THE TIES THAT HEAL: GUATEMALAN IMMIGRANT WOMEN'S NETWORKS AND MEDICAL TREATMENT

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In an attempt to implement the *Federal Welfare Reform Act of 1996,* then Governor Pete Wilson of California issued an executive order that would cut off payments for state-sponsored prenatal care for undocumented immigrants (Kertesz 1996). In effect, this executive order sought to deny nonemergency health care to undocumented persons targeted in Proposition 187, the initiative that was approved by California voters in 1994 but later deemed unconstitutional in federal court. A coalition of civil and immigrant rights groups protested against slashing funds for prenatal care and filed lawsuits that blocked Wilson's initiative. Citizens' groups and politicians who have advocated stringent laws to deter undocumented immigration have focused their efforts on restricting health benefits for undocumented immigrants, so as to eliminate the supposed magnet that attracts them to the United States. The issue of whether undocumented immigrants utilize public health care, and to what extent, remains high on many people's agendas. Thus, in recent years, to speak of immigrant women and health care in public forums has tended to conjure up images of undocumented women delivering babies at state-sponsored hospitals, at taxpayers' expense.

This article does not present additional evidence to support either side of the debate; rather it elucidates a broad and complex web of social relations through which immigrant women procure medical treatment for themselves and their families from a wide range of available sources. The focus is on how immigrant women deal with their

inaccessibility to formal health care resources. Their response involves the creation and maintenance of intricate networks and it is linked to the women's marginal position as poor and/or undocumented immigrants. However, the deployment of informal ties—locally and transnationally—should not be conceived of solely as a strategy to access goods that are formally unavailable to immigrants because of an ambiguous legal status or insecure jobs. Through contacts with people familiar to them, immigrants—documented and undocumented alike—often put together what resembles a "package" of health treatments that includes biomedical care and "traditional" healing practices. Sometimes such treatments are obtained at local hospitals, privately run or community clinics, or directly from family, friends, and friends of friends for whom a particular remedy has proven effective. From friends and family, immigrants procure resources such as money; information about local clinics, hospitals, "*curanderos*,"[1] and physicians; car rides to visit a clinic; prescribed and "traditional" medications brought from home; and even a prayer for their health at a Catholic or an evangelical church. Regardless of where the treatment is actually obtained, however, it is a process that involves contacting friends and family. Thus, most of the immigrants' activities with relation to health care

[1] *Curanderos* are folk healers who work primarily in immigrant communities, recognize Western categories of disease, like colds, and unique categories of illness, like *susto* or *empacho*, and treat illness in a variety of ways, including herbal remedies, massage, prayer, and rituals designed to combat supernatural forces (Weitz 2001) as well as prescription-only pharmaceuticals available in immigrant communities.

occur within the intricacies of informal ties, particularly among the recently arrived and/or economically and socially marginalized.

Empirically, this study is based on the experiences of Guatemalan immigrant women in Los Angeles. The social position of this group vis-à-vis the structure of opportunities—shaped by the larger politico-economic context—makes their case ideal for examining the effects of the broader context on the formation and continuation of immigrant informal networks. This group also presents a unique opportunity to assess the effects of ethnicity on the use of informal ties to access treatment, since the study includes two socioculturally and demographically different groups—indigenous and *ladino* Guatemalans. *Ladino* or *ladina* refers to the nonindigenous Guatemalans who speak Spanish and wear Western clothing; they are mostly mestizos (as well as European descendants) who have been culturally Hispanicized. Indigenous Guatemalans typically (though not always) wear their traditional attire that varies by region and speak one (or more) of 21 Mayan languages. But there are some important social differences between these two groups as well.[2] For instance, indigenous are more likely than *ladinos* to be poor and not have access to formal education or health care; they are also invariably

[2] I do not mean to homogenize important differences among the Maya groups in Guatemala. For instance, some have suffered more than others from the political strife in Guatemala, and therefore, one finds more people from some groups (e.g., K'anjob'al) than from others, even though some of the groups we find more represented in the United States (like the K'anjob'al) are not the largest in Guatemala (like the K'ekchi or Mam).

associated with low social status (Pebley, Hurtado and Goldman n.d.). The aim of this article is not to analyze ethnic differences in how these immigrants use social networks to access medical treatments partly because, as we shall see later, there were no differences in this respect. But I will attend to a general lack of interethnic relations between both groups, as these immigrants usually do not cross ethnic lines to utilize informal networks to access treatment. Thus, in this study, immigrants' use of informal networks to access medical care does not depend on their ethnicity. However, what matters for both groups is gender, as women are much more likely than men to be at the center of networks to procure remedies for both unusual and serious illnesses as well as the more mundane but also more frequent ailments that affect people in their everyday lives. Although my observations highlight women's activities, I will also call attention to the particular configurations of gender relations that influence these informal exchanges.

The focus will be on women's social networks because women are usually in charge of fulfilling not only their own health needs, but also those of their families. In fact, women have been found to be the anchors of family and community life among immigrants (Hondagneu-Sotelo 1995: 22) and to be primarily responsible for family health (Chavira-Prado 1992), so most medical knowledge is transmitted between mothers and daughters (Rubel 1966: 180) and among women in general. Focusing my discussion on the immigrants' social networks as central in obtaining medical treatment should not obscure the fact that these social ties are highly complex and must not be construed solely as havens of support or as interminable sources of assistance. As others have observed (Hondagneu-Sotelo 1994a; Mahler 1995) and I have noted elsewhere (Menjívar 1997,

2000), immigrant social networks are not devoid of tension and can weaken with immigration. Thus, I will underscore the intricacies in these social relations to avoid simplifying them or presenting them solely as "functional" to immigrant adaptation. This conceptualization will bring to the foreground the conditional, negotiated process of seeking and obtaining help, because decisions to ask for and to provide help are contingent and fluid, not predetermined or fixed (Menjívar 2000).

My discussion will include instances of "self-medication," a term that obscures a fundamentally social activity, in which family, friends, neighbors, coworkers, and acquaintances are involved. I will frame my argument within the broader context in which these immigrants live, such as the political economy that affects the immigrants' everyday lives and their class insertion in U.S. society. Examining immigrant women's experiences from this vantage point provides an opportunity to grasp the complexities inherent in these social ties and how people, in their everyday interactions within the broader context, forge such ties. Thus, although the focus is on Guatemalan immigrant women, this case is pertinent to more general conceptualizations of social networks, particularly to the *processual* nature of obtaining and receiving help and to the place of gender in organizing these interactions. The discussion may also be applicable beyond this group, as nonimmigrants, particularly the working poor, may also resort to similar informal networks to obtain the necessities of life—including medical care—as they face the inescapable fact that declining real wages do not match increasing costs of living.

