

Clinical Cultural Competency, Part Two

**Assimilation, Acculturation,
and Alternative Medicines***By Jennie A. McLaurin, MD, MPH***Introduction**

As the United States moves towards even greater diversity, people continue to search for a useful analogy to describe the nation's population. It used to be that America was called the great melting pot, later attempts referred to America as a quilt, a mosaic, or a big tossed salad. But even these latter analogies are not fully accurate, as they imply a static setting. Not only do individual cultures differ, but individuals within a culture differ. Furthermore, individuals themselves have the potential for change over time depending upon their interactions with all the other cultures in their environments.

What does this have to do with clinical care? Quite a lot! The first article in this series (*March-April, 2002 Streamline*) emphasized the importance of noting cultural factors in providing care to farmworkers. This second article will focus on some of the complexities within a culture, and practical approaches to incorporating salient factors into clinical care. Included are several group exercises that may be used in the context of health center staff training.

Acculturation

Cultural factors can become more or less pronounced over time. Often, the farmworker family has distinct cultural variation within the home. There may be working men who are able to speak limit-

ed English, drive a car, and be successful as laborers in America. The home may also include women who do not speak English, do not go outside the home without accompaniment, and try to maintain the type of home that was customary for them in their country of origin. Children may be bilingual, in American schools and extracurricular programs, and able to read only in English. Most practitioners would label this entire family as "Hispanic," yet intuitively know that there were significant cultural differences between family members.

Several definitions can be of help as we examine the variations within culture.

- **Bicultural** individuals function equally well within the traditional milieu and the dominant culture. This may also refer to someone raised in a two-culture household (without either necessarily being the dominant societal culture).
- **Traditional** individuals maintain the historical culture of the family of origin and remain encapsulated by it even if living in a new environment.
- **Acculturated** individuals give up most of their original culture and adopt the dominant culture.
- **Marginal** individuals have little to do with the traditional or the dominant culture. Many homeless people as well as some migrant workers are in this category.
- **Enculturation** refers to the strong influ-

ence of cultural socialization that takes place in the formative years of life. When crisis strikes, people often return to function in the culture of their birth. This explains why a patient who may not usually need an interpreter suddenly needs one when she is fearful, or faced with a serious medical problem. Likewise, people may go back to traditional remedies and family religious beliefs when faced with a crisis. This idea is easily understood when we recall our reactions to September 11 or major episodes of uncertainty and grief.

What are the practical implications of these categorical definitions? First, the clinician is reminded that each patient is unique, and should be treated the way he or she desires, rather than in a cookie-cutter fashion. Second, the clinician can ask questions that will enable communication to be accurate and that will allow planning for special needs. Third, the clinician can recognize the potential impact of cultural factors within the patient's family. Fourth, the recognition of subtle differences in culture can have a dramatic effect on health care delivery (see Barnaga in the resource section).

For example, rather than sorting patients as either needing or not needing an interpreter, center staff can develop a simple list of questions that will identify when an interpreter may be needed (see figure 1). Helpful proxy questions related to acculturation include asking the patient what foods she prefers, what language is spoken in the home, who is in charge of decision-making

Editor's Note: This is the first in a two-part series on cultural competency. In the first article of this series, Dr. McLaurin discussed the knowledge and skill development needed to develop cultural competency. For the first article please refer to the March-April, 2002 issue of Streamline. You can get a copy from MCN's website <http://www.migrantclinician.org/products/Streamline.htm> or by calling MCN at 512-327-2017.

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for the patient, and what traditions are celebrated. Families that include acculturated children and traditional parents often experience stress with this mix. Questioning about this stress factor can be a part of anticipatory guidance as well as a component of a depression inventory.

Complementary and Alternative Medicine

Complementary and alternative medicine (CAM) is a hot topic these days, but it is not news in migrant health. Practitioners are used to hearing that medicines have been shipped from Mexico or bought without prescriptions. Teas, herbs, and other traditional remedies are mentioned by farmworkers. How many of your Hispanic patients with diabetes use a cactus plant to lower their blood sugar? What is your opinion on this? While clinicians may be aware of the potential use of CAM, most have not been taught how to systematically assess for the use of CAM by their patients. Dr. Kathi Kemper has developed a tool that adapts history-taking so that it includes alternative remedies (figure 2). This format can be used in place of asking for a simple list of prescription and over-the-counter drugs.

