MODERN VERSUS TRADITIONAL AND COMPLEMENTARY HEALTH SERVICE PROVIDERS FOR

LATINO IMMIGRANTS IN GEORGIA:
A COMPARATIVE SURVEY ON BOTANICAS

by

COURTNEY J. PARKER

(Under the Direction of Jessica Muilenburg)

ABSTRACT

This study explores the differences between modern versus traditional and complementary healthcare service providers currently serving the Latino immigrant population of Georgia. By interviewing a sample of 5 botánica proprietors and 9 mainstream health workers, who regularly serve Latino immigrants in Georgia – and 1 non-Latino indigenous healer working as a health service provider in Georgia – the following data points were distilled: 1) what the roles and functions of botánicas are in regards to Latino immigrant health and culture in Georgia; 2) what potential might exist for collaboration between the botánica networks and mainstream health service providers and researchers in alignment with goals outlined by the World Health Organization Traditional Medicine Strategy; and, 3) what salient health issues are impacting the Latino immigrant community of Georgia.

INDEX WORDS: Latino immigrant health, Botánicas, Traditional medicine

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Chapter 1

INTRODUCTION

As disparities in access to healthcare deepen globally, the World Health Organization (WHO) has adopted a novel strategy towards integrating more traditional and community-based healthcare options aimed at resolving gaps in access to care (Organization, 2015). The WHO Traditional Medicine Strategy 2014 – 2023 report acknowledges traditional indigenous medicine (TM or TIM) as a "mainstay of health and health care delivery". The organization also confirms therein that TM/TIM "of proven quality, safety, and efficacy, contributes to the goal of ensuring that all people have access to care". WHO's TM strategy has two overarching goals; firstly, enabling member states to channel the potential of TM/TIM (sometimes referred to as complementary medicine, CM or CAM) into "people-centered" universal health systems and coverage. The second, involves promoting safe and evidence-based use of TM/TIM via research partnerships and accordant development of national policies guaranteeing safety and quality.

World Health Organization (WHO) Traditional Medicine Strategy 2014 – 2023

The first global WHO Traditional Medicine Strategy was published in 2002, and included among its itemized priorities: "Research into the TM/CAM genre itself, including social research

into motivation of patients seeking TM/CAM and usage patterns of TM/CAM" (p.24).

Other key points documented in the first publication, officially referred to as 'WHO Traditional Medicine Strategy 2002-2005'(Organization, 2002), included: a definition of traditional medicine; information about the widespread and growing use; information about why it was used so broadly; an analysis of "uncritical versus uninformed skepticism"; challenges in developing traditional medicine's and complementary alternative medicine's potential; the current role of the World Health Organization therein; a framework for action; and, a path for strategy implementation.

Given they did come up with a working, if not official, definition of traditional medicine for the purposes of this original and subsequent initiatives, it is notable to include it here without paraphrasing:

> "Traditional medicine is a comprehensive term used to refer both to TM systems such as traditional Chinese medicine, Indian ayurveda and Arabic unani medicine, and to various forms of indigenous medicine [TIM]. TM therapies include medication therapies — if they involve use of herbal medicines, animal parts and/or minerals — and non-medication therapies — if they are carried out primarily without the use of medication, as in the case of acupuncture, manual therapies and spiritual therapies. In countries where the dominant health care system is based on allopathic medicine, or where TM has not been incorporated into the national health care system, TM is often termed "complementary", "alternative" or "non-conventional" medicine" (p.1).

Regarding what the original WHO communique documented regarding TM's "widespread and growing use", they included an overall notation of its "economic importance".

Noting that in Asia and Latin America, the ongoing use of TM/TIM is often generated from regional cultural paradigms as well as broader sociohistorical contexts, the briefing also points out that in China TM/TIM methods still account for about 40% of all health care delivery. Noting its increasing rather than decreasing popularity, even as contextualized amid modern healthcare advances and broadening access, the authors point out that TM/TIM methods are becoming more and more popular even in many so-called developed countries. Statistics cited at the time of publication indicated that at least 48% of Australians, 70% of Canadians, 42% of Americans, 38% of Belgians, and 75% of the people living in France had accessed complementary alternative medicine at least once. In Malaysia, it is estimated that around half a billion U.S. dollars are allocated annually for TM/TIM and CAM health care (compared to about three hundred million in the U.S.) (p. 11).

