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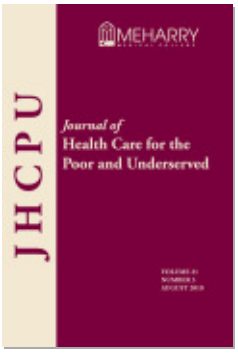

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Health Care-Seeking among Latino Immigrants: Blocked Access, Use of Traditional Medicine, and the Role of Religion

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Abstract: Barriers to health care and use of cultural alternatives are studied from open-ended interviews of 96 Latino immigrants, 12 hometown association leaders, and five pastors and health outreach workers. Frequently mentioned barriers to approaching hospitals and clinics included problems in communication, establishing financial eligibility, and extremely long waits for service. We found frequent use of cultural alternatives, such as herbal medications, obtaining care from Mexican doctors, and some use of traditional healers. The role of religiosity is studied: prayer is viewed as fundamental to health, but the church is not perceived as an aid in physical health-seeking. Health care for Latino immigrants often involves a blend of mainstream and traditional medicine; the study discusses examples of respondents who navigate between the two systems within the interplay of culture and structure.

Key words: Health barriers, cultural alternatives, Latino, immigrants.

Uninsured Latino immigrants may experience a negative reception when they attempt to access public hospitals and clinics.[1,2] Many Americans believe Latino immigrants take U.S. jobs and place a drain on public services such as health care and public education.[3] Anti-immigrant sentiment is evident in citizen patrols for undocumented persons on the San Diego border, an increase in citizen-check raids at work sites by immigration enforcement officers, and the passage of a bill in the U.S. Congress to build a 700-mile fence along the U.S.-Mexican border.[4,5] In this climate, uninsured immigrants seeking health care (whether undocumented or documented) may expect difficult interactions with the public health system,[6,7] and may fear deportation or expensive out-of-pocket treatments. Further, there may be resentment on the part of health providers when uninsured immigrants show up with advanced illness or attempt to use the emergency room for routine care. In this strained atmosphere, how do Latino immigrants survive and deal with their health care needs?

Using a sample of Latino immigrants drawn from neighborhoods known to have

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high proportions of uninsured and undocumented status respondents, the goal of this paper is to explore how this population navigates between conventional U.S. and traditional Latino medicine to treat illness and receive health care. We were guided by three central questions:

(1) What do Latino immigrants perceive as barriers to health care in public facilities such as county hospitals and clinics?
(2) To what extent are Latino immigrants using cultural alternatives such as folk healers, *botánicas* (herbal shops commonly found in Latino neighborhoods), herbal remedies, and care in Mexico? How are these cultural alternatives blended with Western health care-seeking?
(3) How does religiosity play into health-seeking and health maintenance for Latino immigrants? Several questions underlay this one: (a) is the church viewed by immigrants as an aid, coach, or mediator for health access needs? (b) What is the role of personal prayer and faith in health empowerment among Latino immigrants?

Other studies have noted that some Latino immigrants make use of an alternative package of home remedies, folk healers, and medications.[8–14] We do not just replicate these past studies, but note in more detail the complexity of how Latino immigrants combine a wide range of alternatives (conventional medicine, Latino traditional medicine, religiosity), and exert considerable agency in their health-seeking action within an interplay of cultural and structural constraints.

Health status and health-seeking experiences of Latino immigrants. The term *epidemiological paradox* has been used to describe the health status of the Latino population. The apparent paradox is that despite lower income and education levels and very poor access to health care, Latino health outcomes are often the same or even better than those of non-Hispanic Whites.[15] For example, Hayes-Bautista[16] notes that Latinos in California have notably lower mortality rates for three leading causes of death (heart disease, cancer, and stroke) than non-Hispanic Whites. For Latino immigrants the paradox is even more pronounced, their illness rates often being lower than U.S. born Latinos.[17,18]

Although the paradox is one important piece of the U.S. Latino health profile, it diverts attention away from major problems in health and health care. Latinos do not have lower disease rate across all illnesses. Rates of obesity, diabetes, cirrhosis of the liver, homicide, and AIDS are notably higher than those for non-Hispanic Whites.[19] Moreover, access to health care is a persistent problems for Latino health-seekers, both documented and undocumented.[20,21] For Latinos, lack of health insurance is the most significant barrier to health care. They are often in low-paying, hazardous jobs that are unlikely to offer fringe benefits such as health coverage.[2] Thus 30.7% of Hispanics nationally lacked any health insurance in 2008—the highest rate of any ethnic group. The comparison rates for non-Hispanic Whites, African Americans, and Asians are 10.8%, 19.1%, and 17.6%, respectively.[22] Estimates of the proportion uninsured among undocumented immigrants (Latinos and other ethnic groups) range from 60–80%.[23]

Belief barriers, structural barriers and cultural alternatives. Though Latinos, in general, have faced problems of non-accessibility in health services, undocumented

status adds many additional problems. Here, we summarize the Latino immigrant health-seeking experience in three categories.