My research shows that the Guatemalan immigrant women in this study (many of whom were undocumented and had resided only a few years in the United States)

actively sought and obtained medical care—usually a combination of biomedical and "traditional" treatments—through their informal networks. Women's regular contact with other women in places of work, community organizations, the neighborhood, and even public transportation created optimal conditions to muster informal contacts to access medical care. Other studies, notably Rublee and Shaw (1991) and Hagan (1998, 1994) have observed that some immigrant women remain isolated from the larger community and thus have entirely different experiences from the women in this study. Factors such as lack of English-language proficiency, daycare availability, initial orientation, and degree of ethnic community support affect the ability of Latin American immigrant women to participate in work, leisure, and community activities (Rublee and Shaw 1991). Among Guatemalan immigrant women, Hagan (1998, 1994) found that when they work as paid domestics "inside" a house, women do not have opportunities to create the kind of networks with their compatriots and coethnics that have proven beneficial for their male counterparts. The majority of the women in my study were actively involved with others in their immediate environment, interacting mostly in Spanish, and when they worked as paid domestics, were rarely "locked up," as Hagan's informants commonly were.

Mostly due to their inaccessibility to formal health care (because of an undocumented status or low-paying jobs offering no health benefits[3]—as well as to

[3] For instance, it has been observed that even though Latino immigrant parents are more likely to be employed, they work in sectors that historically lack fringe benefits (c.f. Chavez 1986). Undocumented immigrant women are particularly disadvantaged in this

language barriers, cultural differences in the interpretation of illnesses, or a lack of knowledge of the formal system), these women mobilized friends, family, and even acquaintances to assemble something akin to a "package" of biomedical treatments and "traditional" medicines. It should be noted that in many societies around the world people turn to combinations of pharmaceuticals and traditional healing practices, often incorporating the former in the latter (Etkin, Ross, Muazzamu 1990; Price 1989; Pedersen and Coloma 1983), giving rise to "popular" medical systems (Pedersen and Baruffati 1989). It also should be emphasized, that people in Guatemala (as in many other countries around the world) also rely on their social networks for information about treatments, to obtain such medications, and for health-related advice (Bocaletti et al., n.d.; Ferguson 1981; Hardon 1987; Logan 1993). So these practices are not new among Guatemalan immigrants in the United States. Nor is the utilization of informal networks to access treatment a crude transplant of a home country practice. What is worth noting is that in the face of severely constrained legal and financial opportunities and a general lack of access to good quality, formal health care, such informal channels seem to flourish and often become the *sole* conduit for immigrants to access medical care, regardless where the remedy actually comes from.

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regard (Chavez et al. 1997). Therefore, their children, who are often citizens, are also less likely to have health insurance (Halfon et al., 1997).

THE BROADER CONTEXT, HEALTH CARE AND GENDER

Broader forces in the receiving context influence vitally immigrants' everyday lives, as they shape the structure of opportunities available to newcomers (Portes and Rumbaut 1996; Menjívar 2000). Together, immigration laws and local labor markets determine whether immigrants will be eligible to access society's benefits—including education and health—or will be denied them and thus become some of society's most vulnerable and marginal members. Immigrants from a group that enjoys a favorable reception under U.S. immigration law will not have to endure life as undocumented persons and, if market conditions are favorable, will likely have the added advantage of finding a job. I do not mean to deny the importance of other factors, such as the immigrants' own human and other forms of capital, for their initial class insertion and fate in the place of arrival, which are obviously crucial. However, even with high levels of education and job experience, undocumented immigrants (or those who find themselves in an uncertain legal status) find it extremely difficult to realize their full labor-market potential. When they do obtain jobs they are usually the lowest paid ones that offer little, if any, mobility. From this standpoint, Portes and Rumbaut (1996) observe that the forces at play in the context of reception channel immigrants in different directions, crucially influencing the link between individual skills and potential rewards. For Guatemalans, a disadvantaged context of reception means hostile immigration laws, an ever more competitive job market, and a resource-poor immediate community.

The political economy of U.S. medicine reflects broader structural dynamics in the society at large. For instance, the inherent contradictions of health care in a capitalist

society reinforce current deficiencies in the health care system, for immigrants and nonimmigrants alike. On the one hand, ever more sophisticated medical technology is being used to develop complex—and expensive—treatments to prolong life at both ends of the age spectrum. On the other hand, more mundane—and cheaper—treatments that could prevent eventually life-threatening situations among a greater number of the population are given less attention. And while U.S. health policies foster a strong private sector and the maximization of profits in the health care industry, public services have remained profoundly under funded (Waitzkin 1983). Within this context, poor immigrants, like the poor in general, have very limited choices regarding medical care, and when they are undocumented their options dramatically narrow even more. Most of this study's participants are undocumented immigrants, and their choices consist primarily of the fragmented and often depersonalized services available at public hospitals and outpatient clinics for pregnancy-related matters or emergencies, the very services that politicians have threatened to cut off (Shelton 1997). Under these circumstances, prevention is almost non-existent because people do not have access to the (formal) system that usually provides it and, thus, they tend to wait until a health problem becomes serious to seek medical care. Without health insurance (because their jobs seldom offer medical benefits even among the documented), they tend to pay out-of-pocket for the use of private clinics (cf. Rumbaut et al. 1988) usually run by co-ethnics. They also resort to prescription medicine—which they obtain without a doctor's order at local stores—and "traditional" remedies brought from their homelands. Therefore, these

immigrants' "choices" of medical treatment are highly constrained by their class insertion in the United States and by their limited access to its stratified health care system.

Immigrants' informal networks have long been noted for their important place in facilitating migration and for their efficiency in putting a variety of resources—material, financial, and emotional—within the immigrants' reach in the place of destination (Gamio 1930; MacDonald and MacDonald 1964; Mines 1984; Massey et al. 1987; Boyd 1989). The structure of social networks based on kinship and friendship allows immigrants to draw upon obligations implicit in these relationships to gain access to assistance at the point of destination, thus substantially reducing the costs of migration (Tilly and Brown 1967; Choldin 1973; Taylor 1986; Massey 1989). In the past few years, however, new bodies of research have unraveled the presumably less desirable manifestations of immigrant networks and families, suggesting the potential for conflict in these social ties. For instance, immigrants rely on networks to cope with different challenges and to achieve their goals, but the informal regulation that arises from networks can be abusive to participants (Hondagneu-Sotelo 1994b; Menjívar 2000). Thus, researchers have noted both the facilitating component inherent in social networks for individuals to achieve their goals as well as their potential for constraining action (see Portes and Sensenbrenner 1993). In this regard, the context of reception may influence the resources immigrants have available to assist one another, and when means are meager people may not have enough to assist others and networks may weaken (Menjívar 1997, 2000).

