"Le tengo fe" How do women's networks influence the health competence of Latina immigrant mothers living in a rural Midwestern state?

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“Le tengo fe”

How do women’s networks influence the health competence of Latina immigrant mothers living in a rural Midwestern state?

By

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ABSTRACT

This study explores how the health competence of Latina immigrant mothers living in rural Iowa is influenced by their social, cultural and human capitals. By exploring the role of women’s informal networks in disseminating knowledge and practices related to maintaining family health, this study sheds light on the role of cultural values, gendered knowledge and social cohesion in enhancing health competence of Latina immigrant mothers. This study draws a purposive sample from Rural Families Speak about Health (RFSH), a multi-state study that examines the physical and mental health of ethnically diverse rural families with low incomes and young children. A focus group and in depth-interviews were conducted with eight Latina mothers. Findings suggest that Latina immigrant mothers incorporate both traditional and biomedical health beliefs as they devise ways to provide health care for their families within a context that restricts their access to formal health care. Translational and local ties positively affect Latina immigrant mothers’ sense of self-efficacy by providing them with information and resources of biomedical and traditional health care. Latina immigrant mothers make collective decisions regarding health through consultation with their networks. Many of the mothers look inward to relatives for health information. While informal local networks can be a source of health information, these networks are few and often weak. Recommendations include insights on how to mobilize Latina immigrant mothers’ social, human and cultural capitals in order to enhance their agency within the U.S. political-economic context that restrict Latina immigrant’s access to formal health care.
CHAPTER 1: INTRODUCTION

Background and Context

The life of women living in poor rural areas of Mexico and Central America revolves around a traditional gender ideology. It entails a division of labor with a sharpened separation between the feminized realm of reproductive labor and subsistence production and the masculinized realm of wage labor (Olcott 2002). Women are considered the gatekeepers of their family’s health, as well as the carriers of collective healing experiences within and outside the household spheres (Mendelson 1995; Williams and Crooks 2008). In their role as caregivers, women perform several activities such as providing a healthful environment and nutritious food, teaching and monitoring family hygienic practices, diagnosing and treating minor family member illnesses and deciding when to seek lay or professional health care (Mendelson 1995; Clark 1995).

Poor rural women always have faced difficulties in fulfilling their roles as caregivers. Their agency as caretakers has been greatly undermined by global economic restructuring that has taken place under a neoliberal economic and political system. This situation has produced many negative effects such as the decline in the state of public health due to large reductions in government health-care expenditures and the privatization of health care services (Harrison 2004). In Latin American countries such as Mexico, Guatemala and El Salvador, socio-economic inequality has been exacerbated by economic restructuring measures that started in the 1970’s as part of a government development policy. Besides increased economic disparities, such policies led to severe cuts in government spending on basic areas such as health, education, and social security. Thus, rural and urban poor
families had fewer resources to sustain their families. As a consequence, many poor men and women have been forced to migrate to the U.S. in order to provide for their families. Whether poor women migrate with their families or stay in their home country, they face a great burden to provide food and health care for their families (Stephen 1997).

I was particularly interested on how Latina mothers were able to carry out their caregiver’s roles as they migrate to the U.S. The political-economic context underlying the lives of low-income immigrant Latinos in the U.S. informs and determines the kind and the quality of medical resources to which they have access (Chavira-Prado 1992; Menjívar 2002). Several studies have pointed out how Latino cultural health beliefs and values can function as barriers in seeking medical attention and completing medical treatment as an attempt to explain health inequalities among the Latino population. Yet, several studies have provided evidence that economic and political constrains shape the use of health care by low income undocumented immigrants (Chavez, Flores, and Lopez-Garza 1992; Documét and Sharma 2004). Once the financial barriers to health care are reduced, undocumented immigrants are more likely to acquire timely and more cost-effective health care (Chavez, Flores, and Lopez-Garza 1992).

Thus, I wanted to give voice to immigrant Latina mothers who struggle to provide health care for their families within political and socioeconomic contexts that greatly limit their access to formal health care. I wanted to look at cultural health beliefs from a positive perspective. My aim was to shed light about how Latina immigrants incorporate their folk traditional health knowledge, their gendered skills and their collective social values in their everyday struggles to preserve the health of their families. It is well documented that in urban
areas, women’s informal networks play a central role in Latina women’s ability to preserve the health of their families (Menjívar, 2002; Hagan, 1998).

This study was conducted in rural Iowa for several reasons. First, Hispanics account for 16 percent (50.5 millions) of the total United States’ population. More than half of the growth of the total population in the United States between 2000 and 2010 was due to the increase of the Hispanic population. During this time period, the Hispanic population grew by 43 percent which is four times the growth of the total U.S. population (U.S. Census Bureau, 2010a). Even though the Hispanic population grew in every region between 2000 and 2010, the most significant growth took place in the South and Midwest. In the Midwest, the Hispanic population increased by 49 percent. This was more than twelve times the growth of the total Midwest population (U.S. Census Bureau, 2010a).

Second, rural and small towns in the Midwest have experienced an influx of new minority populations, predominantly Latinos, who have come to find employment, mainly in the agro-food industry. For example, some communities in the Midwest and Southeast with meat processing or meatpacking plants represent geographic “hot spots” for Hispanic growth (Gouveia et al. 2005). This is the case of the rural Midwestern town, where my study took place. It is a rural town with a population of 9,000. Over the last decade, there has been a dramatic increase in the Latino population in this town since families have move there looking for jobs and a better life. A meat processing plant has attracted many Latino families to the area. In 2000, 1.79% of the study town’s population was Latino, compared to 6.7% in 2010. It reveals the dramatic growth of Hispanic population in the study town (U.S. Census Bureau 2000a).
Finally, Lichter (2012) discusses how socioeconomic and political barriers to the integration and incorporation of Hispanics into American society, seem to be exacerbated in rural America. Several studies conducted with rural Latina immigrants shed light about how their rural context of isolation and lack of networks place an additional burden to carry out their reproductive and productive roles (Schmalzbauer 2011; Baker 2004).

In this study I use a health competence model based on Bandura’s Social Cognitive theory to conceptualize Latina mothers’ agency and self-efficacy in preserving the health of their family (Fonseca-Becker et al 2010). I use the Community Capital Framework and Feminist Political Ecology theory to analyze how cultural, human and social capitals inform mothers’ health competence (Flora and Flora 2008; Rocheleau1996).

**Statement of Purpose and Research Questions**

The purpose of this study was to explore the relationship between rural Latina immigrant mothers’ informal networks and mothers’ degree of health competence. Health competence is a relatively new model that indicates and individual’s ability for improving and maintaining a balanced state of mental and physical health, including her/his capacity for obtaining health care Fonseca-Becker et al 2010). Health competence is critical for Latina immigrant mothers as they seek to address their family’s health needs within a context that restricts their access to formal medical care. This study explored the roles of social bonding and social bridging capital in shaping Latina immigrant mothers’ health competence, as well as underlying factors that influenced the formation of informal social networks in which health’s knowledge and practices are shared. The study addressed the following research questions:
(1) How do social, cultural and human capitals influence the health competence of rural Latina immigrant mothers?

(2) What is the role of informal women’s networks in preserving the health of rural Latina immigrant mothers and their families?

**Research approach**

Due to my interest in rural Latina immigrants, I collected data for this study in conjunction with the cooperative multi-state research project, Rural Families Speak about Health (North Central Region project 1171). Rural Families Speak about Health examines the interactions of individual, family, community, and policy contexts on the mental and physical health of diverse rural low-income families.

I selected a feminist research approach (Newman 2003; Denzin and Lincoln 2003) and qualitative research methods to address the research questions in order to give voice to rural Latina immigrant mothers as they seek to fulfill their roles as caregivers of their families. Focus group and in-depth interviews allowed me to capture mothers’ perspectives in regard to their everyday struggles, and rich descriptions of their social world (Denzin and Lincoln 2003).

**Significance**

This study emerges from my interest regarding structural factors that lead to health inequities among the U.S. Latino population, as well as from my admiration of Latina immigrant mothers’ attempts and struggles to transform and negotiate contexts of exclusion
they experience. I seek to shed light about the challenges faced by rural Latina immigrant mothers in order to preserve their health and the health of their families.

A better understanding of both the factors that enhance and undermine the health competence of rural Latina immigrant mothers could help inform health care programs and policies aimed to reduce health disparities. The incorporation of Latino cultural meanings and values regarding health into health care programs might render useful in addressing the high prevalence of chronic disease among the Latino population. A closer examination of the cultural, human and social resources that Latina mothers mobilize in order to preserve the health of their families can aid in overcoming the actual and perceived discrimination faced by the Latino population in health clinics and hospitals.

It is important to create spaces, such as this study, in which Latina mothers have the opportunity to interact with other mothers. These kind of social interactions have the potential to empower mothers by creating networks of support than can bring about positive change.

**Organization of the thesis**

The thesis is organized into five chapters and an appendix.

*Chapter 2* provides both a theoretical and empirical background regarding the informal networks of Latina immigrants and their gendered knowledge regarding health.

*Chapter 3* presents the research methodology used to address the research questions posed in this study. Rationale is provided regarding 1) the selection of a feminist research approach, 2) a personal narrative, 3) the study population, 4) data collection, and 5) data
analysis. Additionally, ethical considerations, limitations of the study and issues of trustworthiness of the data are included.

Chapter 4 discusses the major findings of the study regarding rural Latina immigrant mothers’ health competence.

Chapter 5 presents the conclusions of the study and identifies implications for both practice and future research.

Appendix A includes the interview and focus group questions used during the study.

Appendix B includes demographics of study participants.

Appendix C includes IRB approval documents.

Appendix D includes recruitments materials.
CHAPTER 2: LITERATURE REVIEW

The rapid increase of the Latino population in many rural communities across the U.S. is striking. The Latino population is relatively young, with a high prevalence of poverty and lack of access to safety nets. Latino cultural values and beliefs, and the central role of women as caregivers of their families suggest the importance of understanding how Latina mothers find creative and cultural relevant ways to provide health care for their families in a political and economic context that limits their access to formal health care. Women’s informal networks and folk health beliefs play central roles in fulfilling women’s roles as gatekeepers of the family health.

The following literature review provides a theoretical and empirical background to understand informal networks among Latina immigrants and their gendered knowledge regarding health.

Latinos and Health

Data from the 2010 U.S. Census reveals the dramatic increase of the Latino\(^1\) population over the past decade. Hispanics account for 16 percent (50.5 millions) of the total United States’ population. More than half of the growth of the total population in the United States between 2000 and 2010 was due to the increase of the Hispanic population. During this period of time the Hispanic population grew by 43 percent which was four times the growth of the total population (U.S. Census Bureau 2010a). Even though the Hispanic population grew in every region between 2000 and 2010, the most significant growth took

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\(^1\) The 2010 Census defines Latino or Hispanic as a person of Cuban, Mexican, Puerto Rican, South or Central America, or other Spanish culture of origin regardless of race.
place in the South and Midwest. In the Midwest, the Hispanic population increased by 49 percent; more than twelve times the growth of the total population in the Midwest (U.S. Census Bureau 2010). While the U.S. Latino population has increased during the past, so has the prevalence of poverty among Latinos.

The Current Population Report (U.S Census Bureau, 2011a) on income, poverty and health insurance coverage in the United States sheds light about the steady increase in the poverty rate, in particularly among Latinos. The official poverty rate for the U.S. population in 2010 was 15.1 percent, which was the highest since 1993. The poverty rate in 2010 among the Latino population was 26.6 percent, (U.S Census Bureau, 2011b). Low income of Hispanics is reflected in health insurance coverage. In 2010, the percentage of the U.S. population without medical insurance was 16.3. The uninsured rate among Latino population was 31.7 percent, which is the highest of all racial/ethnic groups. These socioeconomic circumstances underlay the health inequalities by race and ethnicity in the U.S.

Health Disparities

The United States is currently experiencing a health care crisis; the maintenance of health has become a challenge for many people (Hunt and Montemayor 2010). Many U.S. residents struggle with high-priced medical care and prescription costs, and shrinking health care coverage. More challenging though, is health maintenance for uninsured or underinsured people, such as minorities and people with low incomes. Such problems are exacerbated for Latinos living in new destinations like the Midwest as they are most likely to have low incomes and be uninsured compared to other population groups (Hunt and Montemayor 2010).
Latino immigrants who have low income and low levels of education often lack competency of the English language, are unfamiliar with the U.S. health care system, and often lack legal U.S. residency or citizenship documentation (Hunt and Montemayor 2010). Cultural, political and socioeconomic barriers prevent community health care services that provide free or low cost medical care to uninsured people being effectively used by low income populations, including Latino immigrant families. Even though state government is commonly looked to provide these services, charities/private health programs often provide for the uninsured due to budget reductions in local, state, and federal governments. The entities are an unorganized collection of publicly subsidized hospitals, local health departments, community clinics and individual clinicians. Health care for excluded populations is extremely variable in its coverage and effectiveness across the country (Schroeder 1996; Cunningham and Kemper 1998). Uninsured people typically receive medical care that is lower in quality than that of those who are insured (Swartz 1994).

Uninsured Latinos, especially new Latino immigrants who have low incomes, delay seeking health care because of the perceived high cost, fear of deportation, and discrimination. Becker’s study (2004) sheds light about uninsured Latinos’ and African Americans’ negatives experiences with the U.S. health care system. They often reported feeling discriminated against because they were uninsured, were often un-medicated or under-medicated, and often delayed health care because of the cost of care. Latinos’ negative experiences were exacerbated by language barriers and legal status.

The health of Latino immigrants is threatened as they are more likely to live with untreated life-threatening illnesses than to seek health care due to barriers they experience. A
life-threatening illness refers to a medical condition that could be either curable or un-curable that is very likely to lead to the patient’s death. In the case of uninsured Latinos, they comprise several chronic diseases, such as, heart disease, diabetes, cancer, stroke and arthritis that have not been either prevented or treated on time due to the lack of access to health care (Becker 2004; Center of Disease Control and Prevention). For instance, in 2005, Hispanics were 1.6 times more likely to die of diabetes than non-Hispanic whites. In addition, Hispanic women were twice as likely as non-Hispanic white women to have a diagnosis of cervical cancer (Center of Disease Control and Prevention). Consideration of Latino’s struggles to access health care underscores structural factors that lead to health inequalities. While these are primarily economic barriers to health care, cultural barriers exist as well.

Several studies have extensively discussed the role of cultural barriers to health care, including lack of English proficiency and culture specific health knowledge and beliefs. Yet, they have overlooked the structural obstacle to health care. A date of study conducted with undocumented immigrants from Mexico and Central America who worked as manual laborers in the U.S. provides evidence that economic and political constrains shape the use of health care by low income undocumented immigrants (Chavez, Flores, and Lopez-Garza 1992). The authors discuss how patterns of health care utilization tend to reproduce political and economic exclusion. Use of health services in the U.S was greatly influenced by resources, specifically medical insurance. Immigrants lacking of health insurance were less likely to seek medical attention than were insured immigrants. Inequalities in health care access are the result, of socioeconomic inequalities (Documé and Sharma 2004). In addition, Chavez et al. found that once the financial barriers to health care are reduced, undocumented
immigrants are more likely to acquire timely and more cost-effective health care (Chavez, Flores, and Lopez-Garza 1992).

The barriers to acculturation exacerbate health disparities among Latinos. A study conducted by Antecol and Bedard (2006) found that recent immigrants have better health upon their arrival to the U.S. than their American counterparts; however this health advantage erodes over time. A report of the health of foreign born population from 1980-1990 showed that overall, foreign-born Hispanics had better health than the U.S.-born population, although this health advantage varied by length of residence in the United States. In this study, foreign born Hispanics were compared with their U.S native counterparts in terms of age and sex. The study revealed that virtually in every measure of health status, and with regard to almost every socio-demographic characteristic, the most recent immigrants were healthier than foreign-born persons who have lived in the United States 10 years or more, as well as healthier than the U.S.-born population (Stephen, Foote, Hendershot and Schoenborn 1994).

Latino immigrant women tend to gain weight and approach the unhealthy American BMI level of many American women. Antecol and Bedard (2006) and Fitzgerald (2010) shed light on how acculturation influences food intake, and how socioeconomic status, political status, job patterns and limited access to health care contribute to the decline on Latino immigrants’ health status. However, recent studies have shown that life experiences of immigrants before moving to the U.S. also can inform health outcomes among Latinos in the U.S. Perez-Escamilla (2010) discusses how acculturation is likely to negatively affect dietary quality and health outcomes of Latinos, especially those coming to the U.S. from rural areas.
Many of the migrants from urban areas have already adopted U.S. unhealthy eating habits in their countries of origin.

**Immigrant Latinas and Health**

*Women as caretakers of their families*

Undocumented Latinos face several structural constraints to preserve their well-being, more specifically their health. Household health work is segregated by gender (Clark 1993). Women perform the role of caregivers within the household and domestic spheres (Mendelson 1995). The historical and contemporary construction of care work within the household situates women as gatekeepers of family’s health, as well as carriers of collective healing experiences (Mendelson 1995; Williams and Crooks 2008). Women perform many health activities both within and outside the household. Such activities include providing a healthful environment and nutritious food, teaching and monitoring hygienic practices, diagnosing and treating minor illness and deciding when to seek lay and professional care (Mendelson 995; Clark 1995).

Women’s agency to perform as caregivers has been greatly undermined by global economic restructuring that is taking place under the current neoliberal economic and political system. Being immigrant poor women and their families the most affect for the global restructuring, which has produced many negative effects such as the decline in the conditions of public health due to the alarming reduction in government health-care expenditure and the privatization of health care services (Harrison 2004) In Latin American countries like Mexico, Guatemala and El Salvador among others, the socio-economic inequality was exacerbated by the economic restructuring that started to take place in 1970s
as part of a developmental policy. Besides of the increased economic disparities, such policies led to severe cuts in governments spending in basic areas such as health, education, and social security. Thus, rural and urban poor families had fewer resources to provide sustain their families. As a consequence, many poor men have been forced to emigrate to the U.S. in order to provide for their families. Women have been facing a greater burden to provide food and health care for their families. Whether poor women emigrate with their families or stay in their country, they have been facing a greater burden to provide food and health care for their families. In their country of origin public health care have been decreased in quantity and quality while in the U.S. these women and their families lack of health coverage at all and depend heavily in charity programs to meet their health need (Stephen 1997).

The political-economic context underlying the lives of low-income immigrant Latinos in the U.S. informs and determines the kind and the quality of medical resources to which they have access (Chavira-Prado 1992; Menjívar 2002). Besides structural factors at macro-level of analysis, there are aspects related to family interaction and gender division of labor that place additional burden to women in immigrant Latino family.
Gender dynamics

Studies conducted among poor Hispanics families living in rural areas in the state of Montana and Iowa shed light about the gender ideology and gender behavior that shape and inform their everyday life experiences and routines as they strive to survive under adverse economic situations (Schmalzbauer 2011; Baker 2004). Schmalzbuer’s examination of the complex gender negotiation that take placing as families develop new survival strategies in the face of major economic shifts illustrates how gender roles within the family are being disrupted and paradoxically at the same time traditional gender ideologies are being reinforced. That is, women are entering to the labor wage force for the first time, while at home they continue to perform cultural appropriate gender activities related with motherhood, care work and family (Becker 2004). The contradictory nature of this dynamic is strongly influenced by the demographic of the families themselves, the majority of whom are from rural Mexico with traditional gender expectations (Schmalzbauer 2011; Baker 2004).

