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Consumption of Health Care among Colonia Residents along the Texas-Mexico Border Region: A Social Marketing Perspective

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Consumption and delivery of health care is unique along the Texas-Mexico border. This region is unique in many ways. Some aspects of its uniqueness are due to its socioeconomic conditions, and its ethnic, linguistic and cultural demographics. The most significant aspect is the border's geographical location, which straddles a developed industrialized economy (U.S.) and an underdeveloped country with a developing economy (Mexico). The interactions between the location and unique culture of the border counties make it an interesting site for the study of public health against the backdrop of migration and globalization. According to Waters (2001), public health is influenced by global migrations and countries that were once able to manage and contain infectious diseases may not be successful given enormous population movements between two disparate countries as seen along the U.S.-Mexico border.

The issue of global public health is becoming important primarily because of the reemergence of diseases especially in regions where they were contained (for example the United States). The rates for diseases like hepatitis A, and tuberculosis are high in border counties along the U.S. – Mexico border (Power and Byrd 1998). The emergence and rise of infectious diseases has been described as one of the most significant health and security challenges facing the global community (Manning 1996, p.1). Of special concern is the knowledge that microbes do not respect borders and incidence of diseases can spread to populations once free from these diseases. The U.S.-Mexico border region is beset with environmental health problems similar to those found in third world countries. The region has much higher rates for water borne and infectious diseases than the rest of the U.S. For example, on the US side of the border, hepatitis A occurs at a rate

three times the national average. According to the Texas Department of Health and Center for Disease Control, the Hepatitis A rate for border counties in 1999 was about three times the national average (18 per 100,000 inhabitants versus 6.25/100,000). Tuberculosis is also a major problem on both sides of the border. In 1998, the rate of reported TB cases in the four US Border States was 17/100,000, compared to a rate of 9.2 in the rest of Texas and 8.7 elsewhere in the country (Texas Department of Health 2002). The border between the US and Mexico is about 2000 miles long and the border region is a swath of land 100 miles on either side of the border. The border region has experienced rapid growth in population. An outcome of the population growth has been the development of substandard residential subdivisions on both sides of the border, known as *colonias.* The word *colonias* means a neighborhood or community in the Spanish language. *Colonias* are defined as unincorporated subdivisions, built outside city limits, on both sides of the US - Mexico border (http://www.hud.gov/texcol.html). Many *colonias* have emerged in rural areas without formally sanctioned local governance and the collective services that local government customarily provides. Some *colonias* may be entire border communities while others are comprised of neighborhoods within incorporated communities. According to the Texas Water Development Board there are over half a million people living in *colonias* along the US - Mexico border. In Texas alone, there are around 1,450 *colonias* with a population of about 350,000 (Texas A & M University's Center for Housing and Urban Development website). *Colonias* are fast developing with growth rate estimates of 7% to 10% per year.

In terms of legal status, 65 % of all *colonial* residents and 85% of those younger than 18 years were born in the U.S. Contrary to expectations, a large majority of

colonia residents, are citizens. In Texas, *colonias* have relatively larger families (5.5 vs. 2.7 statewide) and relatively higher poverty rates (35.8% vs. 18.1% statewide) (Ramos, May and Ramos 2001). The median annual family income is estimated to be in the range of $7000 - $11,000. The poverty rates are at 35.8% compared to 18.1% for the state of Texas (Ramos, May and Ramos 2001). Education levels are low and the dropout rate is high. *Colonia* residents lack education, and job skills and this makes it difficult for the people to get jobs.

The Texas *Colonia*s exhibit all the effects of environmental damage. Most *colonias* have dilapidated homes, lack potable water, and sewer and drainage systems. These conditions make many *colonias* an ideal place for the proliferation of disease. These health problems are compounded by a lack of medical services. In addition to a shortage of primary care providers, *colonia* residents' difficulty in accessing health care is compounded by other factors, including having to travel long distances to health care facilities, lack of awareness of available health care programs and a lack of health insurance. As a result, many *colonia* residents' health care problems go unreported and untreated. About half of the residents do not have adequate water supplies or approved wastewater services. A majority of the *colonias* has dirt roads and no surface drainage systems. Flooding is a problem in the *colonias* compounding the existence of privies. As a researcher, I am very curious to understand how *colonia* residents, who appear to be outside the mainstream, managed their basic medical requirements. The state's medical infrastructure is designed for what are considered regular inhabitants of the state. I suspect that *colonia* residents, would find it difficult to access medical services. This would be further accentuated by a medical system that is not designed to deliver services

to *colonia* residents. Given this gap in the access and delivery of medical services, this study is undertaken to understand heath issues from the point of view of *colonia* residents.

