



9 **Sweet Dreams and Bitter Realities: Nutrition and Health Care in Tunkás and the United States**

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A person who migrates experiences transitions not only in language, culture, and work opportunities, but also in the composition of their diets. In addition, as remittances from migrants in the United States begin arriving in home communities, nonmigrant family members are often able to afford better-quality products and a greater variety of foods. However, poverty and ecological challenges in both sending and receiving contexts continue to limit the kinds of foods available to migrants and their relatives. In a context of economic crisis, when family incomes are more precarious than usual, these choices are even more constrained.

Various potentially serious health conditions are correlated with suboptimal nutrition; diabetes, anemia, high cholesterol, and heart attacks often result from dietary patterns shaped by a lack of healthy foods. To manage these conditions, Tunkaseño migrants and their compatriots who remain in Tunkás must receive ongoing medical care. However, a lack of infrastructure, high costs, and fear of apprehension by U.S. immigration authorities can constrain access to adequate medical intervention.

This chapter explores the connections between diet and health conditions among Tunkaseños in Tunkás and California and describes the medical facilities to which Tunkaseños on both sides of the border turn for treatment. We begin by describing what Tunkaseños eat in Mexico and the United States and then examine the medical treatment available to Tunkaseños suffering from diet- or nutrition-related illnesses. We conclude with a discussion of traditional health care practices, which some Tunkaseños continue to utilize for both diet-related and spiritual ailments.

THE TUNKASEÑO DIET

Several studies of migration and nutrition focus on the connection between migrant settlement in the United States and obesity (see, for example, Kaplan et al. 2004; Romero-Gwynn et al. 1993). For instance, according to Romero-Gwynn and Gwynn (1997), the longer a migrant spends in the receiving society, the greater his or her chance of developing a diet-related illness. These studies, part of the literature that seeks to explain the “Latino health paradox,” find that Latino migrants in the United States are healthier than groups with similar sociodemographic characteristics and enduring exclusion from quality healthcare (Abraído-Lanza et al. 1999). Because migrants also tend to be healthier than nonmigrants from the same community of origin (Oristian et al. 2009), many researchers contend that a positive selection effect leads to the outmigration of the healthiest individuals; these migrants are, it is argued, best suited to withstand the physical hardships of a clandestine border crossing and the difficult labor and living circumstances they encounter in the United States.

However, these studies do not typically include a systematic consideration of the dietary or nutritional context of the sending community. In this section we argue that the lack of complete and quality nutrition in Tunkás has a negative effect on the health of Tunkaseños in Mexico, while access to a greater variety of food in the United States may in fact improve Tunkaseño migrants’ overall health.

For many residents of Tunkás, the daily diet consists of tortillas, beans, chilies, meat, and sodas. Although Tunkás is an agricultural town, most Tunkaseños’ daily food consumption is limited by their financial situation, the unavailability of certain products, and a lack of understanding about what constitutes a healthy diet.

Aside from the corn and beans that Tunkaseños harvest from their family plots and the herbs and spices they grow in their patios, few fruits and vegetables are grown in Tunkás and hence are absent from most Tunkaseños’ diets. As one Tunkaseña woman commented, “Well, I eat what we have available here, and it isn’t much here. When I go to Playa del Carmen, I eat fruits and vegetables.” Moreover, what fruits and vegetables are available are expensive. Señora Andrea, the owner of a small grocery store, explained that Tunkaseños rarely buy vegetables because

of the cost. A potato costs four pesos, while a package of Maruchan or Cup O' Noodles costs five, so many customers opt for the packaged product, which is easier to prepare and more filling.

Meat is a very important part of the Tunkaseño diet, but only for families that can afford to slaughter an animal regularly. Tunkaseño families often raise pigs, turkeys, and chickens for sale or personal consumption. These animals require little space, so they can be raised in patios and yards, and they eat just about anything. As one Tunkaseño explained, "We just give the pig leftovers, and that's enough." By contrast, Tunkaseños do not consume much beef. One of the town doctors explained that there is no land for grazing cattle, and the lack of pasturage makes pork the more popular meat in Tunkás.