Within this context and due to their responsibilities as primary caretakers for their families, women actively tap into female-centered networks that place remedies within reach. Female-centered networks among immigrants, minorities, and impoverished groups have been long acknowledged (Stack 1974; Yanagisako 1977; di Leonardo 1987; Muir 1988; O'Connor 1990; Lamphere et al. 1993). Women have been portrayed as performing what di Leonardo (1987) calls "kinship work" or as the keepers of kin (Wetherell, Plakans, and Wellman 1994). Immigrant women have been found to be the "nodes" that connect people and who initiate and maintain networks through which people migrate and settle, but they do it so subtly that their actions are not always recognized (Brettell and deBerjeois 1992; Yanagisako 1977). Ho (1993) observed that women shape the kinship ties that lie at the core of social life at home and abroad, upon which new "international families" operate. Women have been found to forge new networks as a result of immigration—mostly through their participation in the labor force—independent from those of the men in their families (O'Connor 1990). Kibria (1993) observed that women's networks became diversified as a result of women's newly assumed responsibilities in resettlement. Immigrant women, Hondagneu-Sotelo (1994a: 174) asserted, are drawn into various organizations and social interactions because of their families, and become key players in different forms of community building in the adopted country. And Chavira (1988) characterized immigrant women as "subsidy providers," when they handle and care for their families' bureaucratic matters and link their families to the medical bureaucracy.

But not all women-centered networks "function" smoothly. Mirroring recent findings that have unveiled the underside of networks more generally, women-centered networks have also been found to be contentious and sometimes the sources of tension (Hondagneu-Sotelo 1994b; Menjívar 2000). Nonetheless, when immigrant women do seek access to the formal health care system, they usually do so through their networks with other women (Cohen 1979). Thus, within a context of reception that offers few, if any, resources for newcomers and a health care system in which poor immigrants find it increasingly hard to obtain treatment, women—in their role as caretakers of their families—emerge as the central figures in mustering the means to care for themselves and their families, thus reinforcing the formation of women-to-women networks. Women's central role in providing treatment and medical advice has been found in several settings, including Guatemala (Delgado, Sorensen and Van Der Stuyft 1994). In the context in which these immigrants arrive, this tendency does not simply continue but is enhanced, due mostly to a general lack of access to the formal health care.

This paper is organized into three sections that together illustrate the process by which women fashion their networks to access medical treatment. The first deals with seeking treatment locally, emphasizing its dynamic aspect, meaning, and instances of tension and disappointment as well as of cooperation and trust. The second section focuses on women's networks, as they are key to these processes, and the third focuses on the women's networks that span both the communities they have entered and those of their origin, as such ties are sometimes essential in putting remedies within the immigrants' reach. Before I embark on this discussion, I will present the data and

methods and then provide a brief background of Guatemalan migration and the conditions that these immigrants face upon arrival in order to contextualize better their experiences.

DATA & METHODS

This article draws from data I collected from 1994 to 1995 in Los Angeles, where I conducted 26 in-depth, tape-recorded, semi-structured interviews in Spanish with Guatemalan immigrant women, complemented with participant observation in the places where these women conducted their daily lives, usually their homes, clinics, stores and churches.[4] These immigrants were "recently arrived"; that is, they had been in the United States for no longer than five years when I first interviewed them. In addition to the interview, I conversed informally with these women at other times, as well as with their friends, neighbors, family members, and on a few occasions, with their employers as well. Thus, although the focus of the study was on the women, in the course of my research, I also spoke with the men (husbands, fathers, brothers) in their families. In addition, I met with community leaders and workers, including Catholic priests and evangelical pastors, whose views complemented my informants' stories.

I contacted my informants through language schools, clinics, community organizations, and churches located in various neighborhoods having a high concentration of Guatemalan immigrants. I spent many hours in these locations—which allowed me to gather important observations—during which I helped my informants with

[4] I use pseudonyms in place of the informants' real names.

translations, car rides, filling out forms, or with any information or advice I could provide. Some reciprocated these small favors with invitations to eat a special dish at their homes or to a celebration. Although I tried to ensure that my informants would represent different sectors of the Guatemalan immigrant population by contacting them in diverse places, the small number of informants in this study and the non-probabilistic method of selecting them precludes any generalizations to all Guatemalans in the United States, much less to all immigrants. But in the ethnographic tradition, focusing on a small number of people in-depth over a period of time sheds light on the complex interactions between broader forces and the lives of immigrants at a particular point in time and space so as to understand how larger forces affect social situations (Menjívar 1997).

The 26 Guatemalans include two socio-demographically and culturally different groups—15 *ladinas* and 11 indigenous women. The mean age for the *ladinas* is 30 years and 33 years for the indigenous women. Two-thirds of these women—almost equal proportions of *ladinas* and indigenous—were either married or in consensual unions. On average the *ladinas* had eight years of education, whereas indigenous women had only four years. A quarter of the women mentioned some knowledge of English, but none spoke English fluently. The *ladinas* came from towns and cities in eastern Guatemala, whereas the indigenous women originated in the western highlands, mostly in the Kaqchikel-speaking region, but some were from El Quiché. All the indigenous women and two-thirds of the *ladinas* had earned incomes in Guatemala, and their class and occupational background back home was varied. The indigenous women mostly worked weaving merchandise to sell, and the *ladinas* worked as clerks, housekeepers, and owners

of small businesses. There were a couple of former college students among the *ladinas*, but none among the indigenous women. All the indigenous women were bilingual in Spanish and either Kaqchikel or K'iche, but I interviewed them in Spanish. The *ladinas* lived primarily in Hollywood and south central Los Angeles, and the indigenous were concentrated around Pico-Union, the area immediately west of downtown Los Angeles. Only five of the 26 Guatemalan women in this study had legal documents; a few others were in the process of regularizing their status, mainly resubmitting asylum applications.

BACKGROUND AND ARRIVAL

The circumstances of exit and the context of arrival are of particular importance for Guatemalans because these experiences have shaped their lives in the United States in crucial ways. Many have brought with them traumatic memories of political upheaval in their country during the past three decades (Menjívar 1999). The 36 year-old Guatemalan civil conflict that only ended in 1996 left profound devastation, especially in the countryside. Indigenous communities in Guatemala had gone through substantial transformations in the 1970s, as progressive forms of organization were instituted and new ideologies disseminated (i.e., cooperatives, unions, liberation theology) among the people (Stepputat 1994). The government army responded with scorched earth campaigns and brutal repression (mostly in the first half of the 1980s) as part of the counterinsurgency strategies carried out mostly in the indigenous-populated western highlands where, the government believed, forces promoting social change had sympathizers. By the Guatemalan army's own account, 440 villages were destroyed in these campaigns, an entire generation of community leaders and youth was decimated

(Alvarez and Loucky 1992), and between half a million and one million people were displaced (Manz 1988). Many of these people fled as refugees to neighboring areas—mainly southern Mexico—but a significant number made their way to the United States.[5] Indigenous Guatemalans were joined by *ladino* migrants motivated mainly by economic considerations resulting from broad dislocations during the crisis, though some were also suffering directly from the rampant violence of the period.

