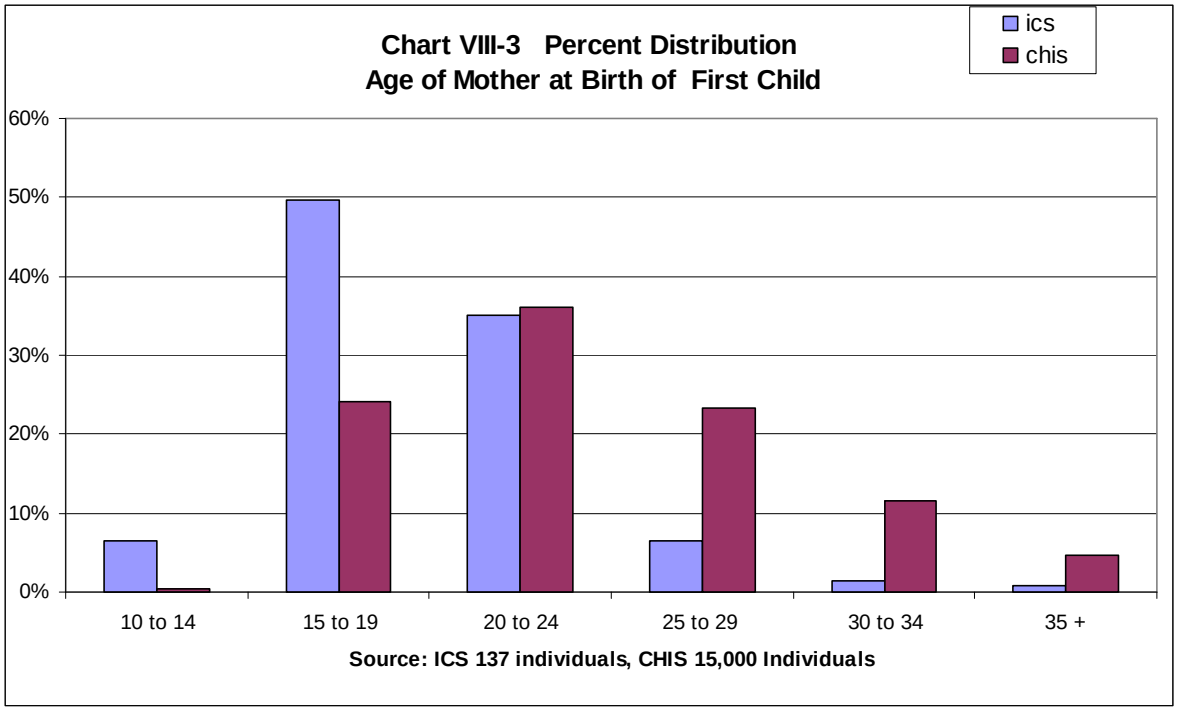
Outreach workers in the Central Valley described indigenous men who were under the impression that contact with pesticides is what could lead to HIV/AIDS. Others believed they could protect themselves by rubbing their penis with lemon following sexual relations. And men who had contracted a venereal disease reported washing their penises with bleach. Even those who were diagnosed with HIV described using bleach on their penises.

Efforts to encourage protective behavior have proved frustrating, these outreach workers report: "We have difficulty persuading our clients to use condoms, even when we provide them. Men just don't want them, and that's it."

VIII-5.5 Phenomenon of teenage pregnancy

All the providers we interviewed remarked on the very early age of pregnancy within this population. The observation is supported by comparing the percentages displayed in Chart VIII-3.[29] A quick examination shows that the median age for birth of first child for all California mothers is in the 20 to 24 year-old range, while for the indigenous women it is in the 15 to 19 year-old range. In fact, for all of California, less than a quarter (24%) of the mothers were 19 or less at the time of birth of their first child, while for the indigenous mothers, more than half (56%) were 19 years old or less.

