Health Practices of Immigrant Women: Indigenous Knowledge in an Urban Environment

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ABSTRACT
This qualitative study of folk health practices of an indigenous Mexican immigrant community in New Brunswick, New Jersey investigates the barriers this community faces, and their effects on its members’ everyday practice of health in a new urban environment. Facilitated by local community organizations, two focus group interviews were conducted with women from this community, along with a questionnaire and multiple field visits. Analysis revealed several themes related to health practices, including the role of food, and how indigenous knowledge influences the community’s beliefs about, and practices of, health. Additionally, several environmental, communication, and systemic barriers also appeared to affect the community’s health practices. This research indicates that providing healthcare access to immigrant communities is a complex issue extending beyond the availability of services and resources. A better understanding of immigrant communities’ socio-cultural health practices may be a key to improving the community’s healthy living and overall quality of life.

Keywords
Community health, immigrant services, access, health practices, indigenous knowledge.

INTRODUCTION
One of the central research agendas of library and information science (LIS) is to explore how to provide communities with better access to information resources. LIS researchers have been spending tremendous efforts helping various communities, such as underrepresented groups and communities with special needs, such as those living with chronic illnesses, to address their information needs and improve their general well-being (Hersberger, 2005; Kaziunas, Ackerman, & Veinot, 2013). To do this, LIS researchers and librarians must undertake the complex task of assessing the information needs of the communities they wish to serve. This needs assessment is a critical step, but not the first step, in the process of ensuring access. Rather, the first step is to identify the community itself and those aspects of the community that affect information access (Veinot & Williams, 2012).

Identifying underserved communities, assessing their information needs, and understanding what factors impact information access for those communities is a complicated process for several reasons, not least of which is the rapidly changing demographics of the United States in the 21st Century. In the state of New Jersey, for instance, the foreign-born population has increased from 12.5% to more than 21% in a span of 20 years (Immigration Policy Center, 2013), and in the central city of New Brunswick, approximately half of the residents are Hispanic (U.S. Census, 2010). In order to best serve its residents, the city government provides many social services and assistance programs to low-income individuals, including a Charity Care payment program for hospital and clinic visits, reduced membership rates to a wellness center, and free door-to-door transportation to health care facilities (The City of New Brunswick, 2014; State of New Jersey Department of Health, 2015). Self-labeled the Health Care City, New Brunswick also boasts world-class teaching hospitals, and is the international headquarters of one of the largest healthcare companies in the world. What makes New Brunswick an interesting case to examine with regards to information and healthcare access is precisely its model status as a city providing strong healthcare safety net services to its highly diverse and rapidly changing population (Stanley, Cantor, & Guarnaccia, 2008).

To explore the broader issues of information access for specific at-risk or vulnerable communities in a large urban center, this analysis of the Hispanic immigrant community’s level of access to healthcare services and health information provides a rich opportunity for LIS researchers. To this end, this paper discusses exploratory study conducted in New Brunswick, NJ, with members of the Mexican immigrant community. In particular, this study investigates (1) how indigenous Mexican immigrants practice health when they settle in a

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new urban environment, (2) how they negotiate their folk health practices in a new healthcare infrastructure, and (3) what specific barriers they encounter when engaging in health related activities. We pay special attention to how traditional methods may clash with or are modified vis-à-vis the local system with its social services and programs, and how this community’s traditional or folk health practices are compromised or challenged by the healthcare system in the United States. By focusing on this community’s specific barriers to practicing health, the analysis provides a better understanding of the concept of access, a central concern of LIS, beyond merely the physical availability of services and resources.

RELATED WORK

This study intersects past and current research across several interdisciplinary fields including library and information science, community-based research, health informatics, sociology, and public health. In this section, we review relevant studies in these areas.

Community-based Information and Health Practices

A proper definition of the concept of community and a discussion of how community characteristics impact access is necessary given that this study’s unit of analysis is a community. Depending on the domain, community has taken on different, though not unrelated, meanings (Veinot et al., 2012). In LIS, for instance, prior work on communities has defined them by geographic, ethnic, or legal characteristics (Caidi, Allard, & Quirke, 2010; Chatman, 1999; Fisher, Marcoux, Miller, Sánchez, & Cunningham, 2004; Hersberger, 2003). Past research has also characterized communities by the nature of the information exchange network in which they engage (Fisher, Durance, & Hinton, 2004; Hersberger, 2003). These studies attest to the impact of personal networks on information behaviors and the effects of contextual factors, such as the immigration experience and public services, on the everyday information practices of immigrants.