For most of the U.S.-bound Guatemalans the trip was plagued with uncertainty, as they usually undertook the journey without a visa—either Mexican or U.S.—and therefore had to travel by land. Most Guatemalans with whom I spoke commented on the perils of the trip, the abuses from common criminals and from immigration officials in Mexico, and in many cases from the *coyotes* (smugglers) whom they hired to bring them into the United States. Guatemalans—as other immigrants who travel by land—were robbed, beaten, and left for dead; many of the women were raped. For some, the traumatic episodes did not end upon arrival in the United States, either because the Immigration and Naturalization Service (INS) arrested them or because they continued to suffer at the hands of the *coyotes* until their families could afford the payment to claim them from the smuggler. Subsequently, they have faced the hardships of life as undocumented immigrants (or of living in a legal limbo) in the United States.

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[5] Many of the refugees who arrived in southern Mexico, after spending years there and without the possibility of return, eventually made their way to the United States.

Gaining legal status once in the United States has been difficult. Guatemalans could apply for political asylum, but the success rate of such applications hovered around 2 percent during the 1980s (National Asylum Study Project 1992). In 1990, as a result of a settlement of a class action suit (*American Baptist Churches vs. Thornburgh* [ABC] legislation) that alleged discrimination against Guatemalans and Salvadorans on the part of the INS, immigrants from these countries were allowed to resubmit asylum applications. The approval rate increased to about 18 percent in fiscal year 1992 (National Asylum Study Project 1992), but it has since decreased to the levels of the 1980s. Moreover, most Guatemalans arrived in the 1980s, too late to apply for amnesty under IRCA (the *Immigration Reform and Control Act of 1986*). The Immigration and Naturalization Service estimates that approximately 60 percent of the Guatemalans in the United States remain undocumented (Immigration and Naturalization Service 1997).[6]

The legal status of these immigrants considerably narrows their employment opportunities. In addition, the Los Angeles local labor market offered these Guatemalans mainly low-wage service jobs with few opportunities for mobility. But during the

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[6] Those Guatemalans who entered the United States no later than October 1, 1990, and registered for ABC benefits by December 31, 1991, or filed an asylum application by April 1, 1990—may benefit from "cancellation of removal" (suspension of deportation), as stipulated in the Nicaraguan Adjustment and Central American Relief Act (NACARA) of 1997 (Immigration and Naturalization Service 1998). Regulations under this act came out in May 1999, so it is unclear how many Guatemalans will benefit from this provision.

recession of the early 1990s (complicated by the 1992 riots in south central Los Angeles) even these low-paying jobs became scarce. Analyzing 1990 Census data, Lopez, Popkin, and Telles (1996) showed that Guatemalan women are highly concentrated in private service (household workers, mainly cleaners and childcare workers in private homes) and in private services (housekeeping, not in private homes); they also work as machine operators in the textile industry (1996: 296).[7] These authors depicted Guatemalans (along with Salvadorans) as constituting "the most vulnerable national-origin group in the United States because they are among the most undocumented.... Their claim to refugee status has never been recognized; and they are about to lose what temporary protection against deportation they had" (Lopez, Popkin, and Telles 1996: 287). All the participants in my study were either looking for work or employed. One owned a small business, while the rest cared for children and the elderly, cleaned homes, or worked in different Latin American eateries.

THE PROCESS OF PROCURING TREATMENT

When people rely on informal ties, it usually takes a few steps, a few knocks on doors, to obtain treatment for an ailment. Kibria's (1993) notion of "patchworking" illustrates this process. Patchworking, according to Kibria, connotes the merging of

[7] Lopez, Popkin, and Telles calculate an index of representation in each of these occupations. They estimate that Guatemalans are 13 times as likely as the general population to work as private servants and 6 times more likely to work as maids; by contrast, Mexicans are 2.3 as likely to work as private servants (1996: 296).

different resources, such as information, services, and education. The notion of cooperation being uneven and sometimes haphazard that is embedded in patchworking is particularly pertinent here, since it conveys more powerfully the process of obtaining help among immigrants with very few resources to share (Menjívar 1997, 2000). This concept is therefore useful in analyzing the *process* by which many poor immigrants exchange help, as it is based on the notion of negotiation at the different stages—which may occur simultaneously or in sequence—in which people and resources are put together to find a treatment for an ailment. In the end immigrants do obtain from friends and family what they need to heal themselves, but this often translates into a process that precludes black-and-white categorizations of getting and not getting help. In this discussion I will highlight key aspects of these exchanges: from whom the women obtain help locally and transnationally, and the process by which they procure treatments from others. Also, because reciprocity lies at the core of these exchanges, I will present both sides, when people give and when they receive assistance.

Friends, Family, Neighbors, and Acquaintances as Local Resources

For nonemergency illnesses and symptoms such as a fever or an upset stomach, putting together treatments means contacting different people, usually women, sometimes sequentially but also simultaneously. I found this multi-stage process among the overwhelming majority of the study participants, both *ladinas* and indigenous. Often the women follow a sequence that starts out by using a remedy that they trust, and if it is not effective, they seek the advice of others. Hermelinda, a 27-year-old undocumented indigenous woman with a fourth-grade education, usually starts out with a home remedy

for her children's illnesses, but if that does not work, she takes them to a community clinic that has a sliding-scale fee where she usually pays only $5. Once, however, after taking her 6-year-old boy to the clinic to rid him of "*empacho*,"[8] she went to a *curandero*—recommended by women from her hometown—who prescribed an herbal tea and prescription medication that Hermelinda purchased over the counter at the corner liquor store. When both her husband and her husband's brother-in-law had an accident with the lawn mower in a yard the had been hired to work on for the day, she asked neighbors for a small loan of money. She bought two injections of penicillin at a neighborhood store, put some hot compresses with a concoction that her cousin recommended on the wounds, and made the men drink a strong pain killer that a woman from the family with whom they shared the apartment gave her. María, another indigenous woman who is 40 years old and has a fifth-grade education and is documented, regularly sends people to a local pharmacy that sells both "mother's remedies" (as some of my informants called traditional medicines) and prescription medicine that is sold without a doctor's order. She also "prescribes" cures that she learned from her mother and grandmother back in Guatemala. "When people tell me that they have a problem that doctors here can't understand, I usually have something for them. For *empacho* I usually recommend that they rub the [ill person's] stomach area with garlic mixed with olive oil. I use chamomile tea for a lot of things. If it's an

[8] According to Rubel (1960: 799), *empacho* is "conceived as a manifestly physiological condition in which a chunk of food clings to the intestinal wall causing sharp pains."

infection, they have to take some penicillin plus an herbal tea to soothe the pain." In most cases, María prescribes a combination of treatments "to attack" the illness better.