What should one do if patients are opting for treatment regimens that go beyond those administered by the center? An old rule of thumb is, first do no harm. Assess the value of the treatment to the patient not only physically, but also emotionally, financially, and spiritually. Work with the patient to collaborate on a regimen that incorporates their values as much as possible. Compromise when able, and leave the door open to reconsideration as needed. The following are some ways that migrant health centers have responded to the desire of their patients to use CAM:

- One center added massage appointments for patients with chronic pain and depression after a nurse practitioner received a license in massage therapy. She found she could get improved adherence to medications for chronically ill patients when they also came in for a massage treatment.
- A study by a physician in a migrant health center revealed that at least 20% of the patients used a non-licensed traditional healer to obtain injections of

FIGURE 1.
ASSESSMENT OF INTERPRETER NEEDS

1. What is the patient’s primary language spoken at home?
2. How long has the patient spoken English?
3. Does the patient read English? What types of things are read?
4. Does the patient read in his/her primary language? (assess level if possible)
5. In what situations would the patient prefer an interpreter? (clinic, hospital, counseling, dental, specialty referral, telephone calls)
6. Can the patient rephrase instructions to staff in English?

FIGURE 2.
ALTERNATIVE CARE HISTORY: ASK PATIENTS ABOUT TREATMENTS IN EACH GROUP

1. Biochemical—prescription and otc herbs, vitamins, and supplements
2. Lifestyle—diets, exercise, mind-body therapies
3. Biomechanical—massage, chiropractic, surgery
4. Bioenergetic—acupuncture, healing touch, prayer, homeopathy (Dr. Kathi Kemper)

medications when they were ill. This initiated an informational campaign on the risks of needle sharing as well as an improvement in communication by providers to patients on why oral medications were sometimes used rather than injected. Prior to this finding, many of these patients would not have fit a risk profile for Hepatitis or HIV.

- Another center realized that a traditional healer was the first-line provider for many of the patients. Rather than fighting against that knowledge, the center staff invited the lay healer to talk with them about her practice and to work collaboratively with them to improve health outcomes.
- Recently, a young migrant child was in critical care at a tertiary hospital. The family was distraught that no curandero had been utilized. The family knew of no such person locally, but was convinced that the child’s death might be avoided if both hospital and traditional healing were used. Migrant center staff found a member of the community who could function as a curandero for the family, and negotiated with the ICU staff to allow the healer to be alone with the child for a period of time. The family and the hospital staff were satisfied with this model of collaboration.

Cultural competency in practice requires that one be a continual learner. Cultural

humility and a desire to better understand your patients are essential. Models for improvement suggest that we often make the greatest progress by taking a series of small steps and pausing frequently to assess if that step is a step in the right direction. The focus of this article is clinical practice, but the organization as a whole must also work towards incorporating cultural competency; the resources that follow address this need. To start with, consider adapting history-taking to include cultural issues, understand your patients’ perceptions of health and illness, their dependence on family systems, and their use of faith and tradition in healing. Recognize that stressful circumstances may alter your patient’s ability to cope, resulting in a preference for the ways of her native culture.

Use the exercises and resources that follow to apply theory into practice.

Exercises for Staff Development on Cultural Competency

The Four Corners Game

Participants start by grouping together in the center of the room. The moderator will begin with one category and assign corners of the room for traits within each category. Participants will go to the corner

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that best describes them. After a moment, participants come back to the center of the room. The moderator then moves on to the next category. The pace is quick, and most participants will have ended up with a variety of people by game's end.