Studies of information practices in health related contexts have also analyzed the information networks that define certain communities. For instance, Veinot’s study (2009) analyzes the different interactions through which community members with HIV share and acquire health related information. More recent work by Kazunias, Ackerman, and Veinot (2013) applied Chatman’s (1999) theory of information worlds to analyze the health related information practices of African Americans managing diabetes. And in their study of a Korean immigrant community in the United States, Yi, Svtilia, & Mon (2012) found that language barriers and a lack of culturally relevant resources online lead community members to rely on social networks for health related information.

Immigrant Communities, Health, and Indigenous Knowledge

Though the past 15 years have seen a surge in LIS research dedicated to the information practices of immigrant communities (Caidi, Allard, & Quirke, 2010), many studies focus mainly on the impact the new local context has on the information practices of immigrant communities (Courtright, 2005; Su & Conaway, 1996). These studies often ignore the effect of community members’ past life experiences and shared knowledge on their present information practices. These past experiences, which contribute to an immigrant community’s rich knowledge store, often come into conflict with dominant norms and beliefs in their new environment. For example, immigrant communities might have different methods of sharing knowledge (Tukiwai Smith, 1999), or different ways of organizing family life, both of which might become problematic in a new society that privileges text over oral traditions or that defines family roles differently. Analyzing how the information practices and knowledge of immigrant communities clash with their new information environment should further enrich LIS research in this area. At the center of the present study, then, is an investigation of the ways in which differing conceptualizations of health may create access problems for the community.

Previous studies define access as the outcomes of a more tangible and systemic nature, such as having insurance or having a primary care physician (Stanley et al., 2008). A broader understanding of access, however, might uncover less tangible barriers, such as socio-cultural barriers, in addition to systemic ones, as proposed by an earlier study, which found that providing public health insurance may be only the first step towards providing access to healthcare for a Hispanic immigrant community (Guarnaccia, Martínez, Silberberg, Cantor, & Davis, 2004). Other issues identified in this study that impede access to healthcare include language barriers, access to transportation, overcrowded health clinics and their limited hours of operation, and the stigmatization of mental health and of substance abuse services.

Because on the focus of this study is the shared folk health practices and information needs of an indigenous Mexican immigrant community, we apply an indigenous ways of knowing (IWOK) theoretical approach. As a theoretical framework, IWOK has been applied to research focusing on Native American or First Nation communities (Marshall, Kendall, Catalano, & Barnett, 2008), and on ethnic groups throughout Africa as well as Asia (Ngulube, 2002; Lwoga, Ngulube, & Stilwell, 2011). Indigenous knowledge (IK) is a highly localized, holistic, experience-driven, and dynamic type of knowledge that is transmitted

1 In this paper, ‘traditional health’ and ‘traditional methods’ are used synonymously with ‘folk health’ and ‘folk methods’ to reflect the use of the word ‘traditional’ in the Mexican immigrant community.
orally within a community (United Nations Educational, Scientific, and Cultural Organization, 2003). This knowledge is not learned in formal education systems, but is produced by and shared within its community, and can be understood as a system of shared values and beliefs that impacts the way members of a community carry out the tasks of everyday life, including health related practices.

Since the present research also analyzes how community-based health practices conflict with the healthcare system and other city agencies, health lifestyle theory is used to guide the research design and analysis (Cockerham, 2005). Rather than understanding health practices as the result of individualistic choices, health lifestyle theory presents a model of health in which structural and social factors impact health practices. According to this theory, individuals share norms and values by dint of their membership in a community, and these shared values shape their health practices. The point of departure for the present study takes the concept of health as defined by health lifestyle theory, particularly the proposition that health is socially constructed, and seeks to understand how the immigrant community’s understanding of health affects its related practices.

