MEXICAN HOME REMEDIES FOR CHILDHOOD ILLNESSES:
A HANDBOOK FOR HEALTH CARE PROVIDERS

By

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Dedication

In dedication to *mi raza*. Be the skew that deviates the standards. Do not continue to be part of the statistics that have lumped and clumped us as an “ethnicity” and not a race. Continue to hold firm to your identity, and identity not solely made up of your skin color or last name, but an identity that represents our past, present and future as Mexican American people.

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The objective of this project was to develop a handbook about Mexican home remedies used for childhood illnesses for use by health care providers providing care to Mexican and Mexican-American (MA) mothers. The handbook was designed to increase knowledge of home remedies and increase understanding of Mexican/MA culture among providers, resulting in improved provider-patient communication and cultural awareness. The long-term goal of the project was to decrease possible harm to children through the identification of potentially harmful home remedies. Leininger’s Sunrise Model provided the conceptual model for this project. Her model highlights cultural assessment of culture care diversity and universality as key concepts in caring for clients. An extensive review of the literature shows (1) limited studies addressing provider assessment of home remedy usage by MA mothers, (2) no studies of mother’s views about use of professional and folk systems and (3) absence of a clear cultural context for MA mother’s practices in caring for ill children. The proposed practice innovation is a handbook for providers about home remedies commonly used by Mexican and MA mothers to treat childhood illnesses. The innovation implementation plan for this project will be a pilot study that will concentrate primarily on provider assessment of home remedies utilizing the handbook.
CHAPTER ONE

Introduction

The objective of this project was to develop a handbook about Mexican home remedies used for childhood illnesses for use by health care providers providing care to Mexican and Mexican-American mothers. The specific immediate outcomes were to increase knowledge of home remedies and increase understanding of Mexican/MA culture among providers, resulting in improved provider-patient communication and cultural awareness. Leininger’s Culture Care Diversity and Universality theory provides the organizing framework for this project. A description of cultural and social structure dimensions of the MA people will follow Leininger’s Sunrise Model/Enabler and will precede a brief description of the MA culture in the United States (U.S.), specifically to the Southwest region of Arizona (AZ). This chapter will also include the significance of this project and the problem statement.

Every culture has its unique way of caring, viewing illness and healing. These views and beliefs many times do not correlate with the views of the dominant society and result in the creation of a cultural struggle. This struggle is due to limited awareness of cultural health and folk medicine beliefs due to factors that include MA patients’ resistance to sharing their beliefs, medical practitioners’ limited cultural assessment, and language barriers (Mull & Mull, 1981). This gap in cultural awareness and knowledge was the basis for Leininger’s Culture Care Diversity and Universality theory development.
Leininger’s Culture Care Diversity & Universality Theory

Leininger believed that nursing care needed to be culturally sensitive in order to meet the needs and expectations of diverse ethnic groups. Without cultural sensitivity ineffective care would result (Leininger, 1996). Key concepts are (a) worldview and (b) cultural and social structure dimensions. Leininger believed care differed from one cultural group to another and was influenced by the groups’ worldview, which Leininger described as “the way in which people look at the world, or at the universe, and form a ‘picture’ or value stance about the world and their lives” (George, 1995, p. 375) and also by cultural and social structure dimensions, which Leininger defined as “the dynamic, holistic, and interrelated patterns or features of culture (or subculture) related to religion (spirituality), kinship (social), political (and legal), economic, education, technology, cultural values, language and ethnohistorical factors of different cultures (Leininger, 1996, p. 73).

Lack of cultural awareness in assessment and knowledge regarding health beliefs and practices of cultural groups found within the practicing community of present day medical practitioners creates miscommunication and misconception between professional and folk systems of healing. This results in not only stereotyping but also improper health care delivery, health preservation, and may cause harm. Leininger emphasized that failure to understand a cultures’ worldview and how cultural and social structure dimensions influence individuals and families will result in culture shock and cultural imposition (George, 1995; Leininger, 1996; Leininger, 1988).
Leininger explained that culture shock results when “an outsider attempts to comprehend or adapt effectively to a different cultural group. The outsider is likely to experience feelings of discomfort and helplessness and some degree of disorientation because of the differences in cultural values, beliefs, and practices” (George, 1995, p. 381). Culture imposition according to Leininger arises when the dominant society “imposes their beliefs, values, and behaviors upon another”, generally when Western views are primarily involved (George, p. 381).

The Sunrise Model/Enabler (Figure 1) depicts culture care diversity and universality related to the MA community, the focused dimensions of religion, kinship, politics, economics, and education in this project allow for an in-depth look at the beliefs of illness of the MAs and how cultural and social structure dimensions influence these beliefs and play a role in folk systems and professional systems. The factor of technology was not specifically addressed in this project except for medicinal technology that encompasses knowledge of proper home remedy preparation.
**FIGURE 1.** Leininger’s Sunrise Model/Enabler

*Leininger’s Sunrise Enabler to Discover Culture Care*

**CULTURE CARE**

- Worldview
- Cultural & Social Structure Dimensions
  - Kinship & Social Factors
  - Cultural Values, Beliefs & Lifeways
  - Political & Legal Factors
  - Environmental Context, Language & Ethnography

**Influences**

- Care Expressions
- Patterns & Practices

**Holistic Health / Illness / Death**

**Focus:** Individuals, Families, Groups, Communities or Institutions in Diverse Health Contexts of

- Generic (Folk) Care
- Nursing Care Practices
- Professional Care-Care Practices

**Transcultural Care Decisions & Actions**

- Culture Care Preservation/Maintenance
- Culture Care Accommodation/Negotiation

- Culture Care Repatterning/Restructuring

- Culturally Congruent Care for Health, Well-being or Dying

Mexican-American Culture

There is a wide diversity of family living patterns and coping behaviors of the MA people that have been influenced by cultural and social structure dimensions. The dimensions, some more prevalent than others, influence a cultural group’s lived experience, culture care values, beliefs, and practices which in turn influence their worldview and effects culture and folk care components. A definition of culture will precede an overview of MA cultural and social structure dimensions following Leininger’s Sunrise Model/Enabler.

Dimensions that are relevant to the context of the study and will be discussed in this background section are: (a) history in the Southwest, (b) religion, (c) kinship and social factors, (d) political & legal issues, (e) economic and health status, and (f) education. Followed by focused key aspects of the MA culture: (a) language & communication, (b) assimilation, (c) acculturation, and (d) the MA community in Tucson, AZ. This wide diversity of dimensions is portrayed in day-to-day living, and influences the family unit and health & illness beliefs and practices. Journal articles published during the last three decades applicable to the background section and focused key aspects of the MA culture were utilized.

Culture

The definitions of culture are numerous; the following description is that of Leininger. Leininger defined culture as “learned, shared, and transmitted values, beliefs, norms, and lifeways of a particular group that guides their thinking, decisions, and actions in patterned ways” (George, 1995, p. 375). Each culture group influences cultural
care practices in Western and non-Western cultures due to their unique set of folk and professional care values, beliefs, and practices (Leininger, 1988).

Background

*History in the Southwest*

The history of the MA cultural group in the American Southwest began in the 1800’s, with roots embedded deeply in their native homeland of Mexico. This section will discuss the Spanish and Anglo history in the Southwest and its effect on the Mexicans and MA people.

Spanish colonization began in the sixteenth century and lasted until 1821, when Mexico achieved independence from Spain. The presence of Spanish influence and control set off the Catholic Church into the region and established numerous missions throughout the Southwest. Intermarriage between the Spaniards and indigenous Indians resulted in a mixed heritage of not only culture but also language and belief systems (Martinez, 2001). The history of conflict and deceit between the United States and Mexico occurred during the attainment of Texas and Southwestern states by the U.S. from Mexico. The Mexican government had opened the barren area known as Texas to settlers under the strict conditions that the settlers pledge allegiance to Mexico and agree to become Catholics. The Anglo American settlers, who outnumbered the Mexican citizens of that region, resisted the proposed conditions. Deceit and uprisings between the two groups occurred and through the political process, Anglo Americans of the territory were able to pass laws that stripped rights and positional status from the Mexican citizens (Martinez, 2001).
This turmoil resulted in the U.S.-Mexico War of the 1840s, which made available the territory north of the Rio Grande to the U.S., which is known as Texas through the Treaty of Guadalupe Hidalgo. In this treaty the U.S. gained full ownership of Texas, California, and areas that were called New Mexico (New Mexico and central & northern Arizona) for the price of $15 million. In 1853 the U.S. purchased from Mexico a strip of land that is now known as Southern Arizona for $10 million, known as the Gadison Purchase. Eventually Mexico lost 1% of its population but half of its territory to the U.S. (Bragdon, McCutchen & Ritchie, 1994; History, n.d; Martinez, 2001).

With the U.S. land attainment through either through war or purchase, a border now separated Mexico from its former territory. Mexicans who stayed in Arizona became Mexican- Americans; Anglos who lived south of the new border were Mexican and were considered immigrants. As agriculture, mining, and the railroad boomed in the Southwest, demand for cheap labor rose, and the U.S. sought Mexican labor. Immigrants continue to come and cross the border that once before was non-existent, and continue to transform America. This is portrayed by Martinez (2001) in the following passage:

For centuries, we have been here, in El Norte de Mexico, long before it became the American Southwest. Our ancestors explored and colonized these lands long before the coming of the children of the pilgrims. But the imposition of a border also made us immigrants. And year after year many of us have crossed the line into the United States, a country that we helped transform, with cessions of territories and the sweat of our brow, into the world’s cornucopia, the land of economic dreams (p. 2).
The current status of MAs as a people, their family life, their worldviews, values, practices, and folk care beliefs can best be recognized through an awareness of their history as Mexicans and as MA people.

Religion

The role of religion in the every day lives of the MA people as well as its role in health and illness will be discussed in the following section.

The majority of MA people are Roman Catholic, with faith and religion being involved in almost every aspect of their daily lives and influencing their beliefs on health and illness, important rites include mandatory baptism of infants and last rites for the terminally ill (Clutter & Nieto, 2000; Kemp, 2002; Warrix, 1995). Religious beliefs are an important influence in the prevention, health maintenance, and healing process of illnesses. To many MA people health and illness are viewed as affairs over which God has influence. Illness being a direct result of bad behavior, being viewed as a castigo, or punishment, from God, health is perceived as a reward from God (Fishman, Bobo, Kosub & Womeodu, 1993; Rehm, 1999; Rodriguez, 1983). If it is believed that God is responsible for causing an illness, in order to cure themselves of that illness, the MA people will offer “sacrifices, promises, prayers or medals to God and patron saints, and will also light candles and visit shrines” (Fishman et al., p. 161).

Having religious faith in terms of health preservation is not sufficient in preventing illness; it is the quality and quantity of time involved in religious affairs that is believed by many to be the source of illness prevention and health maintenance. Researchers Franzini & Fernandez-Esquer (2004) conducted a study utilizing a
multistage probability sample that compared acculturation level, socioeconomic, cultural, and personal characteristics in a sample of 1,745 low-income Mexican origin females in Texas. Data was collected utilizing survey and interview methods. The researchers found that “high levels of religious involvement have a positive moderate association with better health outcomes” (p. 1633).

Two popular forms of religious practices are found within the MA culture: one is organized the latter informal. Organized religion is described as social or formal religion, where religious involvement occurs in the form of church membership and attendance. Informal religion encompasses the essence of spirituality, where faith believers choose to worship God through verbal or silent prayers and attain feelings of closeness to God in an informal setting, such as at home or during their daily activities (Franzini & Fernandez-Esquer, 2004).

Religion plays a dominant role in the every day lives of the MA people. Religious faith is not limited to churchgoers, but also to common folk who choose to worship in informal settings. Religious beliefs that illness is a form of punishment delivered from God and health a form of reward remains a pertinent aspect for many of the MA people.

*Kinship and Family*

The following section will discuss the modern day MA family, the effect of modernization on the traditional family, family member roles as well as extended family and familism.
The role of the MA family has undergone social change due to urbanization and industrialization. Such change is influenced by longevity and time, or lack thereof. MA people are living longer than they did centuries ago, with this longevity comes the need to continue to support themselves and the family longer, this in turn effects the quantity of time and effort MA people can devote to old traditions. In the past family event would last several days, now they are shortened to one to two days (Smith, 2000).

This social change is also seen in the work force; in the past the majority of MA people in the workforce were male, performing labor, or manual work. Presently, both male and female members of the family are employed not only as skilled labor, but also as professionals. MA families favor patriarchal beliefs, yet the current role of women is much stronger (Smith, 2000). Women hold a firmer and much larger role that in the past, not only in the aspect of child rearing practices, but as wage earners and keepers of traditional cultural beliefs and practices (Rodeheaver, 1991).

Within the MA family, roles are clearly defined; the head of the family is the oldest male, who usually gives orders to the younger males (da Silva, 1984; Kemp, 2002). Old age is valued and respected. Usually, older parents go to live with their children, primarily the oldest daughter who will serve as their primary care takers (Jolicoeur & Madden, 2002). The extended family is comprised of godparents, or padrinos, who are involved in family making decisions. The history of extended family grew out of the socioeconomic needs, in order for the traditional Mexican family to function in the social and economic setting, roles and duties were divided among the different generational groups in the family (Clutter & Nieto, n.d.; da Silva).
Familism is defined as “the valuing of family considerations over individual or community needs” and is a very strong and prevalent value in the MA family (Kemp, 2002, p. 4; Bean, Curtis Jr. & Marcum, 1977). A key aspect to the concept of familism is described by Cuellar, Arnold & Gonzalez (1995), as “the importance an individual places on the family, and his or her attitudes towards the family” (p. 341). According to Tamez (1981), to the MA people, the family is “the center of life” (p. 22). An individual is expected to assist the family in time of need; in turn the family will assist the individual. There is an expected obligation expressed through moral responsibility to assist the family, especially in an economic standpoint (Clutter & Nieto, 2000; Cuellar et al.). A main aspect of the MA family is the firm belief of not disgracing or dishonoring the family, if this occurs, the result can be severance of all family ties (Tamez).

The role of the present day MA family has modified the traditional family. This modification is brought forth by a modernizing, faster-paced society. Although some roles have changed, such as women being more dominant in the workforce than their ancestors were, traditions have withstood the force of time and modernization. Although traditions may not be as elaborate and lengthy as in the past, they remain an important aspect of the MA family. Regardless of these changes, some aspects remain intact, such as familism and extended family that serves as the main support system.