In the so-called developing world, extensive use of TM/TIM and CAM health services is often attributed to factors such as accessibility and affordability. The percentage of the populations accessing these services is often higher in more rural areas, as many of the more modern health services and providers remain concentrated in urban areas. High costs of pharmaceuticals – such as antimalarial medications in Ghana, Kenya, and Mali – cause many to turn to TM/TIM since herbal medicines prescribed for the treatment of malaria are much cheaper; and, TM/TIM practitioners are also more likely to bargain, adopt sliding scale fees for payments, or even accept in kind services for barter. And of course, in many developing regions TM/TIM provides culturally appropriate options which are coherent with individual and regional belief systems and values (p. 2).

In developed countries, where it is framed more as an alternative (CAM) – rather than a traditional (TM/TIM) approach – the expanded use of these methods is fueled by larger

concerns about matters such as: the unknown long term and short term adverse effects of modern pharmaceuticals; broad concerns regarding the general approaches and assumptions of allopathic, or modern, medicine; and even issues concerning a lack of public access to health information. While advances in mainstream healthcare have generated longer life expectancies, longer lifespans have also meant extended periods of chronic illnesses such as diabetes, heart disease, cancer, and mental illness. Given the increased periods of time the impacts of such chronic diseases must be navigated, many are apparently turning to CAM methods which they perceive as offering a gentler means of managing their associated symptoms for the long term (p.2).

The WHO Traditional Medicine Strategy 2014-2023 switched gears a bit from defining and outlining the issues and reasons for study – as achieved in the first – and moved towards evaluating the progress being made. Still, they took the time to re-state some of the key points, while updating the guidelines for action (Organization, 2014).

The 2014 WHO publication compiled a list of ongoing challenges to developing TM/CAM potential; these are listed as: policy; safety; efficacy and quality; access; and rational use (p. 12). Between 1999 and 2012, the number of member states that have achieved national level policy on TM has risen from 25 to 69 (p.21). WHO has concluded such policies can provide a sound basis for defining and integrating the role of TM/TIM methods in the context of national healthcare systems, while properly ensuring necessary regulatory and legal mechanisms are intact to promote and maintain: good practice; equal access; safety, efficacy, and, authenticity of therapies offered. Such official recognition and regulation can also attract more sufficient resources for necessary and ongoing research, education and training modalities (p. 11-12). Policies as they exist in some countries have promoted issues around safety and quality of CAM

services such as standards, training and licensure of practitioners. The WHO believes the need for regulation and official policy is greatest in countries where much of the population remains dependent on TM/TIM, yet it has not been duly and officially integrated into the national health care system. At the international level, increased policies enacted at the national levels would also contribute to developing global standards and norms for research on the safety and efficacy of: TM/TIM and CAM; the sustainable use of herbal and medicinal plants; as well as the protection of knowledge and equitable access to indigenous and traditional medicines (p. 18-19).

Although access and affordability are two obvious determinants regarding why many individuals in developing nations seek TM services and products, there is a lack of quantitative data regarding levels of access, and qualitative data relative to individual and collective constraints. The WHO has specifically called for more qualitative research on patterns of use (p.39) and "fostering communications and partnerships between stakeholders" (p.45).

Local Case for Integrating TM

In the course of conducting exploratory research for this study, I gathered information from a variety of stakeholders, including: academic experts (found mostly by sourcing comments made in news articles); Latino immigrants who access botánicas in Georgia; and, botánica proprietors themselves. It was saliently revealed that TM/TIM approaches are often more preventative and lifestyle-oriented (i.e. patients may be advised to change personal behaviors and habits rather than just start taking a pill.) TM/TIM providers also reportedly serve as access points for individuals experiencing barriers to mainstream healthcare – such barriers may be cultural, socioeconomic, geographic, or educational. Ideally, these innately more culturally-oriented health networks could also serve as bridges to allopathic care. If the two sectors (mainstream and TM/TIM, also referred to accordingly as allopathic and non-allopathic) can

establish a strategic modus operandi foundational for integrative care and collaboration, TM/TIM practitioners could also serve to screen patients (and issue referrals) for more serious health problems.