RESEARCH METHODS
To understand the health practices of an indigenous Mexican immigrant community in a new urban environment, this research includes several qualitative investigations, including field observations to learn about the local environment where the community is situated, a structured survey questionnaire, and two focus group interviews with community members.

Accompanied by a local informant, the first author visited three shops in the city that sell imported food products, plants, herbs, and homeopathic remedies primarily to the Mexican community in the area. This early fieldwork provided an initial understanding of this community and also validated our initial assumption of the presence of traditional or folk health practices in the community. Additionally, this early fieldwork allowed the researcher, an outsider in this community, to form strong relationships with community leaders, which is important in community based research, and especially in work with indigenous or marginalized groups, to avoid or minimize the negative effects of research on these vulnerable and often over-researched populations (Tuhiwai Smith, 1999).

Next, the researcher also reached out to two locally based grassroots community organizations in the area. Since this is a community-based research project, and considering earlier similar research studies (Israel, Schulz, Parker, and Becker, 1998), it was important for these local community organizations to help recruit participants, organize the focus group interviews, and provide the location for the groups to meet. Because many of the participants recruited work outside the home and many do not have reliable access to transportation, the local community organizations agreed host the focus group interviews on their own premises. This also helped to ensure that participants felt comfortable in their surroundings in order to facilitate group discussion, and allowed the researcher to assume the role of guest in the community’s home turf as a way of destabilizing the uneven power dynamic of the observer/researcher and observed/participant roles that can often result from this type of research (Tuhiwai Smith, 1999).

Participants
Theoretical sampling was used as the strategy for recruiting study participants (Glaser & Strauss, 2012). The research team recruited a total of 14 participants for this study and arranged two focus group interview sessions. To safeguard the integrity of this method, it is important to ensure that the participants involved form an organic group based on some shared or common trait (Glitz, 1997), which makes it easier to distinguish between personal views and group or community health practices when analyzing the data (Morgan, 1997). In this case, the participants were adult women of indigenous Mexican origin who consider themselves part of the city’s immigrant community. We chose to focus on adult immigrant women in this study because women in this community tend to be the primary caretakers for their families (Andrews, Ybarra, & Matthews, 2013), and therefore serve as a critical lens for the researchers to gain a deeper understanding of the health practices of this immigrant community.

Data Collection
In addition to field observations of the urban retail environment, the main data collection methods consist of focus group interviews and survey questionnaires with 14 participants, which includes questions related to self-assessed health status, family characteristics, and social and demographic information such as languages spoken, highest level of education, and health insurance status. The data collected through the survey questionnaires serve to provide additional context to bolster the data gathered in the focus group interview discussions. The focus group method of data collection was used because it is often preferred in exploratory research that investigates attitudes related to habitual behavior that is not easily observable, and its format easily lends itself to group discussions that solicit common attitudes (Morgan, 1997), such as how community members settle into city life and how they adapt their health practices in this new environment. To facilitate interaction and discussion among participants about health, folk health practices, and the barriers the community faces when engaging in certain health practices in the U.S., a focus group interview guide was also developed.

Both focus groups were conducted in Spanish and audio-recorded with consent from all participants, and one of the researchers served as the focus group moderator. In
addition, the researcher took notes during the focus group interview sessions, enriching the description of each group’s discussion. Each focus group interview session lasted approximately two hours, including explaining the study and the consent procedures, filling out the survey, and the group discussion.

Data Analysis
Audio recordings of the focus group interview sessions were transcribed for data analysis. Both the transcript and notes taken during the focus group interview sessions were analyzed using a 2-step coding method. We employed theoretical concepts developed in Health Lifestyle Theory and community based research on IWOK to analyze the relationship between the community of practice, indigenous knowledge, and beliefs about health among this population. First, an open coding technique (Charmaz, 2001) was applied to extract categories such as ‘natural,’ ‘heritage,’ ‘processed,’ ‘environmental,’ ‘language,’ and ‘interpersonal,’ from the participants’ own narrative accounts related to health, folk health practices, and barriers they encountered, and to their survey responses. These categories were subsequently analyzed using a constant comparative method to compare group and individual attitudes along the dimensions of emotions, practices, experiences, and perceptions that emerged from the participants’ discussion.