These expectations have been cultural and political reinforced throughout the history of Mexico. During the mid-1930, the post-revolutionary government of Cárdenas embarked on its modernization project. The Cárdenas regime’s program of modernizing Mexican economy relied upon gendered ideology of production, which a sharpened separation between the feminized realm of reproductive labor and subsistence production and the masculinized realm of wage labor (Olcott 2002). The double burden face by immigrant women is not different for that faced by wage-earning women living under inequality gender relationships. Yet, immigrant rural Latinas’ burdens are exacerbated by their context of isolation, lack of networks, socioeconomic and undocumented status.
Latinas immigrant women bear the burden of feeding, nurturing and maintaining family health as their exclusively responsibility (Chavira-Prado 1992). Such motherhood responsibilities shape their identities as women and present a burden when they lack of the resources to fulfill their motherhood role.

Chavira-Prado (1992) studied a group of Mexican migrant families working on farms in southern Illinois that provides evidence about central role of women in providing health care for their families under harsh economic and political conditions. The decisions about health care, health needs, child care, and food consumption are largely the women’s responsibility.

This division of labor represents a pragmatic strategy of family survival and does not imply household headship or dominant status, since women’s decisions are most of the times subordinate to men’s. Women’s decision-making involves convincing other to comply with her choices, rather than enforcing them. Besides making these difficult decisions, women must find ways to carry out such decisions. Under poverty conditions, women’s ability to optimize care resources is a valuable family asset (Chavira-Prado 1992; Menjívar 2002).

Women are in charge of everything pertaining to their families' health. They employ their information network to optimize family health by seeking, screening and using information on health-related services, facilities, providers, and programs. They also are the ones that face discrimination at community clinics and hospitals (Baker 2004). In their health care roles within the home, women recommend, administer, monitor, and modify medications and home care prescribed by health care professionals, by healers, or by themselves (Chavira-Prado 1992; Menjívar 2002). In performing their roles as caretakers, women’s networks and the knowledge shared through them are extremely important.
Local and transnational women networks around health

Latina immigrants rely heavily on female networks to perform their role as family caretakers and cultural carriers of the health knowledge (Clark 1993; Harrison 2004). Folk medicinal knowledge is transmitted between mothers and daughters and enhanced by community interaction among women (Rubel 1966). In her study with Guatemala immigrants living in urban areas, Menjívar (2002) examines the complexity of social networks, both local and transnational, created and maintained by immigrant Latinas to obtain medical treatment for themselves and their families. Informal and kin networks acquire more significance within the U.S. political economic context that restrict immigrant’s Latinos access to formal health care (Menjívar 2002; Chavez, Flores, and Lopez-Garza 1992).

Such networks are essential to cope with immigrant women’s inaccessibility to formal health care due to their economic and legal status. Menjívar’s study underscores the social and cultural dynamics of women’s network and how through them women are able to access to a variety of health treatments that include biomedical care and folk/traditional health beliefs. The processes of obtaining medical treatment, regardless of where and what kind of medical treatment is obtained, always involved contracting friends, family or acquaintances. Such women’s networks are both local and transnational. The informal local networks usually involve friends, acquaintances who are also marginalized but have information about resources within their community. The transnational ties usually involve family and extended family living in their home country (Menjívar 2002).

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2 Biomedical or Western medical systems are predicated on the theoretical foundations and techniques dependent on scientific investigation. In contrast, Folk or traditional medical systems provides a broader and more holistic perspective by taking into account the cultural significance and the personal and social meanings of illnesses (Lopez 2005).
These informal networks constitute bonding social capital. Bonding social capital consists of connections among individual and groups with similar background in terms of class, ethnicity, kinship, gender or similar social characteristics. On the other hand bridging social capital connects diverse groups within the community to each other and to groups outside the community (Flora and Flora 2008). The lack of bridging social capital among Latina living in urban areas exacerbates their conditions of exclusion.

In a political and economic context that limits access to good quality formal health care, such informal women’s networks are often the only way to access to health treatment (Menjívar 2002). Yet, it is well documented that rural Latinas, living in rural areas, lack or have very limited access to such informal women networks (Schmalzbauer 2011). Rural migrant families facing economic constrains have fewer social supports as well as different cultural expectations than urban migrants. While urban migrants to look toward extended kin networks for support (Hondagneu-Sotelo 1994), rural migrant families, in the absence of these networks, tent to rely in their immediate families, as a primarily source of support. Immediate families include their husbands, children and in some cases a close relative such as sisters, sisters in law, mothers or mothers in law living in the same area. In addition, rural areas usually lack social services and community organization that offer help to migrant populations. Thus, rural Latinas face even greater isolation than their urban counterparts. (Schmalzbauer 2011).
Seeking health care: Folk and Western Medical Systems

In order to fulfill their responsibilities as a caretakers of the family’s health within a political economic context that limits their access to formal health care services, immigrant Latinas utilize alternative folk medicine resources along with biomedical resources. Thus, it is important to briefly describe what folk medicine systems and how differs from biomedical systems.

Foster (1976) argues that the most important fact about illnesses in most medical systems is the underlying cause assigned. That is disease etiology is the key aspect to cross-cultural comparison of folk medicinal systems. Two basic principles, personalistic and naturalistic, seem to account for most of the etiologies that characterized non-Western medical beliefs. These terms could be used to understand the causes of the illnesses as well as the associated behaviors that follow the diagnostic. In personality medical systems, disease is explained as due to the active, purposeful intervention of an agent, who may be human, non-human or supernatural. Thus, the sick person is seen as victim, and the malady could entail either aggression or punishment. On the contrary, naturalistic systems explain illness in impersonal terms. Disease is caused by natural forces or conditions such as cold, heat, winds, etc. A central concept is the disruption of the balance of the basic body elements. Health conforms to an equilibrium model in which the body maintain and internal balance as well as a balance with her/his social and natural environment (Foster 1976).

In general terms, the folk/traditional medical systems among Latin Americans are a blend between the personalistic and naturalists systems, in which the religious aspect is deeply interwoven. Since the all of the women who participate in this research study were
Mexican, with exception of one from Guatemala, I will focus my literature review in Mexican folk medical systems. Mexican folk medical and spiritual systems are commonly referred as *curanderismo*. Such term encompasses a variety of ancestral practices, treatments and perceived ailments (Lopez 2005). Western medical system is based on the theoretical foundations and techniques derived from scientific investigation. As a result of the conquest and colonization process, Mexican indigenous people incorporate aspects of the scientific rationality imposed by Spain into their cultural health beliefs. Ancestral health beliefs among Mayan and Aztecs incorporate both personalistic and naturalistic aspects of illnesses and health. Thus, the folk medicine provides a holistic perspective of health, which takes into account the cultural significance and the personal and social meanings of illnesses and their treatment. Folk healing is broadly defined as a set of health beliefs and practices derived by ethic, cultural and historical traditions that seek the amelioration or cure of psychological, spiritual, and physical forms (Appelwithe 1995). Folk healing knowledge and practices are transmitted through interaction with family and community members. Folk healing represents an important aspect of cultural identity and social cohesion. That is, it embodies the cultural and social capitals of the communities who rely on such practices.

Folk healing is a holistic perspective, in which human health is conceived as the balance between psychological, physiological, spiritual and interpersonal needs (Lopez 2005). Folk medicine does not dichotomize illness in psychic or emotional ills and somatic disease, but rather acknowledged the interrelation among both (Rubel 1960). There are three central aspects of folk medicine among Latinos. First, the role of the kin in diagnosing and treating illnesses; second, the linkage between religion and illness, which fosters the use of
religious ritual in healing practices; and third the universality of many health beliefs, symptoms and healing practices among Latino communities (Krajewski-Jaime 1991). In addition, Lopez (2005) highlights the personalismo as another important feature of folk medicine. Personalismo refers to the importance of positive social relationships in the maintenance of health and negative social relationships in health deterioration among Hispanic culture. Such informal and personal social networks are particularly important among marginalized and poor groups, serving as major sources of support and integration into the new society.

The linkage between religious and illnesses is rooted in the Roman Catholic religion. Whitelford (2002) explores this linkage in his study about the health status of market vendors in Antigua, Guatemala. His findings shed light about central role of religion on informing the social construction of medical well-being among this group of Mayan indigenous population. There was significant difference between Evangelical Protestants who regard their health situation more favorably than their Roman Catholic counterparts. Yet, religion faith was strongly linked with the notion of preserving the health.

*Common Folk Illnesses, healers and treatments*

Rubel (1960) identifies five illnesses that are conceptually bound together by the Mexican and Mexican-American cultures. Such illnesses are also recognized by some Central American cultures (Menjívar 2002). These illnesses are caída de mollera (fallen fontanel), empacho, mal de ojo (evil eye), susto (fright or shock), and mal puesto (sorcery). The first four illnesses are categorized as males naturales (sickness from natural cause) and
fall within the naturalistic principle and *mal puesto* is imposed by others, it could be either an
evil entity or a person.

*Caída de mollera* affects only infants. Infants are viewed (correctly) as having a
fragile skull. The skull includes the *mollera* (fontanel), which in this immature state is easily
dislodged from its normal position. A blow upon the youngster’s head leads to the sinking of
the dislodged fontanel forces the upper palate to depress and block the oral passage. Often
the child’s mother does not witness the fall and her first indication of trouble is the
appearance of the universal syndrome of *caída de la mollera*, which consists in the inability
of the infant to grasp firmly with its mouth the nipple of a bottle or of the breast, loose
bowels, and constant crying and restlessness.

Even though most women understand the causes and control the curing techniques
for fallen fontanel young women seek the aid from more experience older women, since the
correction of this ailment is perceived as very delicate process. Usually is the grandmother
of the infant that perform the curative technique. The curative technique comprises Catholic
prayers combined with manual procedures to correct the *caída*. The *caída de mollera* can
eventually lead to death if it is not promptly and correctly treated. If the treatment is not
successful, the family recognized that the original diagnostic of “*caída de mollera*” was
erroneous and they seek the aid of a physician. (Rubel 1960).

*Empacho* is an ailment affecting both adults and children and is believed to be caused
by the failure of the digestive system to pass a piece of food causing acute pain. In addition,*empacho* could also be related to emotional conditions. Previous to diagnosis, *empacho* is
often confused with other common indispositions such as gas on the stomach or indigestion.
The distinctive factor for a clear diagnostic is a noise similar to a snap or crack emanating from the abdominal region. Once the nature of the illnesses is identified, a curing procedure is performed to break up and disengage the piece food from its clinging position. The *curandero* or healer attempts to redress the imbalance between opposing qualities of “hot” and “cold” within the sick organism.

During the procedure the back of the patient is carefully pinched, stroked and kneaded along the spinal column, as well as around the waist. The healer alternates the rubbing procedure with the administration of an oral dosage of lead protoxide. However, in many cases, different oral medicines or purge are administrated, such as the castor oil. The purges are administered in order to reestablish the hot-cold balance within the organism. When someone suffers from *empacho* conditions, it is often suspected that the illness has been caused by individual having been required to eat against her/his will, creating a situation of conflict and stress that contributes to the “*empacho*” ailment (Rubel 1960).

*Mal de ojo* is an ailment related with social relationships. Within the Mexican, and Mexican American culture, social relationships are conceived as bearing inherent dangers to an individual’s equilibrium. All individuals are susceptible to the dangers of “*mal de ojo*” but because of their perceived weaker nature, women and children are more prone to suffer it than male adults. Certain persons in the community are considered to posses particularly strong powers over weaker individuals. Such powers are located in the eyes, actions like strong glances, envious expression or excessive attention paid by one person to another exposes the individual to the danger of an unnatural bond and the entrance into her/his body of a strong power of the other.
The most common elements that lead to a “mal de ojo” include relationships in which covetousness or jealousy is involved. Yet it can involve any kind of special attention toward the inflicted person. It symptoms include a sudden severe headache, inconsolable weeping (in the case of children, unusual nervousness and high temperature. In addition, the syndrome appears abruptly, and the first step in the treatment is trying to recall the previous few hours and trace the affected person’s social activity in order to identify a significantly affective relationship. If the family is able to identify such relationship, the suspected person is asked to come quickly to attempt a rupture of the charm following a ritual. In those cases in which the actual agent cannot be recalled to the patients’ side, the bond or charm is broken and the intrusive power of the other is drained by means of sympathetic magic procedures, which usually involve a rubbing process with an egg and religious prayers. Many Mexican and Central American women understand the premises, diagnosis and treatment of mal de ojo, and those who do not have the knowledge can easily learn from other, mainly from other women. This ailment is not considered fatal unless it is improperly diagnosed and treated, such when a physician is unwittingly likely to postpones a proper treatment (Rubel, 1960).

Susto means a fright and the resulting illnesses from a fright. It is generally classified as cultural-bound syndrome that is present in many Latin American cultures. Cultural-bound syndromes are thought to be illnesses created by personal, social and cultural reactions to malfunctioning biological and psychological processes and only can be understood within the context of particular culture or cultural group (Poss and Jezewski 2002).

Susto, as conceived by some Latin Americans, is due to a frightening experience or it may be the patterned reaction of the afflicted person to the annoyances of every-day social
life. Such an experience can lead to a destabilizing causing a part of the self, the *espiritu* (soul), to leave the body (Rubel 1960). The afflicted person, often called *asustado*, experiences symptoms of lethargy, lack of appetite, depression and withdrawal, diarrhea, nightmares and headache (Rubel 1960; Poss and Jezewski 2002). Simple *susto* is easily treated and older women in the community understand the curing procedures. The treatment may include various types of ritualistic sweepings of the body using eggs, lemons, herbs and Catholic prayers. In addition family or close friends or the Catholic priest may be involved in the curing process (Rubel 1960; Poss and Jezewski 2002). Yet, *susto* eventually could be fatal if the curing procedure is postponed or if treatment is delivered by a practitioner not equipped to handles such condition, such a physician (Rubel 1960).

Usually the response to folk illness comprise self-diagnosis and treatment, seeking treatment from extended family member of from folk healers or *curanderos* who are considered uniquely qualified to cure those afflicted with folk illnesses (Applewhite 1995; Poss and Jezewski 2002).

*Incorporating both systems: A decision-making process*

Several studies have founded that Mexican and Mexican-American move easily and freely between folk and biomedical systems, depending on the characteristics and seriousness of the illness (Applewhite 1995). They were able to identify what type of illnesses could be treated and cured within each of these systems and reported to have faith in Anglo physicians to treat some illnesses but relied in *curanderos* to treat others (Poss and Jezewski 2002). In a similar manner, Chavéz (1984) examines several research studies revealing that, despite the fact that beliefs in folk illnesses was widespread among urban Mexican American, such
beliefs and curative practices did not prevent them from consulting physician and using medical services for illnesses not defined by folk concepts.

Wing (1998) identifies and discusses several concepts that regardless geography, cultural origins, or religious beliefs, are shared by both traditional folk system and the contemporary health care system. Similar concepts include origin of the illnesses or etiology, harmony and balance, and community involvement. Such trans-cultural concepts may shed light on the ability of Mexican and Mexican-American and other Latina American cultural groups to moving freely between both systems. Yet, within a context of economic and social exclusion, Mexican traditions and beliefs systems can persist in isolation, particularly when surrounded by mainstream resources which are hostile or inaccessible, or are perceived as such (Lopez 2005). Therefore, for Mexican minorities groups, the need to fulfill health care needs can mean utilizing accessible mainstream services as well as utilizing informal folk health care systems (Lopez 2005).

Latinos who lack health insurance coverage rely heavily on folk medical alternatives (Applewhite 1995; Guendelman 1991 and Lopez 2005). In a study aimed to explore the cultural knowledge, health beliefs and health preferences and practices of elderly Mexican America, the give name and date utilized the Young’s ethnomedical health belief decision making model to describe health care service utilization (Young 1980). That model identifies four factors that influence the decision making process:

1. gravity of perceived seriousness of the illness;
2. knowledge of home remedies;
3. faith in or perceived benefits of a folk remedy; and
4. accessibility of health care, including cost and availability (Applewhite 1995).

His findings shed light about how Mexican Americans with cultural knowledge and faith in folk medicine moved freely from traditional healing to biomedical health care depending on the type and severity of the illness they had, whether it could be treated with home remedies, and whether if they have faith in, feel respected by, and economics resources to visit a physician. Yet, socio-economic and political constraints were the most important factors influencing their views and utilization about Western medical care in the U.S. (Applewhite 1995). These factors working alone or in combination undermine the utilization of health services by Latinos, especially low-income groups and recent immigrants. Such factors include high cost of health care, undocumented immigration status, the relatively low levels of health insurance coverage, and the general unavailability of bilingual services (Chavéz 1984). Thus, the underutilization of U.S. health care services could not be merely explained by the prevalence of folk health beliefs among Latinos as argued by earlier anthropologist’s research (Chavéz 1984).

Theoretical Frameworks

Feminist Political Ecology

Feminist Political Ecology is one of the six major schools of research and activism that focus on gender and environment and their implications for issues of subsistence and economic development and well-being (Harrison 2004). It borrows concepts from other feminist frameworks, by building from their strengths as well as addressing their limitations (Rocheleau, Thomas-Slayter, and Wangari 1996). It is concerned about the social, political
and economic contexts that influence environmental policies and practices. It stresses the uneven access and control over resources that is based on inequalities; it also aims to situate local experiences within a global context of environmental and economic change (Harrison 2004; Rocheleau, Thomas-Slayter, and Wangari 1996). Feminist political ecology’s agenda has been organized around three major themes which are: gendered knowledge, gendered environmental rights and responsibilities, and gendered environmental politics and grassroots organizing (Harrison 2004). Only the theme of gendered knowledge was explored in this study as a part of the cultural health beliefs and practices carried out for Latina immigrant’s mothers living in rural Iowa.

*Gendered knowledge* is grounded in women’s everyday lives and their struggles to survive. Such struggles involve creating, maintaining and protecting healthy environments at home, at work and in regional ecosystems. Under this perspective, women’s knowledge is defined as a “science of survival”. That science is informed by the integrative abilities and holistic approaches that women develop to negotiate the complex link of household, community and landscape. Frequently their science of survival comes into conflict with specialized sciences (Harrison 2004).

*Community Capitals Framework*

The Community Capitals Framework (CCF) provides a venue to analyze community and economic development efforts from a system perspective. Such holistic perspective allows identifying the assets in each capital, the types of capital invested and the interaction
among capitals (See figure 2.1). These capitals are natural, cultural, human, social, political, financial, and built (Flora and Flora 2008). In this particular study the following capitals were examined as well as used to develop implications and recommendation for change.

*Cultural Capital* refers to the values and beliefs that shape people’s world views and how they interact with it. Cultural capital informs every day activities as well as traditions. In additions, cultural capital influences the allocation of power and authority among different groups (Flora and Flora 2008; Emery and Flora 2006).

*Human Capital* refers to people’s skills and abilities. Human capital is acquired throughout the life span, and plays a central role in developing and enhancing people’s access to resources and bodies of knowledge (Flora and Flora 2008; Emery and Flora 2006). The previous concept of gendered knowledge in this section, conflates with human capital’s definition and such conflation is discussed in the discussion’s chapter.

*Social Capital* refers to connections or social relations among people, as well as between people and organizations. Such networks could be either informal or formal. Social capital could be divided in bonding capita and bridging social capital (Flora and Flora 2008; Emery and Flora 2006). Yet, it is important to point out the blurred boundaries among both types since they are not necessarily mutually exclusive. Bonding social capital refers to the networks and connections among people or groups with similar backgrounds, while bridging social capital refers to the networks and connection among diverse groups within the community as well as with other groups outside the community (Flora and Flora 2008. A study conducted by Emery and Flora (2006) reveals the importance of social capital, both
bonding and bridging, in mobilizing other capitals in order to bring about positive change to communities.