**Woman’s Role**

The following segment will discuss two of several roles women in the MA culture uphold: these are as mothers and child raisers. The role of wage earners has previously been discussed in the section of Kinship and Family.
Motherhood

Conventional beliefs on motherhood in Mexico “holds women to an ideal of femininity symbolized by the virgin mother, a woman’s mission in life is to engage fully in domesticity to sustain the family” (Guendelman, Malin, Herr-Harthon, & Vargas, 2001, p. 1806). In the present day where both mother and father are the wage earners of the working family, changes in these traditional beliefs have taken place. Nonetheless, disregarding socioeconomic level, MA women regard their children as “one of the few sources of personal achievement and pride,” with the majority of women having a desire at some point in their life of having children (Guendelman et al., p. 1806). The role of the family is very prevalent in this aspect of the family, young mothers seek advice from their own mothers, relatives, and older women who are knowledgeable in the folk beliefs and practices relevant to the child bearing years, usually all recommendations and advice are carried out due to family influence (Tamez, 1981; Zenk, Shaver, Peragallo, Fox, & Chavez, 2001).

Child Rearing Practices

The MA home is very child oriented; yet strict order is maintained. Although children occupy a very central position in the family, they are not allowed to misbehave (Tamez, 1981). Children are brought up to obey parental authority, and where physical punishment is the primary form of discipline (Escovar & Escovar, 1985). The mother or other strong female role model such as a grandmother, aunt, or older sibling cares after younger children. Children are seldom cared for by someone other than the family. Responsibilities and tasks are assigned to children according to age, with older ones
looking after younger ones. Jobs and responsibilities are differentiated according to sex; boys are assigned to more masculine duties (manual labor, yard work, etc) while females are taught more feminine roles (cooking, cleaning, sewing, etc). It is common for children to live at home until they marry (da Silva, 1984; Tamez, 1981).

Childrearing practices are influenced by parental generational level. Buriel (1993) telephone interviewed 317 MA parents who had children attending one of three junior high schools in Los Angeles to determine how parents influence the school achievement of their children. Results indicated that parents of first and second-generation adolescents reported a more “responsibility-oriented childrearing style” which consists of “earlier autonomy, productive use of time, strictness, and permissiveness” (pp. 987 & 996). Parents of third generation adolescents reported a more “concern-oriented childrearing style” which incorporates more emotional support and higher behavior expectations at home and school (pp. 987 & 996).

The role of women in the MA culture has played an important and dominant role in motherhood and child rearing practices. The effects of modernizing society and generational level may provide a broader outlook on their role as women than just the home makers by permitting them to seek out opportunities that allow them to refine their traditional role and encompass the workforce and also modify the way they raise their children. However, women still carry the primary responsibility for health care treatment decisions regarding illness in their child.
Legal and Political Issues

This section will discuss the several categorical classes of the MA people in the U.S. as well as discuss their past and current political standpoint. Current issues surrounding the MA people and other Hispanics are politically and legally bound.

The legal issues that have beset the MA people have concentrated primarily on the issue of immigration. The population of MA people in this country is made up of several categorical classes. There are those who are U.S. citizens through birth, blood, or marriage, those who entered the country illegally and have established residence or citizenship, and those who are illegally in the U.S. All three categorical classes make up the MA communities across the countries, each influencing and having an effect on the dominant society.

There is a deep immigrant history with natives of Mexico, where immigration to the U.S. began to rise sharply in the 1890s and in the 1940s until the present (Wildsmith, Gutman & Gratton, 2003). The most current immigration law, known as The McMarran-Walter Act or also known as the Immigration and Nationality Act of 1952 has given preference to immigrants with skills, those with close relatives of U.S. citizens, and those with refugee status (Braziel, 2000). The reasons surrounding immigration of Mexican families to the U.S. are socially, historically, culturally, economically, and educationally bound (Kemp, 2002; Rueschenberg & Buriel, 1995).

There are three forms of legal and illegal migration patterns that exist currently in the U.S. The first involves migrant workers who travel to the U.S. legally or illegally. Each year they follow agricultural patterns, once the agricultural season comes to a yearly
end, these migrant workers return to Mexico. Another form constitutes what is known as the “invisible laborers,” primarily men with illegal status, who work as day laborer for individuals or businesses. Most team up and share apartments in order to minimize expenses, money is sent back home on a regular basis. The final group of immigrants consists of families who come here illegally and over time through amnesty and other methods establish legal residential status in the U.S. These families make up permanent residential status within the U.S. communities (Kemp, 2002).

In U.S. history laws were created to prevent the involvement of the MA people in the political system. Laws that single-handedly prevented them from joining and expressing their rightful rights hindered the political involvement of the MA people. These laws included citizenship restrictions, denial of women to vote, “English Only” laws and restrictions, literacy tests, poll taxes, single locations for voter registration, white man’s primaries, annual voter registration and gerrymandering (Martinez, 2001). The struggle of the MA people into the American political system is portrayed by Martinez in the following passage:

We knew the power of unity and the importance of the vote. And here and there, where we could, we had victories, now and then. But it was hard, and it took so long, to begin breaking the colossal chains that locked us out, collectively. Many generations have come and gone, and much struggle waged and pain endured. But not for a moment did we stand still. We labored, we mobilized, we organized, and we fought with all our might, to secure our rights and our rightful place under the northern eagle’s sun (p. 150).
In spite of such struggles, the MA people have proven themselves worthy of important political roles and have made political progress serving in a variety of local, state, and national offices (Martinez, 2001). In the Southwest, specifically to Arizona, the MA people have made profound political marks. In 1878 Estevan Ochoa became the first MA mayor of Tucson, in 1971 Romana Acostas Banuelos (a native of Miami, Arizona) was appointed Treasurer of the United States by President Nixon, in 1974 Raul H. Castro was elected the first Hispanic governor of Arizona, and in 1991 Ed Pastor, a MA, became the first minority congressman from Arizona (AZCentral, 1999b).

The categorical classes that represent the MA people in this country are citizens, residents, and illegal immigrants. All three categorical classes are encountered in conventional America and are widely dispersed among society’s social status. The MA people belong to working low-wage jobs, as well as working as professionals and representing their communities by serving on the U.S. political system. Their status level plays a role in their worldviews, values, practices, and folk systems.

Economic and Health Status

The factors of economic stance and health status collectively are discussed in this section. Both appear to demonstrate a correlation, with one affecting the other, either positively or negatively. The cultural groups in the U.S. are affected by these factors, some to a worse degree than others. The effects of economic and health status are evident in the children of these cultural groups (Flores, Bauchner, Feinstein &, Nguyen, 1999).
The MA people are one of the lowest paid ethnic groups, accounting for an increase in poverty. The federal government considers Hispanic an ethnicity not a race, therefore the statistical factors are representative of numerous Latin races that include the MA people, Puerto Ricans, Cuban Americans, Central Americans, and “other” (NCHHHSO, 1995). Of Hispanic families, 26.5% live in poverty. Men occupy the majority of the Hispanic workforce: 80% of Hispanic men age 16 and over, compared to 57% of Hispanic women, according to the 2000 census. Of Hispanic workers, 41% are employed in service occupations, as operators and laborers; only 14% are employed in managerial or professional occupations (National Coalition of Hispanic Health and Human Services Organizations [NCHHHSO], 1995; Rodriguez, 1983). This is described by Martinez (2001) in the following passage:

Hard work on the northern frontier and deep within Mexico prepared us for back-breaking labor in the United States. But we did not anticipate the long and hard struggle for basic rights, for fair wages, for just treatment. In the United States of America? In the land of justice and equality? By jumping hoops, scaling walls, skirting barriers, embracing luck, seizing opportunity, and working like devils, a good number of us penetrated the middle class, and achieved status and material comfort (p. 91).

The real median income in 2000 for Hispanic families was $33,455 (Hispanic Heritage [HH], 2004). Hispanic, Native American and Black children are the poorest in the U.S. compared to Asian/Pacific Islander and Non-Hispanic White children. 40% of Mexican children in the U.S. live in poverty, compared to Cubans (13%) and Whites
(10%). The rate of poverty among these children is associated with the level of education of their parents, which in turn influences their socioeconomic status (Flores et al., 1999; Mendoza et al., 1991).

Insufficient data is present about illnesses with the highest prevalence among Hispanic’s, specifically to the MA people because of the problem with the classification of “Hispanic” by the federal government who clump all Latin cultures under one ethnicity. What is known is that the Hispanic people are an underserved population by the health care system. This is often times a result of cultural, educational, economical, language, and employment factors. Frequently Hispanics are employed on a part-time basis and do not qualify for insurance, or they are caught being the working poor. They make too much for public assistance programs, but not enough for purchasing private insurance (Ginzberg, 1991; Novello, Wise & Kleinman, 1991).

This observation is also supported by the Council on Scientific Affairs [CSA] (1991): “Mexican-Americans who work tend to have jobs with no insurance benefits and/or they cannot afford insurance premiums for their large families” (p. 249). In the area of childhood health, there is lack of primary care for all age groups due to lack of access to care. This results in Hispanic children suffering from preventable diseases, such as measles, and missing more school days than those who have access to health care (NCHHHSO, 1995). Overall, uninsured Hispanics are less likely to have “a regular source of health care, less likely to have visited a physician in the past year, less likely to have had a routine physical examination, and less likely to rate their health status as excellent or very good” (Treviño, Moyer, Valdez & Stroup-Benham, 1991).
In order to prevent illness, the U.S public health system developed Healthy People plans. These plans are a set of evidence-based health objectives that are revised every 10 years. The most current is Healthy People 2010. One of the three major health goals of this plan is specific to Hispanics in this country; it aims at reducing the number of disparities in the areas of health promotion, protection, and disease prevention (Arizona Department of Health Services, 2004). Since the implementation of this plan, Hispanics continue to remain underserved. Instead of accessing a primary care physician they are frequenting the emergency room as their right of entry into the health care system with chronic illnesses that could have been prevented (CSA, 1991; Northam, 1996).

The cultural and social structure dimension factor of economics plays an influencing role in the culture care values, beliefs, and practices of the MA people, effecting health outcomes, primarily in their children. The level of socioeconomic status acts as a gatekeeper to the health care system. Those that are able to afford their own private insurance or are employed in jobs that provide insurance are able to access and health care services. For the majority of MA people this is not the case; they are employed in low-wage jobs that do not offer insurance; their socioeconomic status is far below the reach of purchasing private insurance. Access to health care results in the utilization and search for other health care means, that often times may be detrimental to their health and the health of their children.
Education

The cultural and social structure dimension factor discussed in the following section is education. This factor does not exist alone; it has in conjunction the dimension factor of economics. Education is a persuading factor in the role of socioeconomic class.

The educational level of the MA people is related to job skills. Less educated individuals tend to have low paying jobs, with an increased likelihood to high unemployment rates and poverty (CSA, 1991). Less educated individuals lack English language skills that prevent them from obtaining better jobs, understanding and obtaining health insurance or state-assisted health coverage like Medicaid (CSA). This is more prevalent and significant with “newly arrived foreign-born Hispanics” (Rodriguez, 1983, p. 137). Currently, 57% of Hispanics age 25 and over have at least a high school education, and 11% have at least a bachelor’s degree (HH, 2004). The prevalence of high school drop out rates is high among Hispanics, with youth dropping out in all high school grades compared to the national population (NCHHHSO, 1995).

The level of education influences career options and choices. For those that become part of the blue collar or manual labor force, higher education is not emphasized. This is the case with the majority of MA people; they make up the greater part of service and labor occupations. First generation immigrants generally come with little to no formal education, limiting their choice of occupation, which sequentially has an effect on their socioeconomic and health status. Education is another influencing attribute in the culture care values, beliefs, and practices of the MA people.
Language and Communication

According to Rodriguez (1983), “Spanish...like any other language, is more than a means of communication; it is the embodiment of a culture. As such, it offers a measure of cohesion, a reason for cooperation, a sense of security...a point of pride” (p. 137). Spanish is the language that represents Mexico and other Latin countries, where it is differentiated by different idioms, dialects, and variations (CSA, 1991; Kemp, 2002; Rodriguez, 1983). Of all the foreign or non-English languages spoken in the U.S., Spanish is the most prevalent and has the greatest opportunity of survival (Rodriguez).

Communication among the MA people is not solely confined to verbal dialect, but also to nonverbal communication. An element that is very prevalent is respeto, or respect. Respect is the essence of acknowledging older individuals, by avoiding direct eye contact with those of higher status, and by acknowledging individuals by titles of respect such as Don and Doña (Clutter & Nieto, n.d.; da Silva, 1984; Kemp, 2002). MA people have shorter personal space standards; they routinely greet individuals with a hug, firm handshake and a kiss on the cheek (Clutter & Nieto; Kemp). Informal settings and conversations are “usually loud, fast, and adorned with animated gestures and body language” (Clutter & Nieto, p. 2).

A native language has cultural ties to its ethnic group. Language is descriptive and unique of a cultural group; survival of language is influenced by its continual usage. This usage is due to a constant flow of first generation Mexicans, the closeness to Mexico, and a large cultural group. Inability to converse in English leads to miscommunication that can result in misconceptions, especially in case of health care. In
order to communicate and learn cultural lifeways, views, and beliefs, knowledge of the native oral and nonverbal language of the cultural group is beneficial.

**Assimilation**

This section will focus on the assimilation process of the MA people and the factors that have affected this process. Assimilation refers to intermarriage, or marital assimilation between cultural groups (Gurak & Fitzpatrick, 1982). The higher the level of assimilation the smaller or shorter the social distance that separates cultural groups. Generational stance plays a role in the assimilation factor, usually first generation have lower rates of intermarriage, while second generation and so forth have higher rates than their forefathers (Gurak & Fitzpatrick). MA people have created their own community, separating themselves from the dominant society. The persistent flow of immigrants across the border allows for continual marriage opportunities, slowing assimilation. A final factor is the Mexican belief in familism, which resists external factors that may disrupt or change family patterns [through intermarriage] (Wildsmith et al., 2003).

Lack of assimilation prevents the mixture of two cultures, which allows for the continuance of traditions, beliefs, and worldviews to prevail within a cultural group. The MA people have been able to resist high levels of assimilation because of their geographic proximity to their native homeland of Mexico, through the retention of their native language, and furthermore because of the continual flow of new immigrants. These prevailing factors assist in the retention and reinforcement of the worldviews and folk systems beliefs of the MA people. Provider assessment and scholarship contribute to the understanding of these traditions, worldviews and set values and beliefs.
Acculturation

Acculturation is defined as the “process of change that occurs as a result of contact between cultural groups … change may occur along several dimensions (beliefs, values, behavioral practices) and be measured as a group or individual level phenomenon.” (Kaplan & Marks, 1990, p. 1313). Acculturation has an effect on the cultural groups that occupy the U.S., including the MA people. Although the commonality of acculturation is present among these different cultural groups, there is a difference among the MA people. This difference lies in the factors that will be discussed in this section that have decelerated the acculturation process and progress within their cultural group.

The effect of acculturation on MA families in the Southwest is influenced by the Southwest's geographic proximity to Mexico and the large population of MA inhabitants in the Southwestern states who have formed their established residence and neighborhoods, or barrios. These factors influence the degree of acculturation of an individual or family and results in biculturalism, where family affairs in the home are reflective of Mexican origin; activities outside the home reflect those of white America (Rueschenberg & Buriel, 1995). The degree of acculturation is dependent on the amount of exposure an individual has to two or more cultures. The greater the exposure the greater the level of acculturation (Cuellar et al., 1995).