Belief barriers. This refers to fears, anxieties, and concerns health-seekers may hold getting care and in approaching the system. Negotiating complex bureaucratic hospitals and being identified as undocumented during intake can produce a high degree of anxiety. Undocumented health-seekers may be concerned about deportation, not being able to communicate with doctors and nurses, the cost of treatment, and long waits for service. These concerns can dampen utilization such that the person only approaches the hospital when extremely ill.[6,24]

Structural barriers. Structural barriers are objective barriers in the system such as an absence of language translators; the treatment one gets with no health insurance; discrimination by ethnicity, class, or immigration status; and economic eligibility procedures that may screen out the undocumented immigrant.[2,7,20] For example, Carrillo et al.[2] note the importance of language interpreter services. Even a minimal language barrier can cause major doctor-patient communications problems. "Spanish speaking patients discharged from the emergency room are less likely than their English-speaking counterparts to understand their diagnosis, prescribed medications, special instructions and plans for follow-up care."[2[p.67]]

Cultural alternatives. Populations that experience belief or structural barriers may especially draw upon cultural alternatives. Latino cultures have long-established traditions of alternative health beliefs and healing practices, which fall under the rubric of complementary alternative medicine (CAM).[14] These practices are viewed as affordable and are highly revered components of culture.[25] Recently-arrived Latino immigrants may make use of herbal remedies and folk healers such as *curanderos* and *naturalistas*. Typically, the *curandero* employs prayer, religious counseling,and *limpias* (spiritual cleansing ceremonies) and administers herbal medications.[26–29] In a study of Guatemalan immigrant women in Los Angeles, Menjívar notes that immigrants "often put together what resembles a 'package' of health treatments that includes bio-medical care and 'traditional' healing practices."[13[p.438]] The use of Latino traditional medicine may be crucial to the adjustment of Latino immigrants to life in the U.S. Other low-income populations may also turn to CAM therapies when they face significant access problems to conventional medical care.[30]

Modern health care utilization may have supplanted the folk system in large urban areas such as Los Angeles. Yet, there may be considerable residues of the system among some immigrants. For example, León, in a current account, describes a center of healing through *curanderismo* in an East Los Angeles *botánica*. A highly respected healer (Hortencia) blends rituals of Catholicism, advice, counseling, and *limpias* to heal her patients. León notes that "many of the men I spoke to . . . sought help from Hortencia to ease the stresses of separation from their families who remained in Mexico."[27[p.106]]

Religion occupies an important role in the health practices of Latinos.[31–32] Individual prayer and faith are considered another part of the alternative system of healing in this study. Our thesis is that religion helps Latino immigrants gain control and bolster their health, whether real or perceived, in the face of health system barriers. Prayer and faith can be important coping mechanisms in acculturation. The role of prayer is well illustrated by the research on the concept of *nervios*.[33] This is a folk illness that refers

to extreme feelings of distress occasioned by major life changes such as the difficult experiences with working conditions that immigrants often encounter in the factories and fields in the U.S. Some research indicates that Latinos use prayer and faith to combat *nervios,* i.e., to gain stability in the face of traumatic adjustments.[33]

There is evidence that churches have become increasingly important in reaching immigrant populations by providing health screening and health education at the neighborhood level. Orr and May note that as hospital emergency rooms have become more crowded and difficult to use, health outreach through parish nurse programs and church-sponsored health projects have become important mediators between the neighborhood and mainstream care.[34]

The interplay among belief barriers, structural barriers, and cultural alternatives provided a theoretical backdrop for analyzing our data. We believe that strategies are crafted in light of these forces. However, in conducting the research reported here, we were not hypothesis-testing or working with a strictly deductive design. Rather, we wanted to investigate inductively how Latino immigrants were constructing their own world of health care utilization.