FINDINGS
The participants in this study discussed holistic views about health shared by the community, such as the importance of food in maintaining health, as well as barriers to folk health practices in their everyday life. They also brought up the interaction of different city agencies, such as the relationship between the public school system and the healthcare system. This section describes the study participants’ key characteristics, their perceptions about health, their shared health practices, several barriers they face, including the need to acclimate to a new urban way of life, and describes how these barriers influence their everyday life health related activities.

Participant Demographics
The survey results reveal that the women who participated in this study were indeed the primary caretakers for their families, in charge of cooking, caring for sick children and other family members, and often contributing to the family’s finances. All but one of the women reported being employed, and all reported being in relatively good health, with only two participants disclosing chronic health problems. Only three participants reported having health insurance, an indication of income level. The participants’ lack of health insurance also indicates they mostly receive health care through the city’s Charity Care program and through the local federally funded health clinic. All but one of the participants had at least a high school education, while two reported having a college or vocational degree. All but one reported speaking Spanish with their families. The average family size included 4.5 family members, and families often include a grandparent or other members of the extended family. The majority of the participants who responded to the question asking about ethnic background reported being part one of several indigenous groups native to Mexico, including Mixtecos, Tacuates, and Zapotecs. Though the literacy level of participants was not of primary interest, while filling out the survey, one participant commented on the difficulty of filling out surveys given the educational levels and Spanish language literacy of many members of the community, which may explain why not all participants completed the survey.

Health Practices
The survey data findings served to validate that participants indeed share enough characteristics to be considered members of the same community. All participants reported engaging in a fair amount of physical activity, such as walking for at least 20 minutes a day or riding a bicycle. Regarding the use of folk remedies, all respondents reported having done so in the past or doing so regularly to treat common illnesses for themselves as well as for their families, though more than half of the women reported having experienced some difficulties in trying to prepare folk remedies after moving to the area. Most of the participants reported having visited a traditional folk healer, though not necessarily in the United States, whereas more than half of the participants reported not having a primary care physician in the U.S. Nevertheless, most participants reported feeling confidence when interacting with U.S. doctors, though some qualified their responses by mentioning a perceived lack of respect for the community’s culture or mentioning they seek care from physicians only if absolutely necessary.

“Over there, it’s more natural.”
To explore the barriers new immigrants face in this study places the critical onus on system problems rather than on the community’s social determinants of health. To better understand the nature and impact of these barriers in everyday life, it is important to first learn how the participants understand the concept of health and how they perceive the role of food and meal preparation in maintaining a healthy lifestyle for this community.

The majority of the focus group participants originally come from rural areas in Mexico and spent their childhood on ranches, cooking over open flames and depending on subsistence farming. They described how diet and fresh food are important to their health.

Over there [in Mexico] it’s more natural because we plant everything there. In fact, even meat, for us it’s fresh from the same day, they butcher the cow, pig, chicken, whatever it is, that same day. [Meat] it’s
never refrigerated like here. We eat a lot of vegetables because there are so many over there. Corn, we plant it because tortillas are natural for us...If we don’t eat tortilla it’s as if we didn’t eat something our body needs. Oh, and chile, too.

The women highlighted the importance of concepts such as ‘natural’ and ‘freshness’ and their need to adjust to not only different ways of procuring food in their new urban environment, but also to the effect of technology on foods, such as refrigeration, stovetop cooking, and food processing. For instance, when referring to cooking methods, one woman described: “Here, everything’s with a stove. Over there, it’s natural, with firewood.” This close relationship with natural food can become challenging after they settle in a new environment, where the types of foods available in local grocery stores and the cost of certain ingredients might not support their health practices. When discussing the differences in food and their ability to prepare the same foods in the U.S., for instance, one participant explained, “It’s just that here, vegetables have too many chemicals. And over there, they’re more natural.” The participants were keenly aware of the relationship between food and health, and they attributed their more natural way of preparing and procuring food with higher quality of health. As one women pointed out, “And over there, no one gets sick, even kids don’t get sick.”