MA families are not all on the same level of acculturation, there are those who are newly arrived to the U.S. and have not acculturated into the American culture, there are those who live in a bicultural family, retaining their Mexican culture and traditions at
home, yet have adapted and integrated into the American culture at school and/or work. Finally there are those who have fully adapted and acculturated into the American culture, having lost all traditional beliefs, practices, and language. The only identifier of Mexican descent is their personal history, last name and/or skin color.

Regardless of acculturation level, the MA people are often clumped together based on their cultural commonality by the American culture; this is described by Martinez (2001) in the following passage:

We welcomed the children of the Pilgrims, and we got along just fine—at first. But more and more strangers from the East poured in, and soon, they, the new majority, became the insiders, and we, transformed into a minority, became the outsiders. It was not easy to be both Mexicans and Americans. Duality spawned ambivalence and many dilemmas. We had no choice but to fashion our own identity. Through we looked like Mexicanos and Mexicanas from the land of the Aztecs and the Zapotecs, living in the United States made us different from them, and they from us. But because we looked alike, the Americanos saw us as one and the same. Simple-minded lumping and labeling erased roots and distinctions. We sought to explain ourselves to the Americanos. We tried to learn English, to fit in, to integrate. But most of them built steely walls around their world, and used their power to keep us in ours (p. 50).

Acculturation is taking place among the MA people at a different level or rate than other cultural groups in the U.S. This difference is that the MA people have continual interaction with first generation immigrants and have a closer proximity to their
native homeland of Mexico. First generation immigrants constantly reinforce traditional values and folk care beliefs to remain unchanged thus influencing greatly the rate and course of acculturative change. The close proximity of Mexico to the U.S. reinforces family bonds and values.

*Mexican-American Community in Tucson*

The MA people in Tucson, Az. are a thriving community that has retained numerous community traditions. Traditions that will be discussed in this section are: (a) religious celebrations, (b) the Day of the Dead, and (c) yearly festivals, conferences and celebrations.

Even though change has occurred in traditional beliefs and practices, many are still celebrated throughout the Southwest. Some have religious ties while others are culturally bound. Among those of the Catholic faith, baptisms, first holy communions, and confirmations are great social events where family from all over the country and Mexico may gather to celebrate these special occasions (Clutter & Nieto, 2000).

*Quinceañera*, is the next special event in life’s’ time line, it is the celebration when a Hispanic girl turns fifteen; it marks the period of when she becomes a woman (Quinceañera, 2003). At the end of life is the celebration of *El Día de los Muertos*, or The Day of the Dead. It is celebrated between October 31 and November 2 and represents death as a continuance. The event allows for the living to have an opportunity to show respect for their deceased loved ones. Family members often times take favorite foods and beverages that were enjoyed by the deceased and adorn the grave-sites with colorful bright yellow flowers (Allen, 2001).
Other patriotic and cultural celebrations practiced by the MA community in Tucson include the *Fiesta de Garibaldi* in April, this *fiesta*, or party, focuses on *mariachi* music and *baile folklórico*, or folkloric dancing. The *Mariachi* Conference is also held in April, it is known as one of the best-known conferences in the U.S. In May, *Cinco de Mayo*, or May 5th, is observed, which celebrates the battle won on May 5, 1862 when the French attacked two forts in Puebla, Mexico. September 11-12 marks the celebration of the Mexican Independence Day from Spain, or *El Día de la Independencia* (AZCentral, 1999a; Benavidez, 1996; Smith, 2000).

The *Norteño* Music Festival & Street Fair is celebrated October 1-2; it features the music of Northern Mexico along with its arts, crafts, and food. Final celebrations are held during the month of December. During the entire month the *Feria Navideña*, or Christmas Market, is held and features figurines and other items for nativity scenes and holiday décor. On December 12 *La Fiesta de Guadalupe* takes place. This celebration is symbolic of the appearance of the Virgin of Guadalupe to Juan Diego. The final festivity is *Las Posadas*, which is a nativity pageant symbolic of Mary and Joseph’s Christmas Eve search for shelter (AZCentral, 1999a).

The MA community in Tucson is prevalent in not only their yearly festivities and celebration but also in day-to-day living. Specifically concentrated within their communities are grocery stores, meat markets, bakeries, restaurants, and retail stores tailored to the MA people. The school system has also established numerous bilingual schools, as well as adult classes that focus on English as a second language. In the area
of communication, there are numerous web sites, local radio stations, local Television station out of Phoenix, as well as newspapers and periodicals in Spanish.

Significance of the Project

Hispanics are the fastest growing and largest minority group in the U.S., constituting 35.3 million (12.5 percent of the nation’s total population), with almost 16.3 million being foreign-born. Current national statistical values on MAs residing in the U.S. are estimated at 58.5% of the total Hispanic and Latino population (Arizona Quick Facts [AQF], 2000). As mentioned previously, the federal government considers Hispanic an ethnicity not a race, therefore the statistical factors are representative of numerous Latin groups that include the MA people, Puerto Ricans, Cuban Americans, Central Americans, and “other” (NCHHHSO, 1995).

Hispanics are located in all 50 states, with the majority residing in California, Texas, Arizona, New Mexico, Florida, and New York; with some of the Hispanic communities native to U.S. territories that were once under ownership of Mexico (NCHHHSO, 1995). Current Arizona statistics estimates the Hispanic population to be 25.3% of the total Arizona population of 5.4 million, with 29.3% of the total population (843,746) of Pima County being of Hispanic origin (AQF, 2000; CSA, 1991; HH, 2004). The growth is influenced by high fertility rates, increased legal immigration, with a minimal percentage caused by illegal immigration (NCHHHSO, 1995).

The mean Hispanic and Latino age in Pima County is 25.5 years. The current population for Hispanic and Latino children under the age of five years old in Pima County is 12,064 and for ages 5-9 the population is 11,963, based on the 2000 Census.
These figures account for 17% of the total population (140,245) for these age groups in Pima County. 70% of Hispanic and Latino children in Pima County live in married-coupled family households as reported by the 2000 Census (Tucson Planning Department, March 28, 2002).

Problem Statement

Nurses providing primary care to Mexican and Mexican-American mothers may be unfamiliar with Mexican home remedies used to treat childhood illnesses. Professional health care providers typically practice under the beliefs of Western Medicine and may not understand cultural context of MA patients. The dominant Western medicine philosophy focuses primarily on pathophysiology and tests, separating mind from body, and less focus on cultural awareness and psychosocial considerations (Reimann, Talavera, Salmon, Nunez & Velasquez, 2004). Non-Western views of healthcare uphold views that body and mind are one and inseparable (da Silva, 1984; Scholz, 1990). The attainment of understanding of MA cultural methods through cultural awareness may lead to harm prevention through the identification of harmful folk remedies.

Deficits in cultural assessment may result in continued usage of harmful folk remedies among the MA people, especially when it relates to infants and children since they are cared for according to the beliefs and practices of their parent(s) and/or guardian. These beliefs and practices “influence both the ability and willingness of caregivers to seek professional help and to comply with the preventative and/or treatment regimen for their children” (Mikhail, 1994, p. 624). For example, Azarcon and Greta are
highly toxic orange and yellow powders containing 97-99% lead used as folk remedies mainly utilized on children for the treatment of the folk illness *empacho* and other intestinal disturbances (Poma, 1984). The prevalence of lead has also been linked to ceramic tableware utilized by many MA families (National Resources Defense Council [NRDC], 2003). Wormwood tea is used to treat diarrhea. It is a “cerebral stimulant and can be psychoactive”, an overdose can result in delirium, cramps, intoxication, and convulsions (Risser & Mazur, 1995, p. 981). These are potentially harmful home remedies that may continue to be used by the MA people, there in no current literature depicting their present day continued usage. Assessing for their usage may lead to harm prevention in children. Refer to the Handbook for further information on these potentially harmful home remedies.

**Summary**

MA groups in the U.S. have different histories of immigration and settlement. Some trace their roots to the Spanish and Mexican settlers who first dominated the Southwest before the arrival of the pilgrims; others are immigrants or children of immigrants. MA cultural beliefs and views of health, wellness, and illness are passed on from one generation to the next. Acculturation is symbolic as generational groups that follow their forefathers will have been exposed more to the dominant society but nevertheless, the impact of health care beliefs and practices are present, perhaps in more in some homes and not as prevalent in others. The Hispanic community are more likely than non-Hispanics to live in poverty, be unemployed or underemployed, have little education, and have little to no health insurance (CSA, 1991). The barriers that hold
these individuals at a disadvantaged status are several. Among these is lack of or insufficient knowledge of the English language, limited income, limited education, limited resources such as transportation and social support systems (Jolicoeur & Madden, 2002; Rodriguez, 1983).

The continual flow of first generation Mexicans into the U.S. allows for the conservation and reinforcement of traditional values and beliefs. Hispanic health and folk beliefs and practices not only have an effect on adults, but also their children. These beliefs and practices influence the caregiver’s motivation and capability to seek out professional medical help and to adhere to treatment regimes. Harm can be prevented through cultural awareness and knowledge of these beliefs and practices. Chapter Two will highlight Leininger’s Culture Care Diversity and Universality Theory, followed by an overview of health beliefs and practices in the MA culture specific to folk systems. A review of the literature will follow.
CHAPTER TWO

Conceptual Model And Review Of Literature

Introduction

Leininger’s Model provides the framework for this study. An overview of health beliefs and practices in the MA culture specific to folk systems will precede effects of cultural and social structure dimensions on MA traditional folk values and beliefs. The literature review will follow.

Conceptual Model

Leininger introduced the key concepts of transcultural nursing and ethnonursing. According to Leininger, transcultural nursing is:

a learned subfield or branch of nursing which focuses upon the comparative study and analysis of cultures with respect to nursing and health-illness caring practices, beliefs, and values with the goal to provide meaningful and efficacious nursing care services to people according to their cultural values and health-illness context (George, p. 373).

Imbedded in transcultural nursing is the importance of emic knowledge, which is referred to as “local or insider’s views and values about a phenomenon (Leininger, 1996, p. 73). This type of knowledge, according to Leininger, is important to identify because it is “directly attained from those who have lived and used this knowledge precisely”, it in not second-hand knowledge, folk (or lay) care systems are a form of emic knowledge (George, pp. 374-375). An example of a folk care system in the MA culture is
*curanderismo*, which according to Maduro (1983) “is based on a set of values, underlying beliefs and premises—that is relatively fixed but implicit, often unconscious, notions of disease causation and cure … it involves a coherent world view of healing that has deep historical roots” (p. 868).

Leininger defined *ethnonursing* as “the study of nursing care beliefs, values, and practices as cognitively perceived and known by a designated culture through their direct experiences, beliefs, and value system” (George, p. 374). The focus of Leininger’s theory encompassed the concept that all cultures have their own distinct and unique values and belief systems that influence their perception of health and illness and influence the delivery of health care. Although each culture may have specific practices, there do exist practice patterns that are common across cultures. The commonalities of cultures Leininger refers to as universality, while the differences are referred to as diversity (Leininger, 1988).

An example of the universality and diversity of cultures occurs in folk healing between Hispanic cultures. The MA people have *curanderismo* which is “rooted in ancient Indian traditions mixed with more recent Spanish customs”, Puerto Ricans have *espiritismo* which contains a mixture of Catholic rituals and tribal African beliefs that are “concerned primarily with solving problems and healing by working through the power of spirits”, and Cubans have *santeria* which is also a mixture of Catholic rituals and tribal African beliefs but “focuses on symptom and health promotion with emphasis on rebirth and beginning of a new life” (Gomez & Gomez, 1985, pp. 246-247).
Health is distinctive and specifically defined by each cultural group, these definitions and views may not be in accordance to other’s viewpoints and ideas, but it is expressed by how a culture group lives out their daily life and roles (George, 1995). For some cultures health may be defined as the will of God, to others health is defined by the absence or presence of pain, and yet to others it is defined by whether or not they are able to work and provide for their family (da Silva, 1984; Fishman et al., 1993; Gonzalez-Swafford & Gutierrez, 1983; Gordon, 1994).

Each ethnic group has their worldview and own culture care diversities and universalities influenced by a variety of factors. These factors, or cultural and social structure dimensions, may change over time, allowing for the ethnic groups worldview and culture care diversities and universalities to change, adapt, or be modified. These cultural and social structure dimensions represent the makeup of a culture group, a makeup that not only helps define an ethnic identity but a cultural stance. Cultural and social structure dimensions influence a cultural group’s lived experience; this is what Leininger refers to as environmental context (George, 1995; Leininger, 1988).

Leininger also emphasized the importance of Culture care, she described as:

Culturally derived, assistive, supportive, or facilitative acts toward or for another individual or group with evident or anticipated needs which guide nursing decisions and actions and are held to be beneficial to the health or well-being of people, or to face disabilities, death, or other human conditions (Leininger, 1996, p. 73).
*Culture care* guides nursing care practice in a holistic manner, in order for culture care to be attained, Leininger implemented three central action and decision methods. These were: (a) culture care preservation and maintenance, (b) culture care accommodation and/or negotiation, and (c) culture care restructuring and repatterning (George, 1995; Leininger, 1996). The one most prevalent to this project is culture care accommodation, which Leininger defined as:

*Culture care accommodation*: assistive, supporting, facilitative, or enabling creative professional actions and decisions that help people of a designated culture to adapt to or negotiate with others for a beneficial or satisfying health outcome with professional care providers (Gordon, 1995, p. 377).

To facilitate proper medical care and achieve *cultural care*, recognition that cultural beliefs and values of another culture different from one’s own are important. This needs to be examined before interaction with the culture group occurs because the “assumptions of one cultural group are not necessarily accepted by another” (da Silva, 1984, p. 4). Secondly, provider personal biases need to be examined beforehand in order to be able to openly respond, acknowledge, and gain knowledge of the beliefs and values of another culture (Reimann, Talavera, Salmon, Nunez &, Velasquez, 2004). A common ground is warranted through culture care accommodation where both provider and client share their own views and opinions of the situation and through negotiation together foster and support beneficial health outcomes.
An Overview Of Health Beliefs And Practices In Mexican-American Culture:

Folk Systems

Health beliefs and practices of the MA people that will be discussed in this section relevant to folk systems are: (a) definition of health, (b) hot/cold concept, (c) fatalism, (d) role of the family, (e) folk medicine/remedies, (f) folk illness, (g) folk healer, and (h) access to medicine/herbs.

Health Definition

Neither prevention nor promotion is valued among the MA health beliefs, which is representative of the higher incidence of chronic illnesses in this cultural group (Kemp, 2002). Health is defined according to the MA people by the ability to function in daily activities, especially in the ability to work. De Silva (1984) points out, “this continued ability is viewed as good luck, good behavior, or a gift from God” (p. 5). Health is also defined by the absence of pain, which hinders early medical treatment seeking. MA people believe that in order to maintain health there must be a balance, the balance between God and nature and the elements of hot & cold. A misbalance causes illness (Fishman et al., 1993).