Underscoring the omnipresence of informal contacts in putting medical care within reach, remedies and treatments do not necessarily have to come from trusted close friends or relatives. Aída, a 27-year-old undocumented *ladina* and a teacher by training, has been able to procure most of what she needs for basic survival through friends and acquaintances. Friends of friends have been very resourceful as well. "People I have met here, from El Salvador, Mexico…have told me what to do when we get sick…I have given the baby anise for a stomachache…oh, a friend from Guatemala recommended it to me." Aída went on, "My husband's cousin's friend is from El Salvador, and I've learned from her that I can give my baby chamomile tea for a colic…. Oh yes, at the bus station the other day someone told me that a spoonful of olive oil before breakfast is good for constipation, so I gave that to my sister-in-law…. No, I didn't know that person. I had never seen her before and I never saw her again. This other lady from Nicaragua that used to ride the bus with me, I don't even know her name, told me where to buy penicillin for an infection my husband had in his foot." Aída said that she has also, on several occasions, "prescribed" remedies to people she knows. In fact, when I was at her place a female neighbor with a bad cold came by. Aída immediately gave her a recipe for a concoction of orange juice, garlic, and honey, plus a couple of acetaminophen pills (a commonly used antipyretic in Guatemala to treat discomfort associated with fever, and found in the United States under the generic name "non-aspirin pain reliever.") her family had sent her from Guatemala. In the case of Margarita, a 29-year-old undocumented

ladina with a 6th grade education, it was people she met "in the streets" who told her that she could seek treatment at Children's Hospital for her toddler. She now does not hesitate to pass on the same information to others in similar situations, whether they are close friends or family members or people she meets while waiting in line at a market, outside church, during a doctor's visit, or at a bus stop.

Sometimes the best medicine is spiritual, a "cure" that can only come from close ones, particularly from other women at church, but also from the church's leaders. Similar to findings from a study comparing U.S.-born Mexicans and Mexican immigrants (Keefe 1982), religious authorities—pastors and priests—also emerged as important sources of support for health-related problems among the people in this study. Maribel, a 30-year-old undocumented *ladina* and an accountant by training, feels that she can count on the people from her church for everything, even to "cure my nerves." A few of the women mentioned that they, as well as their friends and family, suffered from "*nervios*," (nerves), a condition described by Guarnaccia and Farias (1988: 1223) as a "powerful idiom of distress used by Latinos from a variety of Caribbean, Central and South American countries. It is a way through which people express concerns about physical symptoms, emotional states, and changes both in the family and in the broader society."[9] The women attributed the reason for the condition to the stress produced by their

[9] In a study of Greek immigrant women, Dunk (1989) links this psychosocial condition, found among other immigrant women, to working conditions, wages, and gender relations.

financial and/or legal instability, and to worries about loved ones back home. In addition to taking prescription medication, Maribel's congregation prays for her daily when she does not feel well. "Their prayers are my medicine," she explained, "because they are all I have in this world." It is the same for Nora, a 36-year-old documented *ladina* with 6 years of school, whose friends from church visit her at home because she takes care of an elderly woman and cannot leave her unattended, even to go to mass on Sunday. She explained, "If you know that people care for you and are praying for you, it's like magic. One feels better instantly…My problem is my nerves. When I feel bad I take my Valium that my *mommy* sends me from Guate[mala]. Someone told me to take linden water…another lady recommended to me orange blossoms tea…and I feel better with that. But for me, a prayer is just as important as a pill or tea, or maybe even more. It's a cure because it's God directly acting upon you."

There was essentially no difference in how indigenous and *ladina* women used their networks to obtain treatment, which parallels some findings from Guatemala (Bocaletti et al. n.d.) but not others (Cosminsky 1983: 163). Perhaps reflecting indigenous-ladino relations in Guatemala, in Los Angeles there was little, if any, crossover between the two groups when it came to asking for help. Interethnic relations in Guatemala are rooted in an ideology that has placed *ladinos* in a superior position to the indigenous since colonial times. Thus, while there is contact between the two groups, it occurs within a profoundly unequal sociocultural hierarchy. [10] In the U.S. context

[10] For a more detailed discussion, see Smith 1990 and Rosada Granados 1973, among others.

therefore the immigrants' ethnicity per se does not make a difference on whether or how they use informal networks to access treatment; but their inter-ethnic relations (or their absence) do matter. For instance, whereas *ladinas* and indigenous interacted with their own and with people from other nationalities and ethnicities to obtain help, I only observed two cases in which a *ladina* and an indigenous sought and obtained help from across groups. One of these was Mayra's, a 29-year-old undocumented *ladina* with a seventh-grade education. When her family "let her down," she sought Rosa, an indigenous woman who seemed to take anyone who needed help under her wing. Mayra was immensely grateful to Rosa for treating her "as family" and even baby-sitting Mayra's baby occasionally, free of charge. Liliana, a 39-year-old undocumented indigenous woman with a sixth-grade education, said that she has obtained information about clinics and special programs from a *ladina* acquaintance, but she did not expect more than information from *ladinas*. Hortencia, a 50-year-old documented indigenous woman with a sixth-grade education, put it bluntly. " No, I don't have *ladina* friends because they were not my friends back in Guatemala either. I have black, Chinese, Salvadoran, Honduran, all sorts of friends but not *ladinas*. It's more difficult to be friends with them. Of course, if I ever need medical advice I would not even dream of talking with a *ladina* because I don't know any."

Women at the Center

For the Guatemalan women in this study, the process of obtaining medical treatment involves many people: close family members, friends, neighbors,

acquaintances, as well as friends of friends. In the overwhelming majority of cases, it is other women who eventually put within reach a variety of resources. For instance, Nora said that her sister-in-law gives her advice and has helped her with a variety of health-related issues, particularly those she considered "embarrassing." In Nora's words, "When it comes to women's things, I think one consults a woman, right? First I asked my husband's cousin, but she was not well informed…she's young. Then I asked my sister-in-law, so she took me to the doctor to get my birth control pills…Now I know where to go. My husband's niece needed to have a gynecological exam. She asked some women at work, but they weren't helpful, so she came to me and I took her to the same clinic. She wasn't going to ask my husband, she asked me."