**Figure 2.1 Community Capitals Framework** (Flora and Flora 2008)

Health competence and Social Cognitive Theory

Health competence is a relatively new paradigm, aimed to define individual’s activity to improve and maintain a balanced state of mental and physical health, including her/his capacity to obtaining health care (Fonseca-Becker et al. 2010). In this study I conceptualize mother’s health competence in term of maintaining her and her family health, since care
taker of their family is one of their traditional gender roles. A study conducted by Fonseca-Becker et al. (2010) with foreign-born Latino population identified the underlying structure of health competence as well as its value in predicting access to care among this population living in Baltimore, Maryland. Based on Bandura’s Social Cognitive theory, this health competence model proposes a more comprehensive approach of looking at health behavior beyond the domain of self-efficacy by including social and structural impediments that affect human health outcomes (Bandura 2004).

Thus, Fonseca-Becker et al. (2010) developed a model (see figure 2.2) in which health competence was an independent binary variable with two main components: enabling factors and perceived barriers. In their model, health care seeking behavior is the dependent variable or the outcome of interest, while health competence was the predictor of interest. Enabling factors included: self-efficacy, health literacy, and personal and health resources, while perceived barriers included legal status, language, and cost. In addition, the model incorporates other factors, such as socio-demographics characteristics and health history that may influence health-seeking behaviors. Results from their study suggest that Health Competence is a construct that allows identifying latent characteristics that either enable or act as barriers for the health seeking behavior. In short, health competence contribute significantly to the explanatory power of socio-demographic characteristic in predicting Latino’s health seeking behavior and its effect on access to health care (Fonseca-Becker et al 2010).
Even though the above described model aims to offer a more comprehensive approach of health competence among Latino populations, it overlooks cultural and social factors that could function as enabling components of health competence. Several studies of Hispanics cultural norms for health seeking behaviors (Larkey, Hecht, Miller and Alatorre 2001) discuss these cultural and social norms as barriers to health care. Culture specific norms among Latinos such as fear and fatalismo\(^3\) and the use of alternative folk medicine are linked to a reduction the likelihood of seeking conventional care use and that may directly inhibit follow-up on symptoms related with chronic illnesses (Perez-Stable et al. 1986).

\(^3\) Fatalismo is a cultural norm that combine negative expectations with a relinquishment of power to God (Larkey, Hecht, and Alatorre 2001) and is believed that contribute to a poor follow-up on symptoms.
Larkey, Hecht, Miller and Alatorre (2001) discuss the importance of incorporating Latinos cultural values such as confianza (trust), personalismo and the importance of transmitting knowledge through social networks when delivering health messages and health services. Yet, these approaches disregard the value of cultural and social norms in enhancing Latinos’ health competence when access to health care is limited.

In this study I conceptualize Latina immigrant mothers’ health competence in terms of their ability to maintain their health and their family’s health, since caretaker of their family is one of their traditional gender roles. By incorporating social, cultural and human capital into the discussion of health competence, I conceptualize mothers’ health competence from a collectivistic approach rather than the above individualistic approach. Within my approach, women’s networks play a central role in enhancing Latina immigrant mothers’ ability to provide health care for their families and thus their health competence.

The combinations of these theoretical frameworks will allow me to explain health competence in terms of both bio-medical health competence and traditional health competence. The multi-dimensional aspect of health competence is extremely important for women who are the participants of this study, who have economic limitations, undocumented status, are uninsured, not working for wage outside home, come from rural areas within Mexico and/or Central America, are less educated and have poor English proficiency.

My major hypothesis is that the higher the bridging and bonding social capital, the higher Latina immigrant mother’s confidence in dealing with her family’s health issues being the dependent variable the number of alternatives mentioned by Latina immigrant mothers when facing health issues and thus the higher her health competence.
My second hypothesis is that socio-economic factors influence what medical alternatives are used by Latina immigrant mothers. Latina immigrant mothers with economic limitations and undocumented status, who are uninsured, who are not working for wage outside home, and who come from rural areas within Mexico and/or Central America, who are less educated and have poor English proficiency have fewer alternatives to face family’s health issues and therefore less overall health competence.

My third hypothesis is that Latina immigrant mothers with high social bonding capital and bridging capital will show high level of health competence, while Latina immigrant mothers with low social bonding and low bridging social capital will show low level of health competence. The difference between biomedical health competence and traditional health competence is explained by the relation of high-low among both social capitals.

My fourth hypothesis is that Latina immigrant mothers with high boding social capital (both local and transnational) and low social bridging capital will show a medium traditional health competence, while mother with low boding social capital and high bridging capital will show medium biomedical competence.

It is important to point out that I anticipated that all Latina immigrant mothers would incorporate both medical systems in maintaining their family health. Yet, the extent in which each of them is utilized would be informed by differences on social, human and cultural capital.

Finally, I discuss the importance of including the cultural, social and human capital of Latinas immigrant mothers into the discussion of their health competence.
CHAPTER 3: METHODOLOGY

Introduction

The purpose of this study is to explore the influence of women’s informal networks on Latina immigrant mothers’ health competence, focusing on how knowledge is shared through these networks in the maintenance of family’s health. Health competence is critical for Latina immigrant mothers who must address their family’s health needs within a context that restrict their access to formal medical care. I examine how social bonding and social bridging capital shape mother’s health competence, as well as underlying factors that influence the formation of women’s networks and the health practices and knowledge shared through these networks. In seeking to understand women’s networks, the study addressed the following research questions:

1. How do social, cultural and human capitals influence the health competence of rural Latina immigrant mothers?

2. What is the role of informal women’s networks in preserving the health of rural Latina immigrant mothers and their families?

My research is deductive, connecting theory with concrete evidence of the Latina mothers’ every day experiences and perceptions around health (Neuman 2003). My findings’ analysis was guided by the study’s hypothesis and theoretical framework. Yet, emergent

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4 Health competence is a relatively new paradigm, aimed to indicate individual’s activity to improving and maintaining a balanced state of mental and physical health, including her/his capacity to obtaining health care (Fonseca-Becker et al. 2010). In this particular study we conceptualize mother’s health competence in terms of maintaining her and hers family health, since care taker of her family is one of their mainly traditional gender roles. A study conducted by Fonseca-Becker et al. (2010) with Latino population sheds light about the multidimensional nature of health competence, including “enabling factors” (self-efficacy, health literacy, personal and health resources) and “perceived barriers” (legal status, language, and cost). This study suggested that health competence added significantly to the explanatory power of socio demographic variables in predicting Latino’s health seeking behavior.
themes were also indentified and discussed. I wanted to explain health competence, which I define as being made up of both bio-medical and traditional health competence. The multi-dimensional aspect of health competence is extremely important for Latina immigrant mothers who have economic limitations, undocumented status, are uninsured, not working for wage outside home, come from rural areas within Mexico and/or Central America, are less educated and have poor English proficiency.

My key independent hypothesis states that the higher the bridging and bonding social capital, the higher Latina immigrant mothers’ confidence in dealing with their family’s health issues; being the dependent variable the number of alternatives mentioned by mothers when facing health issues. I hypothesize that socio-economic factors influence what medical alternatives are used by Latina immigrant mothers. Latina immigrant mothers with economic limitations and undocumented status, who are uninsured, who are not working for wage outside home, who come from rural areas within Mexico and/or Central America, who are less educated and have poor English proficiency, have fewer alternatives to face family’s health issues and therefore less overall health competence.

I addition, I hypothesize that Latina immigrant mothers with high social bonding capital and bridging capital will show high level of health competence, while Latina immigrant mothers with low social bonding and low bridging social capital will show low level of health competence. The difference between biomedical health competence and traditional health competence is explained by the relation of high-low among both social capitals. I hypothesize that Latina immigrant mothers with high bonding social capital (both local and transnational) and low social bridging capital will show a medium traditional health competence, while Latina immigrant mothers with low bonding social capital and high
bridging capital will show medium biomedical competence (Figure 3.1). It is important to point out that we were expecting that all mothers would incorporate both medical systems in maintaining their family health. Yet, the extent in which each of them is utilized would be informed by differences on social, human and cultural capital.

**Figure 3.1 Relationship between Social Capital and Health Competence**

<table>
<thead>
<tr>
<th>Bonding social capital</th>
<th>High bridging social capital</th>
<th>Low bridging social Capital</th>
</tr>
</thead>
<tbody>
<tr>
<td>High</td>
<td>High health competence</td>
<td>Medium traditional health competence</td>
</tr>
<tr>
<td>Low</td>
<td>Medium biomedical health competence</td>
<td>Low health competence</td>
</tr>
</tbody>
</table>

This section presents the research methodology used to address these questions. I give my rationale for a feminist research approach, for personal narrative, for the study population, methods of collection and analysis, ethical considerations, and issues of trustworthiness.

**Rationale for Feminist Research Approach**

I selected feminist research (Newman 2003; Denzin and Lincoln 2003) approach and qualitative research methods to address my research questions as a way to give voice to Latinas mothers in their struggles to fulfill their roles as caregivers of their families. A feminist approach allowed me to articulate gender, class and race/ethnicity in the discussion of rural immigrant Latina mothers’ struggles in the maintenance of family health (Denzin and Lincoln 2003). Qualitative methods allowed me to capture the individual’s point of view,
examining constrains of everyday life situations and securing rich descriptions of their social world (Denzin and Lincoln 2003). Demographic characteristics of the Latina mothers were incorporated into the discussion in order to identify underlying socioeconomic factors that affect mother’s perceptions and experiences around health.

This approach allowed incorporating my personal experiences of motherhood, health, and health care into the research process. On one hand, my condition of Latina immigrant mother enables me to better understand Latina immigrant mothers’ experiences, feelings and perceptions regarding health. On the other hand, my position as a graduate student, with previous experience working in hospital settings, allowed me to link everyday experiences around health with broader socioeconomic and political context that limit Latina immigrant mothers’ access to health care (Newman 2003; Ellis and Bochner 2003). For these reasons, the findings of this study are presented in the genre of personal narrative.

Rationale for the study population

This study draws its purposive sample from the Rural Families Speak about Health (RFSH), a multi-state study that examines the physical and mental health of ethnically diverse rural families with low incomes and young children. To participate in RFSH, participants had to meet the following criteria: be a mother age 18 years or older, have at least one child age 12 or under, live in a household with an income at or below 185% of the federal poverty level, and live in a rural county. And in the particular case of Iowa, mothers needed to self-identify as Latina immigrants. Respondent-driven sampling (RDS) (Heckathorn 2002) was used to recruit mothers into the study. RDS recruits participants from a friendship network of existing members of the sample. Three initial seeds (participants)
who met the participant selection criteria and who were well connected in their communities were identified. Each seed completed a 3 hour in-person interview. They then were provided three coupons (each containing an ID number) to distribute to members of their own networks who they believed met the study criteria. Mothers receiving a coupon made the decision of whether or not to call the phone number listed on the coupon to complete the screening process. Once a mother completed the screening process and was determined eligible to participate in the study, an in-person three hour interview was scheduled to collect additional data. After she completed the in-person interview, she was provided three coupons to distribute to mothers within her own network. Additionally, mothers received $50 in gift cards to a department store for participation in the in-person interview. This process continued until 83 mothers were interviewed. In addition to the quantitative information collected through the above described interviews, several qualitative interviews were conducted with a smaller number of participants. I was part of the team that conducted these qualitative interviews around health messages, and I use this interaction with mothers to identify mothers who were willing to participate in my study.

The larger study used random driven sampling (Neuman 2003) to identify Latina immigrant mothers who were living in rural areas with young children and who had low incomes. Within this group of mothers, I identified mothers who were interested in participating in my study. I wanted to find a group of Latina immigrant mothers who lived in a rural area that had an economic and political context that restricted their access formal healthcare. It is well documented that rural Latino families face even greater challenges than their urban counterparts in accessing health and social services due to fewer social networks and different pragmatic challenges and cultural expectations, yet little attention is still being
paid to rural Latino immigrants (Hunt and Montemayor 2010; Schmalzbauer 2011). For these reasons, I wanted to understand how rural Latina immigrant mothers fulfill their caregiver roles, and specifically the role of women’s networks in transmitting health practices and knowledge that shapes mothers’ health competence.

All participants lived in a rural town located in a Midwestern state, with a population of 9,000. In the last ten years several Latino families have move into this town looking for jobs and a better life. A meat processing plant has attracted many Latino families to the area. A comparison among the report of Census 2000 with 1.79% of Latino population with the 6.7% reported in the Census 2010, reveal the dramatic growth of Hispanic population in this town (U.S. Census Bureau 2011a).

One focus group and eight in-depth interviews were conducted. In the focus groups only participated five of the eight mothers who were individually interviewed. Thus, the remaining three in-depth interviews were not included in the findings of this study. One of the goals of this study was to engage Latina immigrant mothers in active interaction among them in order to observe how women’s networks function. Thus, the interviews of mothers who did not participate in the focus group were not included in the findings and were only used as a way to validate information shared by other participants.

Appendix B presents participants’ demographic characteristics. The majority of the mothers were originally from either rural Mexico (three) or urban Mexico (one) and just one participant was from rural Guatemala. The average age of the participants was 29 (range from 25 to 34). All of them had a partner, three were married and two were in a domestic partnership. The average years living in the U.S. was 10 years (range from 6 to 14). Two of the mothers had 8th grade or less of formal education, while two other mothers had some
high-school education, and only one mother completed high school education. Most of the mothers (three) were not working outside the household for a wage, only one of them was working a part time job and other mother had temporal informal jobs. Lucia*, the mother who had a full time job, was working for a small company. Her work consisted in packing and labeling boxes that were send them to bigger companies, such as Wall Mart. She shared with me that it was a hard job, that sometimes involve lifting heavy boxes. She used to have medical insurance through this job, but the company was sold and the new owner took out all benefits. Yet, she was thankful to have a job. Esperanza*, who had informal and temporal jobs, was working as a constructor worker with her husband. She was temporally hired when the construction contractor was in need of more workers. Esperanza*learned many of her construction skills from her father. She used to help her father in his job as albañil (construction worker) when she was a young girl back in Mexico. The majority of their partners had full-time job working in the meat processing plant, in construction companies, and in steel products’ factory. The average number of their children was three (range from one to five).

The majority of the mothers lacked health insurance coverage for themselves, since only one mothers reported to have it. She had health insurance through her husband’s work. While all mothers reported to have some type of health insurance coverage for their children, only one mother reported having private medical insurance. All mothers reported to have Medicaid for their children, but three mothers noted that not all their children were covered, since some of them were born in their country of origin, while other were U.S citizens and thus eligible.
Research Design

The process of doing qualitative research is defined by three interconnected activities: theory, epistemology, and methodology (Denzin and Lincoln 2003). Following is a description of the specific ways in which my research questions were examined. The information needed to address my research questions was determined by the conceptual framework and include perceptual, demographic and theoretical information (Bloomberg and Volpe 2008).

(a) Perceptual information refers to Latina mother’s perceptions around women’s networks and health beliefs and knowledge. One focus group and five individual in-depth interviews were used as a primary method of data collection to learn about participants’ experiences around health.

b) Appropriate demographic information was collected in order to understand underlying factors that might inform my hypotheses.

c) Theoretical information was gathered in order to establish what is already known regarding my topic of study and provided me with theories related to my research questions and supportive information to interpret and analyze my data. The process of gathering theoretical information was an ongoing one and was essential factor to interlink the above described information and to assign meaning to my data.

Denzin and Lincoln (2003) discuss how theory, epistemology and methodology are influenced by the personal biography of the researcher, who speaks form a particular class, gender, racial, cultural and ethnic community perspective. Thus, I approached this study as a Latina immigrant graduate student as well as a mother interested in understanding the role of women’s networks used by Latina immigrant mother in fulfilling their traditional gender role
as care givers of their families. I became interested in health issues and motherhood when I was working in a hospital as a dietitian in my home country of Guatemala. When I immigrated to Iowa and started to seek medical care for my own family, I realized how disempowering this experience could be for a Latina mother. And at the same time I learn about the importance of social networks in navigating the health care system. I became aware of all barriers Latina mothers face in order to access to medical care. Yet, it was not until I started to work as a volunteer translator in a free clinic that I truly understood the magnitude and implications of all barriers faced by Latina immigrant mothers in order to provide health care for themselves and their families. In addition, I was inspired by Latina mothers’ resilience and survival skills used to face the limitations that greatly undermined their well-being.

Thus, I approached this research as a Latina mother who understands how traditional gender role shape mother’s identities and every day experiences. This position allowed me to establish rapport with the participants, who were eager to share their experiences to someone willing to listening and able to relate to their issues. At the same time, I approached this research as a Latina graduate student, with a background in nutritional sciences and working experience in hospital settings, who understands how political and socioeconomic factor shape Latina immigrant mothers’ access to health.

The participant and I not only share the same language, but we also share the cultural carries transmitted through Spanish language. My position as a social researcher allows me to link their experiences regarding health and women’s networks with theory and with the broader context in an attempt to provide insights to improve their lives.
I am fully aware that I incorporated my own subjectivities in this study. I was aware of this fact during the whole research process, as I engaged myself in a constant self-reflection that revealed my own biases. Yet, I recognized that bringing these subjectivities as a Latina mother allowed me to establish trust and an empathy with mothers and therefore to collect meaningful and rich data.

For the above described reasons, I present my results in a personal narrative genre, since I took dual identities of academic and personal selves to tell a story about Latina mothers’ daily struggles in maintaining their family health (Ellis and Bochner 2003).

**Methods of Data Collection**

The combination of multiple methodological practices, referred to as triangulation, in a study adds rigor, richness, complexity, and depth to any investigation (Denzin and Lincoln 2009). Denzin and Lincoln (2003) stress that human beings are complex, and therefore the more methods used to study them, the better researcher’s possibilities to gain some understanding of how they go about constructing their lives and the stories they tell about themselves. I used focus groups and in-depth interviews as methods of collection as a way to obtain a fuller and richer depiction of Latina immigrant mothers’ health competence. In order to enhance the interpretative validity of my study, I kept an audit trial (Lincoln and Guba, 1985) to record the steps taken throughout the whole research process. It allowed me to understand my assumption and the steps through which I interpreted my data. I engaged in a constant search for discrepant evidence in my findings. My data at different stages (raw data, reductions data, coding data and synthesis data) was reviewed my major professor who was constantly giving me feedback. In addition, I continuously contrast my data with the literature review in search of similarities and discrepancies.
Focus groups

Focus groups rely upon the systematic questioning of several individuals simultaneously in formal or informal setting (Denzin and Lincoln 2003). Madriz (2003) has furthered the discourse of this method by showing how focus groups can be used in feminist research to study lower socioeconomic class women of color. She describes focus groups as “a way of listening to people and learning from them. Focus groups allow reaching participants who may find face to face interaction intimidating. Focus group can create multiple lines of communication as well as a safe environment to share ideas, beliefs, and attitudes in the company of people from the same socioeconomic, ethnic and gender background. Focus groups not only encourage researchers to listen to the voices of those who have been subjugated, but they also represent a methodology that is consistent with the particularities of everyday experiences of women of color. Madriz (2003) discusses how women have historically used conversation with other women as a way to deal with oppression. For African American, Latina and Asian American women, sharing with other women has been an important way to face and endure their exclusion (Madriz 2003).

A focus group is a collectivist method that brings together people and promotes social change. Madriz (2003) points out how focus group methods can contribute to correcting the individual bias existing in social research by offering a unique opportunity to study individual in their social context and by accessing women’s shared, and often ignored, knowledge. Sharing knowledge and experiences with other women with similar backgrounds not only contribute to the advancement of social research, but also is a way to empower participants by giving them a voice and make them aware of the value of their shared knowledge and beliefs. The interaction occurring within the group fosters empathy and
commonality of experiences by encouraging self-disclosure and self-validation (Madriz 2003).