Methods

Study design. We first interviewed 12 hometown association leaders from Mexico, El Salvador, and Guatemala to become better acquainted with the problems in health care-seeking facing Latino immigrants. Many Latino immigrants in the U.S. keep close ties to families and members of their hometowns in Mexico and Central America by joining hometown associations. The hometown leaders were viewed as key informants who could reflect broadly on health care needs of recent immigrants. The hometown leaders had already been identified as highly respected community leaders in a larger study of immigrant adjustments to urban areas and readily agreed to be interviewed in this study. The interviews lasted approximately one hour and were conducted in either English or Spanish by one of the co-authors of this study. These interviews gave us valuable insights about health-seeking barriers and the use of cultural medicine practices among Latino immigrants in Los Angeles. Insights from "the hometown 12" informed our open-ended interview study and provided the basis for the interview guide of 96 community respondents, our main source of data.

Community respondents: sample and interviews. Ninety-six community respondents were interviewed in Spanish in 2002–2004. The Pico-Union area of Los Angeles was especially emphasized in the sampling. Residents living in this area are very likely to be undocumented and to lack health insurance. The Pico-Union area is sometimes referred to as the *Byzantine-Latino Quarter*.[35] The area can be described as a very large Latino ethnic enclave in which immigrants of Mexican and Central American origin share geographic and social space and patronize the same businesses (such as food markets, clothing stores, medical facilities, and *botánicas*).

Most of the respondents were interviewed in their homes or apartments. However, 21 of the 96 respondents were day laborers and were interviewed at pick-up spots as they were waiting for work. Although we tried to employ chance methods of selection to increase the diversity of the sample (e.g., random households and blocks) this

sample cannot be viewed as proportionately representative of Latino immigrants in Los Angeles. Our sample percentages for origin are 43% Mexican American and 57% Central American, and these percentages correspond neither to the Hispanic Los Angeles County proportions of 77.4% Mexican American, 13.9% Central American, nor to the Los Angeles City proportions of 68.7% Mexican American, 22.5% Central American.[36] Our focus was on obtaining high-quality interviews with a cross-section of Latino immigrants who would talk to us rather than obtaining a proportionately representative sample of the Los Angeles County Latino population. Given the diversity in culture and history among different Latino groups, we cannot assume complete cultural and social similarity among the Mexican and Central American groups in our sample. However, we reasoned that dominant group reactions to uninsured Latino health care-seekers in hospitals and clinics are likely to be very similar regardless of country of origin. Additionally, in terms of health beliefs and practices, some research in Los Angeles suggests a high degree of similarity in cultural health practices in the use of home remedies and alternative healers among Central Americans and Mexican Americans.[13] The Pico-Union area offered the distinct advantage of producing a sample with a high percentage of uninsured Latino immigrants, some of whom would be recent arrivals, and people likely struggling to obtain health care.

This is a very difficult population for researchers to reach; fear and distrust of immigration law enforcement runs high. Questions on citizenship were purposely not asked to avoid non-participation or tension in the interview. Asking a question about citizenship with this population presents a dilemma in research methodology: a respondent could perceive that revealing undocumented status to a stranger (interviewer) could lead to arrest or even deportation. Without a direct question, we cannot state the exact percentage undocumented. Although Pico-Union is commonly defined as a geographical area of recent and undocumented immigrants, we can only assume that a significant number of our respondents were undocumented or living in mixed status households. In partial support of this assumption, it is interesting that a number of respondents inadvertently revealed their undocumented status in the course of the interview (e.g., "You're at the bottom when you go to County without health insurance or papers").

The interviews were conducted by a Spanish-speaking female medical student and co-author of this study. As a perceptive, outgoing person, and a recent Latina immigrant herself, she was able to develop very good rapport with most respondents. However, many of the people she approached were highly suspicious at the outset, especially when presented with institutional review board (IRB) informed consent forms, and she had to work hard to convince them to be interviewed. She presented her credentials as a researcher and as a medical student and emphasized the importance of the study to the Latino immigrant community. She was very successful with day laborers that she encountered at street corners waiting for work. She openly talked about herself as an immigrant in order to establish rapport with them.

All of the interviews were conducted in Spanish, recorded, and transcribed *verbatim*. The interviews usually lasted from 40 minutes to an hour, typically resulting in seven to eight pages of transcribed responses. The overall response rate was estimated to be 70%. The sample can be characterized as follows: Using occupation as the indicator of socioeconomic status, the sample of 96 respondents ranged from day laborers to those

steadily employed in blue-collar or service jobs. Most respondents were in low-income jobs (80%). In terms of gender, the sample was evenly divided. About one-third had been in the U.S. less than five years, 22% between six and 10 years, and 45% 10 years or more. Seventy percent of the sample had no health insurance for themselves, although 10% (of the 70%) had children with at least some coverage. Almost all of those who had been in the U.S. less than five years had no health insurance (94%) versus 61% of those who had been here longer than 10 years. In sum, the sample could be characterized as lower working-class Latino immigrants, mostly without health insurance, a high proportion of which was likely undocumented.