The ongoing heated political climate around immigration has intensified with the election of the new president of the United States, Donald Trump, which in turn has increased the importance of exploring community-based health services as alternatives for reaching underserved and marginalized populations – especially regarding even more vulnerable sub-populations of the Latino immigrant community such as indigenous language speakers. Since individual health is not determined in a strictly biological manner, but is rather a combined product of sociocultural factors – including: language barriers; SES; ethnicity; gender; employment status; working conditions; and, education (Morales, Lara, Kington, Valdez, & Escarce, 2002) – such community-based and culturally tailored efforts could be vital to bridging gaps in healthcare access.

What is a Botánica?

According to – as abstracted from an interview I conducted during the exploratory research for this study – Dr. Hayes-Bautista of the UCLA Medical School, TM-oriented services in the form of botánicas have re-emerged in immigrant communities as alternatives to mainstream care. Per Hayes-Bautista, the botánica is a community health service and product provider rooted in Mesoamerican and other Pre-Columbian indigenous cultures and traditions; and, they generally offer an array of health products and services aimed at treating the 'whole person' – targeting physical, psychological, emotional, as well as spiritual health.

Further exploratory research I conducted revealed in sum that while U.S. culture seems to be appropriating and assimilating more and more TM/TIM from various cultural traditions, the botánica delivers on them in a context of cultural continuity for many indigenous and mestizo immigrants in Georgia, in a manner which perpetuates and respects what has been described by Hayes-Bautista as: the indigenous Latino American commitment to holistic health.

The political climate surrounding immigrant health is extremely constrained right now in Georgia and the Southeast – and in the United States at large – to the point where several state and local health officials expressed how they were not allowed to speak on record about immigrant or migrant health at all. Innovations are often born out of necessity, and one way that Georgia's indigenous and mestizo immigrant communities are apparently taking matters into their own hands, is through the continued momentum and transnational emergence of traditional Latin American botánica culture.

Driving through an immigrant neighborhood in Georgia, one might see, as I did, several botánicas open for business on the same street. A closer look revealed: one which specialized more in herbs and nutrition; another geared more toward spiritual services and advisement; and, yet another that stocked cultural paraphernalia such as ceremonial candles, incenses, and other items which might be considered 'novelties' to the general passerby but are in fact often rooted in traditions of antiquity. I also visited a large market which caters to Latino immigrant communities; and, likewise, found it to host several different botánicas – and again, each seemed to have carved out a unique niche of products provided, or services offered. In this particular market in Georgia, there was a botánica which sold a huge array of healing stones and crystals, peppered with specialty soaps, talismans, and various other artifacts; and in the same market, another which delivered bilingual tarot readings, Reiki healing sessions, and a slightly different

selection of products; and, still another, which was looked after by children who would dart off through the maze of booths and customers to find an adult proprietor if they encountered someone interested in purchasing a specialized spiritual counseling session or items from their wide selection of natural health and culturally oriented products.

During the aforementioned telephone interview, Hayes-Bautista elaborated about how the practice of fusing traditions – such as Catholicism, Santeria, and indigenous lore, to name a few – that comprises the modern botánica culture did not (and will not) end at some specified nor general era or point in time. Reflecting an increasingly globalized world, I found it common to see traditions – such as Japanese Reiki or Jewish Kabballah – emerging in today's botánicas in Georgia, as well as re-appropriations of 'new age' ideas that were probably borrowed from indigenous traditions to begin with. Botánica culture seems to hold no value in ideological or ethnic purity; yet, to the untrained eye their customers may appear to be a seemingly homogenous group. If a 'gringo' (white, North American) enters the premises, there are myriad ways surprise and even distrust are expressed, especially initially. While the customer base may seem somewhat homogenous from an outsider's perspective, I personally noted here in Georgia that they represent a plethora of nationalities and cultural traditions, all with their own unique ties to the services and products represented in their botánica of choice.