For these reasons, the first part of my data collection was a focus group with five mothers. As mentioned above, I gained access to the participants because I was part of larger study about health and well-being in rural Latino families. These five mothers participated in previous focus groups to evaluate core health messages that I conducted with another graduate student. At the end of that focus group I asked the mothers if they were willing to participate in another focus group and all five of them were eager to participate. It was easy to gain their trust, since I already have established a rapport with them. Thus, I took advantage of the infrastructure already put in place as a part of this project.

I met with the participants at a convenient location to them. The focus groups lasted 1 ½ hours. I started the discussion by introducing myself to the participants and explaining the purpose of my study. They also had the opportunity to introduce themselves and shared some information regarding living in Iowa, reasons for immigration, and number of children. Then, I handed out and explained the consent form, which was in Spanish, and they signed them. A gift certificate of $25 was offered as a compensation for their participation. I started the focus group by asking them to describe what they usually do when someone in their family gets sick. Afterwards, I formulated questions to inquire about the persons from whom they receive health advice as well as the type of advice shared through these networks. Discussion about this topic leaded to the discussion of the barriers they face when trying to get medical attention. In addition, I was interested in traditional medicine, since the participants are originally from rural areas in Mexico and Guatemala, where traditional medicine plays a central role in the maintenance of health and well-being. Since I was aware
that this topic was a sensitive one, I started the discussion by asking them the uses of herbs in treating illnesses. This question generated a meaningful discussion about the use of herbs, and how they incorporate both biomedical and traditional health systems in their everyday experiences around health, as well as healers within the community and in other towns of Iowa (Refer to appendix A for focus group questions). Participants’ interactions and discussions allowed comparing their perceptions and experiences in regard to their caregivers’ roles and women’s networks and identify similarities and differences among them.

Finally, it is important to point out that this focus group facilitated a change process in Latina immigrant mothers’ lives. Despite the fact that all participants were living in the same town and three of them even the same neighborhood, they have not engaged in a conversation previous to this focus group. Even though they participated together in a previous focus groups related to core health messages, they did not engage in any meaningful conversation since it was a structured focus group. They limited themselves to answer questions and give their opinions. Yet, in my focus group I asked to share their knowledge and ideas about health in a more unstructured way that encourage conversation among participants. The focus group itself generated the initial formation of social bonding capital among them and the process of sharing knowledge thorough this conversation. That aspect will be further discussed in the findings and discussion chapter. At the end the focus group I asked mothers if they will be willing to meet with me one more time for an individual interview. All of them were willing to meet, and I conducted interviews with them during the following month.
**Individual interviews**

I conducted eight individual interviews with mothers; five of them were conducted with the same Latina immigrant mothers who participated in the focus group, and with other three Latina immigrant mothers who were willing to participate in the study. I did not include the additional three interviews in the analysis because my research focuses on not only measuring but also building social capital and health competence through group empowerment. And since the additional three mothers did not participate in the focus group, the interviews questions could elicit very different answers in since they did not participate in the focus group. I conduct the interviews in each of participant’s homes. I recorded the interviews with two digital recorders for security purposes, and I wrote field notes immediately after the interviews were completed. Interviews lasted between 1 hours and 2 ½ hours.

I used semi-structured, open ended interviews. I use the same questions developed for the focus group (Appendix A) to guide my interviews. Yet, I made follow up questions to further my understanding about mothers’ responses and stories. I did not limit myself to ask questions; rather I engaged in conversations with mothers, so they ask me questions and I responded to them.

I attempted to conduct interviews in a way to circumvent the traditional domination of masculine interviewing procedures, in which the researcher is positioned in a higher hierarchy in relation to the participants. I tried to create a closer and equal relation with the respondents in order to gain a greater insight of their everyday experiences around health (Denzin and Lincoln 2003). At the same time, I strove to make of my interviews a reflexive process, in which I was in an ongoing conversation with myself about the experience, while
conducting the interviews. Thus I can be aware of the differences of ideologies and culture among the respondents and me. Finally, by using open-ended interviews, I attempted to give voice to mothers and preserving their point of view during the entire process (Denzin and Lincoln 2003)

I conducted all interviews and focus groups in Spanish, which were tape recorded and transcribed. The Guatemalan participant was a Quiché (Mayan language) native speaker. But she was pretty fluent in Spanish as well. I assigned each participant a pseudonym in order to preserve their identity.

Method of Data Analysis and Synthesis

Upon the completion of each interview I wrote field notes as a self-debriefing process, recording my observations and impressions of each interview in a journal. In order to conduct my analysis, I listen several times to the audios of the focus groups and interviews. I carried out the process of analysis and synthesis in Spanish and only afterwards translated quotes and sentences of each identified theme into English. Conducting my analysis in Spanish allowed me to preserve the voices of my participants through the whole process of analysis (Madriz 2003).

I started the process with open coding\(^5\) by carefully reading line by line of the transcripts and locating big ideas. I wrote memos notes and assigning initial codes to the data. During this initial coding, I looked for processes, key events, important people, recurrent issues, repetition of words and metaphors that could possible answer my research

\(^5\) Open coding is a first coding of qualitative data in which a researcher examines the data and condense them into preliminary analytic categories or codes (Neuman 2003:461)
questions. At the same time I wrote analytic notes and constantly reviewed my field notes in order to established relations among the emergent themes and issues. I reread and reexamine the transcripts and then I coded the data.

In addition, I was regularly discussed my preliminary themes with my major professor, and her continuous feedback was essential to initial coding of the data. As a second step, I carried out an axial coding\(^6\) by finding links among themes and trying to establish the categories that such themes and issues represented. During this step, I identified categories that were related to my research questions and based on synthesizing the codes. In addition I identified emergent categories, who did not answer to my research questions directly. I was constantly reading, as well as, reflecting on the data, constantly reading through my notes, writing analytic memos and discussing my findings with my major professor. It was an interactive, circular, and ongoing process.

After the above two described steps, I revised my coding shame by use my journal’ note and analytic notes that were part of my audit trial (Lincoln and Guba, 1985). The feedback of my major professor during the entire coding’ process enhances the interpretive validity of my study. During the revision process I was able to add some codes and integrate two different codes in one. I did not eliminate any previous code. Finally, I wrote my findings in a personal narrative genre.

Once I identified the major themes, I identified and selected indicators that support the categories/themes. At this point, I used demographic data to understand the relationships among categories in order to explain hypothesis while addressing my research questions.

\(^6\) Axial coding is a second stage of coding of qualitative data in which a researcher organizes the codes and find interrelation among them (Neuman 2003:462)
Finally I wrote findings statements incorporating participants’ quotations and summarized key findings. The table 3.1 illustrates the sequence of my data analysis.

Table 3.1 **Audit trial** (Lincoln and Guba, 1985; Bloomberg and Volpe 2008)\(^7\)

**Step 1**

- Reviewing and exploring raw data
- Reviewing field notes
- Identifying big ideas and issues

**Step 2**

- Re-read and Re-examine data
- Code and place code data in categories
- Write analytic notes and theoretical notes
- Checking interpretative validity by Review analytic notes and journal notes
- Checking interpretative validity through adviser’ feedback, and revision of literature review.

**Step 3**

- Revising coding scheme
- Codes are added and integrated.
- Reviewing notes about the structure of categories (themes, definition and categories)

\(^7\) In this table I incorporated concepts/graphs of both authors.
**Ethical Considerations**

Prior to interviewing my participants, I provided each participant with written copies of a consent form in Spanish. I explain them the purpose and significance of the study, as well as the procedure of the interview. I explained them that their participation in this study was completely voluntary and they may refuse to participate or leave the study at any time; and that they could skip any questions that they did not wish to answer. This research study was approved by the Institutional Review board of Iowa State University. Appendix C includes the approval documents and Appendix C includes the recruitment materials.

I strove to make them feel comfortable during the whole process of interviewing by respecting their silence and evasive answers. Yet, most of the time they were eager to share their stories. Participant’s rights and interests were considered a priority when reporting the data. I was committed to keep their names and other significant identity characteristics confidential. Thus, I took the necessary measures to secure research’s records and audio files.

**Trustworthiness**

In qualitative research, trustworthiness refers to any effort by the researcher to address the more traditional quantitative issues of validity and reliability. Unlike quantitative
research, qualitative research uses the terms of credibility, dependability, and transferability (Bloomberg and Volpe 2008).

*Credibility* address whether the findings are accurate and credible from the standpoint of the researcher, the participants and the reader (Bloomberg and Volpe 2008). I triangulated my data sources (focus group, interviews and literature review) to enhance the methodological validity of this study. In addition, I reviewed and discussed my findings with my major professor and search for discrepant evidence through my data. Finally, I was able share the findings with five of my eight participants by telephonic conversations. I used these conversations to clarify ideas and make sure that my findings were representing my participant’s voices. I more detailed discussion about the methods I used to enhance the validity of this study is previously discussed in this section.

*Dependability* refers to the extent that research findings can be replicated by other similar studies (Bloomberg and Volpe 2008). In order to achieve dependability I offered a detailed account of the steps used in data collection, data analysis and data synthesis.

*Transferability* refers to the ways in which the reader determines whether and to what extent this particular study within its specific context can be transferred to another particular context (Bloomberg and Volpe 2008). Although generalization was not intended through this study, in the conclusion’s chapter I discussed how my findings could be applied to understand and improve the health competence of Latina immigrants’ mothers, living in other rural areas within the United States.
CHAPTER 4: FINDINGS AND DISCUSSION

These findings reflect the struggles faced by rural Latina immigrant mothers’ in this study in maintaining the health of their families. Such struggles took place in a context of discrimination and exclusion. Yet represent mothers’ agency, resilience, and creative ways to provide care for the health for their loved ones.

The story of these immigrant mothers is deeply interwoven with my own story. Being an immigrant Latina mother myself, I analyze these stories as a mother who understands women’s gender role as caregivers and the associated deep connection with women’s identities. As a social scientist, I am critically aware of how their lives of exclusion and marginalization are linked to my status of a middle class, educated Latina. My advantageous socioeconomic status is based upon an unjust system of exclusion that has forced these women and their families to emigrate in order to survive. Yet, the same inequalities are reproduced as they migrate to this country. While I am raising my daughters with the tranquility of having legal status, steady income and health insurance, these women take care of their families with very limited access to health resources.

Thus, I look into their struggles as a Latina immigrant mother who shares similar values, beliefs, hopes and frustrations in raising my children in a foreign country. But I also reflect on their lives as a social scientist who understands how structural aspects shape their everyday lives and struggles. I am also eager to shed light about the creative ways in which these women find venues to take care of their families. And finally, I reflect on their lives as a woman with social responsibilities and with the urgency to find ways to celebrate and enhance their agency as well as my own agency in transforming our lives in positive ways.
The purpose of this study is to shed light of how the health competence of Latina immigrant mothers living in rural areas is informed by their social, cultural and human capital. In addition, this study examined the role of informal women’s networks in preserving their and their families’ health. A better understanding of this phenomenon can provide useful insights about how to mobilize social, human and cultural capitals aimed to enhance mothers’ agency within a context that restrict immigrant’s Latinos access to formal health care.

**Findings**

Six major findings emerged from this study:

1. The majority of mothers (3 of 5) showed medium traditional health competence and low biomedical health competence. All mothers recognized the effectiveness of biomedical medicine, but all of them reported having had frustrating experiences with their local formal health care providers.

2. Some mothers (2 of 5) showed a medium biomedical competence and low traditional health competence.

3. All mothers who displayed medium traditional health competence had high bonding social capital. Transnational social bonding capital is the most significant in accessing traditional medicine’s alternatives. Mothers with medium traditional health competence report not having any bridging social capital.

4. All mothers who displayed medium biomedical competence showed low bonding social capital at the transnational level and medium bonding social capital at the local level.
One of the mothers showed medium bridging social capital, while the rest of the mothers had low bridging capital.

5. All mothers mentioned trust and faith as the most important factors in choosing health care alternatives.

6. All mothers recognized the importance of women’s networks in preserving their health and the health of their families. In addition, the act of getting together with other mothers had the potential to leverage meaningful conversations in which women shared health practices, positive and negative experiences with health care providers and alternatives to grow their own herbs.

**Finding 1:** The majority of mothers (3 of 5) showed medium traditional health competence and low biomedical health competence. All mothers recognized the effectiveness of biomedical medicine, but all of them reported having frustrating experiences with their local formal health care providers.

One of the principal findings of this study is that the majority of Latina immigrant mothers show medium traditional health competence. Their traditional health competence is deeply influenced by their cultural values, their imperative necessity to take care of their family, and by their limited access to and frustrations with the biomedical health care.

Traditional health competence is deeply interwoven with Latina mothers’ identity and cultural values, which are transmitted by their mothers and other older women from their home country communities. When mothers were asked about health care alternatives, they
mentioned traditional medicine and related the use of herbs and other healing practices with their condition of Latina as well as with their cultural beliefs. Esperanza says:

“Yo uso tés y los rezos también, uno como hispano siempre tiene fe en los tés. Mi mamá que está en México siempre me dice: un té para esto y para aquello...”

“I use teas as well as prayers, one as Latino always has faith on teas. My mother, who is in Mexico, always tells me: a tea for this and for that…”

Carmen also explains her traditional knowledge in terms of being Latina and being raised in Mexico with limited resources:

“Allá [en México], las mamás te enseñan desde pequeña estas cosas, bien yo aprendí todo esto con mi mamá y luego con mi suegra, pues allá [en México] ya ve que a uno no le alcanza el dinero para llevarlos al hospital y es lo único que hace uno allá, darles tés, sobarlos, y todo eso... y se les quita y a veces se les quita más rápido que dándoles suero o medicamento.”

“Over there [in Mexico] mothers teach you all these things beginning when you are young. Well, I learned all of that from my mother and then from my mother in law, because as you know, over there [in Mexico] one doesn’t have enough money to take them [children] to the hospital, and this is the only thing one does over there, give them teas, rubbing them and all of that... and they get well, sometimes even faster than by given them serum or medicines”

In a similar way, Teresa talks about her folk medicine’s knowledge:
“Todos son conocimientos que traigo de allá de Guatemala, pues de lo que me acuerdo que hacían allá [en mi pueblo]. Y bueno cuando llevaba a mi hijo, el que se quedó en Guatemala, con una sobadora o con la comadrona, pues yo miraba como hacían y allí fui aprendiendo. O a veces preguntándole a la mamá o a la suegra: mira mi hijo tiene esto, ¿qué hago? Y pues ellas saben y te empiezan a decir y tú como madre vas aprendiendo…pero todo lo traigo de allá”.

“All are knowledge and skills I bring with me from Guatemala, well from what I remember they used to do there [in my town]. When I used to take my son, the one who stayed in Guatemala, to the sobadora or with the comadrona (midwife), I watched how they did it and I learned from it. Or sometimes, by asking my mother or my mother-in-law: Look my son has this, what do I do? And they know and start telling you. And you, as a mother, are learning… but I bring everything from there”

Besides cultural values, mothers’ traditional competence has been influenced by their limitations in accessing biomedical health care alternatives as well as from negative experiences with health care providers. As a result of these experiences mothers had developed a health seeking behavior system, in which they start treating their children’s ailments at home, with both home remedies and over the counter biomedical medicines. If the treatment is not successful and symptoms persisted or are getting worse, mothers seek medical attention either through emergency room or community clinics. In their stories, three recurrent factors have pushing them to use more traditional alternatives than biomedical ones. These factors are their lack of health insurance due to their legal status, economic limitations, and their frustrating experiences with biomedical health care providers. Mother
with medium health traditional competence mentioned several alternatives such as the use of herbs and home remedies, seeking health care through a curandero (healer), and performing healing practices by themselves. The following stories illustrate how the above mentioned factors have informed Latina mothers’ traditional health competence.

Carmen is mother of three children. Alex, her oldest son, does not have Medicaid since he was born in Mexico. She has been living in the U.S. for seven years. She was raised in rural Mexico and did not complete elementary school. She is a full time mother, whose priority is taking care of her children and husband. Carmen stars her story by telling me that if one of her children is sick, she usually starts treating the illness at home:

“Si es una calentura o un dolor de cabeza, pues yo para la calentura les [a sus hijos] doy medicina que venden en la tienda para el dolor y la fiebre, pero si dijéramos que es otra cosa ya los llevo yo aquí [en el pueblo] a la emergencia del hospital. Aquí [en la emergencia del pueblo] si les duele el estomago, dicen [los médicos] que es un dolor común, un berrinche de niños, que no tienen nada y los mandan de regreso aunque ellos sigan con dolor; y entonces yo mejor les doy té de hierbabuena o manzanilla, y es de estar pendientes si se les quita el dolor. Pues con los doctores nunca entienden eso [dolores de estomago], uno les dice y ellos dicen que es un dolor común, no les dan nada, no les alivian el dolor y pues me queda a mí de hacerles tés, algo natural o sobarles su estomago”.

“If it’s a fever or a headache, well I give them [their children] an over the counter medicine for fever and pain, but let’s say if is something else I would take them to the emergency room here [in town]. Here [in the emergency room] if they have a stomachache, they [the physicians] would say that is a common pain, a child’s tantrum, that they have
nothing and would send them back home, even if they still have pain. So, I would rather give them [to their children] peppermint or chamomile teas and keep watching to see if the pain goes away. The physicians never understand that [stomachache], one explains to them and they say that is a common pain, they give them [to the children] nothing, they don’t relieve their pain and I don’t have any other choice than giving them teas, something natural or rubbing their tummy”

Carmen continues her story by sharing her knowledge about curative teas for different digestive ailments such as vomit, diarrhea and empacho. In her stories she is able to identify what types of illnesses can be effectively treated with traditional medicine while recognize the limitations of traditional folk medicine by indicating that in the case of an infection she must go to the emergency room.

“Siendo infección grande, como de infección de oído o como que tuvieran otra cosa que les da mucha fiebre, pues si tengo que llevarlos a emergencia pero casi yo ya sé que cosas se les quita más con cosas naturales y con té que llevándolos al doctor”

“I have to take them [their children] to the emergency room if it’s a huge infection, such as ear infection or if they would have another condition that gives them a lot of fever. But I almost always know which ailments I can better alleviate by using natural teas than by taking them to the doctor”

Carmen explained how her negative experiences with physicians at the town’s emergency room and clinics have forced her to either treat illness by herself using traditional medicine or look for biomedical alternatives outside the town. Her negative experiences
happened when two of their children, one without insurance and one with Medicaid, were sick with in different occasions.

“Aquí no, aquí los doctores no creen en eso [susto] pero yo sí creo mucho en eso porque no hace poco a mi niño, el más grande, me lo espantaron. Él no comía, no dormía porque si dormía se levantaba llorando. Yo lo llevé varias veces al doctor, porque además de no comer tenía hipo, y ellos me decían: no tiene nada, no es nada. Aquí el doctor nunca me dijo que es lo que tenía, no le mando exámenes. Y a mí se me hacía raro y hasta que yo le pregunté si lo habían espantado y me dijo que lo habían espantado [un perro] y yo misma, como dicen allá [en México] lo soplé con agua y albahaca. Y sí, pues tardo como una semana mi hijo pero después empezó a comer, a jugar y hacer sus actividades que él hacía. Yo lo tuve que curar a mi hijo yo sola, porque aquí [en el pueblo] no lo curaron”

“No here. Here, doctors don’t believe in that [a fright], but I do believe in it because just recently, my oldest son was frightened. He did not eat nor sleep, because if he would sleep, he would wake up crying. I took him several times to the doctor, because besides of not eating, he also had hiccups, and they said to me: he has nothing, it’s nothing. Here, the doctor never told me what was wrong with him, and he [doctor] did not send him to get tests done. And it was strange to me, so I asked him [her son] if he had been frightened, and he told me that a dog had frightened. So, as they say there [Mexico], I treated him by vigorously swishing water and basil in my mouth and then spitting it over him. My son was still sick for another week, but then he started to eat, to play and to participate in all activities he used to do. I had to cured him by myself, because they [physicians] did not cure him here [at the town’s emergency room]”
Carmen goes on explaining how she has performed the curative procedure for susto and constantly referred back to her country of origin and how she has modified this procedure by using ingredients that she can obtain here in the US:

“Soplar es lo que se hacíamos siempre allá [en México] en mi casa cuando nos espantábamos con algo. Es como dicen allá [en México] lo sano que sale de uno y se va hacia él [niño]. Nos soplaban con mezcal o aguardiente, yo como no tengo eso aquí [en el pueblo] pues uso agua, pero con albahaca, siempre tiene que llevar albahaca cuando uno sopla así”

“Spraying infusions from our mouths is what we always used to do at home there [in Mexico] when we got scared with something. It’s like they say there, the healthy from you goes toward him [her son]. They used to spray us by mouth us with mescal or hard liquor but since I don’t have this here [at Mt. Pleasant] I use water with basil. When spraying on someone by mouth, you must always have basil”.