Categories and Corners

1. Languages spoken: 1, 2, 3, 4 (or can do by idiom—English only, Spanish and English, Spanish only if applicable, Other combinations)
2. Birth order in family of origin: Oldest, Youngest, Only, Middle
3. Role in health center or group (optional): admin, nursing, provider, other
4. Country of Birth: USA, Mexico, Canada, Other
5. Region of US residency (present if national group, or if local group, can do by past history): Southeast, Northeast, Midwest, West
6. Gender: Men, Women
7. Parental Status: Grandparent, Non-parent, Empty-Nest, Kids at home

These categories are just a sampling. Although race and ethnicity provide major distinctions, the idea is to look below these and see how often other factors group us or divide us. Sexual orientation and age are also not included here for the same reason, although they should be discussed in follow-up.

Discussion Questions: How do we cate-

gorize ourselves? What separates us in every day life and what draws us together? Are we in the same groupings as our parents? As our children? How are categories helpful? How are they harmful?

Case Discussions: For each case, assign one person to be the patient/family and another to be the provider. List the cultural issues that need to be addressed in designing a management plan for each patient. (Use resource section and previous *Streamline* article as background assistance.)

- A 10 year old boy is a child of migrant workers and is enrolled in a school health center. He has severe persistent asthma. His parents are Mexican and speak Spanish. He was born in the US and speaks fluent English. He travels to Mexico every Nov-Dec to see family between farm cycles. He is >95% for weight, 25% for height.
- A 21 year old African-American single mother of two children, ages 3 and 6, lives in a homeless shelter after leaving a violent migrant camp. She moved from Baltimore to NC and has no local relatives. She is concerned about custody of her children. She has hypertension and is a smoker.
- An elderly Hmong woman lives with her son and daughter-in-law. She has a past history of TB. She has had no preventive care and comes to the clinic because of a persistent cough.

RESOURCES

This is an excellent general comprehensive article on cultural competency, *Cultural Competence in Health Care: Emerging Frameworks and Practical Approaches* www.cmwf.org/publist/publist2.asp?CategoryID=11

A Primer for Cultural Proficiency: Towards Quality Health Services for Hispanics. The National Alliance for Hispanic Health. Includes a general primer on cultural proficiency as well as a workbook for provider staff training. www.hispanichealth.org/primer.pdf

Alternative medicine websites: www.altmedicine.org, www.cccam.nih.gov, www.childrenshospital.org/holistic

Barnga is a staff simulation activity that emphasizes the power of subtle differences in culture as they effect communication. "Barnga places people in a situation where they actually experience the shock of realizing that in spite of many similarities, people from another culture have differences in the way they do things. Players learn that they must understand and reconcile these differences if they want to function effectively in a cross-cultural group." *Barnga* is a fun, easy to run game that works for groups of 9-100. Guidelines for this activity can be purchased from the Intercultural Press at <http://www.interculturalpress.com/shop/barngatext.html> or by calling 800-370-2665.

For insight into the day-to-day life of a migrant farmworker's child, read *The Barefoot Heart*, by Elva Trevino Hart.

Hormone Therapy Recommendations

The U.S. Preventive Services Task Force recommended against the use of combined estrogen and progestin therapy for preventing cardiovascular disease and other chronic conditions in postmenopausal women. The Task Force found evidence for both benefits and harms of combined estrogen and progestin therapy, one of the most commonly prescribed hormone regimens. However, the Task Force concluded that harmful effects of the combined therapy are likely to exceed the chronic disease prevention benefits for most women. The Task Force further concluded that the evidence is insufficient to recommend for or against the use of estrogen alone for prevention of chronic conditions in postmenopausal women

who have had a hysterectomy. A study of estrogen therapy in women who have had hysterectomies is continuing as part of the National Institutes of Health Women's Health Initiative because it has not yet found clear benefit or harm. Visit

<http://www.ahrq.gov/news/press/pr2002/hrtrecpr.htm> to read the press release and <http://www.ahrq.gov/clinic/3rduspstf/hrt/hrttr.htm> to view the Task Force recommendation.

