

Health Promotion Through a Binational Lens: A Study of Health Promoters in Indigenous Mexican Communities

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Executive summary

Our ethnographic research provides a binational lens on the health promoter strategy, specifically focusing on Mixtec and Triqui populations in Oaxaca, Mexico and in California. We examined the health promotion program implemented through the federal anti-poverty program, Oportunidades, in Oaxaca and the Indigenous Health Project implemented by a binational indigenous Mexican migrant-led non-profit in California, Centro Binacional Para el Desarrollo Indígena Oaxaqueño. Indigenous Oaxaqueños represent a growing percentage of Mexican migrants who confront particular political, social, cultural and linguistic challenges in terms of health care access both in Mexico and the United States. Our study focused on the political and economic factors informing program implementation in Oaxaca and California, the specific ways in which promoters help indigenous Mexicans confront the barriers to health care access and information they face, and the social implications of the promoters model.

Our binational research finds that promoters programs in indigenous communities on both sides of the border have an explicit focus on community development and empowerment, two areas which are central to the health and well-being of indigenous Mexicans who have historically been marginalized and under-resourced in both Mexico and the United States. Despite their empowerment focus, however, programs in both contexts fail to take into account the specific cultural and linguistic needs of indigenous communities. In addition, they are mostly targeted to and attended by female participants, which establishes worrisome gender dynamics. Finally, they are informed by a neoliberal economic model that makes program participants responsible without creating or facilitating economic “opportunities” for them.

Introduction

The use of health promoters is fast becoming the paradigmatic model for working with Mexican migrant farmworkers in the United States. Efforts in California led by the California Endowment and Health Initiative of the Américas and implemented by local community-based organizations have been paralleled in other states with high Mexican migrant populations such as Washington, Texas and Illinois to name a few. National conferences such as the Western Migrant Stream Forum held in Spokane,

Washington in January 2008 and on-going binational dialogues and exchanges with Mexican doctors, policy makers and promotores have focused on the importance of health promotores to the Mexican migrant population in the United States.

Our research provides a binational lens on the health promoter strategy, specifically focusing on Mixtec and Triqui populations in Oaxaca, Mexico and in California. We focus on indigenous Oaxaqueños because they represent a growing percentage of Mexican migrants and because they confront particular cultural and linguistic challenges in terms of health care access both in Mexico and the United States. We also look at this population because many of the communities they come from and migrate to have active health promoter programs. Finally, the promotores programs in indigenous communities on both sides of the border have an explicit focus on community development and empowerment, two areas which are central to the health and well-being of indigenous Mexicans who have historically been marginalized and under-resourced in both Mexico and the United States.

What are promotores de salud?

Health promoters have been known by a variety of names in the United States including community health workers, community health advisors, lay health advocates, peer health educators, community health representatives and outreach workers. In Latino communities and in Latin America, they are known as promotores/promotoras de salud. Although the title varies, generally their role in the United States is to offer interpretation and translation services, culturally appropriate health education and information, assist people in receiving the care they need, give informal counseling and guidance on health

behaviors, advocate for community and health needs, and provide some direct services such as diabetes and blood pressure screening.

In Mexico, promotores became a central feature of health and development strategies under the federal poverty reduction program called Progresá. The health promoter position was conceptualized as playing an intermediate role between the program staff and the program beneficiaries. In 2002, under the new version of Progresá now called Oportunidades, the official name of the health promoter changed to “vocal.” Currently, according to the Rules of Operation of Oportunidades, the role of the “Vocales” is to establish a strong relationship between program staff and beneficiary families in order to communicate their requests and suggestions and strengthen the activities having to do with nutrition, social oversight and program transparency. Promotores fulfill this role while attempting to preserve an open and direct communication regarding the norms of the program.¹ Although officially their functions are limited, “vocales” or promotores in rural communities take on a much larger and more complex role, which includes capacity-building and monitoring of the ten to fifteen families under their care, as well as spearheading campaigns about cleanliness, hygiene, immunization and epidemics.

As in the United States, they can give counseling and guidance on health behaviors and provide screenings, they also can administer basic first aid and give injections. Unlike in the United States, promotoras working in rural settings are generally chosen for a specific period of time (one to three years) and are trained by the local doctor or health assistant. They are also beneficiaries of the Oportunidades program,

¹ Poder Ejecutivo, Diario Oficial de la Federación, 28 de febrero de 2007. “Acuerdo por el que se emiten las reglas de operación del Programa de Desarrollo Humano Oportunidades, para el Ejercicio Fiscal 2007”

which means that they receive compensation for their participation. In the United States, the compensation varies according to the job description. Some promotoras work full-time for clinics or non-profits and are paid a regular salary. Others undertake health promotion activities in their spare time and, depending on the arrangement they have with the sponsoring organization, they can either receive a small stipend or nothing at all for their volunteerism. In both countries, most health promotores are women.

Our study

Our research team was interested in three aspects of the health promoter model. First, we wanted to understand the political and economic factors informing program implementation in Oaxaca and California. Second, we wanted to understand the specific ways in which promotores help indigenous Mexicans confront the barriers to health care access and information they face including understanding the biomedical information they receive, navigating the health care system and linguistic interpretation. Finally, we were interested in the social implications of the promotores model. For example, what role do promotores play in fostering the social cohesion of the community? How do they contribute to the individual and collective empowerment of indigenous Mexicans? Do their social roles change as a result of their position as promotores? If so, how? What other social implications does the promotores model have for the indigenous community?

Our research for this project was ethnographic and focused specifically on Mixteco and Triqui communities. We conducted individual and group interviews with health professionals, program participants, community leaders and doctors in both countries, but especially in Oaxaca and California. We also engaged in participant observation of health education workshops, one-on-one interactions between the

promotores and their clients, as well as reviewed health promotion materials and curricula for Mexican and U.S.-based programs working with Mixtecos and Triquis.

Our research team conducted thirty-five informal interviews in Oaxaca and five focus groups with a total of seventy-five participants. Most of our interviews were conducted with people affiliated with the Oportunidades program. We spoke with medical staff at the regional hospitals in Huahuapan de Leon, Santiago Juxtlahuaca and Tlaxiaco, with doctors and rural assistants in the rural medical units, as well as with promotoras and Oportunidades program participants in local towns. We also observed health promotion workshops conducted by the institutional promoter from the hospital in Huahuapan de Leon and reviewed IMSS health promotion materials and programs at the hospital. Our interviews in Juxtlahuaca, Oaxaca also included discussions with staff from a binational indigenous organization, Frente Indígena de Organizaciones Binacionales (FIOB). In addition, we conducted seven semi-structured interviews with staff at the Instituto Mexicano de Seguro Social (IMSS) in Mexico City, the federal office for the Oportunidades program.