I asked Carmen if she knows about a healer in her neighborhood. Several mothers shared this information during the focus group. She told me that she has heard about him, but she has never taken their children with him. She explains that she has heard that he is a very good healer with lot of knowledge, but she considers herself skilled enough to treat illnesses by herself like susto:

“No, no, para eso [susto] no me gusta que otra gente lo haga, siempre lo hago yo. Nunca he ido ni he llevado a mis hijos con ese señor, pero de que dicen que es bueno el señor, pues es muy bueno. Yo no los llevo porque yo puedo, para que se los voy a llevar si lo
mismo que él hace yo puedo hacerlo. Pero me dicen que como para aliviar otros males si, pues el señor si sabe y ahí si me gana él en conocimiento porque él es más grande. Pero dijéramos que lo mismo que él hace es lo que yo hago aquí [en mi casa].”

No, no, for that [a fright] I don’t like other people doing it, I always do it myself. I have never have taken my children to this man [local healer], but they say [other people] that he is really good indeed. I don’t take them [to the healer] because I can do it, so why I am going to take them when I can do the same he does? But I have heard that he can cure other ailments, this man knows a lot and he outdoes me in knowledge because he is older than me. But let’s say that the same thing he does I do here [at my home]”.

Yet, Carmen recognizes the limitations of traditional medicine by sharing with me a time in which her daughter was very sick. She sought medical care several times at the town’s emergency room and clinics, but the physician did not cure her daughter. She feels that the physician treated them with disrespect and completely disregarded her daughter’s illness. She tried to cure her with teas, but her daughter’s condition got worse and she had to seek biomedical care outside her town.

“De mi niña también, hace poco estuvo enferma, tenía mucha fiebre y dolor de estomago, pero aquí [en el pueblo] cuando la lleve de emergencia no le dieron nada, ni suero, ni pastillas ni nada. Volví a llevarla porque seguía con fiebre y no podía caminar del dolor y le hicieron un ultrasonido pero me dijeron que era un dolor común de niños berrinchanos, que era un berrinche. Y pues yo le dije que se me hacía raro porque yo sé como son mis hijos. Y así estuvo una semana mi hija, yo traté con té pero no le pude quitar el dolor y entonces fui a otra clínica, allá en otro pueblo.”
“My daughter was also sick recently, she had high fever and stomachache, but when I took her to the emergency room here [in town] they never gave her anything, not intravenous fluids, not pills, nothing. I took her again, because she continued with fever and she couldn’t walk because of the pain. They did an ultrasound but they said it was a common pain of a child with a tantrum, it was a child’ tantrum. And I said to him [physician] that it seems strange to me because I know how my children are. So, she was sick for one more week and I tried to cure her with tea but I was not able to relief her pain. Then, I took her to another clinic in another town”.

Carmen shared with me her positive experience in this community clinic at this other town. In this clinic, patients have to pay accordingly to their income, usually $10 up to $25 per consult. Another mother told me that it was a county clinic in response to the increase of Latino population in the area. And if patients have Medicaid and more care is needed, they can be referred to clinics and hospital located in a big city. Most of the mothers (4 of 5) shared their positive experiences in this clinic. Most of the mothers agreed the service was really good, because the physicians really care about their health problems and they have very good translators who make them feel comfortable. They pointed out that they can trust these physicians. Also, Carmen explained to me the positive experience she had in this clinic and how she was very thankful because the physicians were able to cure her daughter. For these reasons she does not longer seeks medical care where she lives, and every time she needs medical care she prefers to makes the trip to this other town. This other town is located at 32 miles from where she lives. It takes 40 minutes to get there by car and
there is no public transportation available. Carmen relies on her brother-in-law, who works
nightshift, so usually can drive here there

“Entonces fui a otra clínica, allá en el otro pueblo y allí fue donde le detectaron que
tenía muchas células blancas en la orina. Me dijeron que tenía que llevarla con un
especialista en la ciudad, un doctor para niños, como un pediatra especializado porque
tenían que ver por qué tenía tantas células blancas y pues salía que tenía una infección pero
no sabían qué infección era. Y la llevé al hospital en la ciudad, el doctor [en ese otro
pueblo] me hizo la cita allá en el hospital de la ciudad, me consiguió el doctor y todo eso,
cosa que aquí [en el pueblo] no hicieron. Y allí [en hospital de la ciudad] me dijeron que
tenía una infección por dentro de los riñones que se le estaba yendo para arriba hacía los
pulmones. [Mi hija] tuvo que estar internada dos días y le hicieron muchos estudios y
gracias a Dios le dieron el medicamento que era y se le quitó la infección. Los médicos me
preguntaron porque había tardado tanto en llevarla. Y por eso aquí [en el pueblo] yo a este
hospital ya no los llevo porque siempre me dicen que no tienen nada, no le ponen atención a
uno, no nos hacen caso ni le explican nada a uno. Siempre les hacen lo mismo a los
hispanos, no le hacen caso a uno siempre más a los de aquí [estadounidenses] que los
mexicanos. Y pues si me dio mucho coraje, porque yo busque atención desde antes y aquí no
me hicieron caso”.

“So, I took her to the clinic, the one at the other town, and they [the physicians] found
out she had a lot of white cells in the urine. They said I had to take her to a specialist at the
city’s hospital, a specialized pediatrician, because they needed to figure out why she had so
many white cells; the tests showed that she had an infection but they didn’t know what kind
of infection. So, I took her to the city’s hospital, the doctor [from the other town] made me the appointment, it was something they did not do for me here [in this town]. In the city’s hospital they [the physician] told me that she had a kidney infection and that the infection was beginning to spread toward the lungs. She had to stay in the hospital for two days, they made her several tests and thank God they give her the correct medicine and the infection receded. The doctors asked me why I took so long before taking her to the hospital. That is the reason I no longer take them to the hospital here [in this town], they don’t pay attention to us and they don’t explain anything to us. They always do this to Hispanics; they ignore us, [they] always put more attention to Americans than to Mexicans. I was so angry, because I sought [medical] care when she just got sick and they ignored me”.

Esperanza shares a similar story. She is a mother of five who has lived in U.S. for 14 years. She has some high school education and occasionally works as a construction worker. Yet she faces greater economic limitations than Carmen, since most of her children (3 of 5) did not have Medicaid or any other type of medical insurance and her family does not have a steady income. For these reasons, she relies heavily on traditional medicine. Teas are her first alternative when someone in her family gets sick. But unlike Carmen she usually visits the healer who lived in this town as well as the community clinic in the other town. She also shared her negatives experiences in both the emergency room at this town t and in the clinic at the other town.

“Yo siempre empiezo con un té para mí, ya sea un cólico o un dolor leve pues siempre uso los tés. Y con mis hijos pues uso tés pero también medicina para la calentura o depende de la enfermedad, y si no se les quita pues entonces si veo que están decaídos,
entonces ya así los llevo a la emergencia, bueno solo a los que tienen aseguranza porque unos tienen y otros no, los que nacieron en México no tienen aseguranza”.

“For me, I always start with a tea, I always use a tea when is a colic or a mild pain. With my children I use teas but also medicine to treat fever or depending on the illness. But I take them to the emergency room if I see they aren’t getting better or are gloomy. Well, I only take the ones who have insurance, because some have insurance and others haven’t, the ones who born in Mexico don’t have insurance”

Esperanza explains that for her children, who do not have Medicaid, she prefers to use home remedies and only if they get really sick she would take them to the emergency room. Even with her younger children, who have Medicaid she use traditional medicines as first alternative and she perform some healing practices as sobado and limpias as well. She said:

“Pues trato de darles remedios caseros, cuando ya están graves pues los llevo a la emergencia y pues llega el recibo bien caro pero si los llevo, pues los tengo que llevar. A mis hijo grande lo he llevado con el señor [curandero] porque seguido tiene torceduras porque hace mucho deporte pero a los pequeños lo hago yo en la casa y además tienen seguro”

“Well, I try to give them home remedies and I take them to the emergency room only when they are really sick, because is very expensive, but I take them if I have no other choice. I have taken my older son to the man [healer], because he often has sprains since he does a lot of sports, but with the little ones I rather treat them at home and besides they have insurance”.
Yet, Esperanza shared the time her older son, who is uninsured, got really sick and she still had a lot of debt from the last time she visited the emergency room. So, she decided to take him to the healer in the neighborhood. She has taken him before but just for minor problems such as sprains or muscle aches, and the healer had performed some rubbing procedures called sobados that alleviate her son’s pain. But on this occasion her son had a very high running fever, a strong headache and chills.

“Una vez lleve al más grande mío, que no tiene seguro, de emergencia con el señor porque supuestamente sabe curar otras cosas que no sean torceduras o dolores. Lo lleve porque tenía mucha calentura, estaba sudando y estaba super mal y no quería llevarlo a la emergencia porque ya tenía dos veces que lo había llevado y me llegó el recibo como de $500 cada vez y todavía estaba tratando de pagarlos. Y bueno lo lleve con el señor [curandero] porque él no cobra, nomás lo que uno le quiera dar. Lo llevé y el señor le puso un parche en la nariz y le dio un té, no sé de qué era y como a los diez minutos haga de cuenta que no tuvo nada. Y llamó a mi hermana y le cuento: Mija el señor lo curó, yo no le tenía confianza y cómo vas a creer que le curó. Y bueno desde entonces le tengo confianza.”

“Once I took my oldest son, who is uninsured, to the man [healer], since he supposedly knows how to cure other ailments besides sprains and pains, and it was an emergency. I took him because he had a very high fever, he was sweating, and he was feeling really bad, and I did not want to take him to the emergency room because I had taken him twice previously and I got a $500 bill each time, and I was still trying to pay them. So, I took him because the man doesn’t charge you, only whatever amount you want to give him. I took him and he [the healer] put him a patch in the nose, gave him a tea, I don’t know what kind,
and after 10 minutes my son was completely well like if he never had been sick before. And I called my sister and I told her: *Mija*, the man cured him, I did not trust him and could you believe he cured him? Well, since then I have trusted him [healer]”.

Similarly to Carmen, Esperanza has had negative experiences with physicians in both towns’ clinics. She explains to me how she hardly seeks medical care for herself due to economic constrains, but a few times she has sought medical care for a backache that worries her a lot. Yet the physicians have disregarded her concerns and only have given her treatment for depression. She says:

“*Regularmente yo cuando me en-fermo nunca voy al doctor, bueno porque uno se aguanta ¿verdad?, por lo mismo del dinero. Voy al doctor solo cuando es necesario, como al chequeo anual voy siempre porque allí no me cobran en la clínica de mujeres, solo lo que quiera uno donar. Y bueno además cuando voy y le digo al médico: Oiga yo sigo sintiendo un dolor en la espalda bien feo, quisiera hacerme unas radiografías porque a lo mejor tengo cáncer o algo, porque como yo fumo, y me dice el doctor que no que es nada más estrés y depresión, que sabe que son síntomas de eso y hasta me da las pastillas para la depresión. Entonces yo casi ni le tengo confianza a ese doctor que está en el otro pueblo, se me hace que ni es doctor”

“*Usually when I get sick I don’t go to the doctor, one endures it because of [lacking] money. I go to the doctor only when it’s necessary, like the annual checkup and because it’s free at the women clinic. And besides, when I go to the doctor I tell him: Listen, I am still feeling a strong pain in my back, and I would like you to have me x-rayed, Perhaps I have cancer or something else, because I smoke. And the doctor answered me no, because he says*
is nothing but stress and depression, he knows I have the symptoms of that [depression] and he even gives the pills to treat depression. So, I can hardly trust that doctor who is at Columbus Junction, I think he even isn’t a real doctor.”

Teresa, a Guatemalan mother of two who has been living for six years in the U.S., and has some high school education, also shares similarly stories with Esperanza and Carmen. Yet, she has not had any negative experience with the physician in this town’s emergency room and clinic, partly because she has had few emergencies needing biomedical care. She was pregnant at the time of the interview, and her son was pretty healthy so she only visited the doctor for check up and vaccines. She explained that if one someone in her family is sick, she starts taking care of it with home remedies, and if she sees no improvements she goes to the clinic.

“Pues yo primero los trato aquí en la casa, si tienen como una gripita, pues hacerles tés de manzanilla con miel, bañarlos con agua tibia, darles vapor, o si se enferman del estomago les doy aceite para desempacharlos y así remedios caseros. Si ya veo que es algo más o que no se les quita pues entonces ya los llevo al doctor”

“Well, first I treat them [her children] at home. If they have something like a cold I give them chamomile teas with honey, give them a bath with warm water, or put them a vaporizer; if they have a stomach’s ailment I give them oil in order to desempacharlos [to release food stuck in the stomach] and home remedies like these. I take them to the doctor if I see that is something else or that they are not getting better.”
Teresa, like Carmen and Esperanza, also would rather perform healing practices herself than to take her son with the local healer. She explained how she has her own ideas and skills to cure her son by herself.

“Yo aprendí a sobar en Guatemala cuando lo llevaban a uno con una sobadora y allí fui aprendiendo, igual sé hacer la limpia del mal de ojo, ya me ha tocado porque ya me lo ojearon a mi hijo y pues yo lo curé. Así le toca a uno aquí [en U.S]”

“I learned to do the rubbing in Guatemala when I use to be taken with a sobadora [women who knows how to perform the rubbing] and there I started learning. I can do the limpia [curing ritual] for mal de ojo [evil eye] as well. I had to do it recently because my son was sick from the evil eye and I cured him. This is what one has to do here [in the U.S.]”

When I asked about the local healer, she shared with me her lack of trust toward him and her capability in curing her children herself.

“Sí lo he visto y he oído, pero yo no conozco mucha gente aquí, casi ni salgo y yo no lo tengo confianza. Pues dicen que cura pero yo nunca he ido. Yo ya traigo mis ideas y lo que aprendí en Guatemala, así que casi no te digo, casi ni al doctor recurro yo, es muy poco, solo cuando yo no puedo curarlos”

“Yes, I have seen him and have listened about him, but I don’t know many people here, I hardly leave home, and I don’t trust him. It is said that he cures, but I have never been there. I bring my own ideas and what I learned in Guatemala, so as I am telling you, I hardly even go to the doctor, its rare and only when I cannot cure them by myself.”
**Finding 2:** Some mothers (2 of 5,) showed a medium biomedical competence and low traditional health competence.

Some mothers show a medium biomedical competence. Through their stories they shared a great confidence in biomedical medicine. One of the mothers sometimes uses teas and other home remedies, but only for herself and never with her daughter, while the other mothers not uses them at all. These mothers have had overall positive experiences with health care providers and express fewer economic constrains compared to the mothers who had low biomedical health competence. Mothers who showed medium biomedical health competence expressed disbelief in many components of traditional medicine.

Rosario, a young mother of one girl, has lived in the U.S. for 13 years. She has less than 8\textsuperscript{th} grade of formal education. She was the only mother who had private medical insurance through her husband’s job. She also was the only mother who mentioned that her husband usually accompanied her to medical appointments and that he was really helpful, because he is fluent in English. In regard to traditional medicine she says:

“Casi no creo en esas cosas. Puedo decir creo, nada más porque viene de familia, porque mi mamá creía y nos curaba de empachos y nos ponía algo rojo para evitar el mal de ojo y todo eso... por respecto a sus creencias, pero yo en mí no creo en esas cosas”.

“I hardly believe in those things. I can say I believe only because it comes from family, because my mother believed and she used to cured us from empachos and she used to dress us up in something red to avoid evil eye and all of this…. so I honor her beliefs, but I don’t believe these things myself”
Lucía, a mother of four children, who has a full time job and high school education, also expresses her disbelief in traditional medicine:

“It depends on the traditions and beliefs of each family; it’s according to how one has been raised, right?, If one comes from a family that doesn’t believe too much in these things [traditional healing], and I was raised with the idea that these things don’t exist, that it isn’t truth, so I am this way, well I listen and respect each person’s thoughts but up to a point.”

In contrast to mothers with medium traditional health competence, Lucía and Rosario start treating illnesses with over the counter medicines and hardly use home remedies. Seeking health biomedical health care was the first option if the treatment at home was not successful. Both mother report overall fewer negative experiences with their health care providers that the other group of mothers.

Rosario shares with me what she usually does when someone in her family gets sick:

“Pues uso lo que es regular, pues uso el tylenol, pues yo para mí uso tés porque le tengo confianza a los tés naturales, pero pues para mi hija pienso que es mejor la medicina porque es lo más recomendado para el doctor. Y es que como ella está creciendo aquí [en U.S.] pues como que su cuerpo no está preparado para usar todas las hierbas y todo eso;
"Well, I use what is common, I use Tylenol, but for me I use teas because I have trust on natural teas. But with my daughter I think is better to use medicine because it’s the most recommended by the doctor. And since she is growing up here, well her body is not accustomed to use all the herbs and all of that. Well, for me is different, I was treated with them [herbs] since I was young so it’s like if my body is accustomed to herbs. So, I always take my daughter to the doctor after two days of being sick and sometimes I take her even sooner just to be sure nothing is wrong”.

Rosario shares that even though she just recently moved to the other town; she still seeks heath care at their previous town, where the rest of the mothers live because she already trusts the physicians over there and always has had good service.

"Pues me gusta más la atención en el pueblo que vivía antes, los doctores atienden bien y yo ya les tengo fe, en cambio aquí en este otro pueblo no me los han recomendado, no me han hablado bien de los doctores de aquí. Pero he ido aquí para el chequeo de mi hija y los médicos fueron amables, además generalmente me acompaña mi esposo que habla bien inglés y entonces estuvo bien”

"Well, I like the service better at the town I used to live; the doctors serve you well and I already have faith on them. On the contrary, here in this town, they [people] did not recommend the doctors; they have little good to say about them. But I have taken my
daughter here to her annual checkup, and the physicians were kind. Besides, my husband
who speaks English well enough, usually goes with me, so it went well”

Lucía is a very confident mother, who also treated minor illness at home and always
took their children to the doctor when she was not able to cure them at home. She says:

“Pues si es algo ligero como un catarro pues no es para llevarlos al hospital,
solamente cuando tienen una temperatura muy alta que ya no se les puede controlar con
tylenol y pues remedios caseros casi no uso. O cuando tienen una infección de garganta o
dolor de oído, pues uno sabe que los tiene que llevar al doctor”

“Well, if it’s something mild like a cold, it’s not for taking them [their children] to the
hospital, only when they have I high fever that one cannot control with Tylenol and well, I
hardly use home remedies. Or when they have a throat infection or ear ache, well one knows
that one needs to take them to the doctor.”