Prescription Drug Therapies: Reducing Costs and Improving Outcomes

AHRQ released a Research in Action synthesis that helps to answer questions about which medicines work best at the lowest cost. In addition, the synthesis focuses on the relationship between drug cost and patient outcomes, including the use of more expensive drugs to avoid more expensive treatment costs in the future. This synthesis, "Prescription Drug Therapies: Reducing Costs and Improving Outcomes," is available at <http://www.ahrq.gov/qual/rxtherapies/rxria.htm>. A print copy is available by sending an e-mail to ahrqpubs@ahrq.gov or calling 1-800-358-9295.

Popular Education and Pesticide Knowledge

Amy K. Liebman, MPA, MA

MCN, in partnership with Farm Safety 4 Just Kids (FS4JK) and the National Children’s Center for Rural and Agricultural Health and Safety, recently produced *Aunque Cerca...Sano*, an educational comic book in Spanish to help farmworker parents protect their children from pesticide exposure. The impetus for the comic book was generated from the environmental and occupational health needs assessment that MCN conducted in 2000. In this assessment, clinicians indicated that they would like more environmental health resources for their farmworker clients.

The use of a comic book to promote health messages, builds on the tradition of educación popular (popular education or non-formal participatory adult education) in Mexico and other developing countries. Popular education was used heavily in the 1960s and 1970s and was central to the community-based approach to primary health care services, in which local residents (*promotoras de salud*) are trained to provide preventative and simple curative care. Much of the theory surrounding popular education or non-formal adult education is based on Paulo Freire’s work outlined in the *Pedagogy of the Oppressed*. Other theorists who contributed to popular education include Eric Berne, Malcolm Knowles and Kurt Lewin. It was David Werner, however, in his book *Where There Is No Doctor* that helped popularize the use of lay health workers and *educación popular*. The Centre for Development and Population Activities developed a useful tool to help understand popular education with their comparison of two educational methods — pedagogy to andragogy.

It has only been in the past 10 to 15 years that popular education techniques have been more widely accepted in the United States, and they are now frequently incorporated into many farmworker and community based health programs. The *promotora* model is perhaps the most common application of popular education in this country. Additionally, photonovelas and comic books are often used as tools to assist in the promotion of health messages. Both the comic book and photonovela are popular mediums in Mexico in which

	Pedagogy (Classroom)	Andragogy (Adult, non-formal)
LEARNER’S ROLE	Follow instructions Passive reception Receive information Little responsibility for learning process	Offer ideas based on experience Interdependent Active participation Responsible for learning process
MOTIVATION FOR LEARNING	External: Forces of society (family, religion, tradition) Learner does not see immediate benefit	From within oneself Learner sees immediate application
CHOICE OF CONTENT	Teacher-controlled Learner has little or no choice	Centered on life or workplace problems expressed by the learner
METHOD FOCUS	Gains facts, information	Sharing and building on knowledge and experiences

novellas are published. To promote health, these mediums are used to include health messages and information.

When it comes to developing health programs incorporating popular education techniques, we have much to learn from our colleagues in Mexico and other Latin American countries. To develop our latest resource, *Aunque Cerca...Sano*, MCN and FS4JK partnered with artist, Salvador Saenz, who specializes in the development of popular education materials, and a health promotion specialist, Patricia M. Juárez. Both live in Cd. Juárez, México. The two conducted a formative focus group in the Ejido Benito Juárez, a sending farmworker community about 60 miles from Cd. Juárez in the northern Mexican state of Chihuahua. Two additional focus groups were conducted after the comic book was drafted—one in the Ejido Benito Juárez and one in a farmworker community Anthony, New Mexico, 15 miles from the US-Mexico Border. Focus groups participants were primarily women with young children or grandchildren, either married or living with a farmworker. The production team used the focus group results along with pesticide information, other resources promoting pesticide safety and a general understanding of migrant farmworkers to develop the storyline. The storyline was then sent out for external review to get feed back on its

overall content and technical accuracy. The comments were incorporated into the storyline and the artist drafted black and white illustrations to accompany the story. The draft story and artwork were reviewed and revised several times. It was then tested again in focus groups. The artist incorporated the final comments of these focus groups and produced a print ready copy.