Because there is no federal equivalent to Oportunidades in the United States, our research in California looked at the health promotion programs of a non-profit, Centro Binacional para el Desarrollo Indígena Oaxaqueño (CBDIO), which is dedicated to working on the health and well-being of indigenous Mexican migrants. This binational indigenous organization has offices and programs throughout the state. Our team conducted interviews and engaged in participant observation in three areas where CBDIO implements their Proyecto de Salud Indígena: Fresno, Greenfield and Santa Maria. Research in California involved eight months of working closely with the community

health workers, or promotores responsible for implementing the health promotion programs to primarily Mixteco and Triqui migrants in Greenfield and six months doing the same in Fresno. Shorter visits were made to other sites where CBDIO operates including Santa Maria, Livingston, Madera and Farmersville.

Our research in California included twelve in-depth interviews with health promoters, numerous formal and informal interviews with local civic leaders, community organizers, clinical staff, social service providers, health practitioners, staff members involved with the Agricultural Workers Health Initiative at the California Endowment, staff members involved in the promotores exchange program at the Health Initiative of the Américas, indigenous leaders and health promotion program participants. We also conducted four focus groups in Greenfield and one in Santa María, reviewed written materials such as health curricula and brochures from national organizations like the March of Dimes, the U.S. Department of Health and Human Services and local non-profits operating in agricultural communities in California such as La Union Del Pueblo Entero (LUPE) and CBDIO, some of which have been adapted specifically for working with indigenous Mexican populations in the United States.² International, national and state policies on health promotion and promotores were also reviewed in addition to news and scholarship on health issues affecting Latina/os in the U.S., but specifically in California. Finally, we engaged in participant observation of health education workshops and one-on-one interactions between promotores and indigenous community members.

Although our team conducted extensive research in both Oaxaca and California, we did experience some challenges and limitations. First, the fact that none of the

² The March of Dimes curriculum for reproductive and maternal health was adapted by CBDIO not by the March of Dimes.

members of our team spoke Mixteco or Triqui made understanding and interpreting everything we observed difficult at times. When possible and appropriate, we benefited from the use of interpreters. However, there were some instances, especially in California, in which there was no interpreter or the interpretation was much briefer than the dialogue that preceded it leading us to believe that some of the richness of the interaction was not being conveyed. Another limitation had to do with access to the communities. Although originally we had intended to conduct research as a team in and around Putla, Oaxaca (in the low Triqui region), because of violence in the region we were unable to undertake this research. We were also prevented from doing follow-up interviews with IMSS staff in Oaxaca City because of the political unrest and violence there.

Political and economic factors

The backdrop for promotores programs in both Mexico and the United States consists of several key economic and political factors. The first of these was the growing national and international concern beginning in the 1970's, but reaching its height in the 1980's, with the high cost of providing health care services to national populations, particularly given the demographic changes in which the population was aging, and chronic illness was on the rise-both of which had a large fiscal impact. This was a challenge for those in both the global north and south. Related to this was the concern with the economic and social development of poor and marginalized populations across the globe. A third factor was the emergence of social movements and post-colonial populations in the 1960's and 1970's who demanded more of a role in designing the programs meant to address their well-being. Primary health care was conceptualized as a

way to address all of these concerns at a global, national, local and individual level. The 1978 declaration of Alma Ata outlined the use and benefit of primary health care and called on the participation of governments, communities and individuals to ensure health for all. Community health workers or “promotores” were part of the primary health care strategy adopted at Alma Ata. The concept of primary health care, especially its focus on prevention and health promotion, was subsequently incorporated into the national health and poverty agendas of both the U.S. and Mexico.

In the 1980’s, the widespread adoption of the neoliberal economic model spearheaded by the U.S. and the United Kingdom and implemented through structural adjustment programs in developing countries played a role in the shape and content of health promotion programs. In the attempt to reduce the role of government in population welfare, responsibility was returned to local levels for the care and wellbeing of local communities and individuals. In Mexico, as in the United States, health promoters not only facilitated access to health information and education at the local level, but also simultaneously played a role in over-seeing the health behaviors of local residents and educating them on their roles and responsibilities in this new political-economic climate. Given this, health promotion and health promoters came to play a dual role in terms of helping people exercise their right to health care as well as their duty to stay healthy.

Mexico

The use of community health workers or “promotores de salud” in rural Mexican communities dates back to the creation of IMSS-COPLAMAR in 1979. The intention of this program was to extend primary health care services throughout the nation. This program was developed based on a 1973 modification of the social security law which

sought to address the extreme poverty and profound marginalization of the population whose capacity to contribute to the social security system was limited. Its creation was also informed by the Declaration produced at the international conference on primary health care at Alma Ata, Kazakhstan in 1978. As stated above, this declaration called upon all governments of the world to make primary health care a central strategy for the economic and social development of marginalized populations.³

In 1984, Mexico integrated into article 4 of its constitution the right to health. One year later, the General Health Law (La Ley General de Salud) announced that community participation was both a responsibility and an obligation of people and institutions. This announcement reflected a permanent component of Mexico's development plans for modernization.⁴ In the same year that the right to health was added to the Constitution, the implementation of IMSS-COPLAMAR was reduced to only seventeen states in the Republic and oversight of its health care services which at the time included 911 rural medical units and 23 rural hospitals were decentralized to fourteen states.⁵ In 1989, the name was changed to IMSS-Solidaridad and its infrastructure was broadened. In 1997, the program again underwent a change of name and direction as a result of Mexico becoming an OECD country.

The new program, named Progresá, added education and nutrition to the focus on health and prescribed both a limited role for the state in economic and social development and the equalizing of opportunities for the Mexican population. As a result of this shift,

³ http://www.who.int/hpr/NPH/docs/declaration_almaata.pdf, retrieved on August 17, 2008.

⁴ Rasmussen-Cruz, Bettylu, et al. 1993. « La Participación Comunitaria en Salud en el Instituto Mexicano del Seguro Social en Jalisco. » *Salud Pública Méx*, vol. 35, no.5, 471-476, <http://www.insp.mx/rsp/articulos/articulo.php?id=001321>, retrieved August 18, 2008.

⁵ http://www.imss.gob.mx/IMSS/IMSS_SITIOS/IMSS_06/ProfesionalesSalud/DPM/IO/Historia.htm, retrieved on August 17, 2008.

there was more of a focus on individual and community responsibility for health and well-being. This is evident in the design of the program, which emphasizes “co-responsibility” between the program beneficiary and the government provider of the benefits. Promotores de Salud were central to the implementation of this program mediating between the responsibilities of the government in providing services and the responsibilities of the population in becoming and staying healthy and educated. Finally, in 2002 the program was renamed IMSS-Oportunidades. This most recent iteration is focused on human development through intersectoral action in health, education and nutrition. The goal, as it has been since the beginning, is to achieve the autonomous and healthy development of the socially and economically disadvantaged living in conditions of marginality. Promotores continue to play a strong role in achieving this goal.

