Original Article

DOCTORS, CURANDEROS, AND BRUJAS: HEALTH CARE DELIVERY AND MEXICAN IMMIGRANTS IN SAN DIEGO

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To what extent does the complex set of beliefs and practices relating to diseases, cures, health maintenance, and health care practitioners found in traditional Mexican culture influence the behavior of Mexicans seeking health care in the United States? In this paper I examine data gathered on Mexican immigrants in San Diego County, California, that support the growing consensus that socioeconomic factors affect this population's behavioral patterns regarding health care services much more than do cultural beliefs. Many of the members of this population find that access to conventional U.S. health services is limited by their socioeconomic condition and, for some, an undocumented immigration status. However, the evidence suggests that many Mexican immigrants believe in folk illnesses, perceive U.S. health care practitioners as lacking an understanding of folk illnesses, and feel that this lack of understanding does affect practitioner behavior when they seek health care. In short, the overwhelming significance of socioeconomic factors should not blind us to the importance of cultural beliefs and perceptions about health care, although the latter probably diminish in importance the longer that Mexicans and their descendants reside in the United States.

Recent research on Mexican Americans (which includes immigrants and U.S.-born Chicanos) stresses the preeminence of socioeconomic factors among the causes of this population's underutilization of health services (Cornelius, Chávez, and Castro 1982; Slesinger and Cautley 1981; Marín, Marín, and Padilla 1980; Roberts and Lee 1980; Trotter and Chavira 1980; Lee 1976; Torres-Gil 1978; Moustafa and Weiss 1968; Bergner and Yerby 1968). Specifically, these researchers argue that many factors, working alone or in combination, inhibit the utilization of health care services by Mexican Americans. Among these factors, researchers cite the high cost of health care in relation to the low income levels of Mexican Americans; the undocumented immigration status of a significant segment of the population; the relatively low levels of medical insurance coverage; the general unavailability of translation services; and the inappropriate operating hours or geographical location of health care providers.[1] In a sense, these researchers are responding to an earlier cohort of anthropologists (e.g., Madsen 1964; Rubel 1960; Saunders 1954; Samora 1961; Clark 1959) who argued that continuing belief in folk illnesses and the use of traditional health practitioners best explain the Mexican American's failure to use conventional medical care.[2]

Another group of researchers has been treading a more middle-of-the-road approach (Gilbert 1980; Teller 1978; Farge 1977; Weaver 1973; Nall and Speilberg 1967; Martinez and Martin 1966). While emphasizing the significance of economic and social factors as reasons for underutilization of health services by Mexican Americans, these researchers also emphasize the importance of beliefs about folk illness and folk curers for the understanding of behavior related to the seeking of health care for at least a portion of the overall Mexican American population.

Martinez and Martin (1966) interviewed 75 Mexican American women (24 born in Mexico) in Dallas, Texas. They concluded that belief in folk illnesses was widespread among urban Mexican Americans. However, belief in folk illnesses and curative practices did not preclude the consultation of physicians and the use of medical services for health problems not defined by folk concepts. Martinez and Martin (1966:164) argue that "many Mexican Americans participate in two insular systems of health beliefs and health care." Mexican American rarely seek care for folk illnesses from conventional health practitioners; when they do, according to information recorded by Martinez and Martin, they perceive the treatment received as too slow and ineffective.

Nall and Speilberg's (1967) research among 53 Mexican American (14 born in Mexico) tuberculosis patients in Hidalgo County, Texas, also revealed that cultural beliefs about folk illnesses and practices did not inhibit the acceptance of modern medical treatment for tuberculosis. Twelve of the patients had sought care from a folk curer *(curandero),* and 19 had sought folk cures from a relative or friend in addition to seeking care from a physician. Nall and Speilberg's findings are significant but refer specifically to treatment for tuberculosis, an illness defined in the domain of modern, conventional health care. Thus they do not contradict the study of Martinez and Martin, particularly with regard to the finding that Mexican Americans may not seek care for folk illnesses from conventional health care practitioners or that they often perceive conventional care as ineffective for treating such maladies.