The participants’ discussions also revealed a holistic view of health, encompassing nature, food, and the environment—a defining characteristic of indigenous cultures (Tuhíwai Smith, 1999, p. 105). The relationship between health and nature discussed by the participants reveals a tension between the freshness of food and the technology that is often taken for granted in modern homes. Modern affordances such as stovetop cooking and refrigeration mean that food in the new urban locale is not as fresh and, therefore, not considered as healthy by this particular community. The presence of chemical additives in processed food is also widely acknowledged to be bad for health among participants. This community’s keen understanding of the relationship between the foods they eat, including not only cooking methods but also modes of food production, and individuals’ physical health has strong implications for public health initiatives focusing on preventive health measures.

Environmental Barriers
When discussing their new city life, participants reported a number of challenges they encounter regularly. Navigating their new urban environment has been a challenge for newcomers in this community. Often, preparing food in traditional ways and socializing over a meal lead to a certain amount of culture shock, as one participant described.

Indeed I had to adapt when it came to obtaining the things I was used to eating. Food. We always eat at home. Fresh snacks made at home. Here, well, you had to…I learned what canned beans were, canned vegetables. When I was invited to dinner, I imagined going to eat a home cooked dinner, but no. They took me out to Burger King.

In addition to getting used to eating out more often, community members must also adapt to the lack of fresh ingredients available which, in addition to preparing meals, are also used to prepare home remedies for common illnesses. Often scarce in the city, when available, fresh ingredients, cost much more in the local shops than in Mexico, as the following discussion describes:

Ana: Sometimes, you take them [children] to the hospital and they don’t give them anything, nothing. So, at home, you have to find a way to reduce their fever or a way to suppress their cough or how to help them with their colds...You go to the Oaxaqueña and buy a little remedy, and they charge too much. But, since you need it and you know that back home [in Mexico] it’s good for children’s colds, you buy it. Because you need it.

Paula: [one ingredient] at the Oaxaqueña [local Mexican shop], it cost me $28, when in Mexico, it costs $1.50.

In addition to adapting to higher costs and the lack of fresh food, this new urban life also means a change in the workday for many women. Rather than working at the family ranch, women must now work outside the home, which changes the structure of their day and the amount of time they have available to prepare food at home. Some participants mentioned that because the new routine does not give them sufficient time to prepare fresh food according to their traditional ways, they often have to consume processed foods.

Other environmental factors affecting the community’s health include the housing and living conditions in which many newcomers live. One woman described the city as congested. Houses and apartments in the city tend to be small and are often occupied by several families. One participant described the living conditions as “enjaulado,” meaning, “caged,” and another described the living situation of many in the community as “living pressed up against each other” when explaining that, often, several immigrant families or individuals share one house or apartment by renting single rooms within the same unit. The city environment also makes it difficult for children to play outside, which participants tended to associate with decreased overall health among their children. Participants also attributed the development of asthma

2 All participant names used in this paper are pseudonyms. No names were collected in this study per the protocol approved by the Institutional Review Board.
among children in the community to higher levels of pollution in the city. One participant observed:

I see that the streets are super dirty, and I get to thinking what if we all get together on some weekend when we have time, and together clean up. Try to keep the city clean.

Participants also discussed the prevalence of drug trafficking and drug-related crimes in the city is yet another environmental barrier to a healthy way of life:

There’s also the drug problem. We see the exchange of drugs much more openly [here than back in our hometowns]. It’s more ingrained in the streets.

Communication Barriers
Previous research has investigated barriers to intercultural communication, including differences in values, norms, ways of expressing emotions, and, most obviously, differences in language spoken between interactants (Spencer-Rodgers & McGovern, 2002). These factors become much more problematic when they occur in situations marked by power imbalances, which is often the case for immigrant communities as they settle into a new and sometimes hostile environment. These interactions often take place within a system of inter-agency policies that yields a palpable amount of power over immigrant communities, such as policies that demand of community members to produce document proof that is often difficult or impossible for them to provide. This section presents the types of interpersonal barriers, commonly experienced by the community, that affect participants’ health practices.

Participants reported often experiencing a lack of understanding from their primary care physicians. Indeed, fundamental differences in understanding health, medicine, and legitimate health related practices can often create significant challenges. For instance, participants recounted how doctors reprimand mothers who treated their sick children with home remedies for fear that these remedies would do harm, as the following examples show:

Gloria: And if you say, “I gave him a home remedy,” they’ll say, “don’t do that, Ma’m, you could poison him...You can’t do that yourself,” they’ll tell us. We can’t cure our children...