At the close of the first semester of 2007, IMSS-Oportunidades attended a population of 10,509,367 people. In rural Mexico it helped 2,531,812 indigenous and campesino families in 17 federal entities and boasted a medical infrastructure of 3,548 rural medical units and 69 rural hospitals. The rural medical services also included 225 mobile health units each of which had a nurse and a community health promoter to attend to the most disperse and marginalized localities. By contrast, in the urban environment there were 226 medical centers to attend to 112,506 families in 25 federal entities.⁶ Both its longevity and its broad reach demonstrate this programs efficacy. Many evaluations have also been positive pointing up its role in reducing poverty and health problems while

⁶http://www.imss.gob.mx/IMSS/IMSS_SITIOS/IMSS_06/ProfesionalesSalud/DPM/IO/Pagina+Principal.htm, retrieved on August 17, 2008.

increasing education rates among children.⁷ However, several of our observations coincide with more critical analyses of the program, particularly regarding its social impact, as opposed to its impact on morbidity and mortality rates which are the usual health indicators utilized to evaluate efficacy.⁸ Before turning to our findings, however, we discuss the use of health promoters in the United States.

The United States

The use of community health workers or “promotores” in the United States has been traced back to the 1960’s.⁹ Early attempts to engage community health workers in low-income communities were experimental responses to the persistent problems of the poor and were related more to antipoverty strategies than to a specific or coherent federal or state model of intervention for health improvement.¹⁰ However, beginning in the 1980’s, this strategy began to take hold particularly as a result of the Health Education Training Centers (HETC) program that was dedicated to serving the U.S.-Mexico border region and areas of high immigrant concentration. As a national study on community health workers notes, the HETC program has played an important role in promoting the utilization of community health workers in public health projects.¹¹

⁷ See for example, an article from the International Development Bank, <http://www.iadb.org/idbamerica/index.cfm?thisid=3037>, also see the assessments and evaluations undertaken by the International Food Policy research Institute at <http://www.ifpri.org/>, and those conducted by external evaluators for SEDESOL at <http://www.oportunidades.gob.mx/>

⁸ For critical evaluations, see Hector Ochoa, 2005. “Are health status and health care improving under *Oportunidades*?” <http://www.globalforumhealth.org/filesupld/forum9/CD%20Forum%209/papers/Ochoa%20H.pdf>, accessed 10/5/08; Lucy Luccisano, 2004. “Mexico’s Progresa Program (1997-2000): An example of neoliberal poverty alleviation programs concerned with gender, human capital development, responsibility and choice.” *Journal of Poverty*, Vol.8, No.4.

⁹ “Community Health Workers National Workforce Study,” U.S. Department of Health and Human Services, March, 2007, <http://bhpr.hrsa.gov/healthworkforce/chw/>, retrieved on August 18, 2008.

¹⁰ Ibid.

¹¹ Ibid.

The use of community health workers built on the national health agenda for prevention and health promotion outlined in the 1979 report, *Healthy People: The Surgeon General's Report on Health Promotion and Disease Prevention*. Although *Healthy People* did not specifically call for the use of community health workers in its original agenda, the focus on prevention and primary health care set the stage for the role these health workers would come to play especially in minority and immigrant communities in the United States. The Declaration of Alma Ata and a background paper for the *Healthy People* report were both influential in outlining a strategy for including health workers and educators in disease prevention work.¹² Beginning in the early 1990's, various pieces of legislation were introduced at the state and federal level for incorporating community health workers, however none of them passed.¹³ Nonetheless, the period since 1990 has seen increased use and visibility of community health workers at the community level through publicly and privately funded initiatives, as well as increased research on their impact.¹⁴ This increase in community health workers is also attributable to the increased dialogue and interaction between U.S.-based foundations and non-profits and Mexican government officials who engage in learning exchanges in order to better help and support Mexican migrant populations and communities with high levels of out-migration.

¹² Yoder, Sunny. 1979. "An overview of manpower issues in disease prevention," *Healthy People: The Surgeon General's Report on Health Promotion and Disease Prevention's*. 411-422

¹³ A recent example of this was legislation introduced by Simon Salinas to the 2003-2004 legislature. His bill, AB1963, "Encourages the Department of Health Service Office of Multicultural Health to use promotores de salud (community programs that use workers trained in linguistically and culturally appropriate outreach, particularly for rural agricultural workers) through existing health programs."

Although this bill was passed in both houses, it was vetoed by the governor.
<http://www.maplight.org/map/ca/bill/7786/default>, retrieved on August 18, 2008.

¹⁴ "Community Health Workers National Workforce Study," U.S. Department of Health and Human Services, March, 2007, <http://bhpr.hrsa.gov/healthworkforce/chw/>, retrieved on August 18, 2008.

According to the *Community Health Workers National Workforce Study* undertaken by the U.S. Department of Health and Human Services and published in March 2007, currently the majority of community health workers in the United States are Hispanic or non-Hispanic whites (35 and 39 percent, respectively), and the majority are female (82 percent) between the ages of 30 and 50 (55 percent). The largest concentration of community health workers in 2000 was found in California (9000), with New York running a close second (8000). Although the communities served by these community health workers are diverse including all ethnic and racial groups, Latino populations were served most often (78 percent) followed by African American (68 percent) and non-Hispanic whites (64 percent). The study also found that wages for community health workers varied from volunteer to those paid more than \$15.00 per hour. Volunteer CHWs were employed either by grassroots organizations, usually faith-based, or in outreach and health education efforts designed by university researchers and local health care providers, or in programs with ambitious goals but limited budgets trying to maximize program impact from limited resources.¹⁵ This study found that “programs serving immigrants, migrant workers, and the uninsured were more likely than other types of programs to have volunteer CHWs.”¹⁶

Because there is no coherent strategy or even job description regarding community health workers in the United States, organizations and funders have more autonomy than in Mexico in terms of program design, which leaves a lot of variability in terms of what to focus on and how to do it. Some models see health promoters as more akin to community organizers and teach them to advocate for community members in

¹⁵ Ibid.

¹⁶ Ibid.

areas such as housing and employment, as well as in clinical settings. Other organizations have a more narrowly medical focus providing health information and medical screening for diabetes and high blood pressure. Often the direction and content of the health promotion program is dictated by the funding agency and according to the measures and outcomes they would like to see. National health and poverty agendas, as well as their individual institutional missions often inform funders' objectives.