DISCUSSION OF THE IMPORTANCE OF THE RESEARCH PROBLEM

Though Mexican immigration into the United States is over 100 years old (Gamio 1930), the scale of recent immigration is unprecedented. Since 1965 more than 7 million Mexicans have moved to the US (Gutierrez 1998). According to data from the Census Bureau for the year 2000, 32.8 million Hispanics (12% of the total US population) reside in the US. Hispanics are from different countries and include residents of Mexico (66.1%), Central and South America (14.5%), Puerto Rico (9%) and Cuba (4%), as well as descendants from other Spanish-speaking countries (6.4%). By the year 2050, given current immigration patterns and fertility rates of Hispanics the population is expected to exceed 25% of the U.S. population. Hispanic consumers are attractive to advertisers and marketers because of their buying power which is estimated to be in the range of $380-$630 billion.

It is important to study the consumption and delivery of health care among Colonia residents because of the poor condition of the colonias as seen from the dilapidated homes, a lack of potable water and sewer and drainage systems. All these conditions make the location ideal for the incidence and proliferation of diseases. The Texas Department of Health data show that hepatitis A, salmonellosis, dysentery, cholera and other diseases occur at much higher rates in colonias than in Texas as a whole. All these problems are magnifies by the lack of medical services in the colonias (http://www.sos.state.tx.us/border/colonias/faqs.shtml).

Public policy officials need to understand what makes this region unique. In recognition of the strong and ubiquitous influence of Hispanic culture, culturally sensitive models of care need to be developed to serve this diverse population. Knowledge of this population their practices and preferences will provide important inputs for developing these models. It is evident that communication in Spanish is necessary for certain Hispanics because of their inability to speak or understand English. It is widely acknowledged that behavioral patterns characteristic of a particular culture express the shared values and beliefs of that culture, thus understanding the culture of Hispanics especially as it relates to health and healing is particularly important (Wallendorf and Reilly 1983).

RESEARCH DESIGN

We used interpretive ethnography to explore how *colonia* residents manage their health and consume health care. This methodology is appropriate because it is effective in studying ways in which a social group constructs and lives its particular, indigenous version of reality (Smart 1998, p. 1). Geertz, in The Interpretation of Cultures, captures the spirit of interpretive ethnography:

Believing... that man is animal suspended in webs of significance he himself has spun, I take culture to be those webs, and the analysis of it to be therefore not in search of meaning... The whole point of a semiotic approach to culture is... to aid US in gaining access to the conceptual world in which our subjects live (1973, pp.5, 24)

The conceptual world that we sought to understand and map was one pertaining to consumption. In essence, how did *colonia* residents meet their medical needs? Did they have regular medical and dental check-ups? What did they do in times of emergencies like a snakebites or household accidents? What do they do when a doctor prescribes medicines? Where do they buy medicines? In summary, we sought to recreate their version of how they consume health care services.

We used the services of an interviewer who shared the same ethnicity as our respondents. The interviewer spoke Spanish and had migrated to the U.S. less than a decade ago. She had initially lived in one of the *colonias* and therefore shared many of the experiences as the respondents. In our judgment this enabled her to gain access to the world of our respondents. One can understand the importance of access by quoting Geertz:

The trick is to figure out what the devil they (the members of the community) think they are up to. (And) no one knows this better than they do themselves; hence the passion to swim in the stream of their experience (1983, p.58).

Our interviewer was able to identify with the respondents and empathize with their experiences. Thus, even though the ethnographer cannot perceive what the informants perceive, she could understand and probe further the words, images, institutions, behavior of the informants (1983, p.58).

For Geertz the goal of interpretive ethnography is to develop thick description (1973,p.6) of a community's consumption experience through an understanding of stories, examples, and symbols. In analyzing the data we were guided by two kinds of concepts: experience-near and experience-distant. According to Geertz,

An experience-near concept is, roughly, one which someone- a patient, a subject, in our case an informant- might himself naturally and effortlessly use to define what he or his fellows se, feel, think, imagine and so on, and which he would readily understand when similarly applied by others. An experience distant-concept is one which specialists of one sought or another- an analyst, an experimenter, an ethnographer- employs to forward their scientific, philosophical, or practical aims. (1983,p.57).

The use of experience-distant concepts enables a researcher to take informants stories and narratives and position them within frameworks and theories. This placement of informants experiences within a framework facilitates knowledge construction. Thus, the stories of the informants are unique but by examining them within the context of

experience-distant concepts, a researcher is able to further understanding and knowledge. This allows academics and professionals to generate and apply specialized written knowledge (Smart 1998).