In developing popular education materials, focus groups serve as an important mechanism to gather insight, perceptions and ideas to make sure that material is culturally and linguistically appropriate as well as relevant to the target audience. In putting together the comic book we used focus groups in two ways. We conducted the initial focus group prior to developing the comic book to obtain a better understanding of the knowledge, practices and attitudes regarding pesticides. The second set of focus groups were conducted after the comic book was drafted to make sure that the health messages, story, images and language were appropriate and easily understood. We thought it would be useful to share a summary of the results of the first formative focus conducted in the Ejido Benito Juárez. The focus group not only provided valuable information that we incorporated into the storyline, but it highlighted the need for educational interventions regarding the proper use and the health effects of pesticides. Probably the

most important information to emerge from the focus group is a reminder that many of farmworkers coming from agricultural communities in Mexico are not only exposed to pesticides in the United States,

but they are previously exposed in their sending communities.

Several of our Mexican colleagues will be joining us at this year's National Farmworker Health Conference for a spe-

cial workshop on the development of popular education materials. To order a copy of *Aunque Cerca...Sano*, visit our website at www.migrantclincian.org or contact Farm Safety 4 Just Kids at 800- 423-5437.

EJIDO BENITO JUAREZ FOCUS GROUP—11 PARTICIPANTS

Field Notes—April 20, 2002

The participants were not familiar with the term *pesticidas*. They thought it was a foreign word that came from pests or plagues. They were more familiar with the word *veneno* (which literally translates as poison). They had also heard of the words *fungicidas* (fungicides) and *herbicidas* (herbicides). They also knew the commercial name — parathion — of a commonly used pesticide. According to the participants, the use of parathion is generally limited to the fields. In their homes, they use Mexican pesticide products with commercial names such as Baygon, Okko. They also use an outdoor pesticide containing parathion known as *Gis Chino* in their home.

The participants indicated that they are familiar with application procedures because of their work in agriculture. However, they indicated that they did not have direct contact with the products. The participants know that pesticides are for use in the fields. They are also familiar with the various ways that pesticides are applied — aerial spraying from crop dusters, sprayers attached to tractors and canisters carried on workers' backs.

People in the Ejido store pesticides in tool sheds, inside and outside of the house and under trees. Some participants believe that in-home pesticides are as dangerous as those for use in agriculture.

According to the participants, men are primarily the ones who work with the pesticides. To a lesser extent, sons often help their father when they are fumigating or spraying animals. One of the participants spoke of the time when her husband allowed the children to spray the goats with an insecticide to kill fleas.

All of the participants stated that none of the men use protective equipment when using pesticides. They indicated that it was common for them not to read the pesticide labels. Many of people from the Ejido use pesticides from the U.S. These pesticides are less expensive, but they can not read the labels in English. Mixing practices and use instructions of pesticides are passed through generations or verbally among other farmworkers. The participants clearly mentioned that they did not receive any training about the use or protection measures.

The participants are concerned about the health of their community and stated that they know that something is happening because at the local community health center they read that that the area has the highest rate of cervical and uterine cancer. The also said that that there have been several cases of childhood leukemia and numerous premature births. Many of the participants blame these health problems on the influx of maquiladoras in their region.

The participants commented on one case of pesticide poisoning of an adult and a child. They said that now just the smell of the pesticides make these people feel sick. They think that the remedy for poisoning is to drink milk.

The participants noted that a many of the older men have prostate cancer.

The participants felt that the men would be the most reluctant to change their behavior to lessen the risks from pesticides in the home. They noted that many feel if there are no immediate effects that nothing will happen to them. The residents do not take steps to protect themselves and their children from pesticide exposure. After spraying in the fields, they do not take off their shoes when they come into the house, they do not wash their clothes separately and they only wash their hands before eating.

The participants noted that overall use of pesticides has diminished in the community because the level of agricultural activity has significantly declined.

The participants noted that it is a common practice to use empty pesticide containers. They mentioned a common practice of placing empty pesticide sacks between the mattresses to kill bedbugs. They also used the plastic from the containers to roof their houses.