IMSS-Oportunidades

Confronting health challenges

Although this program has undergone several iterations, its main focus has been the social and economic development of rural and marginalized populations through the provision of primary health care services. It continues to operate within the Mexican Institute of Social Security (IMSS) as a component of the federal anti-poverty strategy. It is built on a hierarchical and centralized strategy extending from the federal office to the local program participants. The core of the program is centered in Mexico City and extends out to rural communities through regional hospitals such as those in Huahuapan de Leon and Santiago Juxtlahuaca, Oaxaca. Program design, undertaken at the federal office, has resulted from extensive research in the local communities throughout Mexico, as well as in international community development techniques and technologies in other developing countries.¹⁷ The design of the program has also been informed by changing political climates within Mexico, as well as changing medical priorities, especially as

¹⁷ For example, the outdoor toilets used in many of the rural villages came from an idea developed in Vietnam. While the overall strategy has been successful, Mexican villagers found the toilets too high and too large for their comfort and thus refrained from using them. They have had more success since they have been re-designed to fit the articulated needs of rural Mexican.

rural out-migration increases bringing more HIV, diabetes, hypertension and other chronic illnesses back when migrants return home.

The federal office has attempted to make the program as user friendly and relevant as possible for rural communities providing a comprehensive health strategy that involves health education in themes as diverse as nutrition, reproductive health and domestic violence, as well as access to preventive medical care through requisite clinical visits. In addition, it provides a stipend to program recipients, which serve as an incentive for their participation. The stipends are provided to the mothers of the recipient families although all family members are expected to fulfill their requirements. These include monthly workshops through the CARA (Centro de Atención Integral para la Salud del Adolescente Rural) for youth in secondary and high school on health, sexuality and reproduction, monthly health education workshops for mothers and annual check-ups for fathers and regular check-ups for women and children. Regular gynecological exams for women are a core requirement of the program given the high prevalence of cervical cancer in these communities.

Medical staff at the hospitals whose work is overseen by the federal office in turn oversees the medical staff in the rural medical units. Generally rural staff includes an advanced medical student called a “pasante” who needs to complete one year of community service to finish his/her degree and a rural medical assistant who is chosen from the local community. While the medical doctors rotate every few years, the rural medical assistants stay on and provide continuity to the program in the local setting. The *pasantes* communicate with the regional hospital on a regular basis often coming in for trainings and supervision. They also report any new cases of disease or any new

pregnancies in their community so that the hospital staff can update their epidemiological map of the region and control for any epidemics or outbreaks. In addition to the *pasantes* and rural assistants, local communities have a group of promotores who are overseen by the *pasante*. Usually there is one health promoter for each ten to fifteen households. The population of the community will determine the number of promotores in any community. While the *pasantes* have some flexibility in terms of how they organize the promotoras in each local setting, there is a formal program that dictates the outcomes and methods they are to use in their work.

Findings

One of our concerns was to know if and how promotores help indigenous Mexicans confront the barriers to health care access and information they face including understanding the biomedical information they receive, navigating the health care system and linguistic interpretation. Our team found that the promotores de salud in rural Oaxaca were effective in helping families access health care services and information. They would provide reminders to families to attend their check-up exams and follow-up with families that neglected to attend their required clinical visits or educational workshops. They were also very effective at detecting health problems or concerns, especially pregnancies; among the families they attended to which they would communicate to the rural medical assistant who would inform the local doctor or hospital. Several elderly patients expressed to us their appreciation of the promotores who would come to their homes and administer their medication or remind them to take it.

In the workshops we observed, the health information was presented clearly with the aid of well-developed visual devices. In one workshop on reproductive health and

sexually transmitted infections, the health promoter (a male presenting to an all female audience), donned an apron with an image of women's reproductive organs printed on it and began to demonstrate how cervical cancer (which was depicted as a crab) begins to enter and spread. In another demonstration, he asked a member of the comité de salud to demonstrate the proper use of a condom by applying it to a banana. Our team found the materials and the presentation to be excellent. Our team also reviewed the materials developed by IMSS utilized by the promotoras in their educational trainings and found them to be very well done, accessible and informative with images that reflected the populations they were serving.

Nonetheless, we did not observe any interactions in which indigenous languages were spoken to provide the health information. We also did not see any materials that reflected indigenous healing beliefs or medicine. Although rhetorically IMSS has attempted to respect local cultural beliefs and practices, their materials and information do not reflect this commitment. All of the information was provided within an allopathic frame and encouraged the incorporation of families into the allopathic system, rather than providing a complementary continuum of care, which balanced indigenous and western medicine. There is no official use of Triqui or Mixteco in the services Oportunidades provides. When interpretation services are utilized, they are generally undertaken by the rural assistant or a family member, both of which impede privacy and confidentiality between the patient and the doctor regarding the material discussed.

In some cases, however, we did learn that local parteras could use the space and materials in the rural medical unit to deliver babies. This is certainly the case in the region of Tlaxiaco where there is also more of an exchange between traditional healers,

mid-wives (parteras), “hierberos” and allopathic doctors within the spaces where IMSS operates, including in the rural medical units. In the hospital in Tlaxiaco, traditional healers give training through an agreement between IMSS, la CDI y la Organización de Médicos Indígenas de la Mixteca Alta (OMIMA). In other regions, however, the sharing of space and knowledge seemed to be up to the discretion of the local doctor. We observed rural medical units around Juxtlahuaca where the two systems did not overlap and the doctors admitted that they did not believe in the practices of traditional healers.

In terms of access to care, although many of the beneficiaries of Oportunidades were fulfilling their health requirements and attending their appointments, we learned that often the hospitals did not have the adequate equipment to follow-up on the necessary tests if problems were detected nor did they have adequate staff to provide the results. In the case of pap smears, often women would not hear back for more than a month, if at all, about whether their results were normal or abnormal. Sometimes the results would be mixed up and delivered to the wrong person. This was troubling given that gynecological exams are a central requirement for female beneficiaries, many of whom had high anxiety about undertaking them for cultural or personal reasons. The rural medical units also lacked adequate medication and materials even for administering the most basic first aid. In one rural medical unit, the cupboards were almost bare and the rural medical assistant wasn't sure when she would receive more supplies.

Another concern regarding access has to do with the extent to which the kinds of information and interventions local community members are receiving are relevant to their particular circumstances, especially in light of increased migration. In communities with large percentages of out-migration, the health profile of the community is changing.

For example, HIV/Aids and diabetes are being introduced into the communities but with little discussion in the health workshops. When HIV/AIDS is discussed, the information is delivered to women and not men. However, the majority of the people transmitting HIV are men and not women, especially those who have migrated. If this information is to be relevant to the affected population, men also need to be incorporated into the workshops on this subject. In the case of diabetes, it affects men and women equally, yet only women receive the education because they are the ones who are required to attend the health workshops. Because women generally do the cooking and oversee the health and well-being of the family, men are not given the chance or the responsibility to learn about or care for their health in the context of the IMSS workshops. This could have harmful consequences for them when they migrate to other parts of Mexico or to the United States, they have no wives or female relatives to help them care for their health, and nutrition and they have little experience or information for doing so. It also places an added burden on the family when they return and are suffering from a chronic illness such as diabetes.