In using this methodology one has to be able to maintain a balance between engagement with and detachment from our respondents' world. Researchers must be alert to the dangers of identifying too closely with the respondents, especially after spending so much time and listening to fairly rich information. We were conscious of this danger and made attempts to develop some social and intellectual distance (Hammersley and Atkinson 1983, p. 102).

Filed interviews took place during the summer of 2001. Ten semi-structured interviews were conducted in Spanish with *colonia* residents. The interview schedule was translated into Spanish and later back translated into English to ensure consistency. The first author trained the investigator. The interviews lasted between 75 and 150 minutes and were conducted over many days, in the *colonias*, often in the participant's residence. A description of the respondents is provided in the appendix.

METHODOLOGY FOR ANALYSIS OF DATA

Data analysis was conducted according to grounded theory procedures (e.g., Glaser and Strauss 1967; Strauss and Corbin 1990). Verbatim transcripts of each interview were transcribed from either audiotapes or field notes. Since the interviews were conducted in Spanish, it was necessary to translate them back into English. A sample of these translated materials was back translated into Spanish to ensure consistency. During the first phase (open coding), data was broken down into discrete events and ideas, and then conceptually similar phenomena were grouped to form categories and subcategories. In the second phase (axial coding), relationships among

categories were articulated: an attempt was made to seek patterns both within and across informants. Finally, in the third phase (selective coding), the central or core phenomena were identified; one that appeared most comprehensive and revealing of the *colonia* resident's individual and collective experience.

FINDINGS

DESCRIPTION OF SITE

Multiple sites were chosen, one colonia was “San Carlos” on Highway 359. The conditions in this colonia are very shocking: the roads are unpaved; most homes are mobile and families share outhouses. The closest water source is 6 miles away and families have to travel to that location for water, which they then store in big containers. The streets are not paved and there are no house addresses. Most of the houses are unfinished with a brick exterior. Some houses are mobile homes. Typically old vehicles manly trucks are parked outside the house. The yard is unkempt with weeds growing tall. Typically the trailer home has two bedrooms and a living room. The windows are covered with screens to keep the bugs out. The floor has holes which were covered by plywood. I could see that this family had no garbage disposal facilities and they burned their garbage in front of their house.

BEHAVIORAL CONSTRAINS-SITUATIONAL EFFECTS ACCESS TO MEDICAL SERVICES

Access to medical services is varied; when a family has Medicaid they report visiting a doctor in Laredo, TX. But when the family has no insurance most often they get medical attention in Nuevo Laredo, Mexico. Further, I found that the concept of routine check ups is abstent and people use healthcare only in emergencies. The location of the research site – within easy access to Mexico has many implications for the consumption

of medical services. From our research we found that most of our adult respondents had no insurance. This is on account of two reasons – one, they do not have a legal status and therefore no access to Medicaid. Two, they hold jobs which are largely hourly. The children can use Medicaid because most of them are citizens. Thus, adults' use of medical services is largely emergency services at local hospitals or mobile clinics that visit the *Colonias.*

FINDINGS

We used a interview schedule to guide our interviews. We present our findings below:

What do you do when your child falls sick?

When they used to have medicaid I took them to the doctor. Now every time they get sick I take them (a el otro lado) across.

What happens if you have a toothache or if there is an accident?

Mi little boy had an accident already in my sister=s house which is located next to Ranchitos. He broke his arm, and we called an ambulance, but the person who was driving the ambulance did not know how to get to these ranches. Then the only thing we could do was to take him to over the highway to wait for the ambulance. A police officer waited with us, and that was the only way the ambulance was able to find us to take my son to the hospital. The persons who drive the ambulances have a hard time finding here. There has been grass burn and some houses on fire, and they do not know where the location of the accident is.

I only rinse my mouth with (listerina) Listerina, or I give my children a Tylenol. I do not have money (pa'l) to pay the dentist. I only rinse my mouth, or I try to take a medicine. If it is an emergency I call the ambulance. My children do not want me to call the ambulance. One day I called the man from the Community Center because this child (Jesus) got burn. A (chamaquito) little boy and his uncle brought him to me. I tough they were playing, you know how the children scream all the time, but after a while I told him "let me see Agustin. I call the man from the Community Center and he helped me. He told me "you were suppose to go immediately to the hospital" and I told him "is because (me tully) I got scare a lot." He told me "go and change your clothes, and I will take you immediately" but my son did not wanted to go to the hospital. He did not wanted to extend his leg, and I had to hit him, and that was the only way he obeyed me. What happened is that a firecracker got on his feet. He was very afraid. He is very afraid to the vaccines, and he did not wanted the doctor to cut his feet. I told him "If you stay

(ansina) like that, you are not going to heal ” My neighbor had tried to cure with a burn cream, but I (nomas) just called the ambulance.