Hot/Cold

The concept of hot/cold is dated back to Hippocrates who defined his theory of disease as a balance between four humors: blood, phlegm, black bile, and yellow bile. Any imbalance among the four humors caused illness (Kay & Yoder, 1987). The Spanish introduced this belief to the indigenous people of Mexico during colonization, and over time this medical theory developed into the hot/cold balance (Fishman et al.,
Illness is caused by either too much hot or cold, or disequilibrium, the restoration of balance utilizes hot or cold foods and treatments (da Silva, 1984; Fishman et al.; Gonzalez-Swafford & Gutierrez, 1983; Smith). The concept of “hot” and “cold” is not representative of temperature or spiciness, rather the intrinsic quality of foods, medicines, and body illnesses and conditions (Messer, 1981).

Cold is associated with phlegm and produces diseases that have less obvious symptoms such as tuberculosis, pneumonia, menstrual cramps, colic, earaches, arthritis, rhinitis, lesions & exudate, and empacho. These are usually caused by exposing the body to cold elements, such as air or water, when the body is hot (da Silva, 1984; Gonzalez-Swafford & Gutierrez, 1983, Kemp, 2002; Mikhail, 1994; Ripley, 1986; Smith, 2000). Hot is associated with yellow bile and produces illnesses are created from within the body and have more visible symptoms, these include conditions caused by vasodilation and high metabolic rate, including pregnancy, hypertension, diabetes, acid indigestion, fever, headache, sore throat, susto, mal de ojo, and bilis (Kemp; Smith). In order to restore balance, cold conditions are treated with hot medications or remedies and hot conditions are treated with cold medications or remedies (Kemp).

The hot/cold concept includes body state. Children are referred to as cold and suffer more from cold conditions than adults, are therefore are treated primarily with hot remedies. Adults are classified as hot, with old people being either hot or cold. The hot/cold balance is a learned system primarily based on trial and error. Young mothers have been exposed previously to concepts of hot/cold, through the wisdom of an older female relative, usually the grandmother, but it is not until they have their own family
that they observe what harms and what heals their families (Kay & Yoder, 1987; Messer, 1981).

Fatalism

Cuellar et al., (1995) define fatalism as “the extent to which people feel their destinies are beyond their control” (p. 341). This fatalistic view, or belief in external control, influences the health of MAs; many believe they have no control over their health status. Fatalism is used when there is no explanation for the cause and distribution of an illness, this is further emphasized by the terms of “being lucky” or referencing to God as being “God’s will or plan” for an illness to occur or not occur (Davison, Frankel & Smith, 1992). The concept of fatalism, or external control, is represented by Mirowsky & Ross (1984):

It is generally believed that the good or bad fortune of the individual is predestined and every occurrence in human existence comes to pass because it was fated to do so. What the Anglo tries to control, the Mexican-American tries to accept. Misfortune is something the Anglo tries to overcome and the Latin views as fate (p. 3).

Role of the Family

The mother or primary female in the family, is the health care provider, who decides when an illness is out of her ability to treat with home remedies and when she seeks help from professional care providers (Gonzalez-Swafford & Gutierrez, 1983; Gordon, 1994; Smith, 2000). Folk remedial and medicinal knowledge is passed down from mother to daughter. Even though the mother or primary female is the chief provider
of health care, the immediate and extended family are closely involved in the care, well-being, and health care decisions of a patient (Gordon, 1994). According to Johnson (1979), “kinship relations determine the pathway to treatment in time of sickness” (p. 71). The family is involved in important decision-making; decisions may often times surpass those of the professional health care provider (Gordon). Family involvement is present throughout the illness process, giving not only moral and social support for the patient, but is involved in the purchase of medications and remedy ingredients, and assists in the preparation and administration of such remedies (Adams, 1986).

Medical treatment begins at home, it is not until an illness is severe or emergent that professional medical help is sought (da Silva, 1984; Mikhail, 1994; Roy, Torrez &, Dale, 2004). The MA people utilize the cultural components of folk systems in the form of folk medicine and folk healers. Economic or educational levels do not “govern adherence to folk systems” (Marsh & Hentges, 1988, p. 260). Roy et al., (2004) states, “folk medicine does not replace modern health care, it supplements it…traditional folk healing is a practical and useful alternative when modern health care is unsatisfactory” (p. 26). Treatment options for MAs people are not confined to folk remedies or folk healers, it is common for parents to practice “self-medicating” on their children through the assistance of neighborhood pharmacies and pharmacists. Parents treat their children with “antibiotics and other prescription medications without a physician’s advice, exam, or prescription” (Roy et al., 2004, p. 24).
Folk Medicine/Remedies

The continued use of home remedies among MA adults and children is due to several reasons, which are their “proven efficacy; they are natural herb products that are inexpensive and readily available in the community” (Adams, 1986; Ripley, 1986, p. 42). They are used to prevent or cure a disease, and are the first line of attack at the illness, and may be used in addition to western medicine in order to speed up the process of healing (Adams; Bushy, 1991; Fishman et al., 1993; Ripley, 1986). Folk remedies not only include herbs, teas, massage, prayers, poultices, and hot/cold balance restoration through food, but also rituals (Bushy; Fishman et al.).

According to Bushy (1991), “after a period of time, rituals become part of the remedy. Repetitious behaviors include dancing, chanting, massage with ointments” (pp. 2-3). The rituals involved in folk remedies include ritual numbers, color significance, and special days. There are two ritual numbers significant in the MA health beliefs; these are 3 and 9. The significance of these numbers is involved in the quantity of times a remedy is to be taken daily, for how many days, for how many times it takes to call a person’s soul back, or the number of silent prayers said (Ripley, 1986; Johnson, 1979).

Color significance is important in some rituals performed by MA mothers during the care of an infant because of the colors’ visual meaning. According to Johnson (1979), “aguita de arroz, or water from soaked rice, is white like milk so it is a satisfactory substitute” (p. 70). Certain days of the week are reserved for curing illnesses, gathering herbs, and preparing remedies. Ripley (1986) points out:
the most effective days for treatment are Tuesdays and Fridays, herbs gathered on 
*el Día de San Juan*, or on Saint Juan Day (June 24) are especially strong, and 
herbal teas are left out in the open air at night, *alserano*, to gather the night’s cold 
air (p. 42).

Even though numerous folk remedies have a pharmaceutical base that can be identified in 
texts, a large number of folk remedies that are in use, and seemingly effective, remain 
unexplained (Bushy, 1991).

The common conditions that are treated at home with folk remedies include minor 
burns, cough, skin rash, fever, diarrhea, abdominal pain, colic, asthma, cough, and ear 
infection (Mikhail, 1994; Risser & Mazur, 1995). It is estimated by Gordon, (1994) that 
“70-90% of self recognized episodes of illness are managed outside the formal health 
care setting “ (p, 309). Folk remedies take one of several forms, most common is to 
prepare ingredients into a drink or to cook them to make a tea, others are topically 
applied, simple recipes have one or two ingredients, ingredients usually found in the 
home. According to Gordon, the majority of “folk remedies are ones mother’s 
themselves used or those that they have seen used by their parents” (p. 313).

*Folk Illnesses*

To the MA people folk illnesses are considered “culturally different labels” for 
serious medical conditions often times they may have knowledge and awareness of folk 
remedies, but can not provide a “translation for its meaning” (Robledo, Wilson & Gray, 
1999; Trotter II, 1985). According to Kemp (2002), folk illnesses are “health problems 
associated with members of a particular group and for which the culture provides
etiology, diagnosis, prevention, and regimen of healing; and which also have psychological and/or religious overtones” (p. 6). The different labels and meanings to these illnesses often times becomes a barrier when confronting Western medicine providers, especially because many MAs feel that these illnesses require “folk treatment” (Mikhail, 1994, p. 635), usually through the care of a curandero (Risser & Mazur, 1995).

In the MA health belief system there are two forms of illness, one is physical and the other is supernatural (Fishman et al., 1993; Ripley, 1986). Folk illnesses, also known as supernatural illnesses, are emotionally coupled. According to Fishman et al., (1993) folk illnesses are caused by “witchcraft, demons, hexes, and the evil eye” (p. 161). There are several types of folk illnesses, most of which can only be treated by a curandero (Risser & Mazur, 1995). The most common folk illnesses that will be discussed in the following sections are: (a) caida de mollera, (b) empacho, (c) susto, (d) mal puesto, (e) mal de ojo, (f) bilis and (g) nervios.

Caida de mollera refers to fallen fontanelle, primarily affecting infants. It occurs when the anterior fontanelle is depressed, which may occur through various causes. Some of these causes include pulling the baby from the breast or bottle too quickly, having the baby fall to the ground, holding the baby incorrectly, tossing the baby in the air too hard, or bumping the baby’s head. Signs and symptoms of this condition are poor suck, loss of appetite, irritability, sunken eyes, decreased tears, vomiting and diarrhea. Treatment for this condition varies, the most common include inserting a finger in the infant’s mouth and pushing up on the palate, holding the infant upside-down over a pot of water just low enough for the tips of their hair touch the water and then slapping the soles
of their feet, putting soap foam on the fontanelle, and turning the infant upside down and shaking the infant (Fishman et al., 1993; Kemp, 2002; Marsh & Hentges, 1988; Smith, 2000; Trotter II, 1985).

*Empacho* is believed to be caused by a bolus of undigested or uncooked food that is stuck to the wall of the stomach or intestine. This condition occurs in any age group. The signs and symptoms of this condition are anorexia, vomiting, diarrhea, indigestion, bloating, and constipation (Fishman et al., 1993; Smith, 2000; Trotter II, 1985). Diagnosis is confirmed according to Fishman et al., by “feeling bundles of knots in the calves of the legs and a large lump in the stomach” (p. 162). Treatment is primarily massaging the stomach or back or pinching and pulling sections of skin on the back to dislodge the bolus (Fishman et al.; Joyce & Villanueva, 1996; Nall II & Speilberg, 1967; Smith; Trotter II).

*Susto* or “fright sickness” is caused by a frightful experience, which is believed to result in the dislodgement of the spirit from the body (Trotter II, 1985). Children and adults are both susceptible to this condition. *Susto* is characterized by extreme lethargy, anxiety, depression, insomnia, and irritability. Treatment is based according to persistence of symptoms. Initial treatment consists of prayers and herbal teas, if symptoms continue then cleansing rituals that include *barrida*, or sweeping, are performed by a *curandero* (Chesney, Thompson, Guevara, Vela & Schottstaedt, 1980; Fishman et al., 1993; Joyce & Villanueva, 1996; Nall II & Speilberg, 1967; Trotter II, 1985).
*Mal puesto* is a condition prompted by jealousy. This condition is considered evil because it is a curse placed by a *bruja*, or witch, upon the request of another. The most common symptoms according to Fishman et al. (1993) are “sudden attacks of screaming, crying or singing, convulsions, and uncontrolled urination” (p. 163). Treatment is based on prayers, massage, herbs, and making crosses on the body with special mixtures (Fishman et al.; Smith, 2000).

Someone with a “strong” eye causes *mal de ojo* or otherwise known as the “evil eye”. This condition affects children primarily. It is believed that the person with the “strong” eye will admire the child, and if that person does not touch the child, then the child gets *mal de ojo*. Symptoms include crying, restless, fever, and vomiting (Chesney et al., 1980; Joyce & Villanueva, 1996). Fishman et al., (1993) report the treatment as “sweeping the body with a raw, unbroken egg in the sign of the cross and reciting three prayers” (p. 163). *Curanderos* are also utilized to treat illnesses caused by the “evil eye” (Scholz, 1990).

*Bilis* is one of several physical-emotional illnesses caused from experiencing a strong emotional state. *Bilis* is referred to as destructive rage, or *rabia*, and is considered a natural disease. Experiencing rage in its most livid form and having a firm belief in the “eye for an eye” revenge cause *bilis*. After experiencing a strong emotional experience, the person is believed to have bile poured into the blood stream causing the person to experience strange symptoms, such as vomiting, diarrhea, headaches, dizziness, migraines, nightmares, loss of appetite and inability to urinate. Treatment is through a *curandero* (Maduro, 1983).
Nervios is present in the majority of Hispanic and Latin cultures. For Mexican Americans, nervios may be an illness, a symptom of illness, or a state of illness. Nervios is representative of “nervousness” or “anxiety”. It is more prevalent in women than men, especially in women who are associated with stress, harassment, abuse, and/or neglect. Symptoms include feelings of desperation, headaches, chest pains, abdominal pains, and high and low blood pressure. Treatment of nervios includes home remedies of herbal teas and medications prescribed by physicians (Baer et al., 2003).

Folk illnesses may be unfamiliar to modern-day practitioners. According to Risser & Mazur (1995), folk illnesses may “be easy to dismiss as bizarre … many patients are unwilling to discuss these illnesses if they believe their providers will not acknowledge them” (p. 981). This is often the case because many providers are under the assumption that they are “all in the mind” (Trotter II, 1985, p.179). Prevention is the best treatment, but is difficult to achieve or maintain because the majority of MA people believe in fatalismo, or fatalism beliefs (Cuellar et al., 1995; Fishman et al.,1993).

Folk Healers

Traditional folk healers in the MA culture are regarded as curanderos who view illness according to Gomez & Gomez (1985) as “not only physical but in social, magical, and religious terms” (p. 248). Curanderismo is rooted deep in tradition and based on a set of values, a tradition that is embedded with Aztec and Spanish medicine (Maduro, 1983). Maduro (1983) points out that the set of values are based on “ well-differentiated worldview and lifelong interpersonal experiences with significant others in various ritual healing contexts, either domestic or religious” (p. 868).
The MA people rely in *curanderos* because this form of treatment fits into their cultural understanding (Roy et al., 2004). MA people seek the help of a *curando* when an illness is out of their control, primarily for folk illnesses or illnesses that won’t resolve because they have been caused by a saint, or curse. *Curanderos* are chosen primarily as those belonging to the family, their second choice would be ones referred by neighbors or friends. Payment has been strictly by donation. The healing aspect of *curnaderismo* is imbedded with holistic views; help is sought not only for physical ailments, but also psychological and social disorders (Fishman et al., 1993; Maduro, 1983).

*Access to Medicine/Herbs*

Throughout the Mexican communities and neighborhoods, otherwise known as *barrios*, the MA people are able to purchase and find common herbs, tinctures, spices, etc. for customary home remedies in local shops referred to as *herbaria* (Ripley, 1986). According to Rodriguez (1983), “barrio families seek health information regarding over-the-counter medications for common ailments such as earaches, toothache, sore throat, cough, etc. from neighborhood *boticas*, or pharmacies, where often times herbs and teas are found for folk remedies” (p. 137). The availability of Mexico and the flexibility of the border also allow the MA people to easily access ingredients for folk remedies that they cannot find in the U.S. Joyce & Villanueva (1980) point out that *herbarias* in Mexico are found “in open markets where venders are allowed to recommend dried herbs that have been successful in alleviating certain ailments” (p. 250).
MA values in the concepts of health, hot/cold and fatalism serve as the basis for their health beliefs and practices. These practices and beliefs are reinforced by the women and supported by the immediate and extended family. This additional woman’s role as primary healer is part of the folk care belief system in the MA culture that includes the usage of folk medicine and folk healers to cure every day illnesses or more specific folk illnesses. Neighborhood pharmacies and the relative closeness of the Mexican border provide the required ingredients that are used in folk medicine remedies. Providers being observant and knowledgeable about these health beliefs and practices through cultural awareness may prevent harm through the assessment and identification of potentially harmful home remedies.