Social Implications

In terms of social implications, our team was concerned with the following questions: What role do promotoras play in fostering the social cohesion of the community? How do they contribute to empowerment? Do their social roles change as a result of their position as promotoras? If so, how? What other social implications does the promotores model have for the indigenous community? We found that the design of the Oportunidades program has positive and negative social repercussions.

In terms of the first, all community members have an understanding and expectation of what the promotoras program will and can achieve. Because of this familiarity, there is a general feeling of cooperation among Oportunidades participants. They understand when the promotoras come to their house to check if their water has been boiled, if their garbage has been burned or if they have attended their appointments at the clinic. In addition, because of its long history (over twenty years in some villages), many of the local women across generations have been exposed to some health education, information and clinical services either as promotoras, recipients of Oportunidades or through conversations with neighbors who participate in the program. Thus, its reach and impact potentially extends beyond those who have been recipients.¹⁸

The promotores program has also been successful in indigenous communities because it builds on the “tequio” model in which each community member is expected to make a contribution to the well-being of the community by carrying out a duty or “cargo” for a specified period of time. The role of promotoras is seen as a cargo, albeit an extra one given that it is required by the federal government and not the local community. Nonetheless, it has been incorporated in some villages as part of the community duties and promotoras, generally all women in the rural indigenous communities, are often chosen at community assemblies. There is a bonus, however, in terms of the fact that IMSS promotores and program recipients receive a stipend for their involvement as well as free health care, neither of which is available in their other cargos. Further, this stipend is given to the women not the men because program planners felt that women would use

¹⁸ There are some regions where the program have a shorter history, however, many of the communities we visited had an extended experience with the IMSS programs. For example, in San Miguel Cuevas, the program has been there for over twenty years. This extended history was one of the principle influences in CBDIO’s choice to adopt it in California given that their Executive Director is from San Miguel Cuevas.

it for household needs and men would keep it for their personal use. It was also felt that providing stipends to women would provide them with some economic and social leverage vis à vis their husbands and contribute to their empowerment as women and mothers.

On the negative side, the design of the program in which some local women receive Oportunidades while others do not has created some tensions in the community. Those who were not chosen to receive the program express resentment and confusion about not having been chosen. This informs their resistance to participate in health education workshops and to access preventive medical care. It also makes them resentful of the federal government, which is perceived to be providing special privileges for some while ignoring others with, similar or, in some cases, more extreme economic needs. For those that do receive the stipend, some expressed gratitude but felt that the economic incentive was not sufficient to meet their needs. In fact, they felt that because they and their families were obligated to attend workshops and clinical appointments, in addition to their “voluntary” work as promotoras, the stipend was an unfair and onerous coercive element imposed by the government. They would have preferred to have programs that provided jobs or job training so women could take care of their needs without the added obligations of attending appointments, meetings and overseeing the participation of their family members in fulfilling their requirements.

Many women expressed their dissatisfaction with the program because it not only created tensions with their neighbors who are non-recipients, but also with their own family members. This occurred when family members did not fulfill their obligations to attend the IMSS programs and services, or when husbands wanted the stipend for their

personal use and mothers were forced to choose between giving the money to their husbands or using it for household needs. We heard stories about teenagers who did not attend their required meetings and whose father's supported their decision against the mother's urging for them to attend. The lack of follow-through of any family member in their obligation resulted in a reduction of the already minimal stipend-another factor that in some cases led to marital tensions.

Further, we found that the information provided in the health workshops did not always lead to women's empowerment even, or especially, when it had to do with women's reproductive health. Patriarchy within the family stemmed some women's attempts to get their husbands to take an equal role in reproductive health. For example, after the excellent workshop mentioned above on reproduction, sexually transmitted infections and disease prevention held in San Rafael located on the outskirts of Huahuapan de Leon, our team conducted a group interview followed by individual interviews with female participants. Many women explained that although they had the information about how and why to use a condom, they could not convince their husbands to do so. In fact, their urgings provoked indignation from their partners who accused them of not trusting them or of having been unfaithful themselves. The women then found themselves in the position of having to acquiesce to unprotected sexual intercourse in order to "prove" their love, fidelity and trust even though they were aware of the risks of doing so.

There were some women that did say that they felt more empowered as a result of the workshops and that they were able to communicate and negotiate with their husbands as a result. There were others who did not feel coerced by the stipend and thought that the

program was a good thing for those families who had very few resources. Nonetheless, many of these same women expressed dissatisfaction at the fact that the stipend was so little and that the government did not provide them with economic opportunities and training in place of teaching things such as how to prepare healthy food that they couldn't afford to buy anyhow.

In terms of the promotoras, their experiences seemed to vary. Some women explained that they had been selected to be promotoras by the town committee and that it was an added burden because they had to fulfill other assigned duties in addition to overseeing ten to fifteen families. They explained that their job as promotora was not counted as one of their "cargos" because they reported to the local doctor or rural assistant rather than the town committee. As a result, they were given other duties to fulfill in their village on top of being a promotora. In San Miguel Cuevas, our research team learned from a member of the comité de salud that the promotoras are also responsible for picking up trash on the weekends. This causes conflict with their husbands because they are not home to take care of them and because they are hunched over in public places exposing their back ends to the town. The garbage campaign also causes tension with the promotoras and those who don't receive Oportunidades because they feel that they have been stigmatized and must carry the burden for the whole town just because they receive a minimal stipend.

Other promotoras, such as those in San Sebastián Tecomaxtlahuaca, explained that they felt good about being promotoras and they were learning a lot from the local doctora. The women explained that they were able to open up about personal issues as a result of the trust they had developed amongst themselves. They also expressed feeling a

greater sense of self-esteem as a result of their promotora training workshops. Several women told stories of standing up to their husbands as a result of the learning they received as promotoras, especially regarding issues related to alcohol abuse and domestic violence. Many of these same women accompanied us on visits to homes of Oportunidades recipients. The families we visited were elderly and were it not for the Oportunidades program, they would have no other source of income. The promotoras and the local doctora were demonstrably proud that they were able to provide a service to the elderly of the village who, in addition to their economic need, required help with remembering to take their medications, attending their doctor's appointments and, importantly, thrived on the social interaction provided by the promotora visits.

An important aspect of the promotores program was the relationship the promotoras had with the local doctor. In communities where the doctor was female and was focused on women's empowerment this focus was reflected in the promotoras feeling like they had more power in their lives and in their relationships. This was clearly the case in San Sebastián Tecomaxtlahuaca. However, in communities where there was a female doctor who was more focused on controlling than empowering the promotoras, the promotoras felt both disempowered and caught between the demands of their families and those of the IMSS staff. We witnessed this in San Miguel Cuevas.