Not only is pork a key component of the Tunkaseño diet, Tunkaseños also use rendered pork fat, known as *manteca*, for cooking. Señora Andrea noted: "People say that *manteca* gives food more flavor . . . and it costs less than oil." Micaela reported that her family generally uses oil at home but purchases lard when money is short. Unfortunately, as is discussed later in the chapter, the extensive use of lard in cooking has serious health consequences for Tunkaseños.

Another meat consumed in Tunkás is venison. Although venison is not a major part of the diet, many Tunkaseños hunt deer for both local consumption and sale. According to Dr. Gómez, "Several families hunt deer and they share the meat. . . . Because it doesn't cost them anything, they can eat venison once or twice a week." Although it is illegal to hunt deer, venison remains an attractive source of protein, especially for families with limited financial resources.

Tunkaseños do not consume milk or fruit juice at levels recommended in nutritional guidelines, mostly because of the high cost of these products. As one shopkeeper put it, customers "buy juice once every two weeks, on payday." Furthermore, 28 percent of Tunkaseño households do not have refrigerators and thus are not able to store milk or juice safely.

Water consumption is also low among Tunkaseños because of the shortage of potable water. Local *cenotes* are contaminated, and one of the town's doctors asserts that the water that is piped to Tunkaseños' houses is not adequately purified. As a result, many Tunkaseños experience chronic diarrhea, salmonella, typhoid, and skin infections. Bottled water

is expensive, and few Tunkaseños have the wherewithal to install better water purification systems in their homes.

Because they are relatively cheap and available, sodas are the most popular drink for Tunkaseños. Unfortunately, sodas contribute to Tunkaseños' high rates of diabetes and high blood pressure, and their prevalence frustrates local health providers who note that Tunkaseños would be better served by purchasing water rather than soda. Finally, there are several cantinas in the town, and about a dozen stands set up around the plaza during the fiesta did an active business selling beer and liquor. Indeed, alcoholism is a problem in some Tunkaseño families.

The diets available to Tunkaseños living in the United States are healthier on the whole than those in Mexico. In the United States people have access to a wider variety of meats, and Tunkaseños purchase beef, pork, poultry, and fish at supermarkets in Anaheim and Inglewood. In addition, migrants' higher salaries make it easier for them to purchase these products.

Although people in Tunkás cannot afford to include milk and fruit juices in their diet, Tunkaseños in the United States do drink milk and juices. Francisco, who lives in Inglewood, mentioned that he only consumed milk once a week when he was growing up in Tunkás, but after he migrated to the United States milk became an important item on his grocery list.

Although some women in Tunkás sell prepared food from their houses, it is easier to purchase prepared food in the United States than in Tunkás. Though there is some evidence that frequent consumption of fast food has negative health consequences for Mexican migrants in the United States (Oristian et al. 2009), other experts argue that the presence of fruit vendors in neighborhoods where Yucatecan migrants settle increases their access to fresh fruits and vegetables and, in fact, helps Yucatecans living in impoverished Los Angeles neighborhoods obtain a more healthful diet (Rosales 2009).

Potable water is also more widely available to Tunkaseños in the United States, who can drink water from the faucet without risk of diarrhea or other water-borne diseases. On the other hand, Tunkaseños in the United States continue to consume a good deal of soda, and some migrants drink considerable amounts of alcohol.

Although we initially hypothesized that Tunkaseños living in Mexico would have a healthier diet than those living in the United States, our

results show that Tunkaseños in the United States actually enjoy a more balanced diet. When people from Tunkás migrate to Southern California or other parts of the United States, they encounter a large variety of foods which their increased incomes allow them to purchase. Unlike the limited availability of fruits and vegetables we found in Tunkás, U.S. markets have plentiful fresh produce, regardless of the season.