Although women may feel more comfortable discussing "women's things" with other women, this woman-to-woman pattern of forging networks extends beyond such matters. For instance, Elvira, a 31-year-old undocumented indigenous woman with a ninth-grade education, said that she often felt more comfortable asking a woman for a favor when she or her relatives have been ill, mostly because women have more experience with and thus, knowledge of, health-related issues. "If it's not my *comadre*, it's my cousin, or someone, but yes, I feel that with other women I can talk. You know, as a woman it's easier. Women have experience in these things. Men don't. They don't even like to take medicine themselves, much less know what to take for an ailment." Underlining the *processual* nature of obtaining and giving help, she added: "Sometimes you ask one [woman] but for one reason or another, she can't help, then you ask another one, and like that. The point is to ask around; one needs to *informarse* (inform oneself)."

With regard to the different perception of what men and women know and can do in these situations, I observed on several occasions that men avoided admitting that they were ill. I suppose complaining about illnesses and doing something about it (unless it was a serious condition) could have been construed as weaknesses, intolerable in a man. As Nora's husband told me jokingly, "For a man, there is no illness that a couple of shots of *aguardiente* (strong alcoholic beverage) cannot cure. That's all a real man needs…he shouldn't complain that something hurts."

Like almost all of the women in this study, Aída feels fully responsible for her family's health needs. She lives in a tiny studio whose only decoration were huge lists of conjugations of verbs in English, so that she will memorize them more easily she said, a gigantic American flag, and her husband's soccer tournament trophy. She is always mindful of her family's health and is industrious in putting together whatever treatments she can find. There was a reminder to herself on the refrigerator door: *Darle las vitaminas a la beiby. Ponerle las pastilla en la lonchera a Luis.* (Give the vitamins to the baby. Put the pills in Luis's lunchbox).

In the case of Angela, she said she has acted as a "doctor" for her family and friends, particularly for those who do not have either health insurance or money to go to a private clinic. She is a 46-year-old documented indigenous woman with a fourth-grade education. Angela has taken care of every illness in her family. She was trained at a hospital to be able to care for her diabetic mother-in-law and has learned every detail about a cholesterol-free diet for her husband. Importantly, she has shared this knowledge (and medications) with others who suffer from the same (or similar) illnesses. "I have

saved many lives," she explained. "The other day my neighbor was worried that her mother didn't have money for the [prescription] pills for high blood pressure, so I gave her a few of these pills until she could get money to buy her own. I always advise people. That's why I tell you that I'm like a doctor. I diagnose, prescribe, and even give medicine to people who can't afford it. So I tell people what to take, sometimes herbs, sometimes Tylenol, well, it depends. I try to help out." Angela's sharing her prescription medication with others is not uncommon because both consulting a physician and purchasing the medication can be very expensive, as it is among other poor immigrants and other minority groups (Harwood 1981).

In presenting these examples of women helping one another, I do not mean to convey an image of them as being overly altruistic and helpful. Sometimes the first person asked was not the one who lent a hand. Other times a person simply did not feel comfortable asking for help because she had been denied assistance in the past. And in other occasions, the very act of asking for help had led to arguments and tension. This does not mean that women are left with no one to turn to; it simply illustrates the *processual* nature of seeking and obtaining help in women-centered networks. Dalila, a 21-year-old undocumented *ladina* with a seventh-grade education, said that she is reluctant to ask her siblings for help when she is ill because in the past they have accused her of being lazy. "I don't tell my sister or my brother that I don't feel well because they think it's an excuse not to work, so that they can support me. They're crazy. So I better ask someone else, like a neighbor or a friend from work, if she can substitute for me or buy me a pill at the store." Nora's sister-in-law has been helpful, but her help at times

seemed conditional and uneven. Nora explained: “Sometimes she thinks that I’m taking advantage of her. But no, I just don’t know where anything is here. The other day I told her that I wanted to go get something like family planning, but she thought that I was doing this behind my husband’s back and started to gossip about me. I don’t know, sometimes it’s difficult to trust others, men and women alike.” In the case of Mayra, her family “had closed all doors” to her after she got pregnant by a man they did not like. “It was awful, I had no one to take me to the hospital, no one to be with me when the baby was born, and I don’t speak the language or anything. Finally, a lady from church told me where to go for prenatal care and by the time I did that I was already in my last two months of pregnancy. The doctor and the nurses scolded me, but what could I do?” And there are also some that claimed that they never ask for help from anybody because they did not want to “owe” anything to anyone. A case in point is Anabella, a 27-year-old undocumented *ladina* with a third-grade education. Emphasizing that she never “needs anyone,” she said that back in Guatemala she gave birth to all her four children on her own; she even cut the umbilical cord herself. Here, it is the same thing; she tries to “inform herself” about medical treatments, and does not recognize as help the information she gathers from people she meets in buses, supermarkets, or church, so as not to become “indebted” to anyone.

Finding a Cure through Transnational Links

Recent research points out that as immigrants establish themselves in the places they enter, they also maintain active ties—through the circulation of people, goods, and money—with their home communities, “building social fields that link together their

country of origin and their country of settlement" (Glick Schiller, Basch, and Blanc-Szanton 1992: 1). These activities, encapsulated into what has been called transnational ties or social fields, include processes that range from the macro level—economic and governance regimes—to the local level—political parties, churches, and community organizations (Levitt 2001). In cases where immigrants are unable to travel back and forth to their homelands—due to financial or legal constraints—these transnational activities remain confined to a relatively small group of people—professionals, couriers, and commercial distributors—who cater to people in both places (Menjívar). Thus, for most of the immigrants in this study, couriers and commercial distributors put within their reach products brought from their homeland or familiar goods brought from other Latin American countries. Such merchandise includes food ingredients, articles of clothing, household goods and, importantly, an assortment of medications, some of which are "traditional" herbs and treatments, but others are prescription drugs.

In some cases pharmaceuticals (e.g., antibiotics, antidepressants, powerful painkillers, etc.) are brought in and sold at local supermarkets, variety stores, and even liquor stores—without prescription. In the countries of the Third World from where many contemporary immigrants originate pharmaceuticals, which are prescription-only in the United States, can be bought without a doctor's prescription (Price 1989; Logan 1993). In fact, in many cases, such pharmaceuticals are so commonly available that they have become integrated into the repertoire of healing practices of "traditional" practitioners (Ferguson 1981; Hardon 1987; Haak and Hardon 1988; Etkin, Ross, and Muazzamu

1990; Pebley, Hurtado, and Goldman n.d.).[11] Thus, it is not novel for these immigrants to use these pharmaceuticals in the same way in the United States when such medications become available. U.S. policy makers and authorities, however, often find this practice too dangerous. For instance, the city of Los Angeles has conducted a very aggressive campaign to eradicate *botánicas* (stores that sell a variety of "traditional" medicines as well as prescription drugs). [12] In reality these medicines are also sold in many other commercial establishments, where such products have a huge mark up and often end up costing more than medication bought with a doctor's prescription. But according to some of my informants, "at least it's medicine that you know works well, not like the Maalox or Tylenol that doctors give here."[13] Often immigrants on their own go to these

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[11] Some researchers have argued that the widespread use of Western medicine in the developing world is the result of the elite establishing medical systems that correspond to their own interests and needs (Frankenberg 1980; Chavez 1986).