Lucía explains that despite some difficulties she always managed to seek medical
care for her children and herself, and overall she is satisfied with the medical care she has
received so far.

“Pues sobre todo a uno se le hace un poco difícil por el idioma porque uno no se
puede comunicar muy bien, pero igual a mi no me importa yo vengo y saco la cita para el
doctor. Voy aquí en el pueblo para los niños que pueden ir aquí y para los que no pueden ir
pues los llevo al otro pueblo”

“Well, it’s difficult for me, most of all because of the language and because one
cannot communicate very well. But anyway, I don’t care and I make the doctor’s
appointment. I go here [at this town] with my children who have insurance and I take the children without insurance to the other town.”

“Les tengo confianza [a los médicos] porque les dan la medicina de acuerdo a lo que le les sale en los exámenes, en los análisis que les mandan, pero gracias a Dios no he tenido ningún problema que yo este desesperada porque un mi hijo esté muy enfermo que no sepa que hacer y que los médicos no sepan porque tiene eso.. hasta ahorita no me ha pasado , gracia a Dios aquí no pasamos de gripas comunes”.

“I trust them [physicians] because they give them [her children] medicine according to the test’s results, but thank God so far, I have not had any problem like I am desperate because my son is really sick and I don’t know what to do, and the physicians couldn’t figure out what is going on. So far, it has not happened to me, thank God, here [at home] we don’t get sick from anything but colds.”

**Finding 3** All mothers who displayed medium traditional health competence had high bonding social capital. Transnational social bonding capital was the most significant factor in accessing to traditional medicine’s alternatives. Mothers with medium traditional health competence reported not having any bridging social capital at all.

These mothers share similarly stories, in which transnational bonding social capital is crucial in order to learn and have access to traditional health practices. Through these networks they have learned about medicinal teas, home remedies and healing practices. Transnational bonding capital includes mothers, mothers-in-law and sisters. As well as reliable older women in the community, known as *comadronas, sobadoras* or *curanderas,*
from whom mothers learned healing practices before leaving their home countries. Here in the U.S, mothers reported to have medium bonding social capital, which includes sisters and sister in law. These relatives offered them a lot of support when they have faced difficulties in preserving their children’s health. Yet, they lacked both Latina and American’s friends and shared with me their feeling of isolation.

Carmen tells me that she learned healing practices and knowledge from her mother and her mother-in-law. Her mother often sends her herbs from Mexico. She also shared that she has a sister-in-law living at Mt. Pleasant, and she has been a great support when Carmen or her children have been sick.

“Allá [México] con mi mamá y me suegra aprendí a usar los tés…”

“There [in Mexico] my mother and my mother-in-law thought me how to use the teas”

“Cuando hablo con mi mamá y mi suegra allá en México, siempre les pregunto: ¿y qué hago para esto y lo otro?”

“When I talk with my mother and my mother in law there [in México], I always ask them: what should I do for this and for that?”

“Yo tengo aquí mis hierbas que compro en la tienda Mexicana, pero mi mamá siempre me manda de México”

“Here, I get herbs at the Mexican store, but my mother always sends me [herbs] from México”
“Pues, el hermano de mi esposo y mi cuñada que son mis compadres me llevaron al hospital y mi comadre se quedo una noche allá con ella [su hija enferma] y yo me tuve que venir a la casa por mis otros niños. Yo la quiero mucho a ella [mi comadre] siempre está allí, es la única persona a la que le puedo confiar a mis hijos. Cuando me alivie de mis dos hijos ella estuvo allí conmigo, me cuidó y todo eso. Y es más por mí, bueno si tuviera a mi mamá o a mi suegra cerca pues sería diferente pero cuento con ella”.

“Well, my husband’s brother and my sister-n-law, who are my compadres (co-parents) took me to the hospital. My sister in law stayed overnight with her [Carmen’s sick daughter] since I had to come back home to take care of my other children. I love her [sister-in-law] very much, she is always there, she is the only person whom I can trust my children. When my children were born, she was with me, she took care of me. It would be different if I had my mother or my mother-in-law living close to me, but I can count on her.”

Esperanza shares a similar story with high bonding social capital which includes her mother who lives in Mexico and her four sisters, two of them in Chicago, one living in Iowa, and one living in Missouri.

“Yo seguido llamo a mi mamá allá en México y le digo: Mami que hago para esto, y pues cuando estaban los niños más chiquitos que lloran y lloran y uno no sabe qué hacer, y yo decía: ¿donde oí esto? ¿quién me dijo esto? y ya le llamo a mi mamá y le digo: ¿Mami,

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8 *Compadres* (Co-parents)'refers to the relationship between the parents and godfathers or a child and is very important social bond which originates when I child is baptized in the Catholic religion in Hispanics families. This relationship entails trust, sharing the parental role and strong lifelong bond between compadres and their families.
usted sabe que es bueno para esto? y ella me dice: A pues mija dale esto, ponele un agua de lechuga o algo”

“I often call my mother there [in Mexico] and I tell her: Mom, what should I do for this? And when my children were younger, sometimes they would cry and cry and one doesn’t know what to do, I would say: Where do I hear about this? Who told me this? So I call my mother and I tell here: Mom, do you know what is good for this? And she would say: Mija give here this or put her lettuce’s water or something”

“Pues para consejos, pues mi mamá nada más yo creo, mis hermanas y mi mamá es todo, y pues mis hermanas también de mi mamá es que saben”

“Well, to get advice, I think only from mom, my sister and my mother, that’s all. And my sisters learn from my mother too.”

Teresa explains that besides her mother, older women from her home town in Guatemala were the primary source of support and information about healing. She also mentioned a few Latina acquaintances in her neighborhood:

“Para eso [consejos] siempre llamo a mi mama allá [en Guatemala] y ella a veces va y le pregunta las señoras que saben de esas cosas y ya luego me llama y me dice que hacer. Y pues también de lo que me acuerdo que hacían estas señoras ya grandes, que son las personas que saben de eso, y pues cuando lo llevaban a uno a que lo sobaran o cuando uno andaba asustado o que lo habían ojeado, pues allí fui aprendiendo”.

“For that [advices] I always call my mom there [in Guatemala], and sometime she asks other women who know about these things. And then she [my mother] calls me back to
tell me what to do. Also from what I remember of what these old women used to do, these old women are the ones who know about all of that [traditional healing], and when I was taken with them to be sobada [rubbed] or when I have been frightened or had the evil eye, well then I started learning.”

“Y bueno pues aquí, tengo pocas conocidas, y a veces les pregunto a otras muchachas de Guatemala que viven aquí cerca y les digo: mi hijo tiene esto, ¿que será bueno darle? Y pues ya te empiezan a decir hazle esto y esto, pero pues más en con mi mamá y mi hermana que vive aquí [en el pueblo].”

“Well, I have few acquaintances here. Sometimes I ask other girls from Guatemala who live close by, I say: my son has this, what should I give him? And they start telling me: do this and that. But, I talk more about this with my mom and my sister who lives here [in this town].”

“Mi hermana siempre anda pendiente de mí, si tengo que ir al doctor viene y se queda con el niño, además ella siembra el apazote, la ruda, el romero, y también la hierbabuena. La vez pasada que ojearon a mi hijo ella me trajo el apazote, la ruda y el romero para curarlo.”

“My sister is always looking after me. If I have a doctor’s appointment, she comes over and stays with my son. Besides she grows apazote, rue, rosemary and also peppermint. The other day, someone gave evil eye to my son and she brought me apazote, rue and rosemary to cure him.”
Finding 4 All mothers who displayed medium biomedical competence had low bonding social capital at transnational level while showing medium bonding social capita at local level. One of them had some bridging social capital.

The two mothers with medium biomedical health competence commented that usually they did not call their mothers or other relatives in their home country to get health’s advices. Yet, one of them seeks health advice and support in her sisters and mother-in-law, who are living in the same town and in other states within the U.S. However, both coincide that they trust physicians to get health’s advices. Only one of these mothers reported to have Americans friends who gave her health’s advices. The other mothers shares how she feels very isolated, since, besides her sister, she does not have any women friends to rely upon in the US, and that she would like to have friendships with other families.

Rosario talked about seeking health’s advice and treatment alternatives through her sister and her mother-in-law. Yet, she stresses that she trusts physicians the most.

“Pues esas cosas [enfermedades] se habla entre hermanas, ¿verdad? y es que yo tengo a las más viviendo cerca, entonces le preguntas a alguien que tiene más experiencia, a las hermanas mayores”

“Well, those things [illnesses] need to be talked among sisters, right? And my sisters are living close to me, so you ask someone with more experience, such as older sisters.”

“Y aquí pues cuento con mi hermana, ella es la que habla más a México y ella pregunta y luego ella me platica. Y es que yo ya no llamo tanto a México, no hablo casi mucho con mi mamá y entonces ella [mi hermana] me dice que cosas le dicen para curar.”
En cambio si hablo mucho con mi suegra porque vive aquí, siempre me anda recomendando que tomar para el mal de orín porque padezco mucho de eso. Pero como te digo, yo casi no creo en esas cosas y pues confío más en lo que dicen los médicos, sobre todo con mi hija.”

“Here, I can count on my sister; she is the one who often calls Mexico. She talks to relatives there, and then she tells me about it. I don’t call often to Mexico, and I can hardly talk with my mother, who lives in Mexico. So she [my sister] tells me about what she has learned about healing. On the contrary, I talk a lot with my mother-in-law because she lives here [is this town]; she is always recommending to me what to drink for urine infection, since I suffer a lot from it. But, as I was telling you, I can hardly believe those things. And I trust more what physicians say, especially in regard to my daughter.”

“Siento que aquí es muy tranquilo, muy solo y a veces uno necesita salir con alguien a distraerse, aquí es nomás familia, la familia de él [esposo], la familia mía y ya, y pues antes trabajaba y tenía amigos pero ahora no.. y pienso que necesitas amistades que quieran lo que uno quiere, que sus hijos jueguen con la mía, salir.. quisiera ser amiga de las mamas de las niñas con las que mi hija juega en la escuela, pero ya ves uno que no habla inglés.”

“I feel that here is peaceful, but one is very alone, and sometimes one needs to go out with someone else and amuse oneself. Here is only with family, his [husband] family, my family and that’s it. I used to worked and had friends but not anymore.. and I think you need friends with your same interests, with children who could play with my daughter, to go out ... I would like to be friends with the mothers of the girls my daughter plays with, but you see..I am the one who doesn’t speak English.”
Lucía is the only mother who had American friends to rely upon. She usually talks with her mother who lives in México but hardly ever ask her for health’s advices. Instead, she relies upon her physician as well as upon her American and Latina’s friends for health’s matters.

“Y bueno aquí en el pueblo tengo amigas Mexicanas y otras que son de aquí [U.S.], son amigas del trabajo que me dan consejos o me han recomendado los médicos del otro pueblo, y bueno me dan consejos y me dicen esto es muy bueno. Eso sí sino es medicina, pues a veces mejor lo llevo al doctor, confío más en el doctor”

“Well, here in this town I have Mexican friends as well as others [friends] who are from here [U.S.]. They are friends from work, and they give me advices or they have recommended physicians at the other town, so they give me advice and tell me: this is really good. Yet, if it’s not medicine [over the counter], sometimes I rather go to the doctor, I trust the doctor more.”

**Finding 5** All mothers mentioned trust and faith as the most important factors in choosing health care alternatives.

All mothers, regardless of whether they show traditional or biomedical health competence, mentioned that having trust and faith in physicians, healers and healing practices shared by their relatives was an important factor in choosing health care alternatives.

Carmen shares her trust and faith in both systems:
“Yo le tengo fe a los tés, yo sé cual té usar para cada padecimiento y se les quita [la enfermedad o malestar] y a veces más rápido que dándole suero o medicamento”

“I have faith in teas, I know which tea I need to use for each ailment, and it cures them [children], sometimes even faster than by given them serum or medicine.”

“Yo le agarre confianza a ese doctor desde que me curó a mi hija, me la mando al hospital de la ciudad donde me la atendieron bien rápido y fueron muy amables allí en la clínica y en el hospital también”

“I trust that doctor since the day he cured my daughter, he sent her to hospital at the city, where she was seen really fast and all [personnel] were really kind at the clinic and in the hospital too.”

Esperanza expresses her trust in the local healer while strongly distrusting the physicians at the community clinic:

“Yo casi ni le tengo fe a ese doctor que está en el otro pueblo, se me hace que ni es doctor”

“I can hardly trust that doctor who is at the other town; I think he even isn’t a real doctor.”

“Y llamo a mi hermana y le digo a mi hermana: Mija yo no le tenía confianza como va a creer que lo curó. Se alivio [su hijo] así de rápido, ya al ratito me dice: ya me voy a jugar fútbol, y pues le tuve confianza después de eso”
“And I call my sister and I tell her: Mija, the man cured him, I did not trust him and could you believe he cured him? Well, since then I have trust on him [healer]”.

Teresa expresses her faith in herbal teas to treat illnesses:

“Pues los uso seguido bastante seguido, como para mí más el té de manzanilla, le tengo mucho fe”

“Well, I use them [teas] often, very often. For me, I use more the chamomile tea; I have a lot of faith in it.”

Rosario shares how she distrusts commercial teas so she grows and prepares her own teas. She also prefers one physician over the other because of the faith and trust she already has in one of them:

“Yo prefiero lo natural, pero no comprado, si no cortar la hierba o comprar la hierba y hacerlo, porque no tengo confianza en las bolsitas, no sé como lo hacen ni que ponen adentro”

“I prefer the natural, but not bought it in a store; I prefer to harvest the herb, or buy the herb and do it myself. I don’t trust [tea] bags, because I don’t know what how it’s done or what it’s put inside.”

“Pues me gusta más la atención en el otro pueblo donde vivía antes, los doctores atienden bien y yo ya les tengo fe, en cambio aquí en este pueblo no me los han recomendado, no me han hablado bien de los doctores de aquí.”
“Well, I like better the service at the town where I used to live; the doctors serve you well, and I already have faith on them. On the contrary, here in this town, they [people] did not recommend the doctors to me; they have nothing good to say about them.”

And Lucía comments about why she trusts physicians while distrusting the local healer:

“Les tengo confianza [a los doctores] porque les dan la medicina de acuerdo a lo que sale en los exámenes”

“I trust them [physicians] because they give them [her children] medicine according to the test results”.

“Yo nunca he llevado a mis hijos con nadie que sabe, no confío en nadie aquí que sepa sobar, bueno sí sé de un señor que cura aquí en el pueblo, que soba y todo esto, pero la verdad no le tengo confianza como para llevarle a mis hijos, ¿y qué tal si no es cierto que sabe?. Allá en México si iba con las señoras que sobaban y daban tecitos, pero aquí no conozco a nadie que le tenga confianza”

“I have never taken my children to be rubbed by someone. Here, I don’t trust anyone who knows how to rub. Well, I know a man who knows how to rub, here in this town, but the truth is I don’ thrust him enough to take my children with him. What if isn’t true that he knows how to rub? In Mexico, I used to go with the older women who rub and give teas, but here I don’t know anyone I can trust.”
Finding 6 All mothers recognized the importance of women’s networks in preserving their health and the health of their families. In addition, the act of getting together with other mothers had the potential to leverage meaningful conversations in which women shared health practices, positive and negative experiences with health care providers and alternatives to grow their own herbs.

All the above described findings were recurrent themes in both focus group and individual interview. Yet, during the focus group all mothers engaged in a meaningful conversation sharing their every day experiences around health and pointing out factors that both enable and limit their roles as caregivers of their family’s health.

Despite the fact that some mothers showed biomedical competence while others showed traditional health competence, they were able to find commonalities in their daily life experiences. All mothers agreed about the language barrier and their difficulties in communicating with the physicians, and their bad experiences with translators in both emergency room and clinics. All mothers were able to relate to incidents of discrimination and what they considered medical negligence. Some of the mother who had lived for many years in the town of study started giving advices to the newest mothers in regard to reliable and unreliable physicians, local healers and some places to buy herbs.

After discussing about how mothers, mother-in-law and sisters comprise important local and transnational networks that represent the primary resource of medical knowledge, healing practice and herbs, mothers started to reflect how taking care of their family is a “women’s job”. They shared how poorly skilled their husband were to take care of someone sick. They stressed the importance of the emotional support they feel thorough these ties with
mothers, mothers-in-law, sisters and sisters-in-law. Finally, mothers shared healing practices, as well as growing practices for herbs and other medicinal plants.

Discussion

My findings suggest that the health competence of Latina immigrant mothers living in a rural Midwestern state is informed by their social, cultural and human capital within political and socio-economic contexts that limit their access to health care services.

*Ties that Heal: Social Capital and Health Competence*

In relation to the study hypothesis, my findings suggest that:

1. The higher Latina immigrant mothers’ bridging and bonding social capital, the more alternative they have to address health issues and therefore their health competence.

2. Both the bonding and bridging social capital that enhance Latina immigrant mothers’ health competence are gendered, formed by kin women’s networks and few women friends.

3. The difference between biomedical health competence and traditional health competence is partially explained by the relation of high-low among both social capitals. Latina immigrant mothers with high bonding social capital (both local and transnational) and low social bridging capital display medium traditional health competence, while Latina immigrant mothers with low boding social capital display medium biomedical competence. Yet, these findings dos not entirely suggest the presence of high bridging among Latina immigrant mothers with medium biomedical competence, since it was present only in one of them.
In their stories Latina immigrant mothers stress the central role of women’s ties in preserving the health of their families. Social bonding capital encompasses transnational and local women’s ties. Both are mainly formed by relatives, such as mothers, mothers-in-law, sisters and sisters-in-law. Through transnational women’s networks, Latina immigrant mothers access to information about medicinal teas, home remedies and healing practices. Equally important, these women’s network provides emotional support when mothers are trying to reestablish the health of a sick member of their family, mainly their children.

Transnational women’s networks provide mothers with the skills, knowledge and confidence to face some illnesses and thus enhance Latina’s mother self-efficacy and confidence in taking care of their family. Yet, such ties enhance mother’s traditional health competence rather than their biomedical health competence.

Similarly, the social bonding capital at the local level among Latina immigrant mothers is limited to kin female members, such as sisters, sister-in law, and mothers-in –law. Through these networks mothers share information mainly about biomedical care services in the area and their reliability. Latina immigrant mothers also share knowledge and healing practices that they bring with them from their home countries. Such gendered knowledge is preserved and enhanced through their translational ties. These gendered family’s ties are also their principal source of emotional support when some family members is sick. Thus, rural Latina immigrant mothers not only face greater isolation but have more difficulties in access to health information and support than their urban counterparts who look toward extended networks for support (Hondagneu-Sotelo 1994; Schmalzbauer 2011).

Moreover, Latina immigrant mothers with medium health competence have no social bridging capital. They have had more frustrating experiences using biomedical when are
compared with the only one Latina immigrant mother who display social bridging capital. These findings suggest that lacking of bridging social capital greatly undermines Latina immigrant mothers’ access to biomedical services and therefore their overall health competence.

These findings coincide with other studies that identify factors or perceived barriers that undermine individual’s health competence. Latina immigrant mothers, living in rural areas, who have economic limitations and undocumented status, whose family is uninsured, who are not working for wage outside home, who come from rural areas within Mexico and/or Central America, who are less educated and have low English proficiency have fewer biomedical alternatives to face family’s health issues and therefore less overall health competence. Latina immigrant mothers are the ones who face discrimination at clinics and hospitals (Baker 2004). Such negative experiences in which mothers have felt that their family’s medical issues and concerns have been disregarded, have forced them to look for other alternatives both traditional and biomedical outside their town.