Guide to Clinical Preventive Services

Recommendations from the current U.S. Preventive Services Task Force, compiled in installments in a 2-volume loose-leaf notebook, are available by subscription. The first installment of the Guide to Clinical Preventive Services, Third Edition: Periodic Updates will be available later this year. The Guide will be updated about twice each year and will contain recently released recommendation statements, summaries of the evidence, background articles, and an index that will be updated with each installment. The recommenda-

tions and evidence summaries to be included in the first installment focus on lipid screening, skin cancer screening, Chlamydia screening, screening for bacterial vaginosis, newborn hearing screening, and aspirin for the primary prevention of cardiovascular events. The second installment, expected in early 2003, will include recommendations and evidence summaries on breast cancer screening, depression screening, chemoprevention of breast cancer, colorectal cancer screening, counseling to promote

physical activity, and osteoporosis screening. Cost of the full subscription, which ultimately will include all recommendations and supporting materials released over a 5-year period, is \$60. You can order the subscription by calling the AHRQ Publications Clearinghouse: 1-800-358-9295 or by sending an e-mail to ahrqpubs@ahrq.gov. Recommendations from the third Task Force are also available at <http://www.ahrq.gov/clinic/uspstfix.htm#review>.

Pizcando Sueños/ Harvesting Dreams

The Voices of Mexican Migrant Women

by Fabiola del Castillo, Fran Ricardo and Robin Lewy of the Rural Women's Health Project
Article Three in a Series of Five

“Pero siempre hay que tener esperanza, ¿verdad?”
 (“But you always have to have hope, right?”)

Farmworking women carry a triple load of pressures as laborers, as mothers/wives and as the key link to the family south of the border. These pressures are often manifested in the high incidence of physical health problems such as Diabetes, high blood pressure, etc. However, *Pizcando Sueños*, a project documenting the lives of Mexican farmworker women in Florida, the concerns expressed by these women reflected more their mental health concerns, than the physical health obstacles they face.

In the testimonies gathered during this project, references which reflected anxiety and stress were intertwined within their discussions of work, their *pueblos*, their family relations and their dreams for their children.

The physical deterioration experienced by many farmworking women, is usually attributed by them to “*la labor*” (work in the fields). We found that often these physical or emotional discomforts are exacerbated by the stress of their many roles, which usually result in increased anxiety. From the testimonies given, it becomes difficult to know what comes first, their physical or mental health issues. Expressions reflecting sadness or worries flowed through the women’s interviews and were intertwined in their concerns about their families that were left behind, their marriages, their relationships with their children, and their struggle to survive in this foreign environment. As you listen to their voices, you can hear their struggle for strength as they deal with the barriers of their realities:

“Desde que yo vine aquí me empecé a enfermar...porque yo allá en México yo era un mujer que ni una me dolía y no más llegué aquí, muy enferma yo he sido ... cuando no de una cosa, de otra ... le digo, hay mamá mejor me hubiera puesto Doña Dolores...y estoy en mi casa y no más estoy pensando en la enfermedad que tengo y me pongo más nerviosa, pero ya ahorita gracias a Dios ya estoy más, más controlada si.”

“Since I came here I began to get sick, ... because in Mexico I was a woman that never suffered a hang-nail and no more



do I arrive here that I have been very sick... when it’s not one thing, it’s another. I said to my mother, ‘better that you had named me Doña Dolores (Miss Pain)’... and at home in my house, I sit and think and think about the sicknesses I suffer and it gets me even more nervous. But now, thank God, I am a little more controlled.”

“...aquí me preocupo, cuando no trabajo me preocupo por que solo mi esposo trabaja y que tenemos que pagar la renta...la luz...el seguro del carro... en México nada más uno se preocupa por pagar la luz y por comprar comida y ya. Aquí hay más mortificaciones que allá.”

“...here I worry, when there is no work...I worry because only my husband is working and we have to pay the rent, lights, car insurance...in Mexico you only worry about paying the lights and buying food and that’s it. Here there are more struggles than there.”