Academic studies published on botánicas consistently call for more research on the botánica's role in modern health systems. In 2001, Gomez-Beloz and Chavez (Gomez-Beloz & Chavez, 2001) discussed their findings from interviewing a sample of twenty-six customers at an immigrant community botánica. The pair concluded that Latino immigrants accessed the services of conventional healthcare providers in an interchangeable manner with botánica providers; and, that the botánica is an important healthcare resource for the U.S. Latino population. Gomez-

Beloz and Chavez issued a specific call for further exploration of the overall role botánicas play in health care delivery. In Viladrich's 2006 study on botánicas and herb-healing practices in New York City, she confirmed the botánica as a primary health service of choice for Latino immigrants. She also observed a markedly reciprocal relationship between botánica providers and their patients, which contrasts with the more hierarchical provider-patient dynamic which often characterizes relationships experienced with allopathic primary care physicians (Viladrich, 2006). In their 2013 study on botánicas in Tampa, Florida, Reeser and Cintron-Moscoso documented how botánicas are found in nearly every U.S. city boasting a significant Latino population, and further confirmed that immigrants access botánicas in tandem with more modern biomedical care (Cintrón-Moscoso, 2012). Latino immigrants I surveyed during exploratory research in Georgia confirmed this dual approach of seeking services from both allopathic (western) and non-allopathic (entities such as botánicas) providers. This behavior seemed to remain consistent regardless of insurance coverage or immigration status.

Despite the relative obscurity of such approaches in mainstream public health circles, neither the mounting calls for research and collaboration, nor the Traditional Medicine Strategy of the WHO, are total outliers in their advocacy for integrating traditional community paradigms of health. After reaching a point of relative saturation in conducting initial exploratory research, I concluded that taking a deeper look at botánicas was aligned with many salient goals of the established field of health promotion as well as some of the specific goals of the WHO Traditional Medicine Strategy, such as promoting research partnerships which could ultimately promote safe and evidence-based use of TM/TIM and resolve access to care disparities in marginalized populations such as Latino immigrants in Georgia.

Immigrant Populations in Georgia and the Southeast

My own experience interacting with Latino immigrants and migrant workers who have ended up living and working in the state of Georgia – with varied levels of permanency – has determined that many arrive here because they are fleeing adverse economic conditions or violence in their country of origin. When considering their previous life experience(s) in their country of origin, which gave them cause to face off with the dangerous journey of illegal immigration, or the bureaucratically arduous process of legal immigration, it became clear most had high motivation to escape some manner of overwhelming or harsh conditions. In the rare instances they make it through either the more formal or informal routes to arrive in the U.S., and then end up in Georgia and perhaps even find some sort of work, they face a new set of challenges and threats to their well-being which must be navigated while simultaneously attempting to adapt to a wholly new culture and (often) learn a new language.

Salient Health Issues in Latino Immigrant Populations

The Center For Disease Control (CDC) (Statistics, 2011) cites the leading causes of death among the U.S. Hispanic and Latino population, overall, to be: cancer; heart disease; and, accidents (unintentional injuries). Infant mortality is cited as 5 per 1,000 live births (Mathews & MacDorman, 2013). According to the CDC, based on the National Health Interview Survey Data in 2014, around 12% of the Latino immigrant population experiences ‘fair or poor’ health at any given point in time. This estimate is slightly higher for Mexicans and Mexican Americans. There is also a slight increase in the incidence rate of fair or poor health for Latino women; and, the percentages tend to positively correlate with increasing age. Hispanic and Latino individuals exhibit the highest percentage of uninsured status of all ethnic groups in the U.S. other than Native Americans. The percentage of uninsured Hispanics and Latinos was 26.5; Mexicans, as a

subethnic category came in at 28.7; while Native Americans, came in at 29.6. For comparison, the percentage of uninsured whites was only 13.5 percent; African Americans, 14 percent; and Asians only 10.4 percent. There are more African Americans and Native Americans on Medicaid than Latinos or Hispanics; it is unclear from this data whether immigration status is a factor. Yet, there are more Hispanics and Latinos holding private insurance than Native Americans, yet less than African Americans. Latino immigrant women are disproportionately affected by obesity, high cholesterol, heart disease, diabetes, stroke, HIV/AIDS, cancer (especially lung, cervical and breast) and mental health issues such as depression. Data collected in 2004 projected that around half of Mexican American women are overweight and experience related heightened risks for diabetes and high cholesterol (Marshall, Urrutia-Rojas, Mas, & Coggin, 2005).