In addition to the community and hometown respondents, interviews were conducted by one of the co-authors with five pastors and community health workers from two large churches serving immigrant Latino neighborhoods, and from QueensCare, a religiously-oriented non-profit organization providing health care to poor and uninsured individuals and families. Site visits were also made to a QueensCare clinic. With these interviews and observations we hoped to gain greater insight into the role of the church and religiously anchored organizations as coaches, aids, or mediators in health care-seeking. Field observations were also conducted in six *botánicas* and markets selling herbal remedies in 2006–2007.

Questions in the interview guide and analysis strategies. Health care-seeking was defined as any behavior or action, taken in response to illness symptoms, to utilize mainstream or Latino traditional medicine. or some blend of the two systems. The interview began with basic background questions concerning age, birthplace, time in the U.S., marital status, occupation in the home country and presently in the U.S., and whether the respondent had health insurance. More important open-ended questions and probes asked respondents what they do when they or a family member becomes ill. This question was purposely left very open-ended as we wanted to understand respondents' world of health care-seeking without imposing predetermined categories. Later, after exhausting respondents' open-ended accounts of health-seeking, we asked about their experiences with county hospitals and clinics, their willingness to use traditional treatments and healers, the degree to which they used herbal treatments extensively for all illnesses or for minor illnesses only, whether they or friends had ever received care in Mexico, their willingness to go to Mexico for care, their judgment of U.S. versus Mexican doctors, and the degree of importance they placed on prayer, faith, and the church for help in health matters. Probes were used consistently to produce stories or accounts of health care-seeking.

The 96 interviews were extensively analyzed for recurring themes, and coding categories were developed to encompass these themes. With a sample size of 96, we paid attention both to the quality and to the depth of responses as well as the frequency with which topics were mentioned. For example, in a question asking if the person would consider going to a traditional healer with a good reputation, we were interested in both the proportion who indicated such willingness as well as the reasons for acceptance or rejection of such healers. We have included percentages in a number of places to suggest prevalence likelihood. But because this a non-random sample, we make no claims on the generalizability of these percentages. For qualitative responses, interviews were read and re-read by two of the co-authors. Three files were developed

for the analysis. A master file consisted of the transcriptions of each *verbatim* interview. A theme file was developed in which data (study participants' responses) were grouped around recurring themes such as respondent's decision points in the use of Western medicine and cultural alternatives. Finally, an analytical interpretive file was developed in which themes were tied back to the major questions of the study and the literature as well as qualitative paradigms that might explain observed response patterns. Interview responses that typified recurring themes were selected and are presented in the findings.

Results

Structural and belief barriers approaching hospitals and clinics. Our community respondents were asked to describe experiences going to county hospitals or clinics. They described many access barriers, speaking of long waits, rudeness, being hurried through the system without medical explanations, and expense problems. By far, the most frequently expressed complaint (65%) concerned long waits; some complained that they had to wait between six and 12 hours for service. Rudeness once served and being hurried through without information was mentioned by 35%, language and communication problems by 41%, and expense problems by 51%. The following quotations from community respondents illustrate the problems respondents experienced (pseudonyms are used to insure anonymity).

> I wouldn't want my enemies to wind up there [at the county hospital]. You have to work a week to go a day to the doctor; you lose a complete day and they don't treat you well. There are long waits and you have fear when you're not legal. If I were a doctor and you arrived sick, I would not ask where you came from; my mentality would be to help you to get better. (Jorge, community respondent from Mexico)

> Badly, sometimes you arrive sick without knowing what it is that you have and they make you fill out forms, and they make you wait like 12 hours. Oh, don't forget in that hospital [County] you can die. There is much discrimination. If you do not speak English and there are no interpreters [available], well, you give up more time waiting like a dog, and only when they see you are dying do they do something. (Juan, community respondent from Mexico)

Having health insurance can make a big difference in treatment. Our respondents often had stories of the very different treatment friends and family members received based on their insurance status. Maria (community respondent from Mexico) is 21 years old and has health insurance through work. She views the service that she receives at a clinic as excellent. Maria describes taking her uninsured mother to county hospital:

> She went to the hospital and it was very bad. You can die there and no one will attend to you. She went there with terrible pain and they didn't see her until the middle of the night after being there since five in the morning. After that, they gave her a pill and they didn't even check where she had the pain. Nothing. It was terrible treatment . . . my mama doesn't speak the language and I had to interpret for her but they wouldn't allow me to enter with her. When they finally allowed me to enter it

> was very gross because my mama didn't understand and I had to translate and she was becoming desperate.