Ana: Our custom is that babies, right after they’re born, since their belly button gets like that, so that they won’t end up bumpy, we wrap them up. And since I didn’t know [that it’s not done like that here] I took him to the hospital bandaged up and I got such a scolding! Never in my life had I been scolded like that—and they told me, “Are you crazy?! Having that baby wrapped up!”

Sometimes, different culturally accepted modes of interaction also present communication barriers, which affect how the participants perceive the care they receive from healthcare professionals. This perception of mistreatment belies an expectation that the patient-physician interaction should entail a certain level of compassion. For instance, one participant discussed unacceptable bedside manners during a recent hospital visit,

My body does not tolerate strong medicines. My body can’t handle 500 of Motrin; my heart starts beating really fast. So, whenever I go to the hospital, they have to give me a wristband that says I can’t receive strong antibiotics. And I went to a specialist Charity Care doctor, and she said, “I don’t know what you’re going to do when you get really sick or have a serious illness. We can’t prescribe you anything.” That’s not a response. That’s no way to treat someone.

Communication barriers also include the community’s unmet expectation of the type of care doctors or pharmacies should provide. Participants, for instance, described frustration at doctors basing their diagnoses on family histories or having to convince their physicians that they or their children are sick.

...But only if you tell them [doctors]. It’s not that we should have to tell them. Rather, they should find the cure for the illness that you’re telling them you have...For example, [they’ll say] you’re likely to have diabetes because your mom has diabetes. That’s not always the case. But here, doctors...you go to them so they can give you a solution but we are the ones who have to find the solution for them or make them understand that the child is sick.

The example above illustrates that the women in this community expect doctors not to rely on them for help with diagnoses. The women in this immigrant community expect doctors to listen to them explain their symptoms, believe them when they say they or their children are sick, and subsequently prescribe an effective cure. These women found U.S. physicians’ overreliance on family history to be an inadequate way to gather relevant information to help treat them or their sick children.

The lack of compassion, bedside manners, and respect of cultural differences regarding health practices can create a strong rift between physicians and immigrant communities. Research on intercultural communication has found that frustration, embarrassment, and anxiety are often associated with interpersonal communication barriers (Spencer-Rodgers & McGovern, 2002). These negative feelings are especially pertinent for communication in healthcare settings, which are already emotionally laden for patients who may be confused by medical jargon, or who are worried about their own health or the welfare of their children. Within immigrant communities, the negative feelings associated with problematic intercultural communication can weigh even more heavily on individuals who are also experiencing
anxiety and worry over their legal status potentially affecting their mental health.

**Systemic Barriers**

A model of Health Care Access Barriers defines structural barriers to health care as attributes of the broader health care system that impede access to health care services, such as long wait times, the need to visit multiple facilities for tests and care, operating hours, etc. (Carrillo, Carrillo, Perez, Salas-Lopez, Natale-Pereira, & Byron, 2011). Beyond the health care system, however, our study found that other institutional barriers are not only at play, but their relationship with one another compounds the access problem for community members. One of the key findings that emerged from the focus group discussions, for instance, was the interdependence of the healthcare system and social service programs, which causes considerable challenges for this community. Specifically, according to the participants, Charity Care recipients receive some funds to use for health care needs, but any funds that are not used are lost or made unavailable for future needs. Participants characterize this constraint of the Charity Care program as causing unnecessary healthcare expenses accrued simply to abide by the program’s policy. Another system issue discussed was how the public schools’ sick day policies force mothers in the community to visit a clinic even when they feel it is not necessary to do so. One participant described a common difficult situation,

In preschool or in daycare, there are times when if the child has a fever one day, the next day you have to take a doctor’s note. Because if not, they say they won’t let him back in [school].

When certain situations engage more than one city agency or institution, for instance when issues involve both the Charity Care program and the public education system, they become even more complicated.

Jennifer: But there’s a great problem when kids are in school. Because if you don’t take them to the almighty doctor, they don’t give you proof that the child went to the doctor, and it doesn’t count as him being sick.

Ana: And with that, they charge the insurance.