Latino immigrants in general have a high prevalence of diabetes and experience a disproportionate share of complications from diabetes – suggesting that there are both diet and access to care issues at the heart of these disparities. The authors of a study on what role acculturation – which is inherently a disruption in cultural continuity – plays in this particular health outcome concluded that higher levels of acculturation among diabetic Latinos in the U.S. is associated with the adoption of unhealthy dietary habits (such as eating more processed foods) post-immigration (Mainous, Diaz, & Geesey, 2008).

Noting nearly one in every four children in the U.S. belongs to immigrant families, as of 2011, Ornelas and Perreira lamented that few studies have assessed how pre-migration factors generate ongoing impacts on Latino health in their publication, ‘The Role of Migration in the Development of Depressive Symptoms among Latino Immigrant Parents in the USA’(Ornelas & Perreira, 2011). Utilizing data sets from the Latino Adolescent Migration, Health and Adaptation Project, the research team analyzed the extent various pre-migration factors – such as the high

relative poverty and intensely stressful life experiences which might have led individuals and families to emigrate from their countries of origin – compound with post-migration issues and social support factors in generating symptoms of depression in a sample of Latino immigrant parents whose children were between 12-18 years of age. Their results highlighted how experiences of extreme poverty prior to immigrating to the U.S. combine with stressors produced by and during the migration experience itself, as well with issues of racial discrimination upon arrival, to produce the development of depressive symptoms in Latino immigrant parents. They also isolated certain protective factors which mitigated the likelihood that the parents would develop depressive symptoms; these included: family reunification, familyism, and social support. Ultimately, understanding health and well-being factors which were antecedents to immigration, help to better understand the compounded issues faced by immigrants as they attempt to assimilate into a new culture.

Protective factors in Latino immigrant health in the U.S. (and individual health in general) include social ties and social support. Viruell-Feuntes and Shulz examined the widely-embraced notion that high levels of social ties and social support may be responsible for generating 'better-than-expected' health outcomes among Mexican immigrants compared with the general U.S. population in their 2009 publication, 'Toward a Dynamic Conceptualization of Social Ties and Context: Implication for Understanding Immigrant and Latino Health' (Viruell-Fuentes & Schulz, 2009). Their literature review examined the relationship between social ties and health using immigration-based variables relative to this particular group and found that this hypothesis came up short in explaining the health outcomes it was supposed to. As a follow-up to their review, the duo conducted a qualitative analysis of social relationships and social context among first generation and second generation Mexican women immigrants in the U.S. Their

results displayed an interplay between the various processes of immigration and social ties, and ended up highlighting the greater importance of maintaining transnational social ties (ties to individuals and family in their country of origin) and related identity support. Their overall findings suggest there are important ways that researchers and practitioners must re-conceptualize the ongoing relationship between social contexts, social ties, and Latino immigrant health. They concluded that immigrant social ties are just as vulnerable as they are critical and cannot be relied upon to sufficiently generate positive health outcomes. After immigrating to the United States, many of the women experienced disappointment and feelings of pressure within their families and communities in the U.S.; and, being embedded in this new community – even among family – did not always translate into a source of support. Crowded living conditions and unstable or otherwise unhealthy working environments tend to bring on a whole new set of health challenges and potentially negative health outcomes. Maintaining transnational social ties, however, was found to play an unexpectedly important role in emotional well-being; as maintaining connections, and even more specifically, being able to provide support to family and friends in Mexico was important in generating a sense of self-efficacy and pride in both first and second generation female immigrants. Identity support was likewise important for both the first and second generation groups; and, access to identity support in terms of resources that assisted the women in developing a positive ethnic identity helped to offset some of the experiences of racialized tension and discrimination in their overall experience as immigrants in the United States (Viruell-Fuentes & Schulz, 2009).

Myriad health issues and disparities affecting Latino immigrant populations are rooted in ongoing challenges of navigating the transition to life in a foreign culture – including: behavioral shifts regarding nutrition and exercise; ongoing and compounded mental health challenges

related to prior trauma and new stressors involved in resettling; and, cultural barriers to preventative, and continuity of, healthcare such as language, or related issues such as insurance or immigration status.