[12] Los Angeles County Supervisor Gloria Molina persuaded Assemblyman Martin Gallegos to introduce emergency legislation to make the selling of prescription drugs a felony and to give county officials the authority to shut down such establishments (Bernstein 1998).

[13] Ironically, when a physician prescribed medications that are normally sold over the counter, such as Maalox, my informants (as well as other immigrants I came across) tended to think that such medication was not potent enough or was simply inappropriate.

establishments to purchase these drugs, but just as often it is their friends, families or acquaintances that inform them of the existence of such places. But other times the immigrants' relatives back home ship the medications directly to their loved ones via couriers, a practice observed among Guatemalans in Florida (Miralles 1989: 83), as well as among other immigrant groups who frequent these stores.

Some of my informants relied regularly on such shipments of medications for their own ailments as well as for those of family members, friends, and neighbors. These transnational "consultations" and practices are an integral part of the process by which people put together a treatment in a "patchwork" manner. People get in touch with friends and family in Guatemala directly or through contacts here "consult" someone back home. For instance, Maribel usually borrows money and gets a ride from her neighbor when she goes to the local clinic, but the medicine upon which she relies for "everything" is a set of medicaments (that usually includes Valium, acetaminophen, and injections of iron) that her sister unfailingly sends from Guatemala every three months. She explains: "You see, here I worry about everything. Sometimes I can't sleep…you know, my nerves. So my sister sends me my pills from Guate[mala] because they don't sell them here [without prescription]. I used to take them only when I had a strong headache, but now I take them for everything else. Sometimes I take them when I feel worried or sad." Nora receives a package containing penicillin, painkillers, and medications for upset stomach and diarrhea from her mother in Guatemala every four to six months. When her husband had an accident at the construction site where he used to

work, she quickly treated his wounds with compresses of an herbal concoction and two penicillin pills, which Nora thought were enough to avoid an imminent infection.

The medicine brought from Guatemala is usually shared with others, contingent upon the illness, relationship, or trust. Nora's husband's niece Antonieta receives calcium pills from her mother that she gives to her children, and when her friends worry that their own children are not growing as they should, Antonieta gives them some of those pills. She also receives injections of iron, which she sometimes shares with her aunt and cousin (mainly when she is in good terms with these relatives), and a friend who used to be a nurse in Guatemala administers these injections to them. Irma, a 26-year-old undocumented *ladina* with a sixth-grade education, usually "borrows" painkillers or medicine for the common cold from her sister-in-law, who regularly receives packages from home. Irma in turn reciprocates with a small favor and shares the medication with people she knows, sometimes people who are not even close friends but who are familiar with the particular medicine. In her words: "Sometimes a person tells me that she is ill, and since I know what's good and she has heard that the medicine is effective, I give her some of the medicine I trust, you know, things that I get from Guatemala. The other day the little girl of a woman I see at the bus station all the time, I only know her name is Sonia, was sick with fever. I gave her the pills that I get from Guatemala and the girl was feeling well in two days. These are very good medicines."

In some cases people not only receive medicines, they also consult those back home and then obtain the necessary medicines via courier. Miriam, a 30-year-old undocumented *ladina* with a sixth-grade education, usually calls her father back in

Guatemala when she is ill. Sometimes she also sees a private physician in Los Angeles, but never without asking her father first, who seems to "know everything about medicine and is accurate with his diagnoses." "I call him because he's very good, he knows what's good for what and even without examining, just telling him the symptoms, he prescribes what's best. I had a pain on my side and told him what I felt and everything, so he told me what to take. I bought the medicine he recommended to me [over the telephone] here, at the store I told you about that sells every medicine you need." Rosa usually consults with her sister and mother back home and, when they can, they send her the medicine—whether it is prescription drugs or an herbal concoction—they think is best for the ailment. But when Rosa's abdominal pain did not subside even after she saw a physician at a local clinic (who told her that she had heartburn and prescribed Maalox), they all realized that she might need surgery. Rosa traveled to Guatemala and had a gall bladder operation there, which finally put an end to her pain. The incident left Rosa—as well as friends and family—wary of the quality of medical care they can receive in the United States.[14] In her words, "Just because we are poor and don't understand the language, doctors here think that we don't have a right to be cured. So they tell you that you have one little thing when in fact you may die." Rosa recommends to everyone she knows that if they suffer from an ailment that is either serious or intractable, they should go back to their countries to obtain the necessary care. In Rosa's view, as well as several other informants', the part of the U.S. health care system that she has been exposed to when

[14] Similar fears and mistrust were expressed by the Mexican immigrants in a study by Cornelius, Chavez, and Jones (1984).

she has sought medical care, is not the best, and when seriously ill, she prefers to seek care that she can "trust" or with which she is more familiar.

Those who have documents (or have relatives who do) sometimes travel just over the U.S.-Mexico border to Tijuana to purchase medicines. Maríaa has a neighbor who goes there every couple of months and brings medicines that she needs. Sometimes her cousin goes to Tijuana to buy medicines that they cannot get here. Nora, who, as a permanent resident, can enter the country without difficulties, goes to Tijuana herself or asks her sister-in-law to buy medications for her there, mostly antibiotics and something for the "nerves." When she explained how she shares that medicine with others, she said: "I give some to people in need. But sometimes people are *malagradecidas* (ungrateful ones) and then I don't want to help them. My neighbor wasn't on speaking terms with me a few months ago, so I didn't give her the pills for the nerves that my sister-in-law brought from Tijuana. Now we talk again, so she's asking me for the pills. Yes, I'll give her a few…we're neighbors, it's better to be in good terms (laughs)."

I noticed that most of the medicines traveled one way—from Guatemala (or other countries in Central America) to the United States. I only came across two instances in which people had sent these goods to their country. Elvira, who does not make much from her work taking care of an elderly woman, struggles to send vitamins for the son she left in the care of her mother in Guatemala. When I asked her why she sent him vitamins she replied, "Because I see how healthy children look here, they grow tall and strong, so I want my son to take vitamins from here. Even if the food he eats is little and not like the food here, at least he'll get the vitamins that make kids here look so nice." And Margarita

sends bottles of Tylenol to her father, who lived in the United States for two years before returning to Guatemala, because it is the only painkiller "he trusts." Margarita adds, "Since the time he lived here, that's all he uses for everything. I guess it is a *maña* (habit) he learned while he lived here."