In our interviews with IMSS staff at the local hospitals, we learned that they too felt caught between the federal mandates coming from Mexico City for outcomes and "numbers," and the needs and practices of the local communities. In one case, a doctor revealed to us that those in the Mexico City office did not understand what it was like to try and work in the Triqui communities where the husbands did not want their wives to

engage in family planning and that doctors who went against the desires of local men could be subject to violent repercussions. The push for numbers at the federal level was impeded at the local level by patriarchy. Although there is extensive violence in the Triqui region of Oaxaca, the doctor's comments, like others we heard from some IMSS doctors in local villages, had a tone of paternalism and were peppered with overtly racist comments about indigenous groups as "ignorant" and difficult. One doctor explained that her job was very hard because "la gente [meaning indigenous community members] no quiere entender. La gente es muy difícil." Although we encountered many health workers in the IMSS system who were trying their hardest to help, when things went wrong or they were being pressured from above, rather than questioning the system within which they worked, their response seemed to be to blame the communities for being so resistant to their efforts.

Our interpretation of the local resistance to the program differs from some of the local doctors we spoke with. We understood its roots to be located in 1) a divisive system whereby some families benefited economically and others didn't; 2) the fact that indigenous health beliefs and practices were de-valued and therefore not reflected in the Oportunidades model; 3) local gender dynamics; 4) mistrust in the program due to lack of materials and staff to follow through with medical needs; 5) racism and discrimination by some of the doctors and IMSS staff; and 6) federal mandates that are out of touch with the local realities in Oaxaca. We also found that participation was mostly driven by the economic incentives and that women would have been as happy to receive job training or economic opportunities rather than educational opportunities regarding health and nutrition that did not get them out of poverty in the short-term.

CBDIO

Confronting Health Challenges

The health promotion program of Centro Binacional para el Desarrollo Indígena Oaxaqueño began in 1997 with an explicit focus on female leadership and empowerment in the indigenous Mexican migrant community. Initially a collaborative effort with a female farmworker group, Líderes Campesinas, the promotores program had a dual focus--to provide health information to indigenous women and to get more women actively involved in CBDIO's sister organization Frente Indígena de Organizaciones Binacionales that was focused on human rights and political activism. The health component focused on themes such as breast cancer, pesticides, diabetes, domestic violence and other health-related issues that indigenous women migrants were dealing with.

In 1998 when funding for the collaborative effort ran out, CBDIO took over full responsibility for the program and conducted numerous workshops and conferences throughout the State of California until 2001, when they received funding from the California Endowment to provide health promotion to entire families. By this time they no longer needed an explicit focus on women, for as they state on their website, "Many women had become involved in the activities of both CBDIO and FIOB."¹⁹ The focus of the new program, renamed Proyecto de Salud Indígena, was 1) to identify communities with a high concentration of indigenous families in Fresno and Madera Counties and identify their needs in order to design the appropriate programs to serve them, 2) Continue illness prevention workshops, 3) conduct basic health exams focused on the

¹⁹ See CBDIO website for the history of the Proyecto de Salud Indígena, <http://www.fiob.org/proyectos/proyectosalud.html>, retrieved on August 18, 2008.

detection of hypertension, diabetes, tuberculosis and HIV, 4) organize health fairs that brought together local social service providers and 5) provide cultural competency trainings to social service providers regarding the Oaxacan indigenous culture. Through an additional grant they expanded this program to work with the Zapotecs in Los Angeles, an area they found challenging due to the urban environment, which made both locating participants and gaining their trust difficult as compared to the smaller rural communities.

From 2004 to 2007, with the support of additional funding, this program was expanded to five counties, including Merced, Fresno, Tulare, Kern and Monterey and also expanded its objectives. The current program focuses on achieving the following goals: 1) Using “promotoras,” or community health workers, to teach the community about the health and social service systems, 2) Provide cultural competency trainings to health and social service providers, 3) Help the indigenous community navigate the health and social service system through the provision of interpretation services, help filling out forms, referrals, etc, 4) Provide educational workshops on illness prevention and good health, 5) Organize three health fairs and learn about services that are available in the community, 6) Organize conferences on the use of traditional medicine in the indigenous community as a medical alternative 7) develop a guide on Oaxacan culture to distribute to health and social service providers which they can use when they help an indigenous person “in order to be more sensitive to their culture, attitude and beliefs and to provide them a more efficient service.”²⁰

The promotores in this program were envisioned as playing a dual role--that of health educator and community organizer. The goal of health promotion for CBDIO

²⁰ CBDIO website, <http://www.fiob.org/proyectos/proyectosalud.html>, retrieved on August 18, 2008.

extended beyond just helping indigenous migrants navigate the health system in California, it was also meant to politicize them by teaching them their rights and encouraging them to become part of a collective effort to advocate for the recognition of those rights for all indigenous Mexicans in California. In light of this vision, all CBDIO promotores receive at least one day of leadership training and on-going training in issues affecting the communities they work in, especially having to do with health service access and health issues affecting the community.

Our team found that in terms of helping indigenous migrants access health services and information, CBDIO promotoras do an excellent job. They assist families in making appointments, accompany them when necessary to the clinics where they help filling out paperwork and interpreting for them. In addition, they provide educational workshops on health topics identified by the community members they serve. These workshops are culturally and linguistically competent as they are delivered in the indigenous language of the program participants by promotores who come from the same communities or region of origin as those they serve. These educational workshops often also benefit from the presence of a health expert such as a nurse, county public health worker or other knowledgeable speaker.

Although CBDIO promotoras do an excellent job connecting families to medical care and helping them navigate very complex health care and health insurance systems, one of the downsides of their program is that they do not integrate indigenous healing practices or beliefs into their program. From a biomedical perspective, this is not a problem, however, it does create problems for program participants when it comes to their ability to grasp the information being presented or to feel that they have been well

attended in clinical interactions. Because the terms, the illnesses and often even the body parts that are discussed in CBDIO's educational workshops are unfamiliar to those in attendance (sometimes even to the promotoras themselves), the information is occasionally inaccessible even when translated as closely as possible into the indigenous language of those in the audience. This was evidenced in a workshop on asthma where after about twenty minutes of explaining the different causes of asthma and how they restrict air to the lungs, one woman raised her hand and asked the promotora, "What are lungs?" The low levels of educational achievement in Oaxaca leave many participants without basic understanding of the body or health risks.

The biomedical information is also difficult to grasp for some indigenous migrants because they work from a less individualized and secularized understanding of the body and its connection to others and the environment. In many cases, illness is interpreted as stemming from social rather than biological causes and treatment must therefore address the social cause, not just the physical symptoms as in allopathic care. Further, because they conceptualize health in terms of a balance between conditions (i.e., hot/cold), indigenous health concepts are difficult to translate in the biomedical paradigm and can create added barriers to accessing health information even when delivered by the promotoras or other health care workers. An approach that translates between the two systems highlighting the importance and uniqueness of both would go a long way to reducing barriers to access and care for indigenous Mexicans.