Yet, Latina immigrant mothers living in rural areas and with limited access to a satisfactory biomedical health care have found ways to preserve their family health with traditional medicine as well as to look for biomedical health care services that could provide them with the expected service. As feminist political ecologists argue, these creative and culturally meaningful ways of accessing to health care are examples of women’s agency, despite their marginalized living conditions, which greatly undermine the well being of their families and themselves (Harrison 2004; Rocheleau et al. 1996).

It is well documented that traditional medicinal knowledge is transmitted between mothers and daughters and enhanced by community interaction among women (Rubel 1966).
Thus, in the absence of community interaction, Latina immigrant mothers use their kin transnational women’s ties to reconstruct their identities as caretakers of the family health (Clark 1993; Harrison 2004) in a foreign country. Thus, women’s agency is reflected in this meaningful process of reconstructing their cultural identities to enhance their health competence.

These findings also support my hypothesis that Latina immigrant mothers who display medium biomedical competence have low social bonding capital at transnational level. These mothers neither share nor receive information through transnational ties with their kin women relatives living in their country of origin. These mothers face fewer economic barriers than mothers who show medium traditional health competence and therefore mainly rely in biomedical care to preserve the health of their families. Yet, these mothers have experienced difficulties in communicating with physicians due to their lack of English proficiency. The only mother who displayed some bridging social capital was the most confident of all mother in seeking and providing biomedical health care for their families despite that some of their children were uninsured. This finding shed light about the importance of social capital in mobilizing other capitals and accessing to resources and information that can aid Latina immigrant mothers in preserving the health of their families (Emery and Flora 2006).

The decisions about health care, health needs, child care, and food consumption are largely made by Latina immigrant mothers (Chavira-Prado1992). The above discussed findings suggest that Latina immigrant mothers rely on women’s networks both transnational and local to take decisions regarding health and to optimize medical care resources under economic and political conditions that limit their access to health care (Chavira-Prado 1992;
Menjívar 2002). Yet, these findings also suggest that Latina immigrant mothers lack of bridging social capital, which exacerbate their conditions of exclusion and undermine their overall health competence (Flora and Flora 2008).

Finally, these findings coincide suggest that both high social bonding and high social bridging capitals can enhance mothers’ health competence. Women’s ties, both translational and local, positively affect Latina immigrant mothers’ self-efficacy by providing them with information and resources of biomedical and traditional health care. Latina immigrant mothers take collective decisions around health. Therefore, social capital and the collective dimension of seeking health care behavior among immigrant rural Latino mothers need to be incorporating into the multidimensional construct of health competence (Fonseca-Becker et al. 2010)

*Mothers as Healers: Cultural Capital, Human Capital and Health Competence*

The role of caregivers is deeply interwoven with Latina immigrant mothers’ identities. Their everyday experiences are constructed around their care work within the family. They see themselves as gatekeeper of their family health and of the collective healing experiences (Clark 1995; Mendelson 1995; Williams and Crooks 2008). In their stories regarding their struggles to maintain the health of their children, fathers are absent despite the fact that all mothers have a partner or husband.

Thus, Latina immigrant mothers rely on other women for diagnosing and treating minor illness and deciding when to seek professional care. Latina immigrant mothers’ lives and struggles to preserve their family’s health revolve around traditional gender ideologies, in which they continue to perform cultural appropriate gender activities related to
motherhood (Becker 2004; Schmalzbuer 2011). Yet, this study suggests that Latina immigrant mothers face a greater burden and isolation in these new destinations, like rural Midwestern towns, in which they lack the kind of network support they used to have in their home town. Latina immigrant mothers recognize that in the U.S there are more biomedical care resources available to them than in their home countries. Yet economic, political and cultural barriers prevent them from utilizing such services on regular basis. Thus, Latina immigrant mother have developed survival strategies by continually incorporating traditional healing practices in their every day struggles around the preservation of family’s health.

The use of traditional healing practices is strongly influenced by the demographics of the Latina immigrant mothers themselves, the majority of whom are from rural Mexico and Guatemala, where traditional gender expectations shaped their identities as mothers and as women (Schmalzbauer 2011; Olcott 2002). The only mother who did not incorporate traditional healing practices in her role of caregivers was from urban Mexico and with high school education. Yet, this mother recalled how she used to visit older wise women in her urban home town when seeking health care for certain illnesses.

The extensive use of traditional healing practices among immigrant Latina mothers can be only partially explained by their cultural beliefs around health (Appelwithe 1995). Other barriers such economic constrain, undocumented legal status, lack of language proficiency and discriminatory and frustrating experiences with biomedical health care providers have forced Latina immigrant mothers to rely more on traditional health alternatives and looking for other biomedical care providers outside their town, which represents further burden due of the lack of public transportation in rural towns.
Traditional healing knowledge and practices are transmitted through interaction with family and community members (Appelwithe 1995; Lopez 2005). This study suggests that in their new destinations, Latina immigrant mothers lack of family and community interaction. Therefore, they constantly rely in transnational interactions by phone with their women relatives. They reconstruct their cultural values and identities by performing traditional healing practices themselves. In the study’s rural town, Latino immigrant families lack of social cohesion, which is a central aspect in transmitting and using traditional healing practices (Appelwithe 1995; Lopez 2005).

Latina immigrant mothers hardly trust the local healers and prefer to perform the healing practices themselves. Even though such survival strategies represent Latina immigrant mothers’ agency and self-efficacy in fulfilling their gender roles as caregivers, they also underscore the lack of trust and social cohesion among Latino immigrant population living in rural Midwestern. Latino immigrant families have neither shared history nor collective memory that can foster trust. Thus, Latina immigrant mothers’ burdens are exacerbated by their context of isolation and distrust, lack of networks in rural towns, and by their socioeconomic and undocumented status (Litcher 2012).

Latina immigrant mothers’ cultural values of confianza and personalismo are central aspects of their every day struggles in preserving their health of their families (Larkey, Hecht, Miller and Alatorre 2001). Trust and faith in physician, doctors, herbs and healing practices function as enabling factors of Latina immigrant mothers’ health competence. Negative experiences with biomedical health care providers have developed distrust among Latino immigrant mothers forcing them to rely more on traditional healing practices or looking for resources outside their town. Thus, this study suggest that cultural values by
themselves do not prevent mothers to seek health care, in a similar manner as discussed by several studies (Larkey, Hecht, Miller and Alatorre, 2001). Latina immigrant mothers’ negatives experiences in which their cultural values and medical concerns has been disregarded and disrespected, along with structural factors has prevented them to seek health care services on regular basis.

My findings suggest that cultural values and healing practices embedded in them could function as enabling factors in the multidimensional model of health competence. Latina immigrant mothers’ everyday struggles to maintain the family’s health represent gendered knowledge and human capital (Harrison 2004) that celebrate Latina immigrant mothers’ agency within marginalized and undermining contexts.

“Entre Mujeres”: Social change through healing

Most of Latina immigrant mothers showed medium traditional health competence while some others displayed medium biomedical health competence. Yet, during the focus group all participants were able to engage in meaningful conversations by sharing their everyday struggles in regard to preserving the family’s health. Their discussions regarding perceived discrimination, medical negligence, language barriers, and low husbands support and involvement allow them to identify commonalties among them. This interaction fostered empathy among them and allowed them to engage in a process of self-disclosure and self-validation (Madriz 2003). When women come together to share their everyday struggles and identify collective survival strategies, social change is being generated. By sharing struggles and survival strategies Latina immigrant mothers began to trust each other. This first interaction among them can have the potential to foster community trust and social cohesion.
It can generate social bonding capital as well as the mobilization of other capitals and resources that can enhance mothers’ health competence (Emery and Flora 2006; Madriz, 2003).

**Limitations of the Study**

For several reasons, the findings and conclusions of this study cannot be generalizing to all Latina immigrant mothers living in rural Midwestern, and who have economic and political constrains that limit their access to formal health care. First, the study sample was limited to five participants and most of them were from Mexico. Therefore, there might be a limited possibility to generalize findings to other Central American countries. Second, most of the participants were originally from rural areas in Mexico and Guatemala. Thus, there might be a limited possibility to generalize to other Latina immigrant mothers who come from urban areas. Second, the methods of collection were limited to focus group and in-depth interviews at one point in time. Thus, these findings provide general ideas that should be further examined. Additionally interactions with Latina immigrant mothers, through participant observation and more in-depth interviews could provide more conclusive findings.

Despite the above described limitations, these findings provide rich and detailed descriptions of social and cultural factors that might positively influence the health competence of Latina immigrant mothers living in rural Midwestern within socio-economic and political context that limit their access to formal health care. I foresee that the knowledge and insights generated by this exploratory study could guide further studies aimed to examine the influence on women’s networks on the health competence of Latina immigrant living in rural Midwestern.
CHAPTER 5: CONCLUSIONS AND RECOMMENDATIONS

Conclusions

Life is hard for Latina immigrant mothers living in rural Midwestern. They have come to this country with the hope for better life with enough resources to take care of their children. A system of exclusion and inequality has forced these women and their families to leave their countries in order to survive. Yet, the same inequalities are reproduced as they migrate to the United States. Their everyday lives take place within political and socio-economic contexts that undermine their access to health care resources. However, this study suggests that Latina immigrant mothers living in rural a Midwestern town, have been able to mobilize their social, cultural and human capitals in order to fulfill their traditional gender roles of caregivers of their family.

This study explored how the health competence of Latina immigrant mothers is influenced by their social, cultural and human capitals. By exploring the role of women’s informal networks and the knowledge and practices shared through these networks in the maintenance of family’s, this study sheds light on how cultural values, gendered knowledge and social cohesion enhance Latina immigrant mothers’ health competence.

Findings suggest that Latina immigrant mothers who have developed medium traditional health competence face several barriers in accessing to biomedical health care. Such barriers include lack of family health insurance, economic constrains, undocumented legal status, lack of English proficiency and perceived discrimination in clinics and hospitals.
Yet, Latina immigrant mothers in this study have mobilized their social, cultural and human capitals in order to preserve their family’s health.

Findings suggest that Latina immigrant mothers with medium traditional health competence rely heavily in their bonding social capital, both transnational and local. Their social bonding capital is gendered, formed mainly with their mothers, sisters, sisters-in-law and mothers-in-law. Through transnational ties, rural Latina immigrant mothers access to traditional healing knowledge and practices and herbs that enable them to cure their children from folk illnesses as well as from minor common illnesses. Thorough local female ties, Latina immigrant mothers have access to information about trusted biomedical local care providers. Women share their traditional healing knowledge and practices through these local networks. Both local and transnational women’s networks offer emotional support to the mothers and enhance their self-efficacy and confidence to maintain their family’s health. Yet, findings suggest that Latina immigrant mothers lack of bonding social capital beyond their family circle and bridging social capital. Their lack of social interaction exacerbates their feelings of isolation and exclusion. In addition, their identities as Latina immigrant mothers with medium traditional health competence are also rooted in their cultural values and beliefs. Aspects such as confianza (trust), family solidarities, and collective decisions around health have enhanced their capacity to preserve their family’s health.

This findings suggest that Latina immigrant mothers who displayed medium biomedical health competence face fewer economic barriers in accessing to biomedical health care providers when are compared with mothers with low biomedical competence. However, these mothers also face barrier due to their lack of English proficiency and have
faced perceived discriminations. Despite the fact that these mothers rely heavily on biomedical practices, they incorporate the use of herbs and other home remedies in their every day practices around health.

Findings suggest that Latina immigrant mothers with medium biomedical health competence show low social bonding capital at the transnational level but medium social bonding at local level. Similarly to mothers with medium traditional health competence, these mothers use women’s local networks to access to information about health care providers in the area and to obtain health advice from female relatives and close friends. Yet, this group of mothers has low social bridging capital and shares feelings of isolation and exclusion with the other group of mothers.

Similarly, Latina immigrant mothers with medium biomedical health competence incorporate their cultural values in their every day experiences around health. Aspects such as trust and faith are central in seeking health care providers and deciding the type of treatment they would offer to their families. Latina immigrant mothers value the opinion and support of women’s relatives and close female friends in relation to health issues. Thus, this findings support the idea that cultural values of trust, collective decisions and family solidarities enhance Latina immigrant mothers’ biomedical health competence as well.

Findings suggest that Latina immigrant mothers regardless their type of health competence, see themselves as the primary caregivers of their families. Their role of caregivers is deeply interwoven with Latina immigrant mothers’ identities. Their everyday experiences are constructed around their care work within the family. They see themselves as
gatekeeper of their family health as well of their collective healing experiences which need to be transmitted to their daughters and younger sisters.

Latina immigrant mothers’ lives and struggles to preserve the family’s health revolve around traditional gender ideologies, in which they continue to perform cultural appropriate gender activities related to motherhood. Yet, findings shed light about the isolations women face in rural Midwestern towns, in which they lack of the kind women’s network support they used to have in their home towns. Latina immigrant mothers recognize that here in the U.S are more biomedical care resources available to them in comparison to their home countries. Yet economic, political and cultural barriers prevented them to utilize such services on a regular basis. Thus, Latina immigrant mothers have developed survival strategies by continually incorporating traditional healing practices and cultural values in their every day struggles in preserving the family’s health.

This study coincide with other studies that both high social bonding and high social bridging capitals can enhance Latina immigrant mothers’ health competence. Women’s ties, both translational and local, positively affect Latina mothers’ self-efficacy by providing them with information and resources of biomedical and traditional health care. Latina immigrant mothers take collective decisions around health through consultation with their networks.

These findings suggest that Latina immigrant mothers mobilize their cultural and human capital to preserve their family’s health. Their healing knowledge and skills embedded in their cultural values function as enabling factors of their health competence. The use of herbs and healing practices are valuable assets for mothers who face economic and political limitations in accessing to formal health care. Therefore, cultural, human and
social capitals should be incorporating into the multidimensional construct of health competence in order to better understand rural immigrant Latina mothers’ struggle around health.

The stories of Latinas immigrant mothers, who participated in this study, are marked by the poverty and exclusion that forced them to migrate. The same poverty and exclusion persist in their new lives as they emigrate to rural Midwestern. Their undocumented status and the lack of female social networks and social support place additional burden on their everyday struggle to preserve the health of their families. But simply regard Latina an immigrant mothers as victims of the political and socio-economic systems in place is to ignore their agency and their capacities in transforming and negotiating these contexts of exclusion. Their everyday efforts to maintain their family’s health through the reconstruction of their cultural identities and through the utilization of their gendered knowledge represent their agency and their creative ways in mobilizing social, cultural and human capitals.

**Recommendations**

One of the purposes of my study was to create a space in which Latina immigrant mothers’ voices and feelings could be heard by other Latina mothers, including myself. During the focus group Latina immigrant mothers were able to engage in meaningful conversations by sharing their every day struggles around health. Their conversations were around perceived discrimination, medical negligence, language barriers, and low involvement of their husbands. They also shared practices they use to overcome some of these limitations. My recommendations focus on the creation of spaces in which Latina
immigrant mothers can share their struggles and difficulties in preserving their health of their families. These spaces might also contribute to generate social change and concrete actions aimed to improve the well-being of Latino immigrant families living in rural areas. Therefore, I recommend:

1. Community organization and institutions working with rural population should create inclusive spaces in which rural Latino mothers’ voices can be heard. For instance, the University Extension office located in the area of my study has in place several programs. One them is related to food, nutrition and health information. This program offers nutritional and health education in Spanish to Latino mothers and could be enhanced by allowing Latina mothers have a more active role, rather than just listening and learning from others. Programs already in place have the potential to create spaces in which Latina immigrant mothers can be empowered by sharing their gendered knowledge around themes of health, food and nutrition.

2. Effort should be directed to create social interactions among rural community members that allow the formation of social bonding and social bridging capital. The creation of community gardens in which herbs, fruits and vegetables could have the potential to create linkage among Latino and White groups living in rural Midwestern. Building trust and shared memory among community member could have the potential to mobilize other capitals that can foster the creation of more egalitarian communities.

3. Initiate conversations with local clinics and hospital about the possibility of collaborative efforts with other institutions in order to offer services that are cultural relevant to the Latino population and can aid in addressing health inequities among Latinos.
4. This study suggests that a community clinic located in a nearby town is striving to reach out Latino population. Thus, research aimed to explore its efforts in offering cultural relevant services to Latino could generate valuable information that could be shared with other rural clinics and hospital around rural Midwestern states.

5. Further research should examine with more detail the influence of women’s informal networks on Latina immigrant mother’s health competence.

6. Future research should be framed within participatory research approaches as a strategy to actively involve Latina women’s in improving their living conditions of their families and communities. More specifically, future research should explore the potential of the use of herbs in empowering Latina women and in generating trust and social cohesion across different groups. In addition, research should be directed to further the understanding of the effects of cultural, social and human capitals in Latino population’s health competence.
REFERENCES


Baker, P. 2004. “It is the Only Way I Can Survive: Gender Paradox among Recent Mexicana Immigrants to Iowa” Sociological Perspectives 47(4):393-408


APENDIX A: Instruments used in Focus Group and Individual Interviews

Questions: Seeking treatment for illnesses

1. Describe what you usually do when someone in your family gets sick?
2. Under what circumstances do you seek professional health care?
3. Tell me about things that make it difficult for you to get the kind of health care you want and need.
4. Do you receive advice about illnesses and treatments from friends and/or families who live in your community?
   If yes, tell me about the kinds of advice you receive, and who gives you this advice.
5. Do you receive advice about illnesses and treatments from friends and families who live outside your community, such as family and friends who live in another town, state or outside the U.S.?
   If yes, tell me about the kinds of advice you receive, and who gives you this advice.
6. Are you able to identify someone who is trusted and respected by women in your community to visit with about diagnosis and treatments for illnesses?
   If yes, who is that person and why is he/she trusted or seen credible to provide such information?
7. Tell me about illnesses that are not recognized or understood by nurses and physicians.
8. Share with me what you do in order to diagnose and treat illnesses that nurses and physicians do not recognize or understand.
9. Do you believe that some of these illnesses are related with other illnesses, such as diabetes, which are recognized and treated by nurses and physicians?
10. If yes, share with me some of the illnesses that are related to one another.

_Preguntas enfermedades y formas de curarlas (Spanish Version)_

1. Por favor, podría describirme qué hace usted generalmente cuándo alguien de su familia se enferma.

2. ¿En qué situaciones busca atención médica?

3. Por favor, dígame qué circunstancias le dificultan conseguir la atención médica que usted desea y necesita.

4. ¿Usted recibe consejos con respecto a enfermedades y formas de curarlas por parte de amigos y/o familiares que viven en su comunidad?

   Si su respuesta es afirmativa, ¿Qué tipos de consejos recibe? ¿Quién le da estos consejos?

5. ¿Usted recibe consejos con respecto a enfermedades y formas de curarla por parte de amigos y/o familiares que no viven en su comunidad? Como amigos y familiares que viven en otro pueblo, otro estado o incluso en otro país?

   Si su respuesta es afirmativa, ¿Qué tipos de consejos recibe? ¿Quién le da estos consejos?

6. ¿Conoce alguien en su comunidad que es conocido/a por sus conocimientos sobre enfermedades y a la vez es consultado/a por mujeres en la comunidad para diagnosticar y curar enfermedades?
Si su respuesta es afirmativa, ¿Qué hace que esta persona sea tan consultada para diagnosticar y curar enfermedades en la comunidad?

7. ¿Conoce usted enfermedades que no son reconocidas o tratadas por enfermeras y médicos?

8. ¿Podría decirme cómo hace usted para diagnosticar y curar esas enfermedades que nos son reconocidas por enfermeras y médicos?

9. ¿Usted considera que estas enfermedades están relacionadas o pueden causar otras enfermedades, como la diabetes, que si son reconocidas y tratadas por enfermeras y médicos?