Effects Of Cultural And Social Structure Dimensions On Mexican-American Traditional Folk Values And Beliefs

The MA people are part of an integrated cultural group that has both universalities and diversities. These similarities and differences are supported by cultural and social structure dimensions, which influence culture and folk care values, beliefs, and practices. The focused folk systems of discussion for this section are: (a) folk illnesses, (b) folk remedies, and (c) folk healers.

Folk Illness

The belief in folk illnesses is influenced by education, income status, and acculturation. The higher the levels of these factors, the less an individual will believe in
these illnesses, since they have assimilated into the predominant cultural belief system (Cuellar et al., 1995; Ripley, 1986). According to Leiser, Doitsch & Meyer (1996), “with increasing education, more and more of the ancient and folk beliefs come to be rejected; while support for statements couched in the medical terminology remain constant” (p. 384).

Folk Remedies

The continued usage of folk remedies in the MA culture is not only a result of proven efficacy over generational trial and error practices, but based on economic factors that play a direct role in their usage, the poorer the patients, the less he will be inclined to use western medicine (Adams, 1986; Roy et al., 2004). Folk remedies are less expensive than conventional medicine, consisting of items found within the home, herbs, prayer, and massage (Braganza, Ozuah & Sharif, 2003; Gordon, 1994; Mazur & Ybarrondo, 2001; Mikhail, 1994; Risser & Mazur, 1995; Zun, Gossman, Lilienstein & Downey, 2002).

A low socioeconomic status is the primary cause of limited access to health care and increased barriers to such access (Fishman et al., 1993). Insufficient income results in negotiating and stretching funds in order to provide for the entire family, if conventional medicine and therapy are costly they will not be utilized, and if it is purchased and used it will be diluted to last longer, other means of health care will be sought as through folk remedies and curanderos (Adams, 1986; Risser & Mazur, 1995). The effects of acculturation on the usage of folk remedies and belief in folk illnesses and curanderos have a direct correlation. Newly arrived immigrants, especially those from
rural villages and towns are more likely to remain firm with traditional Mexican values and health beliefs and practices than the native-born MA people (Rodriguez, 1983).

Although there is strong evidence that economics strongly influence the usage of folk remedies, the literature also has differing views. Fishman et al., (1993) indicated that “many Mexican-Americans use both conventional and folk medicine, and economic status, education, family size, and primary language do not distinguish which persons use folk medicine and which do not” (p. 163). Marsh & Hentges, (1988) stated, “the main implication of these findings is that belief in and use of a folk medicine system are not socioeconomically bound” (p. 260). There is also a middle ground that incorporates choice, not economic status, as the key indicator in the usage of both folk and conventional medicine. This is explicated by Trotter II (1981a):

the utilization of remedios caseros (home remedies) cannot rely solely on the condition of limited access to modern medicine due to economic factors. There is a system of choice operating in which people with health problems sometimes choose to use ethnomedicine and sometimes choose to use conventional medical treatment, and also, sometimes choose to utilize both simultaneously (p. 220).

Folk Healers

The cultural and social structure dimension factors that affect the belief and utilization of folk healers, or curanderos, are economics, educational level, and trust in Western medical providers. According to the study conducted by Risser & Mazur (1995), “Mexican-Americans used curanderos if they had lower economic status and less education… they are less expensive” (p. 980). Many Hispanics who utilize curanderos
do not share the information with their health care provider for several reasons, one as mentioned previously is that many modern day medical providers simply do not believe in folk illnesses and second, MA people may not trust the medical care they are receiving, whether it be influenced by a language or cultural barrier, or knowledge deficit about the illness and its treatment (Cushman, Wade, Factor-Litvak, Kronenberg & Firester, 1999; Roy et al., 2004; Trotter II, 1985).

The mistrust of modern physicians has been studied in the literature. In the study conducted by Johnson (1979), one experienced mother indicated, “all the medicines the doctor gave him in the first days of diarrhea didn’t do any good. And the reason is the doctor doesn’t know the real cause of the diarrhea. Those medicines are not worth anything for babies” (p. 72). Another study that related this distrust in physicians was conducted by Cushman et al. (1999), who cited one informant:

I have faith in my doctors but…a lot of us will go towards more…unconventional methods because those things are tried and true…handed down…I feel better going with the man who’s throwing the bones out in the middle of the ground (than going) to the hospital…you go to the hospital to get your toenails clipped…you come back, your whole leg is gone (p. 194).

The cultural and social structure dimensions that influence the belief in folk illnesses and usage of folk medicine and folk healers are economics, education, and acculturation. The lower the level of education and socioeconomic status, the more prevalent for the MA people to believe in folk illnesses and to seek medical intervention through folk cares methods. Folk remedy usage has demonstrated opposing views from
the literature where educational and acculturation level do and do not influence the usage of folk remedies. There is a body of literature that has shown that choice is what influences folk remedy usage, not cultural and social dimension factors.

The factors of socioeconomic stance, education, and trust are the major contributors to the usage of folk healers among the MA people. Folk healers are less expensive than professional medical practitioners, and they live among their own people, having the same socioeconomic stance. Trust is another important factor; numerous MA people do not trust modern day professional medical practitioners, whether it is due to lack of education, lack of communication, knowledge deficit, or inappropriate cultural care.

Literature Review

*Studies Of Health Care Of Mexican-American Children: Folk Systems And Professional Systems*

A review of the literature was conducted on ten journal articles published during the last three decades. The articles demonstrated consistency over time applicable to the care of MA children using folk systems and other systems. The identification and description of Hispanic mothers’ initial source of advice and help with children’s illnesses and their beliefs about the etiology and seriousness of the illness was studied through nonprobability sampling (Mikhail, 1994). 100 Hispanic women having at least one child under five years old participated in the study. Eighty one percent of these women were born in Mexico with the remainder in the U.S. Information was obtained
from the participants via a bilingual interview method. Two interviews were conducted on each participant; the first was to assess their initial source of advice with their child’s illness and their usage of folk remedies and healers. The second interview focused on demographic data collection of the participants. Content analysis was used to analyze all open-ended questions, allowing for theme recognition and development.

The results (Mikhail, 1994) pointed out that focused illnesses for this study were fever, cough, diarrhea, vomiting, conjunctivitis, skin rash, minor burns and wounds. The most frequent initial source of advice for these women was physicians/nurses followed by relatives/friends, and mother/mother-in-law/grandmother. Eighty one percent admitted using home remedies on their children with 17% having seen a folk healer for the treatment of folk illnesses. The types of home remedies used varied and included the application or ingestion of certain foods, fluids, and herbal teas. Knowledge of the etiology of the diseases varied with several misconceptions present. The majority of the mothers identified the cause of an illness to be a misbalance of hot/cold.

The strengths of this research (Mikhail, 1994) were the usage of a relatively focused sample with the majority being MA, criteria focused on an age group of five years old or under. Demographic characteristics of the mothers were assessed, cause of illness was identified according to what the beliefs of the mothers were, focusing on the cultural aspects of illness, such as the hot/cold balance. Finally this study was able to identify what type of home remedies were used for the targeted illnesses. The limitations of this study were several. The study was specific to folk systems, it did not inquire about professional systems, the sample size was small and not relevant to the population
size of Hispanics in the community, and the study was not specific as to the age of the children; age five and under was specified for this research, but it was unclear at what age level home remedies were used.

Two studies addressed asthma treatment in MA children. In a convenience sample study conducted by Mazur & Ybarrondo (2001), asthma and the identification and comparison of alternative and complementary treatments used for its treatment with the comparison of their potential effective and harmful effects was addressed. Forty eight multicultural parents participated in the study with MAs accounting for 11 participants. Data was collected via structured interviews. The results indicated that illness (asthma) was caused perceived as caused by hereditary, weather, allergies, exposure to cold air and cold foods, and anatomical abnormalities. Of the 48 participants, 39 indicated using either or both alternative and complementary therapies using them in accordance with prescribed medications. Other treatment options included prayer, massage, herbal remedies, vitamins, and over-the-counter medications; specific to the MA people the usage of herbal remedies, prayer, and massage was highest.

Strengths of the (Mazur & Ybarrondo, 2001) study include targeted population was specific to children, parental demographics were mentioned, and the identification of belief causes and treatments used by multicultural parents that included MA. Limitations of this study include sample size was small, asthma was the only ailment assessed, and children age specificities were unclear.

Braganza et al., (2003) conducted a cross-sectional survey of parents of children with asthma attending an urban health clinic with the purpose of studying the prevalence
and correlation of complementary/alternative medicine use among inner-city children with asthma. Three hundred ten participants provided data, 61% were Hispanic, and 37% were African American. The mean age of the parents was 33 years and mean age of the child was 7.2 years. Data was collected via an anonymous survey utilizing a 56-item questionnaire and short interviews. Results of the study showed 89% of the participants had treated their child with some form of complementary/alternative medicine with 50% believing that it was as effective as pharmacotherapy. The most common forms of complementary/alternative medicine used were prayers, rubs, and massage followed by teas, oils, foods, and syrup preparations. The majority of participants believed complementary/alternative medicine to be effective and used them as first treatment of an acute exacerbation, and did not inform a physician of doing so.

The strengths of this study (Braganza et al., 2003) were the assessment of physician awareness of complementary/alternative medicine, the study was specific to children, parental demographics were addressed, reasons why home remedies were used was addressed, and there was a respectable sample size of 310. The study also addressed whether or not the participants voluntarily reported home remedy usage to health professionals. The limitations of this study were several. Asthma was the only ailment assessed, child age was mentioned as a mean age of 7.2, this did not specify what the youngest or oldest ages were.

Risser & Mazur (1995) performed an exploratory study to identify the types of home remedies used for common pediatric problems (fever, cold, stomachache, diarrhea, vomiting, asthma, earache, teething, and toothache) as well as traditional folk illnesses
and their cures in a Hispanic population. Fifty one participants were interviewed, 48 were first generation immigrants; 40 were from Mexico. Forty four spoke Spanish only, with participants being primarily mothers with a mean average age of their children being 10. Data was collected through an interview process. The results indicated that 41% of the participants presumed environmental or behavioral causes for illness in their child/ren and 12% indicated a temperature imbalance. The usage of herbs (teas) and pharmaceuticals were used as a preferred treatment method. For the treatment of folk illnesses the majority of respondents indicated that folk healers were more effective than a medical practitioner, the usage of prayer, massage, herbs, and other rituals were used to cure these illnesses.

The strengths of this study (Risser & Mazur, 1995) were the specificity of the targeted population/participants, the majority were of Mexican origin, the focus was on children, participant perceptions between folk healers and medical practitioners were addressed, remedies used for the targeted illnesses were identified, the mention of hot/cold imbalance as a cause for illness, and one cultural and social structure dimension (parent’s immigration status) was addressed. Limitations of this study were several. Although this study targeted remedies used on children, there was no age specificity as to how young a child is in order to be able to receive these remedies, and the sample size was small.

Johnson (1979) assessed the beliefs about the cause and treatment of infant diarrhea through open group conversations with MA mothers. Strengths of this study include the identification of remedies used for the targeted condition, the mention of folk
beliefs as a cause for illness, the importance of kinship relations in the treatment process, and lack of faith in medical practitioner medicine to treat this condition were also identified. Limitations to this study are numerous. The study participants were identified as MA, no information was present regarding sample size. No cultural and social structure dimensions were identified of the participants, diarrhea was the only ailment addressed, and infant was the focus target group but “infant” age was not defined.

Roy et al., (2004) performed a cross-sectional stratified survey that examined ethnic variations in attitudes about traditional health beliefs concerning the use of home remedies and self-medicating behavior among guardians for their children. In the general population of Dallas, Texas, 1,606 households were contacted by random digit dialing, with surveys conducted over the telephone. Twenty one percent were Hispanic, 19% were African American and the remainders were White. The results indicated that 40 % believed home remedies are better than prescribed drugs for curing illnesses, 25% of the participants believed that unless the illness was an emergency, they would prefer to treat the child at home using home remedies. Hispanics were the least likely to believe in the efficacy of home remedies. This may be due to lack of sharing such information among Hispanics with their health care provider (Padilla, Gomez, Biggerstaff &, Mehler, 2001).

The strengths of this study (Roy et al., 2004) include a large sample size with a mixed sample of participants that included MAs. The target population being assessed was specific to children with the assessment of data specific to health beliefs utilizing generic care components. The limitations of this study are several. No cultural and social structure dimension factors were assessed of the study participants, age was not
well defined, although criteria indicated age 15 or under, it was not specific as to how young children were in which home remedies were being used on.

Robledo et al., (1999) carried out a pilot study to identify Hispanic mothers’ knowledge and health practices regarding caring for their children with respiratory illnesses. Six participants of Mexican origin were selected at a health care center for women and children. Criteria specified the mothers needed to have been born in a Spanish-speaking country of South America and have a child between the ages of 1 and 5 years old diagnosed with a respiratory illness. All the participants had lived in the U.S. for at least 2 years, two spoke English fluently. The ages of the participants were between 22-35 years.

A 48-question guide was used for data collection. The guide assessed socio-demographic data, child health status, upper respiratory infections, and common folk beliefs among Hispanics. Results (Robledo et al., 1999) indicated that the primary source of health services were health care centers or clinics, all the mothers perceived the overall health status of their child as good, home remedies were utilized for the ailments of upper respiratory infection, asthma, pneumonia, and cough. None of the participants had ever been to a local folk healer. The causative factors of upper respiratory infections included imbalance between hot and cold and viruses.

Strengths of this study (Robledo et al., 1999) were the specificity to Hispanic children; perceptions of illness, the identification of illness symptoms by these mothers, and the usage of folk care beliefs and methods. Other areas of assessment included folk remedy and folk healers. Limitations of this study include sample size, child age
specificity was mentioned but it was unclear as to how young a child is in order to administer folk medicine and no cultural and social structure dimension factors were assessed of the study participants.

Gordon (1994) conducted a qualitative analysis study that utilized ethnography, on a convenience sample that addressed how Hispanic health beliefs affect health care practices and what actions are taken to treat symptoms of illness or injury. Eleven Hispanic women participated. Data was gathered using group interviews and was coded and categorized. The results showed an intense collection of home remedies that were utilized for the common cold, flu, fever, diarrhea, vomiting, loss of blood, earaches, pneumonia, and bronchitis. Most remedies were stated as “safe” to use on children. Remedies consisted primarily of teas, ointments, and over the counter medications.