When Maria was asked how much she paid for the services, she responded that she had to give them a check at that moment for $140. Later her mother received a bill of approximately $1,000. She reports calling to make an agreement to pay the bill over time but they would not accept the agreement. The mother's income was judged not to be low (necessary for an extended payment plan) because the mother was living with the daughter, and the resulting household income was too high. Threatened with a collection agency, the daughter finally paid the bill by credit card at very high interest. Maria summarizes, "If you have health insurance they treat you like a queen; if you don't have insurance they treat you like a charity case."

Although many community respondents held negative views or were outraged by the service at county hospital, a few legitimized the treatment as "understandable" given the high volume of cases. For example, Carlos (community respondent from Mexico) felt that people do not understand why they have to wait. He explained "the demand in the hospital is high and many cases are very serious, so people have to wait their turn."

Because of the problems they encounter, many of our respondents mentioned free clinics, and low-cost private clinics as an alternative to the county hospital and county clinics. Depending on the facility, ratings of service ranged from good to very bad. Some reported the same long waits and inadequate service in free clinics but a number of people reported the greatest satisfaction in private neighborhood clinics where the person paid a minimum fee ranging from $40–$70 per visit. Typically, Spanish was spoken by a majority of the staff, the wait was far shorter (1–3 hours) than elsewhere, and the services were judged to be quite good.

Belief barriers. Some of the barriers to health care are due to fears of dealing with institutions such as the emergency room of a hospital because of concerns about immigration status. Just over a third of our sample had not approached county hospital or any other hospital for care. Yet, in practically all cases such respondents spoke of powerful stories of long waits and poor service that they had heard from friends, relatives, and co-workers. These beliefs and fears regarding cost, deportation, or poor service may have a greater impact on under-utilization of services than the objective reality. Enrico (hometown leader from Mexico) commented:

> Supposing that they think that because they are poor or they don't speak English they will not be treated well, or because they don't have legal documents; but as you know, it is not important because they have a right to be attended well.

Many of the concerns expressed in our interviews had to do with lack of health insurance and the fear that the respondent or a family member would not be able to get care when they needed it. One respondent stated:

> I have two daughters and neither has medical insurance. What happens is that it worries us. When someone is sick, I have to spend money [otherwise needed for other things] for the doctor but that just handles the checkups or vaccines; what other alternative do we have? (Cecilia, community respondent from El Salvador)

Cultural alternatives as preferred treatment and coping strategies. In response to barriers to health access, we found that Latino immigrants work out alternative strategies. Some begin with home remedies and other traditional medications, a course of action that is familiar and involves little risk. Others first seek mainstream care with doctors and clinics, but if unsuccessful in "cracking the system" turn to the alternative package of health care behaviors. We found that the alternatives mentioned most were herbal and home remedies purchased in *botánicas* and markets, use of folk healers, the use of doctors and/or medicines from Mexico, and the use of spiritual elements such as personal prayer.

Home remedies, herbs and botánicas. Our interviews revealed that herbs, teas, and other home remedies were widely used as a first treatment. Less than a fourth used them extensively for all illnesses but over half used them for minor illnesses. These remedies were purchased either in *botánicas* or grocery stores catering especially to a Latino population. In visits to *botánicas* we found a mixture of religious and herbal remedies. For example, side by side with herbs and teas, one finds religious figurines, oils, and votive candles. A number of folk illnesses thought to be caused by spiritual disharmony or psychological disturbance are treated with herbal remedies and prayer used together.[25]

Perhaps the best way to describe our interview responses regarding the use of herbals is "a quest for the natural." Respondents wanted something they trusted, and were concerned about Western medications that were seen as external and unnatural to the body. Many commented that herbals were more pure, had no side effects, and were trusted remedies passed down from generations:

> Yes, I use the home remedies more. To me, they are more gentle to your body. There are some pills that weigh you down; there are drugs that do you much harm. Antibiotics are addictive to the body. (Jorge, community respondent from Mexico)

> I was having psychological problems. I went to a doctor and got medications but they made me feel like a zombie. So I went to Tijuana to the *botánicas* and purchased herbs. I have more faith in natural remedies than conventional medicine and I seek help there from people who run the store. (Carolina, community respondent from Mexico)

Hometown leader David's description of the use of herbal medicines among the Maya of Guatemala illustrates the reverence given to herbals as a strong cultural tradition:

> We Maya have remedies that have come to us generation to generation . . . an herb, a plant, a certain treatment that was given to us by our grandparents, our parents. So we use these here because we can't get other treatment.