Moustafa and Weiss (1968) also found that although Mexican Americans often use home remedies before consulting a doctor, they often seek care from physicians afterward. Other researchers (notably Teller 1978; Farge 1977; Weaver 1973) also argue that belief in folk curers has little effect on the utilization of conventional care. Teller (1978:274) found that in the Texas borderlands area the use of folk healers was not prevalent and that when used they served to complement conventional medical care. Teller stresses the poverty of the Mexican-origin population in the area, racism, and the structure of the health care delivery system as the important factors affecting patterns of utilizing health care services.

More recently, Gilbert (1980) found that information about folk illnesses varies according to socioeconomic class among the Mexican American men and women who had recently become first-time parents, who she studied in Santa Barbara, California. The 14 middle-class couples[3] were much less knowledgeable about the specific folk illnesses *mollera caída* (fallen fontanelle), *empacho, susto,* and *mal de ojo* than were the 31 working-class parents. However, even the working-class parents lacked basic information on two of the four diseases. As Gilbert (1980:6) notes, "this is not indicative of tenacious adherence to folk medical beliefs among these new parents."

Gilbert presents an interesting finding concerning where the parents she interviewed would seek care if their children demonstrated the symptoms of a folk illness. None of the middle-class parents, only one of whom was born in Mexico, would seek out a traditional folk healer (*curandero* or *señora*—a woman who knows remedies). Among the working-class parents, 17 of whom were born in Mexico, 8%, 9%, and 5% mentioned a folk healer as an appropriate resource for treating *mollera caída, susto,* and *mal de ojo,* respectively. In addition to variation along class lines, the respondents in Gilbert's sample vary by country of birth, with immigrants reflecting more of a willingness to seek care from a traditional folk healer. Gilbert (1980:7) concludes that socioeconomic factors are strongly related to the underutilization of available health services by the working-class group, but that their "more extensive recognition of folk medical concepts . . . and their preference for treatment within the [extended] family *may* indicate some reluctance to seek help from doctors and clinics for these diseases."

Data on behavior patterns of Mexican immigrants when seeking health care in San Diego County suggest that the cost of health care, the lack of medical insurance, and undocumented immigration status create significant barriers to the delivery of health care to the Mexican-origin population (Cornelius, Chávez, and Jones 1983). For most Mexicans in San Diego, belief in folk illnesses or preferences for folk curers did not surface as major reasons for not seeking health care from U.S.-based health practitioners. However, the evidence also tends to support the position that belief in folk illnesses and belief in a lack of understanding of such problems by U.S. health practitioners influences behavior patterns related to health service use, particularly the use of Mexican-based health practitioners and the possible use of a *curandero* under some circumstances. A small but significant segment of the Mexican immigrant population held such attitudes; however, though such beliefs did appear as responses to health-related questions and cannot be overlooked entirely, survey evidence suggests that Mexicans in San Diego County do not consider folk illnesses to be major health problems.

Mexican Immigrants in San Diego

Between March 1981 and February 1982 the Center for U.S.-Mexican Studies at the University of California, San Diego conducted a survey of 2103 individuals born in Mexico but at the time living or working in San Diego County (Cornelius, Chávez, and Jones 1983). Great care had to be taken to ensure the confidentiality of the respondents, many of whom were undocumented immigrants. Researchers established initial interview contacts throughout the county. Subsequent interviews were identified through a network sampling or "snowball" sampling technique, which relies on the individual's network of social relations (Cornelius 1981). The interview schedule consisted of a series of closed questions followed by several open-ended queries that allowed for the gathering of extensive qualitative information despite the survey format.

The sample population consisted of 51.1% males and 48.9% females. About half (49.4%) of the informants did not have proper documentation from the Immigration and Naturalization Service. The age of the informants varied by immigration status. Those without documents tended to be young; 61.4% of them were under 30 years of age, compared to only 24.7% of the legal immigrants.