Strengths of this study (Gordon, 1994) were the assessment of health beliefs in a Mexican American population and identification of folk care actions taken to treat illness or injury in children through the usage of home remedies. Limitations of this study are several. Although most remedies were stated as being safe for children, age group was not specific or identified. No cultural and social structure dimension factors were assessed of the study participants.

Rehm (1999) conducted a descriptive, in-depth interviewing study that explored religious faith in MA families dealing with chronic childhood illnesses. The sample consisted of 25 MA parents from 19 families who had been coping with chronic illness (congenital heart disease, genetic syndromes, cancer, cerebral palsy) from 2-11 years. Spanish was the preferred language choice for the interview process by participants. The
researcher used an interpretive study method that employed symbolic interaction. Data was analyzed using constant comparative analysis. Results showed six unifying dimensions of religious faith that related to parental care taking and family decision-making. The six dimensions were: (a) Will of God (b) Links between God and medical care (c) parents enable God’s Will to be enacted (d) obligations of families to God (e) intercession with God on the family’s behalf and (f) faith in God encourages optimism.

Strengths of this study (Rehm, 1999) included the assessment of the cultural and social dimension factor religion/religious faith as a coping mechanism for parents dealing with chronic illness in their children, the focused population was consistent with MA parents and adults and the identification of six dimensions, illustrating that spiritual and religious actions not fatalistic views guided care. Limitations of this study include a small sample size, and religious faith was the only cultural and social structure dimension addressed.

Flores et al., (1999) conducted a bivariate and multivariate data analysis on 99,268 Black, Mexican, Native American, Asian, and Non-Hispanic White children from the 1989-91 National Health Interview Surveys. The purpose of the study was to characterize the demographic, health status, and use of health services in the 5 major American ethnic groups; explore whether ethnic subgroups have additional distinctive differences and investigate whether ethnic differences in health and use of services are explained by differences in family income and parental education. The sample size consisted of 62,992 non-Hispanic Whites, 17,553 non-Hispanic Blacks, 12,765 Hispanics, 2,516 Asian/Pacific Islanders, and 1,067 Native American children age 18 and
younger. The results indicated the children that were the poorest, least healthy, and had parents with the least level of education were Hispanics, Blacks, and Native Americans. 35-41% live below the poverty level compared to Whites (10%) and 66-74% were in excellent or good health compared to Whites (85%).

Strengths of this study (Flores et al., 1999) was the assessment of the cultural and social dimension factors of economics and parental education and its impact on children’s health and use of health services. The sample size was large, incorporating numerous ethnic groups that included Hispanic. Children were the targeted population. Limitations include data on Mexican Americans was inconclusive due to “Hispanic” labeling; folk care was not addressed.

Summary

There have been numerous studies regarding MA use of folk systems, effects of cultural and social structure dimensions on health, and patient-physician communication. These provide a great deal of useful information for practitioners but seem to be missing some essential elements for achieving full understanding of MA illness caring practices in treating illness in children. There are several key deficits in the literature about MA mothers care for children who are ill: (1) only one study addressed provider assessment of home remedy usage by MA mothers (2) no studies of mothers’ views about use of professional and folk systems and (3) absence of a clear cultural context for MA mothers’ practices in caring for ill children.

The purpose of the proposed project is to develop a handbook that will decrease possible harm to children through the identification of potentially harmful home
remedies. The specific identified immediate outcomes are to increase knowledge of home remedies and increase understanding of Mexican/(MA) culture among providers, resulting in improved provider-patient communication and cultural awareness. This chapter described Leininger’s Culture Care Diversity and Universality theory. Key concepts that were addressed were transcultural nursing, ethnonursing, emic knowledge, and universalities and diversities of cultures. A general concept of culture was discussed as well as an overview of health beliefs and practices in MA Culture specific to folk systems, and pertinent cultural and social structure dimensions that influenced the Mexican and MA folk systems. Chapter Three will focus on the practice innovation description.
CHAPTER THREE

Practice Innovation Description

Introduction

The proposed practice innovation is a handbook about home remedies commonly used by Mexican and MA mothers to treat childhood illnesses. The term “home remedies” is used synonymously with Leininger’s term “folk systems of care”. A handbook was selected as the most practical format for the majority of providers, especially those in rural settings. The handbook will be convenient and inexpensive. It will be readily available (it will fit in the pocket of a lab coat) when providers are interviewing patients or are involved in other activities in their practice setting. It does not require travel to in-person classes or Internet access.

The information provided in the handbook is drawn from review of literature about: 1) home remedies often employed by Mexican and MA mothers and 2) information suggesting that health care professionals may be unaware of the home remedies used by Mexican and MA mothers, 3) lack of knowledge among many providers about cultural dimensions of communicating with Mexican and MA mothers. The purpose of the handbook is to provide information to health care providers about the common home remedies and about cultural features/patterns that may be useful in enhancing patient-provider communication about the home remedies. Leininger’s Sunrise Model/Enabler provides the conceptual framework for this innovation, with an emphasis on cultural competency and understanding between health providers and the clients they care for. A brief overview of Leininger’s model is followed by a detailed
description of the proposed handbook, discussion of the feasibility of creating and
distributing the handbook, and plans to assess relevant outcomes for health providers
using the handbook.

**Leininger’s Sunrise Model/Enabler**

Cultural awareness is a key feature in Leininger’s Cultural Care Diversity &
Universality Theory. Without cultural awareness, nursing care would be ineffective,
therefore improper care and management of patients would result (Leininger, 1996). As
mentioned previously in Chapter One, a cultural struggle develops when the views of one
cultural class do not correlate with those of the dominant society, thus resulting in a lack
of cultural awareness (Mull & Mull, 1981). As mentioned earlier in Chapter Two,
Leininger’s Sunrise Model/Enabler depicts culture care diversity and universality related
to the Mexican-American community and how cultural and social structure dimensions
influence their beliefs of both professional and folk systems.

Lack of cultural awareness of the influencing factors of cultural and social
structure dimensions jeopardizes the delivery of culturally competent care by providers
due to the development of miscommunication and misconception between professional
and folk systems of healing. Misconceptions and miscommunication hinders the
development of culture care preservation, accommodation, and/or repatterning, thus
inhibiting the delivery of culture congruent care (George, 1995; Leininger, 1996).
Leininger recommends providers learn as much as possible about the culture and folk
systems care of people they are caring for in order to “provide care that would be
culturally congruent and meaningful to clients” (Leininger, 1996, p. 73).
The proposed innovation of the handbook utilizes Leininger’s Sunrise Model/Enabler as the facilitator to bridging professional systems with folk systems through its development. It is up to the provider as a professional to integrate the information in the handbook to foster culturally sensitive care. Shown below is a model developed by the author illustrating how the handbook is utilized as a bridge to join professional and folk systems as an extension to Leininger’s Sunrise Model/Enabler.

Both folk and professional systems are illustrated as their own individual identity with each of their corresponding factors within it. Stemming from each system is the corresponding practicing subsystem: 1) Mexican/MA mothers/families and 2) Medical providers. The bridging of these two subsystems by the handbook is demonstrated by free flowing arrows that portray parallel communication and free flow of shared ideas due to cultural awareness and culture care accommodation. This results in prevented problems, with the final outcome of positive child health outcomes.
FIGURE 2. Bridging Folk and Professional Systems

Folk Systems
- Folk Illness
- Folk Remedies (Home)
- Folk Healer

Professional Systems
- MD
- PA’s
- Nurses
- Nurse Practitioners

Handbook

MA Mother/Family → Medical Provider

Cultural awareness & Culture Care
Accommodation:
↑ Provider-patient communication
↑ Knowledge home remedies
↑ Mexican/MA culture understanding
Negotiation

Problems Prevented:
1. No delay in medical care
2. No usage of harmful home remedies
3. No Misdiagnosis
4. No unnecessary testing
5. No misunderstanding of options & prognosis by patients
6. No problems with: treatment adherence, patient satisfaction & follow-up

+ Child Health Outcome
**Description of the Proposed Innovation**

A handbook format was selected over other possible education strategies for several reasons. Primarily, the handbook will be readily available to providers who can utilize it while interviewing patients, or have it on hand as a reference source in their practice setting. The handbook will be time-saving and user friendly for it will consist of organized sections that will allow for easy accessibility and will also include a section for “Notes” where the provider can record other home remedies used by their patients and updates. The handbook will also be cost effective, it will not require the provider to travel to a seminar, nor will it require modern technology, such as Internet access, which is not readily available in some rural care settings.

The name of the handbook will be “A Guide to Mexican Home Remedies for Childhood Illnesses”. The handbook will be small enough (6” height x 4” wide) to fit in a lab coat pocket and will use both English and Spanish terms for home remedies to assist in provider-patient communication. The handbook will have four sections: 1) introduction, 2) Mexican culture, 3) Mexican home remedies, and 4) Notes section. The introduction will give an overview of cultural awareness and of the problems that may arise when health providers lack cultural awareness. The second section will present an overview of MA culture, focusing on cultural and social structure dimensions.

The third section consists of three components: 1) Common illnesses presented in alphabetical order with the home remedies used to treat each illness, 2) Home remedies (presented in both Spanish and English) separated into groupings based on the usual formula used for the remedy as well as strengths of the remedy based on patient size.
Teas, tinctures, and extracts have different strengths. Strengths of the remedy are important in regards to human size. The weaker and lighter a tea is, the safer it is for an infant while the same tea seeped longer into a darker strength is appropriate for an adult and can do harm to an infant (National Institute of Health: Office of Dietary Supplements, 2003; S. Ewing, personal communication, March 18, 2005). The final component to this section is, 3) potentially harmful home remedies, their side effects, and safe alternatives. The final section of the handbook is a “Notes” pages so providers may write any remedies they learn about which are not in the handbook. The e-mail address of the author will also be provided in this section so that providers can share new updates with the author for future revisions of the handbook.

*Feasibility*

The handbook will be developed in three steps and then distributed to volunteer health care providers whose practices include many Mexican and MA mothers. The success of the handbook in improving communication between providers and clients about Mexican home remedies for childhood illnesses will be assessed through baseline and post-handbook chart reviews and interviews with providers.

Handbook development: a volunteer panel of two providers with experience with Mexican/MA mothers and two (bilingual) MA mothers will review the first draft of the handbook. They will be asked to comment on ease of reading, organization and accuracy of information. Second, the handbook will be revised to incorporate their suggestions and they will be asked to review the revised handbook one more time. Third, final revisions will be made and the handbook will be ready for submission to a publisher.
Printing and distribution: The handbook will be approximately 20 front/back pages (10 point type minimum for main context) and the printing cost will be $200 for 20 black and white copies with a paperback cover (KINKOS, personal communication, February 19, 2005). The first printing will be distributed to 20 volunteer providers at a cost of $10.00. This first group of volunteers will be asked to meet with the author at the time of purchase and in one month. They will also be invited to participate in a free evaluation of the usefulness of the handbook. This will be discussed in Chapter Four.

Identified Innovation Outcomes

The specific identified immediate outcomes are to increase knowledge of home remedies and increase understanding of Mexican/MA culture among providers, resulting in improved provider-patient communication and cultural awareness. The long-term objective of the handbook is to decrease possible harm to children through the identification of potentially harmful home remedies.

Summary

The proposed innovation for this project is a handbook for providers titled “A Guide to Mexican Home Remedies for Childhood Illnesses”. This handbook includes not solely home remedies commonly used by Mexican and MA mothers for treating common childhood illnesses, but sections on potentially harmful home remedies and an introduction to the Mexican culture. The handbook will be practical and inexpensive, fitting inside a lab coat pocket. Providers can have it readily available while they are interviewing their patients. Providers will not need expensive technology, such as computers or Internet access, to utilize this handbook, nor will they need to travel to
seminars or classes, which is essential in rural settings. Leininger’s Sunrise Model/Enabler provides the conceptual framework for this innovation.

The feasibility of the innovation will require the involvement of volunteer providers as well as volunteer MA mothers (bilingual) to assess the ease of reading, organization and accuracy of information. The printing and distribution of each handbook will cost $10. The first printing will be distributed to 20 volunteer providers who will meet with the author at the time of purchase and then in one month to evaluate the usefulness of the handbook. The focus outcome measures of the innovation concentrate on: 1) increase provider knowledge of Mexican/MA home remedies, 2) increase understanding of Mexican/MA culture among providers, resulting in improved provider-patient communication and cultural awareness and a long-term goal of, 3) decreasing possible harm to children through the identification of potentially harmful home remedies. Chapter Four will focus on the innovation implementation plan.
CHAPTER FOUR
Innovation Implementation Plan

Introduction

In this chapter the complete description of the innovation implementation plan for this project is discussed. Other areas to be addressed in this chapter will be: (a) rationale for the implementation plan and implication of the data, (b) feasibility of the implementation plan, and (c) ethical and human rights issues associated with the implementation plan.

Complete Description of the Innovation Implementation Plan

The literature review established that although there is continued usage of home remedies among Mexican/MA mothers in treating illness in their children, there is insufficient data about provider assessment of home remedy usage in their clients. The innovation implementation plan for this project will be a pilot study that will concentrate primarily on this issue. Three large clinic settings will be chosen in Tucson that are heavily frequented by Mexican and MA mothers. Twenty volunteer providers from the selected clinics will be recruited to participate in evaluating the effectiveness of the handbook in meeting the goals. The number “20” corresponding to the number of providers is arbitrarily chosen, a sufficient sample size was sought to enhance result accuracy. A pre-test will be utilized to assess provider knowledge of common home remedies. A primary chart review will also be conducted on the accessible population: all children with Mexican/MA mother’s as their primary caretakers seen in the clinic
within the last month. Documentation of home remedy assessment by the provider will be the information reviewed (Haber, 2002).

After the primary chart review, the handbook “A Guide to Mexican Home Remedies for Childhood Illnesses” will be presented and reviewed with the 20 practitioners. One month after the primary chart review is conducted, a post test of knowledge about common Mexican home remedies and about cultural aspects of communication will be administered to the providers. The effectiveness of the handbook in improving communication about home remedies will be assessed through pre- post-tests, provider interviews and chart reviews and noting the number of times Mexican home remedies were discussed (and noted) in charts of Mexican or MA mothers who visited the clinic with an ill child. The pre-handbook data will be collected from all qualifying charts in the month prior to the time when the provider purchased the handbook (that is, on any visits by mothers who are Mexican or MA of an ill child). The post-review will be conducted on all qualifying charts, one month after the provider purchased the handbook. In addition, providers will be interviewed at the time they purchase the handbook and one month after purchasing the handbook to elicit their perceptions about communication with Mexican and MA mothers about home remedies.