“Aquí me preocupo por mis hijos, por que en la escuela, que ya les ofrecen esto (alcohol, cigarrillos) que ya les ofrecen el otro (drogas).”

“Here I worry about my children, because in the school they are offered some of this (alcohol, cigarettes) and a little of that (drugs).”

“...yo de que se me mete en la cabeza cosas,

me siento mal, de tanto que estoy pensando me baja el azúcar y pues me entran muchos nervios. Me siento bien desesperada a veces y me falta aire y poco a poco trato de echarme las cosas al lomo y trato de no preocuparme. Me siento bien mal.”

“...the things that I get in my head, I feel bad, and with all the worrying my sugar level drops and then I get all nervous. I feel really desperate and sometimes I can’t get enough air and then little by little I try to let go of all the weight on my shoulders and I try not to worry. I feel really bad.”

“...últimamente me he sentido mas decaída y yo creo que es por la edad, por el yo me imagino que es por la tristeza que tengo los problemas.”

“...lately I have been feeling more exhausted and I think it is because of my age, because of it I imagine that my sadness is what causes my problems.”

“Allá en México no tenía preocupaciones, es aquí donde las he tenido.”

“There in Mexico I didn’t have any worries, its here that I have had them.”

“Pues todo duele en cuanto uno tenga vida.”

“Well everything hurts as long as you are alive.”

“Allá en mi pueblo es más sano.”

“Back in my pueblo it is so much healthier.”

It is impossible for women to separate themselves from what is happening here in their daily lives and back home on the other side of the border. Doubts and worries abound even when the women receive communication from “home.”

“Cuando ellos me manden una carta la leo 3 o 4 veces al día, mire y mire y pienso- ¿Será que me pase de algo? Y la repito de nuevo y ahorita ya hablándonos por teléfono se queda uno ya conforme.”

“When they send me a letter I read it 3 or 4 times a day, I look at it over and over and think, is there something that I missed? And then I read it again, and then when I speak with them by phone, I calm down.”

Staying Healthy

"Yo soy como los pájaros que si no vuelan se enferman."

"I am like those birds that if they can't fly, they get sick."

The lifestyle and living conditions of the farmworking women have challenged them to call on traditional home remedies to deal with their aches and pains, or a delayed visit to the local clinic when they can no longer endure their ills. But, beating the oppressive stress and depression has required a combination of approaches to overcome, what for some women, have become a debilitating illness. With so many migrant farmworking women having to live their experiences in silence, depression becomes an even greater obstacle for women to overcome.

Paradoxically, many women found that hard work was a remedy for their preoccupations (worries). Working and staying busy served as a key antidote to depression. Simple, yet successful strategies expressed by the women included maintaining constant activity, talking to a spouse or comadre and an unwavering reliance on their faith.

"Pues yo creo trabajar, porque al doctor casi no voy, pensar un poco positivo, -y el trabajar también te mantiene saludable..."

"I think it's the work, because I almost never go to the doctor, to think a little positive- and the work too helps to keep you healthy..."

"...yo creo que en México me enfermaba más. Yo no entiendo, yo creo que por que trabajo, por que voy y ya regreso hasta en la tarde así, pienso que es eso, y allá uno no trabaja en nada."

"...I think that in Mexico I got sicker more. I don't understand. I think it must be the work, because I go and I don't get home until late, I think it is this, over there no one does any work at all."

"Platicar con la gente, distraerme y jugar con mis niños...Porque si me quedo un rato sola a veces, que mis niños me duermen y pa' estar sola, mejor voy con me concuña aquí vive luego, me voy con ella y ahí me agarro platicando...si me quedo yo sola, no pos no voy a estar a gusto. Fíjese que no más esta uno sola y nomás esta uno pensando en cosas que no debe (voz lenta) y más se altera uno de los nervios y sin embargo así de perdís me distraigo..."

"To talk with people, distract myself and play with my kids...Because if I stay alone sometimes, when my kids go to

sleep and I'm alone, better I go to my sister-in-law that lives close by, I go with her and we get talking...if I stay alone, I don't like being alone. You know, as soon as one is alone and you start thinking of things that you shouldn't (voice slows), your stability changes and you get lost...I distract myself..."