Mexican immigrants play a major role in the agricultural, service, and light industry sectors of the local economy. Most undocumented workers in the sample (59.2%) earned a gross income of $7500 or less, while only 34.8% of the legal workers lived at that income level. Women generally earned less than men. The median income of the female interviewees was $6500 per year, while for men it was $7800.

Health Care Utilization Patterns

The majority of the Mexican immigrants in the San Diego sample have utilized local health care services on one or more occasions. When questioned about the most recent occasion when they needed medical attention (Table 1), over three-quarters of the interviewees responded that they had sought care from a health care provider located in San Diego County. Most (10.5%) of the remainder did not seek medical attention anywhere or sought care on the Mexican side of the border. The percentage of respondents who had never sought medical care was much higher among the undocumented (17.7%) than among legal residents (4.7%).

During their most recent illness, the immigrants in our sample sought health care from hospitals and clinics more often than from any other source, as Table 2 shows. Sixty percent of the respondents who sought any medical attention at all chose hospital or clinic-based care. However, well over one-third of the respondents sought care from private physicians.

Only seven persons admitted to having sought care from a *curandero* (practitioner of traditional Mexican "folk medicine") for their last health problem. In other categories of health care the study revealed a prevalent use of pharmacies, particularly in Mexico, where drugs that require a prescription in the United States are sold over the counter (cf., Logan, in press). The category "other" in Table 2 also includes dentists, an optometrist, a chiropractor, and a local woman *(inveccionista)* who administers injections of drugs purchased from a pharmacy in Mexico.

A sizable group of immigrants in the San Diego sample appear to fall outside the county's local health care delivery system. Nearly one out of five immigrants in the sample (19.8%) had not sought health care in the United States on any occasion. Some of these individuals have not sought medical care anywhere, and others prefer Mexican-based care.

TABLE 1. LOCATION OF HEALTH CARE PROVIDERS USED DURING MOST RECENT ILLNESS.

	Number	Percentage
San Diego County	1559	77.4
Orange County	3	0.1
Los Angeles County	10	0.5
Other U.S. location	18	0.9
Tijuana	112	5.6
Hometown in Mexico	76	3.8
Other Mexican location	24	1.2
Have not sought medical care	212	10.5
Total	2014	100.0%

TABLE 2. TYPE OF HEALTH CARE PROVIDER USED DURING MOST RECENT ILLNESS.

	Number	Percentage
Hospital/Clinic	1033	60.0
Doctor	650	37.7
Curandero	7	0.4
Other	33	1.9
Total	1723	100.0%

A number of related reasons surfaced as to why certain individuals had not sought health care in the United States. Many of these migrants said that they were young and healthy and therefore had no occasion to seek medical attention. This explanation corresponds with the concept of migration as a process that selects the young and hardy in a given population. However, responses to specific questions concerning the use of health care facilities indicate certain obstacles, both real and perceived, which help explain under- or nonutilization of health services by the Mexican immigrant population.

The high cost of health care is one such obstacle. Over half (52.5%) of the individuals interviewed believed that they did not have enough funds to cover the cost of care from a hospital or clinic in the United States. The problem of the high cost of health care is compounded by the low levels of medical insurance coverage among both the documented and undocumented segments of this population (Table 3). Both legal and undocumented respondents displayed a pattern of medical insurance coverage distinctly below that of the general U.S. population in 1980, among whom 70% were insured under private health insurance plans (President's Commission 1983:95).

When questioned further, another 28.6% of the respondents expressed fear of seeking care from a U.S. hospital or clinic. These respondents cited most often their undocumented immigration status to explain their fear. Thirty-nine percent feared that using medical facilities and filling out the required forms (e.g., an application for Medi-Cal) might lead to their deportation. Patients who do not return for important follow-up visits or do not follow a doctor's advice about seeing a specialist, even when an appointment has been made, often do so because of fear related to their immigration status. Sometimes these patients behave in this way because they do not understand the purpose of follow-up visits or appointments with specialists, both of which they often view as increasing the cost of health care.