TUNKASEÑOS' HEALTH CARE OPTIONS

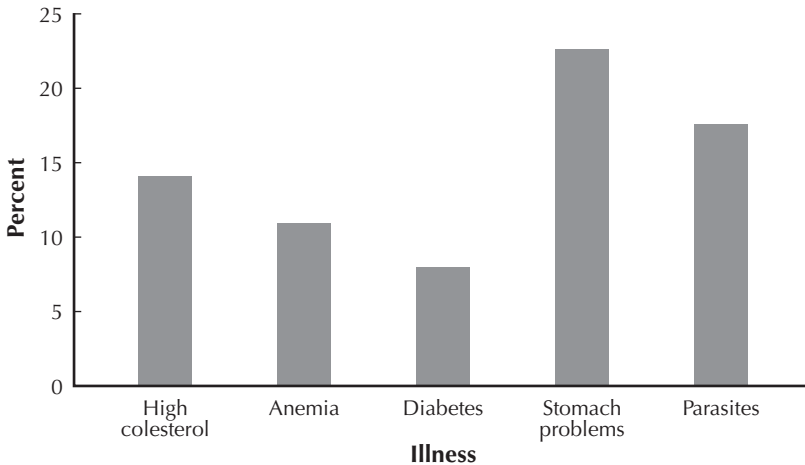
A person's diet and overall health are related, and a balanced and nutritious diet can prevent many of the chronic illnesses that are most common in Tunkás, such as diabetes and high cholesterol. However, given the challenges to maintaining a healthy diet, illnesses do occur, and access to good health care becomes critically important in keeping Tunkaseños healthy. Two types of health care services are available to Tunkaseños: Western-style medicine, which involves doctors, nurses, and medical practitioners at clinics and hospitals; and traditional health practices, which are provided by specially trained community members who heal physical and spiritual ailments with plants, herbs, and spiritual remedies.

The town's clinic, located on the central plaza, has two doctors, a dentist, and three nurses. The doctors work at the clinic full time but do not live in the town. In addition to providing routine care,¹ the clinic has an operating room for performing simple procedures and delivering babies. The clinic staff maintains detailed patient records and submits an annual report on the town's health condition to the Mexican Department of Health. According to these reports, diabetes is the second most frequently diagnosed illness in Tunkás, with 352 cases identified in 2008.² Diarrhea and gastrointestinal diseases followed, with 246 and 234 diagnosed cases, respectively.³ Fourteen percent of Tunkaseños included in our study

1. The local health service provides ambulance transportation to hospitals in Izamal (about a thirty-minute drive from Tunkás) and Mérida. These hospitals treat patients with serious, chronic, or life-threatening illnesses that cannot be adequately treated at the clinic.
2. Respiratory illnesses such as colds and flu were the most commonly diagnosed ailment. The clinic reported 1,554 cases in 2008.
3. The clinic reports higher incidences of certain illnesses than the self-reported health information obtained through our survey. This discrepancy may emerge because a person with the same problem has visited the clinic multiple times; each visit is recorded as a separate event, which would inflate the numbers reported by the clinic.

reported suffering from high cholesterol, 11 percent from anemia, 8 percent from diabetes, 23 percent from stomach problems (including gastritis and chronic diarrhea), and 18 percent from parasites (figure 9.1).

Figure 9.1. Self-Reported Incidences of Nutrition-Related Illnesses among Tunkaseños

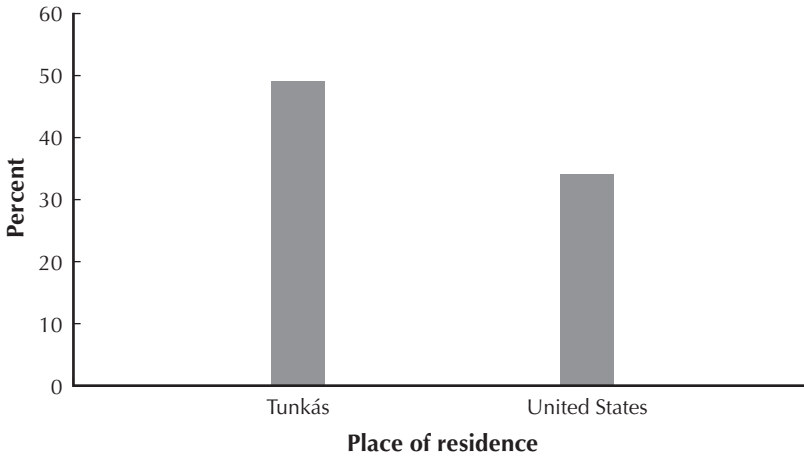


In all, just under half of Tunkaseños (47 percent) reported having been diagnosed with or suffering from a diet- or nutrition-related illness. When the data are broken down by migration status, we find that a higher percentage of Tunkaseños who live in Tunkás suffer from nutrition-related ailments than their U.S.-based counterparts (figure 9.2), supporting our hypothesis about the connection between better food options in the United States and better health conditions among migrants.