The secondary chart review will employ simple random sampling; all available charts will be assigned a consecutive number beginning with 1 (one). As with the primary chart review the information sought will be noting the number of times Mexican home remedies were discussed (and noted) in charts of Mexican or MA mothers. Once all charts have been assigned consecutive numbers a table of random numbers will be
employed. The primary investigator will then pick a random number from the table and reads consecutive numbers in a diagonally up direction. The secondary chart review will be conducted on charts that correspond with the numbers on the table. Simple random sampling will be selected to decrease the risk of bias (Haber, 2002).

Rationale for the Implementation Plan and Implication of the Data

The purposes of the pilot study are numerous. For one, it will establish baseline data gathered in the primary chart audit on current practitioner assessment and knowledge of home remedy usage among their Mexican/MA clients. Secondly, it will evaluate the effectiveness of the handbook by comparing baseline assessment data with data from the secondary chart review and interviews with providers. The aim of the comparison is to evaluate for a change or correlation in provider documentation compliance in the evaluation of home remedy usage of their clients. Thirdly, the pilot study may provide data of additional home remedies being used by Mexican/MA mothers and possibly prevent harm through the addressment of the usage of potentially dangerous home remedies. Finally, the findings of the pilot study will determine the “feasibility of conducting a larger scale study and establish that sufficient scientific evidence exists to justify subsequent, more extensive research” (Haber, 2002, p. 255).

Feasibility of the Implementation Plan

Based on the 2000 Census, the current population of Hispanic and Latino children age 9 and under is 24,027 (Tucson Planning Department, March 28, 2002). This is a significantly large population base that will allow and support sufficient data collection;
there is no need for travel outside of Tucson to obtain data. Time and accessibility to client charts and 20 providers are factors that may impede the pilot study.

**Ethical and Human Rights Issues Associated with the Implementation Plan**

The evaluation plan does not include direct contact with the mothers. Data gathered will be based solely on chart reviews. The only human contact to be made by the primary investigator will be with the providers of the clinic during interviews and the presentation and review of the guidebook. The human subjects committee will be required for approval of the pilot study due to privacy issues in regards to accessing private charts of the mothers and their children.

**Summary**

This chapter provided a complete description of the innovation plan of a proposed pilot study for this project. Other areas that were addressed were the rationale for the implementation plan and implication of the data, the feasibility of the implementation plan, and finally, the ethical and human rights issues associated with the implementation plan. If the pilot study with 20 providers demonstrates the effectiveness of the proposed handbook a publisher will be approached for wider distribution of the handbook. Presently there are numerous publishers who incorporate herbal or complementary therapies/medicine into their publishing profile, among them is Elsevier Science, who is the largest health science publisher (Elsevier Science, 2005).

The process of proposing a book to this publishing company involves specific criteria in an outline process. The criteria for the proposal is as follows: (a) working title, (b) aims and scope of the book, (3) target market, (4) contents, (5) approximate number
of words, and (6) illustrations and tables (Elsevier Science, 2005). Other information required for the proposal that is not to be included in the outline is a review list of other titles on the same subject as the handbook (including those in preparation) along with publication details for each title. Additional information included in the review list is to provide the essentials of what makes the handbook unique and different from the other titles. Other information sought in the proposal is a list of the author(s), editor(s), and contributor(s) of the handbook along with a sample chapter (Elsevier Science, 2005).

Conclusion

In conclusion, today the MA people are the fastest growing and largest of all cultural groups (NCHHHSO, 1995; Rodriguez, 1983). The MA population includes first, second, third, fourth, and fifth generation MAs. The MA people have their unique set of cultural beliefs, patterns, and values that they have retained from homeland of Mexico, which influence aspects of their daily living and are incorporated to members of the family in spite of generational levels and acculturation (Cuellar et al., 1995; Gordon, 1994). The people of Southern Arizona encounter MA cultural views and values in an assortment of mainstream settings that include health care settings. The review of the literature identified numerous studies in which home remedies were utilized by Mexican/MA mothers when treating illness in their children, yet only one study reported the assessment of home remedy usage by providers. In Leininger’s Culture Care Diversity & Universality Theory, Leininger emphasized the importance of cultural assessment as the key foundation for accommodating and understanding the needs of specific populations in order to provide cultural care. A cultural assessment by providers
is essential since “cultural differences in worldviews, perceptions of illness, linguistic barriers, cultural values…the greater the differences, the greater the likelihood of misdiagnosis, miscommunication, and misunderstanding” (Cuellar & Gonzalez, 1995, p. 352).

The U.S has come to be known as the melting pot assembled by many. This is who America is; it is a homeland not composed of solely one identity, but of many identities that united form one nation. Americans continuously walk out of one culture and into another; as a result many are “cradled in one culture, sandwiched between two cultures, straddling all three cultures and their value systems” (Anzaldúa, 1992, p. 387). This project is merely focused on one of the numerous culture groups bring together the U.S. Each cultural group has their own worldview, unique set of values and beliefs about illness, wellness, and health maintenance influenced by cultural and social structure dimensions that can be a basis for future projects. If this project can decrease possible harm to children through the identification of potentially harmful home remedies and increase knowledge of home remedies and enhance understanding of Mexican/MA culture among providers, resulting in improved provider-patient communication and cultural awareness, then this project has successfully generated success.
APPENDIX A

HANDBOOK
A Guide to

Mexican Home Remedies For Childhood Illnesses

Vickie Clous RN, BSN
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A Note to the Reader

The goal of this handbook is to provide information to health care providers about the common home remedies utilized by Mexican/Mexican American mothers when treating illness in their children and to increase provider cultural awareness of this particular ethnic group in an effort to enhancing patient-provider communication and foster culture care accommodation.
Section I
Introduction

As a medical provider you may not be aware of home remedy usage among your Mexican and Mexican-American mothers to treat common childhood illnesses. These home remedies consist of herbal teas, massage, rubs, ointments, etc. The majority of the remedies are harmless, yet there remains a number of remedies that are potentially dangerous and can cause harm to the child.

As a provider it is important to be culturally aware of your patients’ ethnicity because the beliefs and practices of the parents and family not only influence the ability and willingness to seek professional medical help but also to comply with treatment regimens for their children.

Every culture has its unique way of viewing and defining illness and healing; these definitions and views may not be in accordance to your viewpoints and ideas. This may create a cultural struggle where your ideas and those of your patients do not correlate. This cultural struggle is further fueled by your client’s willingness to share their beliefs with you, your knowledge of their culture and language barriers.

Culture Care Accommodation

A common ground for bridging your ideas and those of your patients is referred to as culture care accommodation. With your awareness of their culture, your guidance, support, and assistance you may be able to help your Mexican/Mexican-American clients adapt to your professional recommendations.

This may involve negotiation between you and your client, a negotiation between professional and folk systems in order to come to a common ground that fosters and supports beneficial health outcomes.

This is important with infants and children since they are cared for according to the beliefs and practices of their parent(s) and/or guardian.
**Problems That Occur**

The problems that can arise when there is lack of cultural awareness include:

- Delay in medical care
- Usage of harmful home remedies
- Improper diagnosis
- Unnecessary testing
- Misunderstanding of options and prognosis by patients
- Problems with: treatment adherence, patient satisfaction, and follow-up

**Section II**

**Mexican/Mexican-American Culture & Its Effect on Health/Health Care**

The following are beliefs and values of the majority of Mexicans/Mexican-Americans but not all.

**Health Definition:**

- Neither prevention nor promotion is valued among the MA health beliefs (representative of higher incidence of chronic illnesses in this cultural group)
- Health is defined by the ability to function in daily activities, especially in the ability to work
- Health is also defined by the absence of pain (hinders early medical treatment seeking)
- To maintain health there must be a balance between God and nature & the elements of hot & cold
- A misbalance causes illness

**Hot/Cold:**

- Illness is caused by either too much hot or cold = disequilibrium
- Restoration of balance utilizes hot or cold foods and treatments
- The concept of “hot” and “cold” is not representative of temperature or spiciness
- Concept representative of the intrinsic quality of foods, medicines, and body illnesses and conditions
- Cold diseases/illnesses have less obvious symptoms: tuberculosis, pneumonia, menstrual cramps, colic, earaches, arthritis, rhinitis, lesions & exudate, and empacho
- Usually caused by exposing the body to cold elements, such as air or water, when the body is hot
- Hot diseases/illnesses are created from within the body and have more visible symptoms: conditions caused by vasodilation and high metabolic rate: pregnancy, hypertension, diabetes, acid indigestion, fever, headache, sore throat, susto, mal de ojo, and bilis
- To restore balance, cold conditions are treated with hot medications/remedies and hot conditions are treated with cold medications/remedies
- The hot/cold concept includes body state
- Children are referred to as cold and suffer more from cold conditions than adults, are therefore are treated primarily with hot remedies
- Adults are classified as hot, with old people being either hot or cold
**Fatalism:**

- Belief in external control
- Definition: the extent to which people feel their destinies are beyond their control
- Many believe they have no control over their health status
- Fatalism is used when there is no explanation for the cause and distribution of an illness
- Further emphasized by the terms of “being lucky” or referencing to God as being “God’s will or plan” for an illness to occur or not occur

**Religion:**

- Health and illness are viewed as affairs over which God has influence
- Health is perceived as a reward from God
- Curing: sacrifices, promises, prayers or medals to God and patron saints are offered, and will also light candles and visit shrines
- Quality and quantity of time involved in religious affairs is the source of illness prevention and health maintenance

**Communication:**

- Verbal: Spanish language, sole usage by majority of first generation Mexicans
- Non-verbal: respect or “respeto” is very important when addressing older adults
- Avoid eye contact with those of higher status
- Acknowledge individuals by titles of respect: “Mr., Mrs., Don and Doña"

- Shorter personal space standards
- Greet individuals with a firm handshake
- Informal settings, conversations are loud, fast, and adorned with animated gestures and body language

**Role of the Family:**

- Primary health provider = the mother or primary female in the family
- She decides when an illness is out of her ability to treat with home remedies and when she seeks help from professional care providers
- Common for mothers to believe that children are only sick when acute symptoms are present = delay in medical treatment seeking
- Folk remedial and medicinal knowledge is passed down from mother to daughter
- Always ask the mother “what does your mother think this illness is or caused by?...What does your mother think the treatment should be?” If possible have both mother and grandmother present
- The immediate and extended family are closely involved in important decision-making; decisions may often times surpass those of the professional health care provider
Folk Systems:

- Utilize folk medicine and folk healers, “curanderos”
- Economic or educational levels do not preside over adherence to folk systems
- Acculturation level and usage/belief of folk remedies, folk illnesses & curanderos have a direct correlation
- Newly arrived immigrants (especially those from rural villages and towns) are more likely to remain firm with traditional Mexican values and health beliefs and practices than native-born
- Folk medicine does not replace modern health care, it supplements it
- Traditional folk healing is a practical and useful alternative when modern health care is unsatisfactory
- Treatment options not confined to folk remedies or folk healers
- Common for parents to practice “self-medicating” on their children through the assistance of neighborhood pharmacies and pharmacists
- Parents treat their children with antibiotics and other prescription medications without a physician’s advice, exam, or prescription

Folk Medicine/Remedies:

- Continued usage = proven efficacy; natural, inexpensive and readily available in the community
- Used to prevent or cure a disease
- First line of attack at the illness
- May be used in addition to western medicine in order to speed up the process of healing
- Include herbs, teas, massage, prayers, poultices, and hot/cold balance restoration through food & rituals
- Most common is to make a tea
- Others are topically applied
- Ingredients usually found in the home
- Ones mother’s themselves used or those that they have seen used by their parents
- Continued usage = economic factors, the poorer the patient, the less they will be inclined to use western medicine
- If conventional medicine/therapy are costly they will not be utilized, and if it is purchased and used it will be diluted to last longer
- Choice also a key indicator in the usage of both folk and conventional medicine
**Folk Illnesses:**

- “Culturally different labels” for serious medical conditions
- Have psychological and/or religious overtones
- Known as supernatural illnesses, are emotionally coupled
- Many feel that these illnesses require “folk treatment” through a *curandero*
- Caused by “witchcraft, demons, hexes, and the evil eye”
- May be unfamiliar to modern-day practitioners
- Many patients are unwilling to discuss these illnesses if they believe their providers will not acknowledge them
- Belief in folk illnesses influenced by: education, income status, and acculturation
- Acknowledge these illnesses, even suggest to the parent if they think the child has…….(whichever folk illness you feel fits the child’s signs/symptoms)
- The higher these levels, the less an individual will believe in these illnesses
- Most common folk illnesses:
  - *Caida de mollera* or “fallen fontanelle” (affecting infants):
    - Occurs when the anterior fontanelle is depressed
    - May occur through various methods:
      - pulling the baby from the breast or bottle too quickly
      - having the baby fall to the ground
      - holding the baby incorrectly
      - tossing the baby in the air too hard
      - bumping the baby’s head

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**Signs and symptoms:** poor suck, loss of appetite, irritability, sunken eyes, decreased tears, vomiting and diarrhea

**Treatment:** inserting a finger in the infant’s mouth and pushing up on the palate, holding the infant upside-down over a pot of water just low enough for the tips of their hair touch the water and then slapping the soles of their feet, putting soap foam on the fontanelle, and turning the infant upside down and shaking the infant

**Assess** for Shaken Baby Syndrome! Educate Parents!

**Empacho:**

Caused by a bolus of undigested or uncooked food that is stuck to the wall of the stomach or intestine.

Occurs in any age group.

**Signs and symptoms:** anorexia, vomiting, diarrhea, indigestion, bloating, and constipation

**Diagnosis** is confirmed “feeling bundles of knots in the calves of the legs and a large lump in the stomach”

**Treatment** is primarily massaging the stomach or back or pinching and pulling sections of skin on the back to dislodge the bolus
Mal puesto:
Prompted by jealousy.
Considered evil because it is a curse placed by a bruja, or witch, upon the request of another
Common symptoms: sudden attacks of screaming, crying or singing, convulsions, and uncontrolled urination
Treatment: based on prayers, massage, herbs, and making crosses on the body with special mixtures

Mal de ojo or “evil eye”: 
Affects children primarily
Person with the “strong” eye will admire the child
Persons would not touch the child, then they get mal de ojo.
ALWAYS touch the child!
Symptoms: crying, restless, fever, and vomiting
Treatment: sweeping the body with a raw, unbroken egg in the sign of the cross and reciting three prayers. Curanderos are also utilized.