A large percentage of the informants (21.3%) were afraid to use U.S.-based care because of their inability to speak English. Another, 7.8% of the interviewees also feared seeking care because they feared shots and other forms of treatment; 7.1% lacked information on where to seek care; 7.1% lacked faith in U.S. doctors and the U.S. medical system; and 5% believed U.S. doctors lack an understanding of their health problems (see Moustafa and Weist 1968:39; Clark 1959:235; Saunders 1954:114-124).

TABLE 3. PERCENTAGE OF RESPONDENTS WITHOUT MEDICAL INSURANCE COVERAGE, BY IMMIGRATION STATUS.

	Without insurance	Total number	Percentage
Undocumented	685	795	86.2
Documented	315	671	46.9

Chi square (χ^2) significance = .01.

The information on utilization patterns indicates that Mexican immigrants do not use folk curers or other nonconventional health care practitioners in proportionately large numbers. A major obstacle to health care for this population is the high cost of U.S.-based medical care combined with a low level of medical insurance coverage. In addition, undocumented immigrants feared to use health services because they believed such action would lead to their deportation. Other fears, both real and perceived, also inhibited the use of health services, including a small percentage of respondents who lacked faith in U.S. doctors and believed U.S. doctors did not understand their particular health problems. Other than this last subgroup of interviewees, responses to the survey questions did not reveal that belief in folk illnesses or belief in the relative superiority of folk healers created an obstacle to the utilization of health services by Mexican immigrants.

Seeking Care in Mexico

Rather than completely neglecting their health problems, many of the immigrants who have not sought care in the United States resort to health care providers in Mexico. The data suggest that Mexican immigrants commonly return to Mexico for health care. Almost one-third of the sample (30.8%) had done so on at least one occasion since their arrival in San Diego County. The most commonly used health care providers on the Mexican side are those located in the border city of Tijuana, although some immigrants go all the way back to their hometowns in Mexico to seek care. Eighty percent of those who seek care in Mexico do so on a regular basis, having sought care more than once. Over half (52.4%) of those seeking care in Mexico have done so many times and will continue this practice.

Questions on the last health-seeking trip to Mexico were designed to gather information on the type of health care provider from whom interviewees sought care. Most of these border crossers (75.8%) go to Mexico seeking the personal attention provided by a private doctor. Almost 1 out of 10 interviewees (9.7%) who went to Mexico seeking health care sought out pharmacies. Traditional practitioners also serve this population of border crossers. Seventeen respondents sought a *sobador* and six sought a *curandero,* representing 2.9% and 1%, respectively, of those who sought care in Mexico.

As to why Mexican residents in the United States would seek care in Mexico, the pattern is clear (Table 4). Interviewees sought care from practitioners with whom they had a relationship; from these practitioners they would receive the kind of treatment and understanding of their health problems that they expected at a cost they could afford. The much lower cost of health care on the Mexican side of the border is a major factor in the decision concerning where to seek care. However, the alternative of seeking care in Mexico is one primarily open to legal residents who can move freely across the border.

TABLE 4. REASONS FOR SEEKING CARE IN MEXICO (N = 586).

	Percentage
Acquainted with doctors, convenient	36.5
Less expensive	19.8
Bad experience in U.S.	9.0
Language	8.2
Fewer problems in Mexico	6.0
Don't trust U.S. doctors	5.8
Returned by immigration officials	0.5
Other	14.2
Total	100.0%

Interestingly, almost 15% of the informants who sought care in Mexico turned to Mexican practitioners because of previous bad experiences with the U.S. health care delivery system, or, perhaps related to those experiences, they did not trust U.S. doctors. These fears relate to a general feeling among interviewees that U.S. doctors and hospital/clinic staff do not sufficiently explain health problems and treatments. As an interviewee put it, "They [U.S. doctors] never explain what your health problems are." Lack of confidence in U.S. practitioners often stems from an experience that resulted in ill-feelings, cultural misunderstanding, or unmet expectations.