[29] This graph displays, first: the age of the 137 mothers from the Indigenous Community Survey (ICS), by different age groups, and second: the age of all California mothers for different age groups from CHIS data. The sample size in the CHIS for these women is approximately 15,000. For details see: http://www.chis.ucla.edu/methodology.html



This early age of marriage and childbearing is deemed culturally acceptable within indigenous communities, and Mexican physicians serving in Oaxacan villages report that it is not unusual for young girls to give birth to their first child at age fourteen. Women's health experts, however, warn that giving birth at such a young age can result in premature births and low birth weights, endanger the young mothers' health, and increase their risk for malnutrition, high blood pressure and anemia. Nevertheless, the girls often go on to bear a second child while still at a very young age, compounding health risks for themselves and their children.

What is culturally acceptable in their home context can place the indigenous on a collision course with norms, institutions and laws in the United States. In the U.S. there are serious legal issues associated with being an underage teenage mother, especially if the father is a few years older and the girl is in the United States without her own parents nearby. One provider has learned that in some indigenous communities a girl of 13 is considered ready to go out into the world, and that girls aged 13 and 14 are coming across the border, without a parent or close relatives, in order to look for work.[30] This provider went on to describe what can happen when one of these underage and unaccompanied girls becomes pregnant by a man even just a few years older than her. She told of a hospital where the nurses thought it their duty to call in Child Protective Services. This has only served to compound the problem: the father is arrested and jailed, while the

[30] A Mexican regional newspaper *Imagen de Zacatecas*, reported an increasing number of unaccompanied minors crossing the border to the U.S., noting that in 2008 more than 19,000 of these unaccompanied children and youth were deported to Mexico. It listed Oaxaca and Guerrero among the principal states of origin. August 25, 2009. http://www.imagenzac.com.mx/migrantes/daran-apoyo-a-ninos-migrantes-deportados

young girl ends up frightened and alone in a strange country, with a new baby, unable to speak English or Spanish, and with no means of support.

Health workers describe a profound and unmet need for education around sexuality, the risks of teenage pregnancy, birth control and U.S. laws. However, efforts to reach out to educate the community on these matters have encountered deep-seated cultural resistance. One outreach worker, already sensitive to the reluctance Latino parents have towards discussing sexuality with their teens, reported making absolutely no headway with indigenous groups for whom the topic of sexuality is simply a taboo topic, and bearing children at a young age an accepted norm.

VIII-5.6 Domestic violence

Outreach workers and health providers consider this a serious problem that is both hard to get at and has not yet been addressed. It is a problem whose roots lie deep within indigenous communities and Mexican society where women have few rights and where violence against women is accepted as "the cross women must bear."

Activists working in Mexico report that while family violence is gradually being addressed in urban areas, it remains high within indigenous communities where, according to one estimate, it affects between 30 and 40 percent of adult women.[31] While we have no data regarding its prevalence in California, there is no question that this practice has crossed the border, and that it endures within indigenous households and causes considerable pain and suffering.

Paramount among the barriers to addressing this problem in California is the lack of a culturally-appropriate strategy. Health workers encounter multiple cases of women who are victims of abuse by their partners, but find the women are unwilling to press charges against their abusers for fear of finding themselves in an even worse predicament when they are ostracized by both family and community. An outreach worker described the case of an indigenous woman on the Central Coast: she was unusual in that she sought help from a community organization and agreed to go into a shelter in order to escape her abuser. However, once her time was up at the shelter and she had to move out, her entire community rejected her.

Consequently indigenous women who speak no English, and often only limited Spanish, are left with no alternatives but to remain prisoners of abuse. A Central Valley service provider described the women victims she encountered as neither able to go to the police, nor to leave their husbands, because there simply was no place for them to go.

Some health providers have talked of screening their patients for domestic violence. However, in the absence of culturally-appropriate programs and services, they see little point. On the Central Coast one group has organized informational meetings to address a multitude of topics, including sexual assault and domestic violence. The activist

[31] See the Family Violence Prevention Fund: http://endabuse.org/section/programs/global_prevention/_project_context

spearheading this group reports that while the meetings are well-attended, there are many in the indigenous community who don't want to have anything to do with the organization out of fear that their women will become "uppity." At present, providers and activists wishing to help indigenous women are constrained by the lack of appropriate counseling services, the lack of safe housing for those wishing to escape their abusers, and the inertia of a community that does not consider it a problem.