"Pues con mi esposo hablamos mucho, en la noche nos ponemos a platicar y en la noche yo le digo sabes que yo me siento así por esto y el me dice: Mujer, vamos a orar y vamos a pedirle a Dios."

"Well, with my husband I talk a lot, at night we sit and talk and I tell him that I feel this way and why and he says to me, 'Woman, we are going to pray and ask God for guidance.'"

Of the women interviewed, it was their faith that seems to be the consistent and overlying saving grace that helps them to work through both their mental and physical health challenges. Though many of their expressions are simply stated, they typify the depth of their strength.

"Esa fe que tu tienes, no la dejes para nada..."

"That faith that you have, don't ever let it go..."

"Por que con la fe todo se puede, que la fe es lo último que se pierde."

"Because with faith, you can make it, your faith is the last thing you lose."

"...pero siempre hay que tener esperanza, verdad?"

"...but you always have to have hope, right?"

"Qué a veces me deprimó un poquito de estar pensando, pues como quiera todas las noches yo oro y digo le pongo todas las cosas en manos Dios..."

"Sometimes I get depressed from so much thinking, so every night I pray and say that I put everything into God's hands..."

The journey made by Mexican farmworker women is full of struggles. But even with the stress and worries that the women experience, it is their strength and faith which allows them to move forward as they struggle to harvest their dreams.

Pizcando Sueños is a project of Fabiola del Castillo, Fran Ricardo and Robin Lewy of the Rural Women's Health Project. For more information about the *Pizcando Sueños* project, or to read other articles in this series, please visit our web site at: www.rwhp.org/pizcando.

CALENDAR

Western Migrant Stream Forum

January 30-February 1, 2003
Mesa, Arizona at the Sheraton Phoenix East Hotel & Convention Center
Wendy Nitta at the Northwest Regional Primary Health Care Association – (206) 783-3004 or email (wnitta@nwrpca.org)

52nd Annual EIS Conference

Epidemic Intelligence Service (EIS),
Epidemiology Program Office, CDC
March 31-April 4, 2003
Atlanta, GA
Erica Lowe at 404-639-4000
<http://www.cdc.gov/eis/conference/conference.htm>

National Farmworker Health Conference

May 1-3, 2003
Phoenix, AZ
NACHC
(301) 347-0400
www.nachc.org

National Health Care for the Homeless Conference

May 29-31, 2003
Washington, DC
1-888-439-3300
hch@prainc.com

48th Annual Meeting American College of Nurse Midwives

May 30-June 5, 2003
Palm Desert, CA
760-341-2211
<http://www.midwife.org/meeting/>

National Conference on Asthma

"Meeting the Challenge of Healthy People 2010: Preventing and Controlling Asthma"
June 19-21, 2003
Washington, DC
Catherine Porterfield at 202-973-8679
<http://www.asthma2003.net/about.asp>



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Women and Heart Disease

The National Heart, Lung, and Blood Institute has a new campaign directed at women and heart disease. Copies of “The Heart Truth for Women” brochures are available by calling 301-592-8573 or see below for the web site. The brochure features women telling their own stories about heart disease and provides information about risk factors and a checklist of key questions to ask the doctor.

Trustworthy sources to contact for additional information on heart disease are provided. Order up to 50 free copies of this short, easy-to-read brochure. Larger quantities of the brochure are also available to institutions on a cost-recovery basis. Available in English and Spanish. To see and order the brochure, please visit <http://emall.nhlbihin.net/product2.asp?sku=02-5206>.

Behavioral Health Resource

Joint Commission Resources (JCR) has announced the publication of A Practical Guide to Documentation in Behavioral Health Care, 2nd Edition. This book is designed to help behavioral health care professionals improve their documentation practices and comply with Joint Commission standards. To view full text visit: <http://www.jcaho.org/news+room/news+release+archives/practical+guide+to+documentation+in+bhc.htm>



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