Prompted by comments of this kind, we wanted to know the extent to which respondents were using herbal and home remedies as a response to feelings of blocked access in mainstream facilities. We coded the data in terms of whether this view was expressed at any point in the interview; half of our respondents expressed this view. Thus, for some, at least, the use of homegrown alternatives is clearly a coping strategy.

Curanderos and limpias. *Curanderos/as* work through herbal medications, spiritual interventions, and massage, often with the purpose of removing hexes.[24] The *curandero* tries to heal both the person's soul and their body. Many of the spiritual treatments or *limpias* employed by a *curandero* are tied to folk illnesses such as *susto* (fright) or *mal de ojo* (evil eye). However, in our early interviews, when asked about approaching a *curandero* for medical care, overwhelmingly our community and hometown respondents rejected the possibility. The view expressed was that Latino immigrants in Los Angeles were not using *curanderos* routinely. For example, Manuel (hometown leader from Mexico) stated, "No, I don't believe so. We do not believe in *brujeria* (sorcery). We believe that teas can help; the true medicine, not *curanderos*."

Because the term *curandero* was receiving a negative response in our early interviews, we increasingly used the terms *sanador* or *naturalista*. These are more general terms for "healer" and often refer to one using massage and herbal remedies rather than *limpias* or spiritual cleansing ceremonies. Eighty-five community respondents were asked the question "If you knew of a *sanador* or *naturalista* with a very good reputation, would you go to that person for a health problem?" Just under a third of the sample expressed a readiness to use a folk healer without hesitation. The others were evenly split between those strongly rejecting folk healers and those stating they might go to a folk healer for specific reasons such as lower cost, but would prefer care from a doctor. Following are examples of the segment completely rejecting folk healers and the segment partially accepting them:

> No, I would not go. I believe they are all charlatans and they play on the ignorance of many people; there is no reason to go. (Enrique, community respondent from El Salvador)

> Well, I would go [to the healer] one time for consultation, and if I got better I would go back. I'd go try it out. But I would prefer a doctor. If I had insurance, I'd go to the doctor, but since I don't have insurance I would use a home remedy or go to the *sanador*. (Jorge, community respondent from Mexico)

In sum, a significant number did not rule out an alternative healer in the sense of an herbal or massage specialist but there was reluctance among our respondents to use a *curandero* and the comments suggested that the *brujeria* or sorcery connotation causes ambivalence or distancing for some respondents. Of course, it is also possible that the reluctance was a function of methodology. As we noted earlier, the interviewer for the community sample presented herself as a doctor-to-be, and this could have biased responses in the direction of mainstream care.

For some, doctors in Mexico are better. A significant number of our community respondents had a very positive response toward seeking care in Mexico. Though about one-half stated that they had not (or could not) consider this option, 15% had gone to Mexico for health care and 24% stated that they would definitely go if they had a need. Many of our respondents favoring the Mexican option spoke of easier access to physicians, cost savings, and higher doses for medications as strong advantages. However, what was even more interesting to us was the greater proportion who spoke of the quality of care in terms of time spent with the patient, careful explanations, and a

generally more holistic approach, i.e., Western medicine in a more culturally sensitive form. This was evidenced by reports from a number of our respondents that Mexican doctors focus on treating the causes of illness rather than the symptoms. Note the following comments in which respondents compare Tijuana doctors and U.S. doctors:

> Yes, they [Mexican doctors] directly ask how you are feeling and speak with you a longer amount of time than here; we feel a greater confidence with them because they ask about the illness not the symptoms. That is the difference. (Jaime, hometown leader from Mexico)

When Teresa (community respondent from Mexico) was asked about the quality of care she received in Mexico, she responded:

> SUPER BIEN. Because they spend more time with you and if you have a pain, they personally check it, and later you feel better. But here, no; here they don't do anything for you. The doctors here are . . . competent; it's just that they don't examine a person as they should. And there, they take time with the patient and talk to you; they explain well what you're supposed to do . . .