Two important points need to be emphasized concerning the data on interviewees who seek health care in Mexico. First, some individuals sought nonconventional health care practitioners in Mexico, although the proportion of interviewees doing so was not large. Second, discontent with U.S. health practitioners influenced the decision of many interviewees to seek care in Mexico. Related to this last point, many interviewees who chose Mexican-based care believed Mexican doctors understood their health problems. These two points indicate the importance of beliefs and perceptions about health problems and the delivery of health care which influence behavior patterns among a significant subsection of this population.

Folk Illnesses and Folk Practitioners

The folk illnesses that have been mentioned in this paper do not have equivalent terms in English. They do have descriptive definitions that have been prominently discussed in the anthropological literature (Kay 1977; Kiev 1968; Rubel 1960; Madsen 1964; Clark 1959). These ailments have their own culturally defined causes, which can be found in both the natural and magical domains.

In response to the survey questions, respondents occasionally mentioned folk illnesses. Although interviewees may have sought care for folk illnesses in Mexico or locally from a "traditional" source (e.g., a *curandero,* relative, or neighbor), they did not exclude conventional care. However, their attempts to have folk illnesses cured by U.S. doctors often led to frustration and cultural misunderstanding. Consequently, some Mexican immigrants in the sample believed U.S. doctors and other health practitioners were unaware of their health problems, particularly the illnesses common in folk culture. The following field note by one of the interviewers in the San Diego research team exemplifies the problems of communication and mutual misunderstandings of behavior and motivations that develop around the seeking of care for folk illnesses:

> While the interview was in progress, the respondent's wife became worried about their one-month-old baby's health. They showed me the top of the baby's head and said that the *"mollera esta caída"* [fallen fontanelle] and that is why the baby was sick. They have been to a clinic to have the baby checked. This was a great source of distress and anger because they have been there several times and, according to the interviewee, "all they do at the clinic is take blood from the baby. They took out so much blood that the baby cannot get better." They were also told at the clinic not to breast-feed the baby for a while and give it a milk-free substitute. But the father [respondent] says that a mother's milk is best and does not understand why they told them to stop breast-feeding. He said, "they [the doctors] never explain what they do and I do not want to ask because I don't want them to think I do not trust them or have faith in them." He would like to take the baby to a private doctor, but "doctors don't believe in *mollera caída.*" Instead, they are taking the baby to a relative who has previous experience with such health problems.

Different perceptions of health problems, combined with a lack of communication between patient and health care providers who are often unaware of the Mexican patients' beliefs, sometimes lead interviewees to use nonconventional health practitioners (D. Mull and J. Mull 1981). As stated, seven interviewees in the sample admitted to having used a nonconventional health care practitioner—a *curandero,* or folk doctor—during their last illness. A somewhat larger group (27 individuals, or 1.3% of our sample) volunteered that they had used *curanderos* in the past (see Table 5). However, the number of interviewees that had sought care from a *curandero* at some point in their lives is undoubtedly much greater than the number who "volunteer" such information. Significantly, a large group (23% of the sample) stated that they would be willing to seek care from a *curandero* if circumstances warranted it.

Most informants (79.4%) had heard of *curanderos.* However, their attitudes toward such health practitioners varied. When asked about the services *curanderos* provide, almost half (44.4%) of the interviewees replied in positive terms, reflecting that they perceived *curanderos* as healers and health practitioners. However, many informants (34.4%) viewed *curanderos* in negative terms. "I don't believe in *curanderos*" was a common reply. Another 20.6% of the informants did not know about the services *curanderos* provided, had never been to a *curandero,* or were unfamiliar with *curanderos.*

Among interviewees who were willing to seek care from a *curandero,* 14.9% stated that they would do so primarily for

TABLE 5. USE OF NONCONVENTIONAL HEALTH CARE PROVIDERS.