Another explanation for the prevalence of gastrointestinal illnesses—particularly chronic diarrhea and parasites—is the lack of adequate hygiene in food preparation or storage. Kitchens in Tunkás are often small buildings outside the primary residence, so meal preparation takes place only a few feet from the household’s turkeys, chickens, and pigs, whose activities cause feces and other contaminants to become airborne and then be deposited on foods prepared on outdoor fireplaces. The notable lack of potable water exacerbates residents’ susceptibility to gastrointestinal problems, and nearly a fourth of homes (23 percent) lack indoor

bathrooms. Even in homes that do have a sewage system, the intermittent availability of hot water makes it difficult to maintain adequate hygiene.

Figure 9.2. Tunkaseños Reporting a Nutrition-Related Illness, by Place of Residence



Pearson Chi-square = 10.63; $p < .001$).

A lack of information about proper nutrition may also contribute to the prevalence of diet-related illnesses among Tunkaseños. A nutritionist comes to the clinic once a month to give *pláticas* (short seminars) about healthy eating. However, the nutritionist's primary concern is preventing malnutrition among children, not educating adults on healthful eating. According to the clinic's nurse, the nutritionist "gives demonstrations on bottle feeding and distributes nutritional supplements." The government's Oportunidades program also provides occasional informational sessions about good hygiene and nutrition. These presentations address the entire family, but not everyone attends these meetings, and the recommendations that are made can be hard for Tunkaseños to follow. As Micaela noted, "it's difficult to do what the doctor says because it's hard to find good food here. But we do what we can." Though they may be difficult to implement, the recommendations go to the core of the many factors that account for the prevalence of diabetes in Tunkás: alcoholism, obesity, and a diet heavy in lard, soda, and meat, but light in fruits and

vegetables. Dr Carlos Escalona, from the health center in Tunkás, said that many cases of diabetes could be prevented if people ate fish instead of pork and cooked with vegetable oil instead of lard. Unfortunately, by the time a patient visits the doctor with the symptoms of diabetes, it is often too late to reverse the disease.

In addition to a healthy diet, exercise is an important part of nutritional well-being. However, many Tunkaseños fail to follow a healthy daily exercise routine. Though most Tunkaseños walk everywhere rather than driving, routine walking does not constitute cardiovascular exercise. According to the staff of the rehabilitation center in Tunkás, Oportunidades has launched campaigns to encourage Tunkaseños to exercise and include a physical workout in their daily routine, but the campaign has had only limited success. As Dr. Gómez noted, "We at the clinic try to promote exercise, but we've got a lot of older people who can't move easily, and besides, the people are not accustomed to doing exercise."

We constructed a multivariate model to explore some of the factors linked to diet-related diseases among Tunkaseños. We tested for a relationship between certain sociodemographic characteristics and the illnesses discussed above (high cholesterol, diabetes, anemia, stomach problems, and parasites). The reference category is 0 (diagnosed with none of these illnesses), and the test was conducted on respondents who indicated that they suffer from at least one of these five diseases (table 9.1).

In the model, advanced age was directly related to a greater incidence of nutrition-related diseases, and the relationship was statistically significant. As people age, their overall health often declines, so it is not surprising that older respondents in both Tunkás and the United States were more likely to report nutrition-related ailments than were younger Tunkaseños. However, age was the only statistically significant explanatory factor for U.S.-based respondents; gender, marital status, the consumption of fast food or frozen meals, and relative wealth were not statistically important explanations for the occurrence of nutrition-related diseases among Tunkaseños living in the United States.

In Mexico, however, many of these factors were related to the likelihood that respondents had been diagnosed with a nutrition-related disease. Women were more likely than men to suffer from one of the diet-related illnesses; respondents who eat out regularly reported higher

incidences of these diseases; and both relative wealth and receipt of remittances were positively related to the likelihood of a respondent reporting that he or she had been diagnosed with at least one of the diet-related illnesses we included. This last point—that more prosperous Tunkaseños suffer more frequently from diet-related illnesses—hints at the relationship between household income and meat consumption. That is, families that can afford to eat more meat are more likely to suffer from ill health as a result of their consumption patterns. On the other hand, the relative frequency of diet-related illnesses among women may have less to do with differential nutrition and more to do with more regular medical visits (which increase the likelihood of a diagnosis) and female-specific health patterns, such as anemia during pregnancy.