Gloria: Even if they don’t prescribe anything.

Doctors reportedly prescribe over-the-counter medications such as Tylenol simply in order to charge the cost of those drugs against the Charity Care dollars and therefore prevent those funds from expiring or becoming unavailable. The structure of social service programs for low-income individuals, such as the Charity Care program, creates barriers for the immigrant community. Participants described how the paperwork needed to apply for Charity Care makes this process problematic:

Lupe: …they asked for one document, then they asked me for another, then another, and I tell them, unfortunately, I don’t have any of them.

Olga: They ask you for proof of where you live, um, proof that you have a bank account, or proof of income…

Lupe: And they tell me, “well, how are you going to pay?” It’s not that I’m refusing to pay…

The issue here is related to the immigrant community’s living situations. Since immigrant families or individuals often sublet rooms in a single house, many do not have a lease or a utility bill in their name to prove they are local residents. This lack of documentation, which can include the lack of a bank account, can prevent immigrants in this community from receiving payment assistance for healthcare services. What these women described is a tightly interlocked system of policies at different levels of urban life that forces them to interact with the health care system even when they do not see a need or a benefit. The systemic barriers faced by this community highlight issues that are potentially similar for other immigrant groups living in the area. Further research with other immigrant communities in the city might show this is a greater problem affecting more than one group.

**DISCUSSION**

This study analyzes an immigrant community’s understanding of health, its indigenous knowledge and folk health practices, as well as its members’ experiences navigating health services in an urban area with an advanced health care system. Though the study was conceived as an investigation of folk health practices, participants spoke at length about food. Since folk remedies are essentially made of the same ingredients as food (i.e. herbs, leaves, vegetables), this emphasis on food should not be surprising in discussions about folk health. Participants also shared various obstacles to their health practices regarding their overall health as they moved from rural areas in Mexico to an urban environment in the U.S. In this section we situate this immigrant community’s holistic concept of health and its folk health practices within the broader agenda of LIS research. Particularly, the discussion will focus on the role that health practices play in defining a community, the concept of health as a socio-cultural practice, and a reconsideration of the concept of access in LIS.

**Community Health Practices**

Despite differences in age, education, length of stay in the United States, Mexican state of origin, or indigenous background among participants in the study, they all share

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3 The Charity Care program is the New Jersey Hospital Care Payment Assistant Program offered to low-income individuals.
a similar set of practices related to health and to maintaining a healthy way of life, including their reliance on folk remedies and fresh food, traditional methods of cooking and eating, and their ways of sharing this knowledge across generations. In rural Mexico, where more than two generations live in the same house, women acquire knowledge about health, including herbal remedies and the healing properties of plants from their parents or grandparents orally and through observation. For instance, one participant described learning midwifery skills in Mexico during her youth by watching her grandmother prepare herbal teas to induce labor for pregnant women in the community—knowledge she was able to use after emigrating to the U.S. when her sister went into labor many years later. This shared set of folk health practices, as well as the oral, visual, and practice-based mode of knowledge transfer, is a useful way to characterize this immigrant community when considering information practices since the oral tradition distinguishes indigenous ways of knowledge from others (Tuhiiwai Smith, 1999).

Researchers in LIS have long extended their research agenda from a cognitive approach to include more habitual or routine activities people undertake when interacting with information (McKenzie, 2003). The findings of the present study illustrate that participants from the immigrant community share a significant level of indigenous knowledge about health and health practices, as indicated by the near universal use of folk remedies within the community, and therefore they constitute a community of practice (Wenger & Lave, 1991). Understanding the immigrant community’s shared beliefs and socially constructed practices is key to supporting the information needs of its members, including health related information needs, as they settle in a new urban environment.

Health as Socio-cultural Practice
Our findings support health lifestyle theory arguing that health practices are indeed socially determined (Cockerham, 2005). In this study, health-related community practices, such as food preparation and caring for sick children, are guided by beliefs about what the most natural way is to address health in everyday life. Our participants’ emphasis on “natural” as a key concept associated with maintaining a healthy way of life indicates a holistic view of health, which is consistent with previous research on indigenous ways of knowing (Tuhiiwai Smith, 1999). The relationship between the individual and the environment is very strong for this community, and food is a link between the two. Beliefs about the natural quality of food—such as whether ingredients are fresh or processed, whether food is prepared at home or not, or whether it has been refrigerated, cooked with a stove or over an open fire—all represent this community’s understanding of healthy living.