	Would use		Have used	
Type of practitioner	N	%	N	%
Curandero (folk healer)	479	23.3	27	1.3
Espiritualistas (spiritual healer)	84	4.1	8	0.4
Bruja (witch)	51	2.5	3	0.1
Sobador (massager)	1359	66.4	107	5.7
Chiropractors	903	45.1	64	3.2

chronic gastrointestinal problems. A small percentage (5.5%) mentioned *empacho,* which is the Mexican folk term for stomach pain often believed to be caused by food sticking to the stomach or intestinal lining (cf., J. Mull and D. Mull 1981). Another 17.6% of these interviewees would seek care from a *curandero* for any pain or general health problem. For 6.2% of the respondents, *curanderos* served as the health providers of last resort, should conventional treatment fail. Many interviewees (14.8%) stated they would seek care from a *curandero* for problems they believe U.S. doctors have not heard of and therefore would not treat, such as *"mal de ojo"* (the negative influence exercised over an individual's well-being by being stared upon by a particularly strong personality; infants are particularly susceptible) and *"mollera caída"* (fallen fontanelle).

While the possibilities that a folk illness might actually lead to care being sought from a *curandero* are not great, neither are they completely remote. For example, 7% of the mothers in our sample believed one or more of their children had suffered at some point from *mal de ojo.*

Willingness to seek care from a *curandero* varies with age (Table 6). Older (over age 30) respondents were much more willing to seek care from a *curandero* than were younger interviewees. Younger respondents often commented that they and other people in rural areas would use *curanderos* and other folk practitioners because doctors were not available, but that they would not use them here in the United States where doctors are available.

The amount of time Mexican immigrants have been in the United States has little effect on the proportion of respondents who would seek care from a *curandero.* For respondents who have been in the United States 10 years or less (N = 1246), 21.8% would seek care from a *curandero* if necessary, whereas 20.9% of those respondents in the United States longer than 10 years (N = 593) would do so. The illnesses or conditions that make a *curandero* a legitimate and appropriate alternative to conventional health care under certain circumstances persist among some Mexican immigrants, even after lengthy residence in the United States.

Attitudes toward *curanderos* vary according to whether informants migrated from a rural or urban area. Most of the informants (67.9%) had migrated from an urban area, although they originally might have been from one of the smallest rural communities (*rancho* or *hacienda*) or from a small town dependent on agricultural production *(pueblo).* Rural migrants (27.6%, N = 631) were much more willing to seek care from a *curandero* than were migrants from urban areas (20.9%, N = 1332; chi square significance = .05). However, the percentages of respondents who volunteered they had actually been to a *curandero* were similar: 1.4% of both rural and urban migrants. As migrants increasingly experience urban life before migrating to the United States, they appear to view *curanderos* in less positive terms. Perhaps rural migrants have had more opportunity to rely on the care of folk healers and thus have learned to place more faith in their abilities.

Although a relatively large number of respondents were willing to give *curanderos* the benefit of the doubt as to their abilities to cure, only a handful of respondents expressed interest in using *espiritualistas* (spiritual healers) and *brujas* (witches) as health care providers, and then only as a last resort. The attitudes reported in Table 7 suggest the reasons respondents avoid such practitioners.

By contrast, interviewees looked favorably upon *sobadores*—practitioners who manipulate or massage affected areas of the body. Interviewees considered *sobadores* effective in dealing with such problems as sore or pulled muscles, strains, sprains, back injuries, bone dislocations, and fractures. As reported in Table 5, two-thirds of our interviewees have used a *sobador* or would be willing to consult one if the need arose. Over 45% of the sample also would be willing to try, or have already tried, an American chiropractor for treatment of the same kinds of musculoskeletal problems. In fact, an examination of the type of health care practitioners from whom care was sought for work-related accidents reveals that chiropractors were seen in 9.4% of the cases and *sobadores* in 5.3%.

In addition to nonconventional health practitioners, Mexican immigrants often come from areas in which the use of herbs or medicinal plants to cure health problems is still quite effectively practiced. Not surprisingly, 70.1% of the interviewees had used herbs or medicinal plants for health problems (Trotter 1981a, 1981b). Interviewees appear to associate these health problems with lifestyle, or everyday life; thus they do not consider appropriate

TABLE 6. USE OF CURANDERO BY AGE DIFFERENCES.