Table 9.1. Factors Explaining Nutrition-Related Illnesses among Tunkaseños

	Mexico-Based	U.S.-Based
Age	.02*** (0.00)	.04** (.02)
Male	-.59*** (.15)	-.54 (.42)
Married	-.15 (.16)	.08 (.4)
Eating out	.06** (.02)	.03 (.04)
Wealth	.01** (0.00)	0.00 (0.00)
Remittance recipient	.67*** (.18)	—
Landowner	.27 (.15)	—
Chi-square	57.01	8.08
Pseudo R ²	.05	.05*
N	817	134

* $p < .05$; ** $p < .01$; *** $p < .001$.

Robust standard errors are in parentheses.

Finally, although we hypothesized that having access to land for growing crops might be a way for some Tunkaseños to incorporate fresh fruits and vegetables in their diet, there was no statistically significant relationship between land tenancy and the prevalence of diet-related illnesses.

OBTAINING TREATMENT: DOCTOR VISITS IN TUNKÁS AND THE UNITED STATES

Whether or not they suffer from chronic nutrition-related illnesses, all Tunkaseños require access to health care. We initially hypothesized that Tunkaseños would have a harder time obtaining medical attention in Tunkás than in the United States, given that Tunkás is a small, rural town. However, we found that it is easier to get medical care in Tunkás, for several reasons. First, the town's clinic treats patients who cannot afford to pay for care, removing the economic constraint on health care. Second, many U.S.-based Tunkaseños worry about being apprehended by immigration authorities if they utilize public health care facilities such as hospitals and emergency rooms, and they forgo medical attention for this reason.

Because health care is easier to obtain in Mexico, respondents who live in Tunkás reported visiting the doctor more frequently in the year prior to our survey than did their U.S.-based counterparts: Tunkaseños in Tunkás visited the doctor an average of 4.3 times in 2008, while Tunkaseños in the United States sought medical attention an average of 2.8 times during the same period (table 9.2). These differences persist when the data are disaggregated by gender: both male and female respondents in Mexico visited the doctor more frequently than did male and female respondents in the United States. However, in both countries, women reported visiting the doctor more frequently than men. Women in Mexico visited the doctor substantially more often than did women in the United States; the difference in the mean number of women's doctor visits in the two countries is statistically significant at $p < .01$.

Table 9.2. Difference in Number of Doctor Visits, by Gender and Place of Residence

	Female	Male	Difference in Means (gender)	N
Live in Mexico	5.1	3.4	1.7***	863
Live in U.S.	3.4	2.6	0.8	146
Difference in means (location)	1.5***	0.8		
N	505	493		

*** $p < .01$ confidence interval for hypothesis that means are statistically different.

WHO HAS ACCESS TO MEDICAL CARE?

Medical coverage programs that facilitate access to health care are an important element in explaining the use of health care options in Tunkás and the United States. For instance, there has been a hue and cry in the media about undocumented Mexicans coming to the United States to obtain free or inexpensive health care, yet we find that Tunkaseños actually have better and more regular access to health care in Mexico than in the United States.

The clinic in Tunkás treats all Tunkaseños who need medical attention, regardless of ability to pay. However, most of the clinic's patients are registered in one of several government-sponsored medical insurance programs. According to the clinic's records, 598 patients were covered by Seguro Popular in 2008, 30 had ISSSTE coverage, and 32 received care under the IMSS program.⁴ All of these programs were designed to help low-income Mexican families reduce the costs of medical care and improve the overall health status of Mexican citizens.

Seguro Popular is a federal-level medical insurance system for low-income Mexicans. It was launched in 2001 to protect the population most at risk of health problems due to low income levels and to reduce the number of families living in poverty as a result of burdensome medical expenses. Individuals are eligible for Seguro Popular coverage if they are not insured under another federal health care program, if they fall below a certain income level, and/or if they have at least one child between the ages of eighteen and twenty-five who is pursuing higher education.