Research in the health and social sciences tends to characterize non-Western beliefs about health and medicine as “alternative medicine” (Barnes, Bloom, & Nahin, 2008) or “ethnomedicine” (Murguia, Peterson, & Zea, 2003). This characterization privileges approaches to medicine endorsed by Western institutions and assumes that scientifically sanctioned methods are not only better, but are also the only way to, ensure the health of communities, but also the only way to treat illness. The characterizations of folk health practices as ethnomedicine can also confuse several different types of cultural practices and beliefs, such as obfuscating the relationship between spiritual ceremonies and physical health (ibid.). To compare the effectiveness of Western medicine treatment versus folk remedies is beyond the scope of our research. The purpose of our study, rather, is to argue that indigenous immigrant communities, with their rich, practice-based knowledge, may perceive and practice health differently than the methods sanctioned and supported in American cities. Understanding these immigrant communities, their shared beliefs, and how these beliefs affect health practices is critical for the way our cities address public health services, especially as the immigrant population continues to grow in the United States.

Rethinking Access in LIS
Access is an important focus of research in health sciences and LIS research (Guarnaccia et al., 2004; Veinot et al., 2012). As a concept, however, access remains ill-defined. Often it is used to mean the provision of a resource or service to a community free of charge. That a service or resource exists or that it is freely available, however, is not enough. Such a restricted way of conceptualizing access does not account for all barriers, such as the communication, environmental, or systemic barriers to access that a community might experience. For the immigrant community in this study, the mere existence of public assistance programs such as Charity Care, local shops carrying imported goods from Mexico, and various healthcare facilities is not sufficient to ensure adequate access to quality health. In actuality, many of these programs create cumbersome systems, such as requiring a doctor’s note to let a child back in school after an illness, which forces a parent to visit a health clinic often to receive an unnecessary prescription for over-the-counter medication. The three main barriers to health practices highlight the need to better understand this immigrant community’s own indigenous ways of knowing and doing.

A central research question in LIS is to determine what factors impact a community’s level of access to information resources and services (Veinot et al., 2012). Defining access as simply the physical availability of a program or service can hide other important barriers that marginalized communities face in their everyday life information environments. Socio-cultural approaches to community health practices, such as the one applied in this
study, can help city governments, public health agencies, and community organizations to provide immigrant communities with better access to health information and services—all of which are key to maintaining good health. Such a re-conceptualization of access can inform the design of social programs and information resources, and could improve the provision of public health interventions that fit within the community’s shared health practices and with its own set of shared beliefs.

CONCLUSION
This paper presents findings and analysis from an explorative qualitative investigation of the folk health practices of a Mexican immigrant community in New Brunswick, New Jersey. Our study contributes a unique account of immigrant women in the U.S., focusing on their health practice, and access to healthcare, social services, and other resources. We hope to provide a deeper understanding of the concept of access, which is a central concern of LIS researchers to understand human behaviors and help improve information and social services, with an ultimate goal of improving the quality of people’s lives. Our analysis reveals a complex environment of differing health practices, including those sanctioned by the U.S. national health care system, those of health care professionals working in the area, and those of the immigrant community itself. This plurality of health practices creates an environment that can be difficult to navigate for immigrants as they carry out the activities they associate with maintaining good health for themselves and their families.

While our research is limited to mainly two focus group interviews, it nonetheless has valuable practical implications for city agencies, healthcare providers, and other community outreach programs, including libraries, that serve immigrant communities. Ensuring equitable access to health services and health information is a complex issue that goes beyond the availability of services. Future work will include perspectives from healthcare practitioners, public health agencies, and other stakeholders who work with immigrant communities to help improve community health, which should deepen our overall understanding of the complexity of providing and ensuring equitable access to health information and services for at-risk or marginalized communities. A better understanding of these diverse and socially constructed health practices that interact in a single urban locale should provide a lesson to researchers and practitioners who work with immigrant communities to ensure equitable access to health.

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