What do you do when you fall sick? When your husband falls sick?

Anytime I have been sick, I run (pal otro lado) across. If the doctor gives me medication here some times I buy it in Nuevo Laredo because is cheaper, but lately the prices are almost the same. Anyways is always cheaper in Nuevo Laredo. In the case of an hospital emergency, I go over here because they give you opportunity to pay in installments. When my husband gets sick, I take him across too.

I only call the ambulance. I tell my children “if you see that something happened to me immediately call 911” Jaime (namas) sees me (tirada) laying on my bed, and he says to me “can I bring you something to eat, do you want me to clean” and I tell them that when his mother is (mala) sick they have to do something about it. Is like a lady who burned her child. I told her “take her to the hospital” but she got really scared, because we were doing some meat outside, and suddenly (agarro vuelo) the fire got some papers, because there was a lot of trash on the floor, and everything got on fire. What I did is that I had the mop (tirao) on the floor, but she instead of taking her daughter, took the (mopeador) mop, and I think it was because she was so scared, and she did not realized when her child got burn.

Do you use any home remedies? Ask for details, remedies to cure stomachaches, earaches, fever etc.

Yes, some times. I use herbs like Manzanilla when my little girls has (le duele la panza) an stomachache, or Hierbabuena (good herb) for stomachache. I use Laurel when my children have (aire) pain inside their chest. I use Vics for cough.

When I have them yes. For a headache, I use a Tylenol. You know, one uses the cinnamon and the cumin because they are very good for the children to get rid of the phlegm. A lot of people uses mount herbs like “cenizo” which is very bitter, but as soon as you take it, it help you to get rid of the cough. My children tell me that herb is very bitten. This (chamaquito) child (Agustin) is coughing and coughing all night. I go to the herb store and I bring home remedies. If I have money, I go to the doctor across, and I bring something. If not I do something (a la volada) as soon as I can. I am not like those Mexican people who say “give him this or give him that” like I told them one time “how am I going to get a nail in my mount” and they told me is not a real nail. (Clavo) Nail is the name of a herb you buy in the store for tooth pain.

What do you do with the prescription that the doctor fills out? (do nothing, take it across, and take it to a drugstore in Laredo

My husband gets prescriptions and I (surto) buy them (a el Aotro lado.@) across. There is a medicine that here it cost me $100 y in Nuevo Laredo cost me $40. The doctor

recommend me to go and buy my prescription in Nuevo Laredo because they are cheaper.
When the prescription is from here, I take it to the pharmacy.

Do you buy everything that is prescribed?

When it is for me, I usually do not buy it. I take my children to a pharmacy which is located by Market street. There is an old doctor who gives you medicine at lost cost. He prepares those medicines, and thank God, everything that he had giving us, has been working on us. He is a doctor. He has his doctor title hanging on the wall, but I think he does that because he wants to help the people. Like for example a very expensive medicine with him only cost $5.

No, when I was pregnant yes, but right now no.

If you visit a doctor do you fill out the prescription he/she writes? Where do you fill it out, in which drug store?

No because over her the stores are very expensive. I go to the herb stores, and I ask the persons in charge what is good for this, or what is good for that, and they tell me. Like when I have to ask them to take me, I say please. I do not say like the Mexican who use to say, "take me." No, you have to say, " Hey, can you do me the favor to take me" because you cannot threat them. I do not laugh at them but I correct them by telling them that here in the U.S. you talk differently, but I do understand that they talk in a Mexican style.

Or do you buy only half the amount? Why money problem?

Yes sometimes I do not have enough money from my paycheck to buy the medicines for my husband. He goes to the public clinic, and to me the visit is very expensive. It cost $22 and the medicine costs $10, but the doctor sometimes gives him a Acoupon@ in order for him to get his medicine for free.

CONCLUSIONS AND PUBLIC POLICY IMPLICATIONS

As a result of the population growth along the border and because of the socio-economic conditions, over half a million people live in substandard residential subdivisions known as *colonias. Colonia* residents typically work on the farm, in construction or in the service industry. In Texas, 74% of the entire migrant and seasonal farm-workers live on the border (University of Texas System, 1994). Most of the

residents are uninsured and do not have access to adequate health care. In this research we attempted to explore the role of public health services in the lives of *colonia* residents. We found that for our respondents the concept of preventive medical attention in the form of regular check-ups and dental care is not known. Our respondents use doctors and hospitals, mainly emergency rooms mainly for emergencies. We also found that our respondents' consumer services on both sides of the border. Mexico was attractive mainly because of economic advantages and cultural comfort. One major concern highlighted by our study was the practice of not buying medicines prescribed by doctors or buying only what they could afford. Not taking medicines or not completing a prescription could lead to drug interaction problems, patient risk factors, not treating the disease effectively and lack of follow-up of patients.