DISCUSSION AND CONCLUSIONS

The cases in this study offer an opportunity to make a few points regarding both the use of immigrant social networks in accessing medical treatment and the inner workings of these informal ties. The politico-economic context in which immigrants live is crucial, as it shapes the structure of opportunities for immigrants and ultimately determines the kinds of resources to which they have access, both for themselves and to help others. This broader context cannot determine the immigrants' actions altogether, but it delimits their range of action and shapes their choices. Thus, the immigrants' legal status determines whether they will have access to nonemergency formal medical care; the "choices" for the undocumented are quite limited these days. For those who have a stable legal status (e.g., documented), the jobs they are more likely to perform dictate whether they will have health benefits. Also, local, state, and federal policy define the terms under which care is provided. Within this broader context, immigrants, like poor people without access to formal health care, tend to resort to "alternative" methods, in which friends, family, neighbors, and acquaintances become key in putting remedies within reach. In this social milieu, however, these are not "alternative" methods but entirely commonplace practices that are widely known and available, often the only and first ones to which people have access.

Among immigrants with few resources, seeking medical treatment is a profoundly social process that involves primarily women, conforming to their socially ascribed role of keepers of the family. Rooted in the macrostructural conditions that govern their daily lives, these women's informal ties are fluid and dynamic; they are situational and change in composition depending on a variety of contingencies. Giving and receiving help in this context is more akin to "patchworking," in Kibria's (1993) conceptualization, than to a straightforward exchange of goods. As illnesses and the ill persons differ so do the arrangements people make to seek treatment. Furthermore, these social networks involve local and transnational actors, demonstrating the importance of the continuity of ties with home communities for these immigrants. Through these contacts immigrants obtain vital help that often makes a difference, literally, between life and death. However, I would not want to excessively romanticize the viability of these informal ties. There are cases in which immigrants do not obtain help from those familiar to them so easily, as when they have to ask more than one person for assistance before they find someone who will help. The point here is that obtaining and receiving help through these informal networks often represents a complex, negotiated process punctuated by disillusions, tension, and frustration as much as by cohesiveness and support (Menjívar 2000). This conceptualization takes us away from idealized images of support among immigrants as well as from rigid frameworks that categorize networks as helpful or unhelpful.

It is fair to note that some of the immigrants in this study also relied on informal ties to secure medical treatment back home even though they had access—by virtue of their economic position or employment—to a wide range of choices in medical care. But

once in the United States such ties are often their *only* means to obtain medical treatment, regardless of where remedies eventually come from. Thus, this practice is neither a crude transplant of a home country behavior nor simply a strategy to respond to current conditions. In this sense, the context in which these immigrants arrive tends to homogenize their previous experiences, sociocultural background, and status, and it puts most of them on an equal footing in accessing medical care. In this regard, it is noteworthy that whereas these immigrants' ethnicity may not impinge on the extent to which they utilize informal ties to access remedies, inter-ethnic relations (or lack thereof) remain important to observe. For instance, the obvious absence of networks that cut across ethnic lines to access medical treatment indicates that nationality per se may not necessarily provide grounds to develop informal networks, for there are other important social demarcations (such as ethnicity) that influence the formation and maintenance of these social ties. A worthwhile line of research would be to investigate (perhaps using methods that permit broader generalizations) how individual characteristics—gender, social class, human capital, and ethnicity—interact in other contexts so as to assess variations in medical choices, knowledge of treatments, and use of informal networks in immigrant health, and how social positions (such as ethnicity, class, gender) may shape such ties.

The content of these informal exchanges is worth noticing. There seems to be a belief that when people, particularly poor populations like the immigrants in this study, resort to informal ways to find medical care, they will usually seek "traditional" treatments. Sometimes it is assumed that in the absence of access to the formal medical

system, poor Latinos will rely on "alternative" healing practices (Giachello and Andersen 1981 in Suárez 1992). However, the immigrants in this study make use of "traditional" healing practices as much as of prescription medicine that is widely available both over the counter in the neighborhoods in which they live and from loved ones back home. So the use of "traditional" health practices does not offset the use of biomedical practices. On the contrary, these practices are almost always used in combination and become available through informal contacts. In using them, these immigrants' actions thwart lines of demarcation between the different worlds of dissimilar health care systems. As Bade (1994: 84) observes for Mixtec migrants, when they practice health care in California, they "move across, beyond, and between not only medical systems, but also social and linguistic barriers, cultural landscapes and political borders."

Although this study is based on a small number of informants who have recently arrived in the United States, and thus precludes generalizations, there are a few points that may have policy relevance. First, immigrant women figure prominently as transmitters of medical knowledge and providers of care, an important point for policy makers to note. Perhaps it is their networks that hold the key to unravel the famous epidemiological paradox among Latinos (e.g., they tend to be healthier than socioeconomically comparable groups). However, policy makers—and the public alike—who view immigrant networks as interminable sources of assistance, should be aware that in many cases, it is impossible for the immigrants to rely on these informal networks for help. The burden of taking care of newcomers may bee too heavy for their relatives—who may already be having financial (and legal) problems—to shoulder. And when they

do receive help from friends and family for health-related concerns, such assistance may be sporadic and does not represent a real alternative (only a good complement) to formal (and preventive) medical care. It should also be noticed that similarly to the lack of preventive care among poor nonimmigrants (Helton 1996), the participants in this study typically postponed seeing a physician until the problem became severe. As has been observed elsewhere (see Leclere, Jensen, and Biddlecom 1994), recently arrived immigrants, like most of this study's participants, tend to have fewer contacts with health care practitioners This is an important point to note for those involved in delivering health services to communities with high concentrations of poor immigrants, as well as for public health workers in general. Also, similarly to results from a study of Mexican immigrants in San Diego (Cornelius, Chavez, and Jones 1984: 93), this study's participants tended not to utilize large hospitals or emergency rooms for health care. Community clinics that offer sliding scale fees seemed to be the preferred provider, a slightly more common pattern among undocumented immigrants than among their documented counterparts. These findings contradict popular beliefs about undocumented immigrants' heavy use of state hospitals (which are likely to be used mostly for pregnancy-related matters or serious emergencies). Thus, perhaps efforts to curb undocumented immigration should be redirected away from an emphasis on cutting off these immigrants from the formal health system (tactics based on the presumption that immigrants overuse state-sponsored medical services), to policies focused on preventive care (that would ensure an overall healthy population) aimed at poor or marginalized groups, immigrant and non-immigrant alike.

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