The inter-institutional Oportunidades program attempts to lower the extreme poverty existing in Mexico by increasing educational attainment and improving health care. Oportunidades provides regular economic transfers to families who need financial assistance to help cover their children's educational expenses. In exchange, the children and their mothers must commit to regular medical visits and nutritional counseling. The program also helps families headed by single mothers; the health of these single mothers is of particular importance because deteriorating health among single-parent caretakers can lead to an increased burden on children, at the cost of their educational opportunities.

4. IMSS is the Mexican Social Security Institute, and ISSSTE is the parallel institution for government employees.

Several programs help low-income Tunkaseño families in the United States access medical attention. However the process is difficult, and the undocumented status of many U.S.-based Tunkaseños complicates the situation still further. Fear of deportation can prevent undocumented migrants from seeking needed medical attention (Sack 2008), and visiting the hospital was the fourth most common response we received when we asked respondents to identify what most worries undocumented migrants living in the United States. Nevertheless, we found no statistically significant difference in the frequency of doctors' visits between documented and undocumented Tunkaseños living in the United States.

Medicaid and Medicare both require patients to present documents confirming legal residency in the United States. As discussed in chapter 2, 20 percent of Tunkaseños living in the United States currently rely on some form of public medical assistance (Medicaid, Medi-Cal, or Medicare) for their health care, and 40 percent of Tunkaseño migrants have used these programs at some point during their stay in the United States.

Other programs such as LA ORSA (Los Angeles Outpatient Reduced-Cost Simplified Application) and a few private clinics in Inglewood and Los Angeles are alternative sources of medical care for illegal immigrants. LA ORSA provides outpatient care to uninsured and low-income residents of Los Angeles County. Applicants must demonstrate residency by presenting water, electricity, or gas bills. However, they need not prove legal residency in the United States. Once accepted in LA ORSA, participants can receive care from two dozen private and public clinics without having to present any documentation.

Many of the U.S.-based Tunkaseños we interviewed have private insurance through their employer; 40 percent of respondents living in the United States reported that they have insurance provided by their employer or the employer of a family member. Although just over 40 percent of U.S.-based Tunkaseños pay out of pocket for medical care, we found that Tunkaseños share information about private doctors who are willing to treat patients at a reduced cost. One doctor in Anaheim charges \$50 for a consultation regardless of the nature of the complaint. Such doctors are not listed in any media; information about them travels by word of mouth among Tunkaseños.

While undocumented Mexican migrants used to return to Mexico to receive health care, increased border security and the associated high cost of reentry discourage this approach. Concomitant with the bottling up of undocumented migrants in the United States in response to enhanced border security there may be a bottling up individuals who are in need of medical attention but are unable or afraid to seek treatment. During the health care reform debates of 2009, advocacy groups, including the National Council of la Raza, sought to ensure that any universal health care option would be accessible to the millions of undocumented migrants living in the United States; however, at the time of writing there was as yet no specific health care reform legislation being voted on by the U.S. Congress.

TRADITIONAL HEALTH CARE

Tunkaseños sometimes turn to traditional medicine out of preference or when scientific medical treatments are not available. While traditional healing does not replace Western-style medicine, it does provide a parallel line of health care to Tunkaseños; the individuals who utilize traditional health care services typically do so in conjunction with visits to scientific medical practitioners.

Traditional health practitioners include *curanderos* (healers), *hueseros* (bonesetters), *parteras* (midwives), and *brujos* (individuals supposedly possessing magical powers obtained through a pact with the devil).

Doña Socorro, one of the four *curanderos* practicing in Tunkás, has twenty-five years of experience treating patients for *mal de ojo*, *susto*, *miedo*, *viento*, and *dolor de cabeza*. *Mal de ojo* results when an individual causes illness or other misfortune to befall another person through a glance accompanied by evil intent. It is generally believed that children are more susceptible to *mal de ojo*. Doña Socorro is able to determine if someone is suffering from *mal de ojo* simply by looking in the person's eyes:

When they bring a child to me, it's because one of the eyes gets smaller. First it's big, then it's tiny. To cure it you prepare herbs. You grind them, add anís, and rub the concoction on the child from the top of the head to the tips of the fingers. Then you wrap the child in a cloth until they sweat it out.