Access to health care is an important issue along the border. Health care is beyond the reach of many border residents because of low rates of health insurance coverage, combined with low incomes. Many United States residents cross the border into Mexico in search of health care, in order to take advantage of lower costs, or to consult with Spanish-speaking care providers. (Healthy Border 2010: An Agenda for improving Health on the United States-Mexico Border)

According to the United States-Mexico Border Health Commission in many border communities' primary care providers are lacking. Counties or areas within counties are designated as Health Professions Shortage Areas (HPSA) for primary care when the ratio of population to primary care physicians rises above a the level of 3000 inhabitants per physician. In 2000, about one third of the U.S. border population resided in such shortage areas. The shortage of primary care providers was particularly acute in

the Texas border region, where more than 70 percent of border residents resided in shortage areas.

Another factor affecting access to health care is lack of health insurance. Even in areas with sufficient numbers of physicians, persons lacking health insurance are less likely to obtain preventive care or to have routine physical examinations. In the border region of Texas, an estimated 30 percent of the population does not have health insurance. Our research has implications for public policy and we discuss a few of them.

Public policy officials need to understand what makes this region unique. In recognition of the strong and ubiquitous influence of the Hispanic culture, culturally sensitive models of care need to be developed to serve this population. Knowledge of this population their practices and preferences will provide important inputs for developing these models. It is evident that communication in Spanish is necessary for certain Hispanics because of their inability to speak or understand English. It is widely acknowledged that behavioral patterns characteristic of a particular culture express the shared values and beliefs of that culture, thus understanding the culture of Hispanics especially as it relates to health and healing is particularly important (Wallendorf and Reilly 1983). The importance is magnified when considers the class and cultural disparities between physicians and patients. It is not enough to translate the content of a Hispanic patient' s speech; one has to explain the cultural expectations as well. Without such knowledge, physicians can remain ignorant of what motivates a patient's responses. Difficulties in confidentiality can arise when interpreters and patients are part of the same small ethnic community. Working with nonprofessional interpreters or family members is fraught with hazard.

They may modify the questions we physicians ask out of their concern for privacy, or they may change the answers our patients provide for a variety of well-meaning reasons.

Colonia residents need training and education especially in water management and use. Residents lack access to running water and adequate sewage facilities. These conditions contribute to high incidents of communicable and water borne diseases. Long-term solutions will require the investment of billions of dollars in infrastructure and radical changes in the way water is used regionally. However lessons from developing countries can be applied to address these problems. We refer to the *Promotoras*. The *promotora* model originated in developing countries and was used heavily in the 1960s and 1970s as a community-based approach to primary health care services, in which local residents are trained to provide preventative and simple curative care.

Cultural beliefs about the causes and cures for illnesses play an important role in health management of people in this region. We found that all our respondents had integrated home remedies into the way they managed their and their families' health. Any health care system designed for this group will have to acknowledge and value the role of folk beliefs and home remedies and integrate it with the western scientific model of treatment.

Public health along the U.S.-Mexico border requires increased and nuanced attention, both because of the magnitude of health related problems and also because of the uniqueness of this region. Culture, socio-economic status, low levels of human capital, and cross-border access to medical services complicate the understanding, delivery, and management of health services. This narrative has provided a context and some details in understanding how culture and social class impacts access to health care.

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Table 1
Profile of Respondents

Name	Age	Education	Number of Children	Language	Governmental Help	Occupation of husband
Susy	42	9th grade	2	Spanish	No	Migrant worker
Claudia	29	4th grade	7	Spanish	Medicaid, medicare, and TANF	
Noemi	28	Junior college	2	Spanish and English	No	Construction worker
Josepha	41	7th grade	5	Illiterate	Foodstamps, Medicaid, TANF	Migrant worker
Rosario	29	4th grade	4	Spanish	Foodstamps, Medicaid, TANF	Husband in jail
Norma	42	6th grade	2	Spanish	Disability	retired
Rosy	30	6th grade	5	Spanish and English	Foodstamps, Medicaid, Disability, TANF	Taco stand
Lupita	58	2nd grade	6	Spanish	No	Construction worker
Hilda	32	5th grade	2	Spanish and English	No	Construction worker
Sussana	41	7th grade	7	Illiterate	Foodstamps, Medicaid, TANF	Migrant worker