Susto or “fright sickness”:
Caused by a frightful experience, which is believed to result in the dislodgement of the spirit from the body
Children and adults are both susceptible
Signs and symptoms: extreme lethargy, anxiety, depression, insomnia, and irritability
Treatment is based according to persistence of symptoms
Initial treatment: prayers and herbal teas, if symptoms continue then cleansing rituals that include barrida, or sweeping, are performed by a curandero

Nervios:
May be an illness, a symptom of illness, or a state of illness
Representative of “nervousness” or “anxiety”
More prevalent in women than men
Especially in women stressed, harassed, abused, and/or neglected
Symptoms: feelings of desperation, headaches, chest pains, abdominal pains, and high and low blood pressure
Treatment: home remedies of herbal teas and medications prescribed by physicians

Bilis (a physical-emotional illnesses):
Causes: experiencing a strong emotional state in its most livid form and having a firm belief in the “eye for an eye” revenge
Referred to as destructive rage, or rabia,
Considered a natural disease
After experiencing a strong emotional experience, the person is believed to have bile poured into the blood stream causing the person to experience strange symptoms

**Symptoms:** vomiting, diarrhea, headaches, dizziness, migraine’s, nightmares, loss of appetite and inability to urinate

**Treatment:** through a *curandero*

**Access to Medicine/Herbs:**

- Throughout the Mexican communities and neighborhoods or “barrios”
- Local shops referred to as “herbaria”
- Neighborhood *boticas*, or pharmacies
- The availability of Mexico and the flexibility of the border also allow MAs to easily access ingredients for folk remedies that they cannot find in the U.S.
- Open markets in Mexico where vendors are allowed to recommend dried herbs that have been successful in alleviating certain ailments

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**Section III**

**Common Childhood Illnesses & Home Remedies**

**Asthma:**

- **Herbal teas:** Chamomile, oregano, spearmint, mullein
- **Oral preparations:** Honey and lemon
- **Massage/Rub:** Aloe Vera, Vicks Vapor
- **Aromatherapy:** Eucalyptus

**Colds:**

- **Herbal Teas:** Oregano, chamomile, cinnamon, cumin, eucalyptus, mullein, spearmint
- **Oral preparations:** juice from purple onion, juice from water boiled raisons, honey with lemon

**Colic:**

- **Herbal Teas:** chamomile, cumin, spearmint, anise
- **Massage:** Abdominal

**Constipation:**

- **Herbal Teas:** Anise

**Conjunctivitis:**

- **Optic preparations:** Chamomile drops or wash for eyes

**Cough:**

- **Herbal teas:** (single or a combination of) oregano, cinnamon, eucalyptus, chamomile, garlic, cumin, mullein (sweetened with honey)
- **Oral preparations:** honey and lemon, water from boiled raisons

**Cramps:**

- **Herbal Teas:** Chamomile, anise, spearmint
Diarrhea:
Herbal Teas: spearmint & chamomile, cumin
Oral preparations: rice water, increased clear liquid (made of water, sugar, lemon) lemonade with salt, 7-Up or clear soda with salt, suero (rehydration fluid made of water, sugar, lemon, or banana), spearmint tea with salt, baking soda and lemon.
No milk or food

Earache:
Herbal Tea: spearmint
Otic preparations: warmed nuda leaf in ear, warmed large piece of garlic in ear

Fever:
Herbal Teas: cinnamon with honey & lemon
Topical preparations: Alcohol rubs, tepid baths

Minor Burns:
Topical preparations: cold water, pork lard, cooking oil or butter, aloe vera, raw onions, egg white

Minor Wounds:
Topical preparations: wash with soap and water, clean with lemon juice

Nausea:
Herbal Tea: chamomile

Skin Rash:
Topical preparations: cornstarch, alcohol rub, body lotion, water with baking soda, arnica, lemon, oatmeal powder, rub with watermelon shell, cotton clothes

Sore Throat:
Herbal Teas: Oregano

Upset Stomach:
Herbal Teas: spearmint, chamomile, cinnamon

Vomiting:
Herbal Teas: spearmint & chamomile, cinnamon, ginger.
Oral preparations: suero (refer to diarrhea section)

Common Herbal Remedies: Adverse Effects
**The Natural Medicine Comprehensive Database contributed extensively to this section and the section Safety Ratings**

The remedies are separated into groupings based on the usual formula used for the remedy. Teas, tinctures, and extracts have different strengths. Strengths of the remedy are important in regards to human size. The weaker and lighter a tea is, the safer it is for an infant while the same tea seeped longer into a darker strength is appropriate for an adult and can do harm to an infant.

Topicals

☀ Aloe Vera (Zábilá): Topically, aloe gel is used for burns and wound healing, psoriasis, sunburn, frostbite, inflammation, osteoarthritis, and cold sores. No adverse effects reported if used topically. Aloe Vera Gel is considered “Possibly Safe” when used topically but reports there is insufficient reliable information available to establish its safety for pregnant or lactating women and recommends that they avoid using this remedy temporarily.
<table>
<thead>
<tr>
<th>Liquid Extracts</th>
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<tbody>
<tr>
<td><strong>Arnica (Arnica):</strong> Topically, arnica is used for the inflammation and immune system stimulation associated with bruises, aches, and sprains. It is considered Possibly Safe when used in amounts commonly found in food. It has Generally Recognized As Safe status (GRAS) for use in foods in the US and can safely be used for short periods of time on unbroken skin. Avoid with acute inflammation, high fever or asthma. Can cause throat and stomach irritation. Prolonged topical use may irritate skin. Considered as Likely Unsafe when taken orally in medicinal quantities and should be avoided by pregnant and lactating women either orally or topically.</td>
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<td><strong>Eucalyptus Oil (Eucalipto):</strong> Topically, eucalyptus oil is used for inflammation of respiratory tract mucous membranes, rheumatic complaints, and nasal stuffiness. Considered Likely Safe when used orally in amounts commonly found in foods. Eucalyptus oil has Generally Recognized As Safe status (GRAS) for use in foods in the US. It receives the rating of Likely Unsafe when undiluted oil is ingested orally. Ingesting 3.5 mL of undiluted oil can be fatal. It is extremely toxic if ingested. May cause slurred speech, ataxia, muscle weakness, unconsciousness, seizures, and contact dermatitis. Significant depression of conscious state can occur with ingestion of 5cc or more of 100% oil.</td>
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<td><strong>Oil of Oregano (Orégano).</strong> Orally, oregano is used for respiratory tract disorders such as coughs, asthma, croup, and bronchitis. Oregano is also used orally for gastrointestinal disorders, such as dyspepsia and bloating. It is also used orally for dysmenorrhea, rheumatoid arthritis, urinary tract disorders including urinary tract infections (UTIs), headaches, and heart conditions. The oil of oregano is also used orally for intestinal parasites, allergies, sinusitis, arthritis, cold and flu, earaches, and fatigue. Oil of Oregano is considered as Likely Safe when used orally in amounts commonly found in foods. Oregano leaf and oil have Generally Recognized As Safe (GRAS) status in the US. It is considered as Possibly Safe when used orally or topically and appropriately in medicinal amounts. Do not take undiluted drops internally, large doses cause stomach irritation. Apply sparingly to broken skin, will sting. Considered Possibly Unsafe in pregnancy. There is insufficient reliable information (no studies) on the safety of oregano when used in medicinal amounts while nursing.</td>
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Cumin (Comino): Orally, cumin is used as an antiflatulent, stimulant, antispasmodic, diuretic, aphrodisiac, for stimulating menstrual flow, treating diarrhea, colic, and flatulence. It is Likely Safe when used orally in amounts commonly found in foods. Cumin and cumin oil have Generally Recognized as Safe (GRAS) status in the U.S. There is insufficient reliable information available on using medicinal amounts when pregnant or lactating. Side effects include allergic reaction & contact dermatitis. Orally, use of undiluted cumin oil has phototoxic effects.

Ginger (Jengibre): Orally, ginger is used for motion sickness, morning sickness, colic, dyspepsia, flatulence, chemotherapy-induced nausea, rheumatoid arthritis (RA), osteoarthritis, loss of appetite, post-surgical nausea and vomiting, migraine headache, and for discontinuing selective serotonin reuptake inhibitor (SSRI) drug therapy. It is also used orally for anorexia, upper respiratory tract infections, cough, bronchitis, as a galactagogue, diaphoretic, diuretic, as a stimulant; and for treating stomachache, diarrhea, nausea, cholera, and bleeding. It is considered as Likely Safe when used orally in amounts commonly found in foods. Ginger, ginger extract, and ginger oil have Generally Recognized as Safe (GRAS) status in the U.S. It is Possibly Safe when used orally and appropriately in medicinal amounts, even in pregnancy. Not known to cause adverse side effects, not to be taken undiluted.

Mullein (Gordolobo): Orally, mullein is used for respiratory tract mucous membrane inflammation, cough, whooping cough, tuberculosis, bronchitis, hoarseness, pneumonia, earaches, colds, chills and flu, fever, allergies, tonsillitis, and tracheitis. Other uses include asthma, diarrhea, colic, gastrointestinal bleeding, migraines, and gout. It is also used as a sedative, narcotic, diuretic, and antiarheumatic. No known adverse effects, but there is insufficient reliable information available about the safety of mullein.

Anise (Anís): Orally, anise is used for dyspepsia and as a pediatric antiflatulent and expectorant. Considered as Likely Safe when used orally in amounts commonly found in food. Anise and anise oil have Generally Recognized as Safe (GRAS) status in the US. Anise is Possibly Unsafe when used topically at medicinal strengths. Anise contains furanocoumarin constituents that may cause photosensitivity reactions when skin is exposed to UV light. Not to be used longer than 4 weeks, at risk for hypokalemia. Anise is considered as Possibly Unsafe when used orally in medicinal amounts in Pregnancy. Formally considered as Possibly Unsafe in lactation due to the lack of safety studies. Anise has traditionally been used to promote lactation. Anise contains furanocoumarin constituents that may cause photosensitivity reactions when skin is exposed to UV light. Not to be used longer than 4 weeks, at risk for hypokalemia. Anise is considered as Possibly Unsafe when used orally in medicinal amounts in Pregnancy. Formally considered as Possibly Unsafe in lactation due to the lack of safety studies. Anise has traditionally been used to promote lactation.

Chamomile (Manzanilla): Orally, German chamomile is used for flatulence, travel sickness, nasal mucous membrane inflammation, allergic rhinitis, nervous diarrhea, attention deficit-hyperactivity disorder (ADHD), restlessness, and insomnia. It is also used for gastrointestinal (GI) spasms, inflammatory diseases of the GI tract, GI ulcers associated with nonsteroidal anti-inflammatory drugs (NSAIDs) and alcohol consumption, and as an antispasmodic for menstrual cramps. It is considered as Likely Safe when used orally in amounts commonly found in foods. German chamomile has Generally Recognized as Safe (GRAS) status in the U.S. Side effects include hypersensitivity, contact dermatitis, urticaria, anaphylaxis (rare).

Cinnamon (Canela): Considered as Likely Safe when used orally in amounts commonly found in foods. Cassia cinnamon has Generally Recognized as Safe (GRAS) status in the US. Considered Possibly Safe when used orally and appropriately in medicinal does, there is still insufficient number of studies completed concerning it’s effect on pregnant and lactating women and they should avoid using it temporarily. It can cause Oral lesions, irritation, erythema multiforme, contact dermatitis when used in excess.
Safety Ratings

LIKELY SAFE:
The product has undergone a rigorous scientific evaluation equivalent to a review by the FDA, Health Canada, or other governmental authority and has been found to be safe when used appropriately. Or reputable references generally agree that the product is safe when used appropriately based on two or more randomized, controlled, clinical trials involving several hundred to several thousand patients and published in refereed journals; or based on large-scale post-marketing surveillance showing a low incidence of significant adverse effects.

POSSIBLY SAFE:
Reputable references agree that the product might be safe when used appropriately, and there are human studies reporting no serious adverse effects.

POSSIBLY UNSAFE:
There is some evidence suggesting that use of the product might be unsafe.

LIKELY UNSAFE:
Reputable references agree that the product can be harmful, based on human studies or reliable case reports of significant adverse effects.

UNSAFE:
The product has undergone a rigorous scientific evaluation or a review by a reliable regulatory agency and found to often cause clinically significant harm to humans. Or large-scale post-marketing surveillance shows a high incidence of significant adverse effects.

INSUFFICIENT EVIDENCE:
There is not enough reliable scientific evidence to provide a Safety Rating.

Foods

🌿 Spearmint (Yerba Buena): Orally, spearmint is used for digestive disorders, including flatulence, indigestion, nausea, sore throat, diarrhea, colds, headaches, toothaches, cramps, cancer, bile duct and gallbladder inflammation, gallstones, upper gastrointestinal tract spasms, irritable bowel syndrome (IBS), and inflammation of respiratory tract. It is also used as an aromatic, stimulant, antiseptic, local anesthetic, and antispasmodic. It is Likely Safe when used in amounts commonly found in foods. Spearmint and spearmint oil have Generally Recognized as Safe (GRAS) status. Spearmint is Possibly Safe when used orally or topically for medicinal reasons.

🌿 Garlic (Ajo): Traditionally has been used to relieve cough, colds, flu and rhinitis. Clinical trials do not support such uses. No known contraindications, except hypersensitivity to garlic. Garlic is Likely Safe when used orally and appropriately. Garlic has been used safely in clinical studies lasting up to four years without reports of significant toxicity. It is Possibly Unsafe when used topically as it might cause severe skin irritation. Garlic is Possibly Safe in children when used orally and appropriately, short-term. It is Likely Safe when used orally in amounts commonly found in foods for pregnant women.
Potentially Harmful Home Remedies and Safe Alternatives

✿ Rue (Ruda):
   Uses: Empacho
   Side Effects: Safety poor if ingested. Fresh rue can cause severe kidney and liver damage when more than 120 grams of leaves or 100 mL of oil are ingested. Rue can cause severe gastrointestinal upset, systemic complications, and death. Dried rue leaves contain less volatile oil than fresh rue, and has milder effects. When fresh rue is applied topically it can cause contact dermatitis and severe photodermatitis.

✿ Wormwood tea (Estafiate):
   Uses: Bilis & Empacho
   Side effects: Convulsions, dizziness, seizures, coma, confusion, hallucinations, and even death.

Safe Alternative Remedies:
   Massage: Abdominal and back massage with warm oil
   Herbal Teas: Chamomile and spearmint
   Topical: warm compress to affected outer ear.

✿ Greta & Azarcón, also known as Albayalde, Liga, Maria Luisa, Alarcon, Coral y Rueda:
   Total lead contents of 70-99%
   Uses: Empacho
   Side effects of lead: can affect almost every organ and system in the body, specifically the central nervous system. Lead can cause behavioral problems and learning disabilities, to seizures and death. Children are most at risk, their bodies are growing quickly. Lead can affect a child's mental and physical growth. Lead may decrease reaction time, cause weakness in fingers, wrists, or ankles, and possibly affect the memory. Lead may also cause anemia and can also damage the male reproductive system.

✿ Elemental mercury (Azogue):
   Uses: Empacho
   Side effects: Chills, mouth sores, swollen gums, nausea, vomiting, abdominal pain, diarrhea, headache, weakness, confusion, shortness of breath, cough, chest tightness, bronchitis, pneumonia and kidney damage.

✿ Laundry bluing (Anil):
   Uses: Empacho
   Signs of poisoning: Burning pain in the chest and abdomen, intense nausea, vomiting, diarrhea, headache, sweating, and shock. Injury to the brain, liver, kidneys and stomach may also occur.
Section IV
Note Page

This section is provided so you can write any remedies you learn about which are not in this handbook.

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