One of the most frequent traditional ailments in Tunkás is *susto*, or fright. Doña Socorro explained that *susto* invades a small child's body when he or she is scared. To cure *susto*, Doña Socorro makes a sachet of lemon and orange tree leaves and *epazote*, and places it in the child's bed. Another treatment for *susto* is an infusion of *much* (lemon leaves) and tamarind leaves, which is strained and given to the patient to drink.

Empacho is a traditional illness diagnosed among young patients. *Empacho* "is caused by having food stick to the stomach lining . . . by forcing a child to eat food he does not like or want, [or giving] children too much to eat" (Trotter and Chivara 1981, 91). *Empacho* is cured with a purgative or an infusion of herbs. According to Trotter and Chivara, "in some cases the healer massages the part of the back behind the stomach with warm olive oil and pulls on the skin. The skin is said to make a snapping noise when the trapped food particles are loosened" (1981, 92).

Traditional healers also treat patients who have cancer, advanced diabetes, and chronic degenerative diseases. Doña Socorro asserted that a mixture of tarantula poison (extracted from the spider with a needle) and milk cures cancer and diabetes. Doña Socorro's grandparents taught her the art of curing when she was a little girl, and she would like to pass her knowledge to a daughter or another close relative, but few are interested. The remuneration she receives for her services may be a dissuading factor for potential apprentices; Doña Socorro has no set fee for her treatments and healings, and she often treats patients for next to nothing, noting that what she does is "an obligation to the community."

Doña Luz, a *partera* in Tunkás, began practicing midwifery nineteen years ago after her mother helped her through her own pregnancy and delivery. Doña Luz uses massage to position the baby for delivery and helps women during birth. "After the infant is born, I look after the woman, I dress her, I clean her, and I visit her on the third day. I visit her three times a week." Doña Luz charges a fixed amount of 300 pesos per birth. Like Doña Socorro, Doña Luz would like to pass on her knowledge, but "no one wants it."

Regina, another local health care provider, emphasized that her knowledge is a "gift." Regina specializes in bone alignment, and she believes that only someone born with the gift can become a *huesero*. Regina, who is now around thirty years old, learned to align bones from her father when she was only nine, and she began working as a *huesera*

five years later. She works on “broken bones and sprains, fixes hips, and provides healing massages (*sobas*) to women’s uteruses.” Patients come to Regina instead of a chiropractor because she is able to help heal damaged tendons, while, according to her perspective, chiropractors “only snap bones.”

Regina, who now lives in Cancún, travels to Tunkás every two weeks to treat her patients. She charges her Tunkás patients slightly less than those in Cancún: in Cancún she charges 100 pesos (about US\$8.50) to treat a specific muscular pain, and 200 pesos (\$16) for the whole body, compared to 70 and 100 pesos, respectively, in Tunkás. Like Doña Socorro, Regina occasionally does not charge any fee, because “sometime people just need help.” If Regina feels that a patient is in need of more intensive medical treatment, she sends them to the doctor.

Although Tunkaseños’ use of traditional medicine is limited in the United States by the lack of practitioners and changing preferences in medical treatment, some Tunkaseños do seek out the traditional healers who have migrated to the Los Angeles area. As in Tunkás, however, traditional care is typically a complement to rather than a substitute for Western-style medical attention.

Two traditional health care providers from Tunkás—a *sobador* and a *curandero*—now live in Los Angeles. Like their counterparts in Tunkás, they draw on knowledge accumulated over generations and attempt to assist everyone who comes to them for help. Don Simón, the *sobador*, learned the art of healing massage from his grandfather and has been providing massages to patients in Tunkás and the United States for over thirty years. Don Simón treats all parts of the body though, unlike Regina, he does not work on broken or damaged bones.

Like Doña Socorro and Regina, Don Simón does not charge a fixed fee for his services, instead accepting “whatever the person wants to give” in exchange for treatment. His stated lack of interest in the financial aspect of his practice suggests that, like the traditional healers in Tunkás, he adheres to the principle of curing as a civic obligation rather than a way to earn an income. He explained, “A lot of patients go to the doctor, and the doctor tells them that nothing’s wrong. Then they come to me and I treat them, and they get better.” However, like traditional healers in Tunkás, if Simón sees a patient that he cannot treat adequately—cases of shattered bones, for instance—he sends them to a doctor or specialist.