One difficulty that indigenous migrants experience in the United States that cannot be overcome in a health workshop is the low literacy and numeracy levels of program participants. Statistics show that among the populations from the three regions under

study in Oaxaca, Tlaxiaco, Santiago Juxtlahuaca and Huahuapan de León, the illiteracy rates for those over fifteen years old are 12 percent, 30 percent and 10 percent respectively.²¹ In order to understand how to fill out paperwork, read their blood sugar, or engage in numerous other activities related to health monitoring, they would need to improve their ability to read, write and count.

One of the reasons that CBDIO has been unable to integrate more indigenous knowledge and practice into their health workshops is due to funding constraints. Because the funders often dictate the programs and/or outcomes they would like to see, CBDIO has little flexibility to alter these mandates. On one occasion, they applied for funding for a program that would not only provide biomedical health education, but would also develop a community garden with medicinal herbs and plants to be used by the same local residents who would attend their health workshops. The funder they applied to awarded money for the workshops but not the garden claiming that it was a deviation from medical care rather than a complement to it.

Social Implications

In terms of the social effects of CBDIO's health workshops, one of the main functions they fulfill is to provide a forum for social interaction and community belonging. Insofar as they bring together indigenous community members to discuss health issues, they are also community building exercises, which build individual and

²¹ INEGI, II Censo de Población y Vivienda, 2005, www.inegi.gob.mx. Information on education levels of indigenous migrants in California is limited. However, data does exist on indigenous farmworkers in Santa Barbara County. See "What Parents Think Families Need," a 2007 publication by First 5, Santa Barbara County based on a Survey with Mixteco families where they found that 96% of those surveyed had less than an eighth grade education level; See also "Portrait of a Laborer: Indigenous Farmworkers in Santa Barbara County," a publication by the Central Coast Environmental Health Project (CCEHP), summer 2006, where they found that on average Oaxacans had 5.7 years of formal education compared to 7.4 for non-Oaxacans.

community capacity to confront health challenges and barriers to access, as well as to strengthen community bonds. The community building aspect of CBDIO's workshops is probably the most positive role they play insofar as they establish and build on social networks in the indigenous migrant communities. The health workshops are also useful because they teach recent migrants the laws and norms in the United States regarding broadly defined public health issues such as child abuse, domestic violence and car seat use for children. They also provide some information on occupational health and safety in the workshop on pesticides in the agricultural fields. On rare occasions, they were used as a forum for discussion of information on changes in immigration laws, Homeland Security activities such as possible raids in the local community and on legal rights/responsibilities.

The role of CBDIO's promotoras is significant in terms of the help they provide indigenous migrants in navigating and understanding a complicated medical system and biomedical culture. These systems are perceived as so complex and diverse by recent migrants that on several occasions research team members were told, "What we need are programs to teach us how to use the programs." They also help migrants, especially women and children, access much needed resources that impact on their health including food stamps, the food bank, Women, Infant Children (WIC), Medical, education services, legal services and clinical services. In addition to the aid and information they provide the community, paid promotora positions provide women opportunities to get ahead economically while also fulfilling a leadership role in the community. These factors can be particularly empowering for indigenous women who often have few opportunities to exercise economic or political power in their communities of origin.

Although most often the promotores are women, some promotoras work together with their husbands to fulfill their roles thus strengthening family bonds while making community health and well-being a family priority.

Although there were many positive aspects to CBDIO's promotora model, there are also some negative effects that have more to do with the political-economic climate in which the program unfolds than with the program itself. For example, the fact that they are teaching community members how to care for themselves in the context of California is necessary and positive, however, the 'duty to be well' also puts an added burden on indigenous migrants to assume more responsibility for their health in what is often perceived as a confusing and overwhelming system. It therefore requires a significant investment on their part to both learn the system and to follow its recommendations. This added burden is the result of government disinvestment in social services, especially for migrants without legal documentation. The increasing privatization of community services also means fewer resources to support health care (i.e. bus transportation to the hospital), overworked staff with limited time to spend with patient, and a complicated insurance system that continually needs to be de-mystified by the promotoras, social service providers and health professionals.

Given the reduction in social and community services, non-profits such as CBDIO have tried to fill gaps in services and information to marginalized communities. However, non-profit work often provides few or no health benefits, demands long work hours and no job security insofar as it is grant-driven. These factors can be disempowering for health promotores who advocate for health care access and information on behalf of the community, but have little access themselves. It is especially challenging for women who

often have to work evenings and weekends when their own families are home and would like to spend time with them. The double shift, in which they are taking care of other families needs during the day and their own families at night, takes a toll on the promotoras who in some instances are pressured by their husbands to quit their jobs and come work in the fields with them where they would not only have the same schedule, but also the husbands could watch over their activities.

Further, because funds are often limited, organizational resources are as well. In Greenfield, few financial resources meant that the only affordable office for the promotoras was a small space donated by the Chief of Police with barely enough room for the two promotoras and their desks, let alone the families they served. The limitations of this space, which had no heater, no air conditioner and no bathroom, led one of the promotoras to comment that conditions in the fields were better than in the office because at least in the fields they have water and bathrooms. In Greenfield, as in the other counties where they work, the fear that grants would not be funded always left the promotoras doubting whether they would have a job in six months or a year.

Insofar as non-profit work is funding-driven, the targeted outcomes mandated by health funders often do not address structural or political conditions (i.e. the effects of capitalism, racism, labor exploitation, immigration reform, etc.). Further, a focus on these issues might jeopardize their non-profit status. Indeed, the above mentioned efforts to address possible immigration raids, changes in immigration legislation and legal rights within the context of the health promotion program were undertaken with caution and in conjunction with other political organizations so as to avoid putting CBDIO's non-profit status in jeopardy. Their status as a non-profit also means that they have little room for

advocacy efforts to reform the systems that impact health care access and information (i.e. immigration, medical, educational, etc.). For example, the influence of immigration laws on access to health care for undocumented migrants can not be understated. Not only does fear of Homeland Security prevent many from attending or receiving medical services, their condition as migrant workers also means that because they often follow crops they have limited follow-up with the same health care practitioner and they must re-apply for health insurance services with every move. As a non-profit, they can do little to address these issues. Further, these factors are compounded by the racism and discrimination indigenous migrants experience by some social service providers (especially mestizo Mexicans) who treat them as inferior either because they do not dominate Spanish or for the fact that they are indigenous, Mexican, undocumented or all of the above. Finally, because non-profit work is grant driven, the program direction and outcomes are often dictated by the funders which leaves little room for negotiation by CBDIO staff on the topics or outcomes they would like to see.