Would you seek (have you sought) care from a curandero?	Under 30 years of age		Over 30 years of age		Total	
	N	%	N	%	N	%
No	713	80.5	817	71.4	1530	75.4
Yes	164	18.5	309	27.0	473	23.3
Totals	886	43.6%	1144	56.4%	2030	100.0%

Chi square (χ^2) significance = .01.

TABLE 7. ATTITUDES CONCERNING ESPIRITUALISTAS AND BRUJAS.

Principal response	Number	Percentage
Espiritualistas (spiritual healers)		
Don't believe in them	447	36.1[a]
Not good for anything	378	30.5
Rid a person of evil spirits, tell future, communicate with spirits	208	16.8
To cure, to cure using spirits, prayers	108	8.7
Take your money	48	3.9
Other	50	4.0
Brujas (witches)		
Don't believe in them	981	62.6[b]
Bewitch people, make them ill	307	20.1
Rid a person of evil spirits	51	3.3
To give false hopes	48	3.1
To take your money	37	2.4
To cure illness	19	1.2
Other	85	7.7

[a] Espiritualistas percentage based on 1242 cases.
[b] Brujas percentages based on 1528 cases.

seeking care for them from a doctor, hospital, or clinic, or they might put off seeking care for such problems.

While informants listed a wide range of health problems as treatable by medicinal plants, most problems can be categorized as gastrointestinal problems. Such problems include stomach pains, indigestion (53.8%), *empacho* (2.8%), colic (3.9%), sick stomach associated with menstruation (0.7%), *bilis* (bile in the stomach as a result of anger or intense emotion, 1.6%), and diarrhea (0.7%); medicinal plants are used to remove air from the body (2.6%), and as a laxative (1%). Other types of problems treatable by herbs include cough, colds, fever, influenzas, sore throat (10.8%), headaches (3.3%), *nervios* (intense nervousness, 3.8%), arthritis, rheumatism (1.4%), anemia (1.1%), and bladder problems (1%). Importantly, illnesses that can be treated at home with medicinal plants include folk illnesses such as *bilis*, *empacho*, and *nervios*.

Folk illnesses surfaced when interviewees discussed problems treatable by a *curandero* and at home using medicinal plants. In contrast, not one folk illness was cited by informants when discussing the health problems that led them to seek care from a private physician, hospital, or clinic during their last health-seeking experience. Consequently, folk illnesses, which appear to affect a small but significant segment of this population, are not illnesses that would generally lead Mexican immigrants to seek care from a conventional U.S. health practitioner.

Conclusion

A belief in folk illnesses and folk practitioners did not significantly deter Mexican immigrants in San Diego from seeking conventional medical care. The primary sources of resistance to the utilization of U.S. health services are economic, and, for the undocumented, fear of being detected. Other factors, such as language and negative experiences, also deterred some interviewees from seeking health care. But the high cost of care, given the resources available to the interviewees, limited the actual accessibility of health care to this population.

However, the evidence does not allow the conclusion that a belief in folk illnesses and the efficacy of *curanderos* and *sobadores* has no influence on the decision-making process concerning the seeking of health care. While no single folk illness or traditional health practitioner surfaced in significant numbers in response to any specific question, the cumulative effect of the incidences of folk illnesses that arose in various aspects of the immigrants' health care experiences indicates that such beliefs persist among this population and influence, to some yet undetermined degree, behavior related to the seeking of health care.

Although perhaps only a minority of the Mexican immigrant population have folk beliefs that result in avoidance of conventional care, many more may suffer health problems that they perceive as folk illnesses. However, in many cases, they will not describe their health problem in terms of a folk illness to a conventional health practitioner who they believe is not familiar or effective with such problems. Mexican immigrants who seek care for folk illnesses from U.S. doctors who are unfamiliar with such illnesses will often become frustrated and turn elsewhere for treatment, for example, to a practitioner in Mexico, a *curandero*, a home cure, or to a relative or friend who "understands" such problems. The evidence presented here suggests that U.S. health practitioners need to be aware of and to understand folk illnesses in order to ensure that effective health care is administered to all members of the Mexican-origin population.