10. Si su respuesta es afirmativa, explíqueme cómo están estas enfermedades relacionadas entre sí.
<table>
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<tr>
<th>Pseudonym</th>
<th>Country of Origin</th>
<th>Age</th>
<th>Marital Status</th>
<th>Years living in the U.S.</th>
<th>Number of children</th>
<th>Educational Level</th>
<th>Working Status</th>
<th>Spouse/Partner’s working status</th>
<th>Household Income Range</th>
<th>Mother’s health insurance status</th>
<th>Children’s health insurance status / source</th>
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<td>10</td>
<td>4</td>
<td>High School</td>
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<td>Full-time</td>
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<td>No</td>
<td>Medicaid but not all</td>
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<td>Mexico</td>
<td>25</td>
<td>Married</td>
<td>13</td>
<td>1</td>
<td>8th grade or less</td>
<td>Not working</td>
<td>Full-time</td>
<td>$30,000-$34,999</td>
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<td>Yes</td>
</tr>
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<td>Esperanza</td>
<td>Mexico</td>
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<td>Domestic partnership</td>
<td>14</td>
<td>5</td>
<td>Some high school</td>
<td>Informal employment</td>
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</tr>
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<td>8th grade or less</td>
<td>Not working</td>
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<td>No</td>
<td>Yes Medicaid</td>
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</table>
APPENDIX C: IRB APPROVAL DOCUMENTS

IOWA STATE UNIVERSITY
OF SCIENCE AND TECHNOLOGY

Date: 4/22/2011
To: Dr. Kimberly Greder
1086 LeBaron Hall

From: Office for Responsible Research

Title: Core Health Messages: A Strategy to Improve the Health and Well-Being of Rural, Low-Income Families

IRB Num: 11-015

Approval Date: 4/20/2011
Continuing Review Date: 4/14/2012
Submission Type: New
Review Type: Expedited

The project referenced above has received approval from the Institutional Review Board (IRB) at Iowa State University. Please refer to the IRB ID number shown above in all correspondence regarding this study.

Your study has been approved according to the dates shown above. To ensure compliance with federal regulations (45 CFR 46 & 21 CFR 56), please be sure to:

- Use only the approved study materials in your research, including the recruitment materials and informed consent documents that have the IRB approval stamp.
- Obtain IRB approval prior to implementing any changes to the study by submitting the "Continuing Review and/or Modification" form.
- Immediately inform the IRB of (1) all serious and/or unexpected adverse experiences involving risks to subjects or others; and (2) any other unanticipated problems involving risks to subjects or others.
- Stop all research activity if IRB approval lapses, unless continuation is necessary to prevent harm to research participants. Research activity can resume once IRB approval is reestablished.
- Complete a new continuing review form at least three to four weeks prior to the date for continuing review as noted above to provide sufficient time for the IRB to review and approve continuation of the study. We will send a courtesy reminder as this date approaches.

Research investigators are expected to comply with the principles of the Belmont Report, and state and federal regulations regarding the involvement of humans in research. These documents are located on the Office for Responsible Research website http://www.compliance.iastate.edu/irb/forms/ or available by calling (515) 294-4566.

Upon completion of the project, please submit a Project Closure Form to the Office for Responsible Research, 1138 Pearson Hall, to officially close the project.
INSTITUTIONAL REVIEW BOARD (IRB)
Application for Approval of Research Involving Humans

SECTION I: GENERAL INFORMATION

Principal Investigator (PI): Kimberly Greder
Phone: 515-294-5906
Fax: 515-293-5507

Degrees: PhD, MS, Bsc
Correspondence Address: 1086 LeBaron Hall ISU

Department: HDFS
Email Address: kgreder@iastate.edu

Center/Institute: CHS

Pl Level: Faculty, Staff, Postdoctoral, Graduate Student, Undergraduate Student

Alternate Contact Person:
Email Address:

Correspondence Address:
Phone:

Title of Project: Core Health Messages: A Strategy to Improve the Health and Well-Being of Rural, Low-Income Families

Project Period (Include Start and End Date): [mm/dd/yy] 2/1/11 to [mm/dd/yy] 12/31/11

FOR STUDENT PROJECTS

Name of Major Professor/Supervising Faculty:
Signature of Major Professor/Supervising Faculty:

Phone: Campus Address:
Department:
Email Address:

Type of Project: (check all that apply)
- Research
- Thesis
- Dissertation
- Class project
- Independent Study (490, 590, Honors project)
- Other. Please specify:

KEY PERSONNEL

List all members and relevant experience of the project personnel. This information is intended to inform the committee of the training and background related to the specific procedures that each person will perform on the project.

<table>
<thead>
<tr>
<th>NAME &amp; DEGREE(S)</th>
<th>SPECIFIC DUTIES ON PROJECT</th>
<th>TRAINING &amp; EXPERIENCE RELATED TO PROCEDURES PERFORMED, DATE OF TRAINING</th>
</tr>
</thead>
<tbody>
<tr>
<td>Kimberly Greder</td>
<td>oversee project; provide training for interviewers</td>
<td>9/19/00 human subjects training; coursework and led projects using both qualitative and quantitative methods and analysis</td>
</tr>
<tr>
<td>Flor Romero De Slowing</td>
<td>co-lead focus group and individual interviews; transcribe and translate interviews; data analysis</td>
<td>2-11-10 human subjects training, graduate student, data analysis, literature, translation; qualitative research and quantitative research methods courses</td>
</tr>
<tr>
<td>Angelice Reina, Masters of Science</td>
<td>co-lead focus group and individual interviews; transcribe and translate interviews</td>
<td>9/07 human subjects training; graduate student, data analysis, literature, translation; qualitative</td>
</tr>
</tbody>
</table>

Office for Responsible Research: IRB 9/13/10
<table>
<thead>
<tr>
<th>Name</th>
<th>Task</th>
<th>Training Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Samantha Young</td>
<td>literature review</td>
<td>8-17-09 human subjects training; graduate student, data analysis, literature, qualitative research and quantitative research methods courses</td>
</tr>
<tr>
<td>Samantha Davis</td>
<td>conduct individual interviews; recruit focus group and individual interview participants</td>
<td>12-11-10 human subjects training; college coursework; training specific to conducting individual interviews</td>
</tr>
<tr>
<td>Janet Smith</td>
<td>supervise Samantha Davis and Julieta Parker</td>
<td>12-10-10 human subjects training; graduate coursework in research methods</td>
</tr>
<tr>
<td>Julieta Parker</td>
<td>conduct individual interviews; recruit focus group and individual interview participants</td>
<td>1-4-11 human subjects training; college coursework; training specific to interviewing</td>
</tr>
</tbody>
</table>

If you don’t know your training date, contact the Office for Responsible Research for assistance.

To list additional personnel please attach separate sheet.
APPENDIX D: RECRUITMENT MATERIALS

Improving Health of Latino Families

If you are a Latino mother of young children join us to share your ideas for improving the health of Latino families!

Who: Latino mothers who have at least one child age 12 or younger and who have lower incomes

What: A two hour focus group interview will be conducted to learn about health concerns of Latino families with young children, and factors that shape their health care decisions. During this interview, mothers will be asked to share their opinions about messages that can improve the health of Latino families.

When: (insert date and 2 hour time period of the focus group interview)

Where: (insert address and name of building of the focus group interview, e.g., Henry County ISU Extension office; Henry County public library)

You will receive a children's book and a $25 gift card for your participation in the focus group interview.

The focus group interview is part of the study, "Core Health Messages: A Strategy to Improve the Health and Well-Being of Rural, Low-Income Families," conducted by Iowa State University. Participation is voluntary, and names of participants will not be shared.

If you would like to participate in the focus group interview, please call one of the individuals listed below.

Samantha Davis, research project staff, Henry County- Iowa State University Extension, 319-601-0239 or

Julieta (Cecy) Parker, research project staff, Henry County- Iowa State University Extension, 319-931-0172
Mejorando la Salud de las Familias Latinas

¡Si usted es una madre latina con niños pequeños acompañenos y comparta sus ideas sobre cómo mejorar la salud de las familias Latinas!

¿Quiénes?: Madres Latinas que tienen al menos un niño de 12 años o menor y con ingresos económicos limitados.

¿Qué es?: Una entrevista grupal, de dos horas de duración, se llevará a cabo para conocer las preocupaciones con respecto a la salud de las familias Latinas con niños pequeños, y los factores que determinan sus decisiones en torno al cuidado de la salud. Durante esta entrevista, se les pedirá a las madres que compartan sus opiniones acerca de ciertos mensajes dirigidos a mejorar la salud de las familias latinas.

¿Cuándo?: (coloque la fecha y la hora establecida para la entrevista grupal)

¿Dónde?: (coloque la dirección y el nombre del edificio donde se llevará a cabo la entrevista grupal, ejemplo Henry County, Oficina de ISU Extension; Henry County, biblioteca pública)

Usted recibirá un libro para niños y una tarjeta de regalo de $ 25 por su participación en la entrevista grupal.

La entrevista grupal es parte del estudio, "Los mensajes básicos de salud: Una estrategia para mejorar la salud y el bienestar de las familias con bajos ingresos que viven en áreas rurales", realizado por Iowa State University. La participación es voluntaria, y los nombres de los participantes no serán compartidos.

Si a usted le gustaría participar en la entrevista grupal, por favor llame a alguna de las personas que se listan a continuación.

Samantha Davis, personal de investigación del proyecto, Henry County- Iowa State University Extension
319-601-0239

or

Julie (Cecy) Parker, personal de investigación del proyecto, Henry County- Iowa State University Extension
319-931-0172
INFORMED CONSENT DOCUMENT

Title of Study: Core Health Messages: A Strategy to Improve the Health and Well-Being of Rural, Low-Income Families

Investigators:
Kimberly Greder, associate professor, Iowa State University
Flor Romero De Slowing, graduate student, Iowa State University
Angelica Reina, graduate student, Iowa State University
Samantha Trevino, project interviewer, Iowa State University

This is a research study. Please take your time in deciding if you would like to participate. Please feel free to ask questions at any time.

INTRODUCTION
The purpose of this study is to pilot test health messages with Latino families who live in rural areas and lower incomes. This study will also try to identify what influences families in making health care decisions. You are being invited to participate in this study because you are a Latino mother with at least one child age 12 or under, and have lower income.

You should not participate if you are under age 18, do not have any children age 12 or under, or do not have a lower income (e.g., income at or below 200% of poverty).

DESCRIPTION OF PROCEDURES
If you agree to participate, you will be asked to participate in a two hour focus group interview. During the interview you will be asked to respond to a series of questions related to your opinion about specific health messages, as well as your perspective about what influences the health care decisions families make. For some of the questions, you will share your responses verbally. For other questions, you will share your responses using a "clicker" which is an electronic device that is held in your hand. You push the button (i.e., button A, button B) on the clicker that best corresponds to your response. Your individual response will not be shown to the group, or associated with your name. The focus group interview will be audio-taped, transcribed and translated. No names will be included in the transcription.

RISKS
We do not anticipate that you will experience any physical or emotional risks from participating in this study.

BENEFITS
If you decide to participate in this study there is no direct benefit to you. It is hoped that the information gained in this study will benefit society by creating effective health messages for mothers with young children who live in rural areas and have lower incomes.

COSTS AND COMPENSATION
You will not have any costs from participating in this study. You will be compensated for participating in this study by being offered a children’s book and a $25 gift card to a local store. The children’s book and gift card will be distributed after the focus group interview. You will need to sign a form indicating that you received a gift card, as well as a form indicating that you received a children’s book.
PARTICIPANT RIGHTS
Your participation in this study is completely voluntary and you may refuse to participate or leave the study at any time. If you decide to not participate in the study or leave the study early, it will not result in any penalty or loss of benefits to which you are otherwise entitled. You can skip any questions that you do not wish to answer during the focus group interview.

CONFIDENTIALITY
Records identifying participants will be kept confidential to the extent permitted by applicable laws and regulations and will not be made publicly available. However, federal government regulatory agencies (i.e., U.S.D.A.), auditing departments of Iowa State University, and the Institutional Review Board (a committee that reviews and approves human subject research studies) may inspect and/or copy your records for quality assurance and data analysis. These records may contain private information.

To ensure confidentiality to the extent permitted by law, the following measures will be taken:
Your name will not be included in the transcription of the focus group interview. Names will be replaced with codes such as "R1- respondent one; R2- respondent two". The audio tapes will be stored in a file drawer in the lead researcher's locked office at ISU and destroyed after five years. The transcriptions will be stored on a password protected secured server at ISU. The translated transcriptions that have participants' names coded (i.e., R1, R2) will be shared with the research project staff and the grant P.I. at the University of Massachusetts. If the results are published, your identity will remain confidential.

QUESTIONS OR PROBLEMS
You are encouraged to ask questions at any time during this study.
For further information about the study contact: Kimberly Greder, 515-294-5906 or kgreder@iastate.edu. If you have any questions about the rights of research subjects or research-related injury, please contact the IRB Administrator, (515) 294-4566, IRB@iastate.edu, or Director, (515) 294-3115, Office for Responsible Research, Iowa State University, Ames, Iowa 50011.

*****************************************************************************************

PARTICIPANT SIGNATURE
Your signature indicates that you voluntarily agree to participate in this study, that the study has been explained to you, that you have been given the time to read the document, and that your questions have been satisfactorily answered. You will receive a copy of the written informed consent prior to your participation in the study.

Participant's Name (printed) __________________________________________________________

(Participant's Signature) ___________________________ (Date) __________________________
Documento de Consentimiento Informado

Título del estudio: Mensajes básicos de salud: una estrategia para mejorar la salud y el bienestar de las familias de bajos ingresos que viven en áreas rurales.

Investigadores:
Kimberly Greder, profesora asociada, Iowa State University
Flor Romero estudiante de postgrado, Iowa State University
Angélica Reina, estudiante de posgrado, Iowa State University
Samantha Treviño, entrevistadora del proyecto, Iowa State University

Este es un estudio de investigación. Por favor, tómese su tiempo para decidir si le gustaría participar. Por favor, no dude en hacer preguntas en cualquier momento.

INTRODUCCIÓN

El propósito de este estudio es realizar una prueba piloto de mensajes de salud con familias Latinas de bajos ingresos económicos y que viven en áreas rurales. Al mismo tiempo, este estudio tratará de identificar los factores que influyen en la toma de decisiones con respecto al cuidado de la salud. Usted está siendo invitada a participar en este estudio porque es una madre latina con al menos un hijo/o menor de doce años y su familia cuenta con ingresos económicos limitados.

Usted no debería participar si es menor de 18 años, no tiene un niño(a) menor de 12 años o no tiene ingresos económicos limitados. (ej. Ingresos en o por debajo del 200% de la línea de pobreza).

DESCRIPCIÓN DE LOS PROCEDIMIENTOS
Si usted acepta participar, se le pedirá a participar en una entrevista grupal que durará aproximadamente dos horas. Durante la entrevista tendrá que responder una serie de preguntas destinadas a conocer su opinión acerca de algunos mensajes específicos de salud. Así mismo, se le pedirá su punto de vista con respecto a los factores que influyen en las familias a la hora de tomar decisiones sobre atención médica. Para algunas de las preguntas, usted va a compartir sus respuestas en forma verbal. Pero para otras preguntas, usted deberá usar un clicker", que es un dispositivo electrónico que usted tendrá en su mano durante la entrevista grupal. Para responder a preguntas utilizando el "clicker" deberá oprimir el botón (por ejemplo botón A o el botón B) que mejor refleje su respuesta. Su respuesta será individual y no será vista por todo el grupo ni asociada con su nombre. La entrevista de grupo será grabada y filmada, transcrita y posteriormente traducida. Ningún nombre será incluido en la transcripción.

RIESGOS
No creemos que la participación en este estudio pueda representar algún riesgo físico o emocional para usted.

**BENEFICIOS**

Su participación en este estudio no le traerá beneficios directos para usted. Sin embargo se espera que la información obtenida a través de este estudio pueda beneficiar a la sociedad ya que permitirá la creación de mensajes de salud eficaces para las madres con niños pequeños, con bajos ingresos viviendo en áreas rurales.

**COSTOS Y COMPENSACIÓN**

Su participación en el estudio no representará ningún costo para usted. Usted será compensado por su participación en este estudio con un libro para niños y una tarjeta de regalo de $ 25 de una tienda local.

**DERECHOS COMO PARTICIPANTE**

Su participación en este estudio es completamente voluntaria y usted puede negarse a participar o retirarse del estudio en cualquier momento. Si usted decide no participar en el estudio o retirarse antes de que termine no recibirá ninguna sanción ni perderá los beneficios a los que tiene derecho. Usted puede saltarse cualquier pregunta que no desee responder durante la entrevista grupal.

**CONFIDENCIALIDAD**

Los documentos que identifican a los participantes serán mantenidos en forma confidencial hasta donde las leyes y regulaciones lo permitan, y no se harán públicos. Sin embargo, las agencias reguladoras del gobierno federal (como por ejemplo, USDA), los departamentos de auditoría de Iowa State University, y el Institutional Review Board de la Universidad (que es el comité encargado de revisar y aprobar los estudios de investigación en seres humanos) puede inspeccionar y/o copiar registros con su información como una forma de supervisar la calidad en el análisis de datos. Estos registros pueden contener información privada.

Se tomarán las siguientes medidas para garantizar la confidencialidad hasta donde la ley lo permita: su nombre no será incluido en la transcripción de la entrevista grupal. Los nombres serán reemplazados por códigos, como por ejemplo: "R1-participante uno; R2-participante dos". Las cintas de audio se guardarán bajo llave en un cajón de un archivo localizado en la oficina de investigadora principal de la Universidad y serán destruidos después de cinco años. Las transcripciones se guardarán en un servidor de la Universidad, el cual estará protegido por una contraseña. Las transcripciones traducidas que tienen los nombres de las participantes con códigos (es decir, R1, R2) serán compartidos con el personal del proyecto de investigación y con la concesión de IR de la Universidad de Massachusetts. Si los resultados son publicados, su identidad se mantendrá confidencial.

**PREGUNTAS O PROBLEMAS**

Se le anima a hacer preguntas en cualquier momento durante este estudio.

Para más información sobre el estudio, por favor contacte a Kimberly Greder, 515-294-5906 o kgreder@iastate.edu.

Si usted tiene preguntas con relación a sus derechos como participante en este estudio o acerca de los daños que pueda causarle este estudio, por favor contacte al administrador de IRB, (515) 294-4566, IRB@iastate.edu, o al Director, (515) 294-3115, Office for Research, 1138 Pearson Hall, Iowa State University, Ames, Iowa 50011.

******************************************************************************
FIRMA DEL PARTICIPANTE

Su firma indica que usted voluntariamente acepta participar en el estudio, que se le ha explicado en qué consiste el estudio, que usted ha tenido tiempo de leer la información y que sus dudas han sido satisfactoriamente resueltas. Usted recibirá una copia del consentimiento escrito previamente a su participación en el estudio.

Nombre del participante (escrito) __________________________________________

(Firma del participante) __________________________________________

_________________________ ________________
ACKNOWLEDGMENTS

I would like to thank and express my gratitude to those who helped me during the entire process of this research. I owe my gratitude to Dr. Cornelia Flora for her advice and her extensive and insightful comments that greatly contributed to the writing of this thesis.

I would like to thanks Dr. Michael Whiteford for introduce me to the field of Medical Anthropology and for his insightful comments and conversations that helped me determine my research topic. I would like to thank Dr. Kim Greder for allowing me to conduct my research with participants of her project Rural Families Speak about Health (RFSH) and for her support during my graduate work.

I would like to thank Latina mothers, who participated in this study, for their meaningful stories that made possible this research.