Plainly, traveling to Mexico for care is a risky option for those who do not have permanent residency or temporary visas. When travel is not possible, a family member or friend may be recruited to buy medications in Mexico.

Personal prayer and health. We wanted to know if Latino immigrants facing illness turn to personal prayer as a kind of health action. The interviews suggest that prayer is viewed as essential to health and as a part of the immigrant survival process. Many of our community respondents spoke of using prayer for prevention. Note Sabrina's (community respondent from Mexico) comment when asked how important prayer is in her life:

> Prayer in my life is not important, it is fundamental! Because I attend church infrequently, to me it represents my values and my faith. When I am not ill, I pray to God that I don't get sick. God hears one and knows what one needs.

Similarly, Manuel (community respondent from El Salvador) notes:

> It [prayer] is one of the most beautiful things that one can have. When one asks God, it is everything. I believe that God listens. Since I have been in this country I have never been sick except for occasional fever or flu.

In our sample of 96 interviews, 75% stated that prayer was extremely important and 19% felt it was of some importance. Moreover, 90% stated that they had prayed for their own health or the health of a family member or friend. We also found it quite interesting that church attendance was not at all related to the belief in the importance of prayer. Those who only occasionally attended or never attended church services were just as likely to state that prayer and faith were essential to health as those who were frequent attendees. These data highlight the distinction between personal religiosity and organizational religiosity.

Though prayer was seen as an important part of preventive health and as a cure for self and others, only a minority believed that prayer alone was sufficient as a cure for illness. The view more commonly expressed was that prayer should be combined with herbal remedies or seeking medical attention.

Use of the church. Churches can initiate disease screening and other health promotion programs, and act as a mediator between the health seeker and a hospital or clinic.[34,37] However, it was clear from our community interviews that the church was not viewed as a place where one would obtain health support or advocacy, although food and clothing distribution were frequently mentioned. Moreover, regular church attendance was not a part of the lives of the majority of our community respondents. Only 30% of our community respondents reported some or regular attendance at services, primarily at a Catholic Church. Another 39% reported occasional attendance and 31% said that they never attend. Religious attendance was not related to health access in our data. Frequent attendees were just as likely to complain of poor health service as non-attendees.

There was an interesting discrepancy between our interview responses concerning the church as not important for health issues and our own fieldwork observations. In our fieldwork we observed striking examples of health outreach from religiously anchored organizations. We were especially interested in a non-profit known as QueensCare formed with the sale of Queen of Angels–Hollywood Presbyterian Medical Center. In this organization, registered nurses (RNs) provide free health screening in churches, temples, mosques, and non-public schools. These parish RNs attempt to provide culturally sensitive and holistic care to the uninsured at the neighborhood level, often successfully combating immigrant's fears in approaching hospitals. These Queens Care family clinics see about 100,000 patients a year with many coming to the clinic via the parish nurses. However, our 96 respondents were largely unaware of this ambitious neighborhood outreach. It was suggested by a Queenscare director that the reason for this is that the programs are quite new and centered only in certain neighborhoods. Additionally, since most of our respondents were not actively connected to a church, they may have been cut off from informal networks of communication about such health services.

A case study in moving across the alternatives: Artemio. It may appear that Latino health seekers are using but one kind of alternative. In fact, many of our respondents had stories that indicated a great deal of trial and error shifting across mainstream care and the alternatives. For example, Artemio made extensive use of both mainstream medicine and the alternatives**.** Artemio is 50 years old. He was born in Guatemala. He has been in the U.S. for four years. He says he came to better his economic situation. In Guatemala he was a farmer; presently in the U.S. he cleans offices. He does not have any health insurance. Artemio describes taking his very sick wife to a county hospital. She was in considerable pain. After a four-hour wait with no one seeing her, he reports she left the hospital in pain and sought care from a *naturalista*. This healer gave her herbs and she began to feel better. The *naturalista* noted that she had a problem in her colon and recommended seeing a physician. Rather than returning to county hospital or a clinic in the U.S., Artemio then accompanied his wife to Tijuana to see a Mexican doctor. The Mexican doctor verified the problem in the colon, and

she was cured with treatments that she received there. Thus, closed doors of access in mainstream care in the U.S. prompted the use of a natural healer and a return to Mexico for trusting, thorough communication with a Mexican doctor. Artemio noted that he and his wife frequently use *remedios caseros* (home remedies) and he has great faith in their healing powers, especially in early or preventive stages of illness. But when the problem is more advanced then, he notes, "one has to take a strong drug to alleviate the symptoms." Artemio regards mainstream and alternative medicine as both important but takes them at different times in the progression of the illness. Artemio does not attend church; he thinks the pastors put too much emphasis on money and contributions. Prayer, however, is very important to him: "prayer from the heart cures, makes one whole, and brings one harmony . . ."