A final tension that occurs in the context of the promotoras program is whether and how much of a stipend/salary to provide to promotoras if anything at all. Many funders and non-profit staff believe that the promotores positions should be voluntary, as that will demonstrate more of an investment on the part of the promotores. However, even in Mexico, these positions are not voluntary and the incentives that women receive extend beyond the good feeling they get when helping the community insofar as they provide tangible financial and physical results. Our interviews with non-CBDIO promotoras reveal that voluntary promotores programs add to the burdens of economically strapped families with limited free time. Further, in addition to giving their

free time, promotores often use their own resources (e.g. car, gas, etc) and have to pay their own childcare. In some cases, they also have to deal with the gossip and prejudice of community members who are not promotoras and who for a variety of reasons dispute their capacity to teach the community about health issues or resent their role as community leaders. Paying them thus bestows legitimacy on them and provides the organizational backup to support their authority.

Conclusions

Our research team set out to study three aspects of the promotora strategy in indigenous Oaxacan communities in Mexico and California. First, we wanted to understand the political and economic factors informing program implementation in Oaxaca and California. Second, we wanted to understand the specific ways in which promotores help indigenous Mexicans confront the barriers to health care access and information they face including understanding the biomedical information they receive, navigating the health care system and linguistic interpretation. Finally, we were interested in the social implications of the promotores model. For example, what role do promotores play in fostering the social cohesion of the community? How do they contribute to the individual and collective empowerment of indigenous Mexicans? Do their social roles change as a result of their position as promotores? If so, how? What other social implications does the promotores model have for the indigenous community?

Our findings reveal that neoliberalism has shaped the direction of the promotores model in both Mexico and California since the 1980's and as a result, health promotores have helped communities and individuals exercise their right to health care as well as their duty to stay healthy. In terms of addressing barriers to health care access and

information, we found that promotores do an excellent job in both Oaxaca and California, although because neither of the programs we studied incorporate indigenous knowledge or medical beliefs, they are not as culturally relevant as they could be and thus some of the health information is either lost in translation or rejected by program participants. For example, in one case in California during a discussion on the ways to control asthma, a Mixtec woman raised her hand and informed the speaker “we don’t think like that.” She went on to explain how Mixtecos go to a healer who passes an egg over the body to cleanse it and how asthma is an illness caused by emotion which in her opinion the doctors in California don’t understand or know how to heal.

Finally, in terms of the social implications of the promotores programs, we found mixed results. On the one hand the information and economic incentives provided did seem to empower some community members in both California and Oaxaca, however, they also had disempowering effects that affected family and community dynamics. Part of the negative aspects of the promotores programs has to do with the structural constraints of these models. In Mexico these have to do with mandates that are developed at the federal level and passed down to rural communities. In California, these have to do with funding mandates and targeted objectives that are not responsive to the social and political determinants of health, as well as limitations experienced by non-profits in terms of advocating for reform or change. Given our findings, we provide the following policy recommendations:

Mexico

- 1) Take into consideration the diversity of communities and cultures--some are more "traditional" than others and some have more experience with biomedicine.

- 2) Incorporate local knowledge and customs into health curricula and workshops .
- 3) Include more involvement of men and more responsibility put on them to fulfill program requirements.
- 4) Provide economic opportunities and job creation/training to program participants, not just health education.
- 5) Make anti-discrimination training part of the curriculum for doctors in medical school, as well as required and on-going gender and cultural sensitivity trainings.
- 6) Address social and political factors in health education workshops. Don't just give people solutions or options designed at the federal level, but help them understand and truly be a part of the solution in ways that are not coercive.
- 7) Build on cross-border networks as a site for mutual learning and information exchange regarding life on the other side (the "other side" could refer to what's happening in Mexico while they're away as well as what life is like in the United States for those that don't migrate). Link migration to health issues such as HIV/Aids, diabetes, depression, etc.

United States

- 1) Consider local context (including ethnic and racial tensions) and available services-- this will determine health needs and solutions.
- 2) Make information accessible (language level, terminology and framework should be sensitive to culture and education level of recipients).
- 3) Incorporate indigenous knowledge and customs into health curricula (i.e. social versus individual perspective, idea of balance, indigenous medicine). Part of this incorporation could include the recuperation of the knowledge and use of plants in

Mixteco and Triqui communities through the creation of community gardens where medicinal uses are taught to those who are interested.

- 4) Incorporate educational component for social service providers, medical staff and civic leaders who interface with indigenous migrants--this should include anti-discrimination and cultural sensitivity training.
- 5) Incorporate perspectives in health education workshops that show the intersection of health, immigration, employment and housing in the United States--do not just take biomedical perspective of health education based on top national indicators of poor health. In other words, incorporate discussion of the political and social determinants of health.
- 6) Pay promotoras in the United States, especially when many of them are women and mothers who work a double shift in the field and at home. Understand that they have competing interests and pressures such as husbands who don't want them in the public eye or who would prefer that they work with them in the fields rather than as promotoras.

Dissemination

Our research in California provided the basis for Rebecca Hester's dissertation, "Embodied Politics: Health Promotion in Indigenous Mexican Migrant Communities in California," Politics Department, University of California, Santa Cruz, June 2009.

We are also presenting our findings at a professional conference: Rebecca Hester and Patricia Zavella, "Preventing HIV Risk among Indigenous Women Migrants from Oaxaca: Transnational Health Promotion," Paper written for the panel, "Migration and Shifting

Sexualities among Latinos/as in California: Implications for HIV,” The American Sociological Association meetings, August 9, 2009, San Francisco, CA

The three researchers plan to write articles for publication.

References

- Central Coast Environmental Health Project (CCEHP), 2006. “Portrait of a Laborer: Indigenous Farmworkers in Santa Barbara County,” Summer.
- First 5 Santa Barbara County, 2007. “What Parents Think Families Need.”
- INEGI, II Conteo de Población y Vivienda, 2005, www.inegi.gob.mx
- Luccisano, Lucy, 2004. “Mexico’s Progresa Program (1997-2000): An example of neoliberal poverty alleviation programs concerned with gender, human capital development, responsibility and choice.” *Journal of Poverty*, Vol. 8, No. 4.
- Ochoa, Hector, 2005. “Are health status and health care improving under *Oportunidades*?” <http://www.globalforumhealth.org/filesupld/forum9/CD%20Forum%209/papers/Ochoa%20H.pd>
- Poder Ejecutivo, Diario Oficial de la Federación, 28 de febrero de 2007. “Acuerdo por el que se emiten las reglas de operación del Programa de Desarrollo Humano Oportunidades, para el Ejercicio Fiscal 2007.”
- Rasmussen-Cruz, Bettylu, et al. 1993. « La Participación Comunitaria en Salud en el Instituto Mexicano del Seguro Social en Jalisco.” *Salud Pública Méx*, vol. 35, no.5, 471-476.
- U.S. Department of Health and Human Services, 2007. “Community Health Workers National Workforce Study,” March. <http://bhpr.hrsa.gov/healthworkforce/chw/>
- Yoder, Sunny. 1979. “An overview of manpower issues in disease prevention,” *Healthy People: The Surgeon General’s Report on Health Promotion and Disease Prevention*. p. 411-422.