Despite the long history of traditional health care practices in Tunkás, just thirty-five Tunkaseños (4 percent of our sample) reported having visited a traditional healer in 2008, and only seven indicated that they prefer a traditional healer to a clinic doctor. Most traditional healers report that when people are suffering from a serious problem, they go first to seek advice from one or more doctors, but eventually they turn to the traditional practitioners. That is, the number of people who seek traditional remedies as a first option is declining.

Findings from our 2009 survey in Tunkás and California suggest that international migrants virtually never use the services of traditional health practitioners. This stated lack of interest contrasts with results from the previous MMFRP study in Tunkás, which showed a marked preference for traditional health care among international migrants: in 2006, 29 percent of international migrants reported preferring traditional health care providers to doctors or clinics, and the researchers speculated that this preference was “a coping mechanism that enables them to integrate their cultural identity with their new reality [and represented] a spiritual connection to Tunkaseño land and culture” (Prelat and Maciel 2007, 216). Despite the presence of two traditional healers from Tunkás in the Los Angeles area, Silverio, a young man born in the United States to Tunkaseño parents, stressed his preference for Western-style medicine: “I don’t believe in that stuff [traditional healing]. If I get sick, I go to a doctor at the clinic and I buy medicine. I don’t go to a *curandero* because I don’t believe in what they do. They aren’t trained to cure people. That’s why I don’t go.”

Several factors may explain this preference. First, respondents may have opted not to acknowledge use of traditional health care practices for fear of social censure from the field researchers; they may have thought that an expressed preference for Western medicine would be more “appropriate.” Second, increases in medical infrastructure and government support for federal and state health initiatives such as Oportunidades and Seguro Popular over the past several decades have made Tunkaseños more accustomed to and comfortable with Western-style medical attention and its associated care givers. Furthermore, the relative scarcity of traditional healers among the Yucatecan community in the United States limits access to traditional practitioners. Finally, because many of the

traditional health care providers are of advanced age and are not finding apprentices interested in learning their skills, the number of *curanderos*, *parteras*, and *hueseros* is dropping in many Yucatecan communities, and young people are increasingly familiar only with treatment delivered by scientific medical providers.

Nonetheless, some Tunkaseños continue to seek out traditional healers, though usually in conjunction with scientific medical care. Thus the two systems appear to be complementary rather than competitive, at least from the perspective of the traditional healers; doctors at the clinic remain dubious about some of the *curanderos'* practices.

CONCLUSION

Migration creates many challenges for families and households. Prolonged separations, family disruption, and new forms of social exclusion can make life difficult for Tunkaseño migrants in the United States and their relatives in Tunkás. However, financial and employment opportunities in migrant destinations remain a strong lure for Yucatecos and Mexicans more generally. This chapter has examined another set of challenges and benefits inherent in migration, specifically, the changes in diet among migrants and the constraints on their access to health care in the United States. We argue that migration can lead to a more healthful diet, given the greater variety of products available in the United States. However, access to health care is easier to obtain in Mexico.

These dynamics generate various health challenges for Tunkaseños. In Tunkás, people are generally less healthy but have better access to medical attention, while in the United States migrants are healthier but have a harder time obtaining regular medical care. In the meantime, in both Tunkás and the United States people are drifting away from traditional health care providers in favor of scientific or Western-style medicine. In the United States this shift can be attributed to a lack of providers, while in Tunkás the government-run medical facilities that offer "modern" care and charge little or nothing for treatment have reduced Tunkaseños' reliance on *parteras*, *hueseros*, and *sobadores*. As younger generations grow up without the experience of visiting these traditional healers, their popularity will likely continue to diminish and their knowledge may become a thing of the past. However, the Mexican government's provision of

information about the importance of proper nutrition, good hygiene, and adequate medical attention is only effective to the extent that towns like Tunkás have access to fresh fruits and vegetables, running water and sanitation, and clean medical facilities.

Tunkás's clinic is well run and is well regarded by town residents, but the persistent lack of healthy foods, compounded by inadequate sanitation systems and enduring poverty, likely means that many Tunkaseños will continue to suffer from easily preventable diseases. Tunkaseños who live in the United States have a better outlook for their nutrition and hygiene. Yet, as the U.S. debates over reforming health care and immigration policy rage on, it is worth remembering the millions of undocumented migrants who need safe and continuing access to quality health care.

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