NOTES

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[1] Based on work in t o communities in Mexico, each with similar folk beliefs concerning health, Young and Garro (1980) reached similar conclusions: factors related to the accessibility of a health care facility determined usage of health services.

[2] The earlier cohort of anthropologists mentioned here examined a Mexican-origin population, which tended to be have more individuals who migrated from rural areas in Mexico than the communities of Mexican Americans being studied more recently. In addition, these earlier researchers did not examine socioeconomic factors, which have come to the forefront of current research.

[3] Gilbert (1980:2) determined class affiliation of the couples by examining the husbands' occupations. Middle-class occupations included clerical, sales, managers, technical, or professional positions. Working-class occupations included laboring, semiskilled, or crafts positions. How this determination, which relies on occupation, relates to the more common determination of class affiliation based on income is unclear.

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Review Article

ATTENDING BIRTH AT THE MARGINS: THE "MIDWIFE PROBLEM"

Traditional Birth Attendants: An Annotated Bibliography on Their Training, Utilization, and Evaluation. *L. Oddi* and *B. Pizurki,* compilers. Geneva, Switzerland: World Health Organization, 1979. Pp. 68. n.p. (paperback).

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Historically, concern over "the midwife problem" emerges with the possibility, however slight, of physician-based maternity care (Wertz and Wertz 1977). In mid-19th-century England as the status of general practitioners and obstetricians rose, midwives were increasingly portrayed as the "garrulous, tippling, and distinctly unprofessional figure of Dickens' Sairey Gamp" (Donnison 1977:60), obviously not a good choice for a birth attendant. In 20th-century United States, the stock image of ignorant and unkempt immigrant and rural southern midwives still appears at times in physicians' perspectives on inappropriate birth attendants. Distaste for these nonprofessionals helping at birth is clear in this comment Alan F. Guttmacher made in a book about pregnancy, birth, and family planning for lay readers (Guttmacher 1973:100):

> When the word "midwife" is mentioned in the United States, one immediately conjures up a decrepit, kindly, illiterate, often not too clean old "granny" type of woman, a creature whose only professional claim was the number of children she herself had had, plus a desire to be an obstetrix [female obstetrician].

When the medical model of childbirth is ascendant, midwives whose practices are based on other models are viewed as risky (and lesser) attendants. Since midwives are seen as helpers in ordinary "women's work" rather than as experts able "to do everything possible," they pale by comparison with physicians. Physicians, on the other hand, are seen as better equipped to handle the really difficult birth-related problems, and thus they—or their subordinates—are seen as more suitable attendants than independent midwives working outside their purview. Often, too, legal restraints on midwives accompany this medical dominance in the division of labor in childbirth. This is no less the case for traditional birth attendants (TBAs) in the Third World than it is for lay midwives in the United States currently.

However, recognition of the continuing shortage of professional medical personnel in the Third World, particularly in rural areas, has led to a reexamination of "the midwife problem" there. With formal encouragement from international agencies such as the World Health Organization (WHO) in its Alma Ata Declaration of 1978, many countries are attempting to integrate TBAs into clinic-based services instead of trying either to abolish or to ignore them. The collections under review here are evidence of how widespread the interest in this integration is.

Funded by the United Nations Fund for Population Activities (UNFPA), this annotated bibliography of 178 entries and its first supplement with an additional 62 provide a valuable service. Much of the information collected in its pages is drawn from ephemera: theses; mimeos; synopses of papers presented at regional conferences, workshops, and working parties; proceedings of international meetings; government agencies' working papers in maternal and child health and family planning; government documents; obscure journals; and unpublished papers. There are few listings of materials produced before 1970, and few listings of easily found journals or studies. Obviously, this is an important source of documents which might otherwise be unknown or inaccessible to serious planners, health workers, and researchers. Included materials cover not only traditional birth attendants but also government sponsored and placed auxiliary midwives at rural health centers, and lay midwives in the United States. Such coverage implies a focus on primary-level maternal care on the periphery of medical