Discussion

In this study we have attempted to show how culture interacts with social structure among Latino immigrants seeking health solutions. The interviews suggest that neither cultural nor structural barriers act independently to constrain human action in health-seeking. Rather, cultural alternatives and structural barriers interact; choices are available and strategies are worked out within this interaction. This finding agrees with Swidler's well-known essay on culture in action: "Culture influences action not by providing the ultimate values toward which action is oriented, but by shaping a repertoire or 'tool kit' of habits, skills, and styles from which people construct 'strategies of action.'"[38[p.273]] For some who are in good health, the use of cultural home remedies is sufficient as a first health action; it is familiar, involves little risk, and allows people to avoid structural impediments. Note that even among those who have never used mainstream medicine directly, the structural impediments are present in the form of chilling reports and stories about long waits, language problems and difficulty in establishing financial eligibility. Many others approach mainstream care first and, if not successful, shift their action strategies and use cultural alternatives as a fallback. Thus, neither culture nor structural impediments completely determine action; there is a repertoire of choice and a certain amount of space in which a variety of actions can take place. Our study is thus consistent with medical pluralism, in which Latino immigrants use whatever health care resources are available to them, and goes a step further by noting the considerable degree of agency that is employed in carrying out strategies of action.[9,13,38] This was illustrated by Artemio's and his wife's journey from county hospital to a folk healer to a Mexican doctor.

Our explanation is quite different from some recent research that deals with acculturation as the major determinant of Latino health and unequal access.[18,39] Our interviews suggest that the use of folk medicine provides an important adjustment to stifling barriers. This is not some kind of attachment to a backward folk medicine as some stereotypes suggest.[28] Rather, the interview data we have presented emphasize belief and structural barriers and the turning to herbals and other cultural alternatives as a rational response to real barriers in access. We do not want to romanticize the alternative system (the use of traditional medicine may delay necessary treatment), but our respondents seemed to be saying, "Thank God we have something to fall back

on." Recall that half of our respondents mentioned using herbals and *botánicas* because they could not get other treatment.

Some of our respondents stated that they trusted doctors in Mexico more than those in the United States. Many said that Mexican doctors charge less, take more time with patients, and provide more holistic care, enabling them to provide more exact treatments. U.S. doctors are viewed as hurried, not listening well, and drawing quick conclusions about the patients' illnesses without considering their input. There is important significance in the widespread use of traditional medicines (e.g., *botánicas*, herbals) and the belief held by some of greater trust in Mexican doctors. Both involve a greater sense of control or agency for the sick person. They have confidence in the healing powers of these two alternatives and the person is exerting some control in the process. This again illustrates the repertoire of choice and personal agency that we are emphasizing in this study.

An important contribution of this study has to do with the place of religion in the health-seeking experience. Personal religiosity (as prayer) and organizational religiosity (as church attendance) appear to be quite distinct in the lives of these respondents. Church attendance was rather low in the sample, and our respondents did not view the church as a coach, negotiator, or aid in health care-seeking, this despite our field observations of very effective parish nurse health screening (QueensCare organization) in certain neighborhoods. On the other hand, our respondents indicate that prayer and faith are fundamental to health. Daily prayer is common and prayer over health matters for self or others is almost universal in this sample. Rather than passivity or fatalism, the interviews suggest that prayer is seen as empowering action; i.e., something that gives one stability, something that increases health protection, and something that greatly contributes to a cure.

Health care for immigrants is often cast in a negative light and seen as draining public services and overcrowding hospital emergency rooms.[40] This study indicates that many Latino immigrants never receive care because of very difficult real or perceived barriers. Further, the very negative perception of public medicine expressed by our interviewees suggests that some Latino immigrants delay treatment for serious illness until the alternative system is exhausted, leading to far more expense to the health seeker and to the hospital when the person seeks help at an advanced stage of illness.

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In Memoriam: Co-author Yessenia Rivera unexpectedly died during the processing of this manuscript. With skill and warmth, Yessenia conducted the majority of the community interviews in this study and without her excellent work this study would not have been possible. Yessenia's dream was to return to Honduras and set up a clinic for the underserved. We dedicate this article to her memory.

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