Problem Statement and Research Questions

To understand the broader health issues faced by the indigenous and mestizo Latino populations of Georgia and the Southeast, it is crucial to understand if and how they are accessing appropriate health services. It is also important to understand what factors may influence their behavior in terms of compliance with general recommendations, or adhering to prescriptions offered by mainstream health services. Considering this, it is also vital to understand: the botánica's role as a potential alternative to mainstream health services; whether it ever functions as an antecedent to accessing mainstream health services; and, how it functions when accessed in tandem with mainstream health services. Is there an overall synergy which arises; or, are the two health service cultures constantly working at cross purposes? If there is a huge disconnect, is this something which can be addressed in a way that generates a greater coherency and consistency in care for individuals and populations who are accessing both modes of health services? Beyond these questions of 'if' and 'how', it is also important to understand 'why'. What are the salient issues that cause immigrant Latinos in Georgia to access botánicas? Does it stem from a basic mistrust of the mainstream culture in Georgia and the Southeast in general? Is it an attempt to maintain a crucial sense of cultural continuity and cultural identity in their overall experience of attempting to assimilate to a new country? Are immigration status and insurance coverage significant factors; and if so, to what degree?

The main research questions proposed for this study are:

1) What roles or functions does the botánica play in immigrant Latino health and culture in the Georgia?

2) Is there a potential for a collaborative relationship to emerge between botánica proprietors and public health researchers and medical practitioners in Georgia?

3) What salient health issues affect the Latino immigrant community of the southeastern United States?

CHAPTER 2

LITERATURE REVIEW and CONCLUSIONS

To better understand Latino immigrants' patterns of accessing TM/TIM outlets – in this case, botánicas – it is important to review existing literature documenting health disparities and salient health issues affecting this population of individuals.

Latino Immigrant Health Disparities Overview

Notable findings from the National Health Interview Survey, 2010-2015 (Control & Prevention, 2015) documented that: Puerto Rican adults were more likely than Central or South American adults to report serious psychological distress within the previous month; more likely to suffer multiple chronic morbidities; and, also more likely than Mexicans to suffer a poor health status in general. Percentages of adults reporting poor health status, when broken down into sub-ethnicities showed Puerto Ricans at 19.2%; Mexicans at 17.4%; Central or South Americans at 12.3%; and Cubans at 14.7%. The percentages of adults reporting multiple chronic conditions came in at 20.8% for Hispanics (compared with 24.6 for non-Hispanics); 16.6% for Central or South Americans; 18.6% for Cubans; 20.8% for Mexicans; and, 27.3 % for Puerto Ricans. Possible reasons for the variances in trends here are discussed at the conclusion of this section. Regarding adults who had ever experienced serious psychological distress, the Hispanic population came in at 4.1% while the non-Hispanic population reported at only 3.2%. Regarding subethnicities who experienced serious psychological stress, Central and South Americans

reported at 3.3 %; Cubans at 3.7%; Mexicans at 3.9%; and Puerto Ricans at 6.2% (Lucas, Freeman, & Adams, 2016).

Health conditions which were prohibitive of maintaining gainful employment had somewhat similar distributions among Latino and Hispanic subethnicities, but non-Hispanics reported a much higher incidence rate here – and again, this will be discussed more in the conclusion of this section. The non-Hispanic population presented morbidity-based barriers to work at 6.8%; Hispanics in general at 5.2%; Central or South Americans at 2.9%; Cubans at 3.9%; Mexicans at 4.8%; and Puerto Ricans topping the list again at 11.4%. Percentages of each group who experienced health problems that impacted their social ties and participation were similar, comparatively. Non-Hispanics reported this experience at 3.9%; Hispanics overall at 4.4%; Central and South Americans at 3.1%; Cubans also at 3.1%; Mexicans at 4.7%; and Puerto Ricans at 6.3% (Lucas et al., 2016).

Overall, NCHS data confirms that despite trends and variances within subethnicities, the Latino and Hispanic populations in the U.S. experience higher incidence rates of poor health status, which correlates with higher reported incidence rates of health status-generated restrictions on social participation and serious psychological distress. Interestingly, fewer individuals in this population cite negative health outcomes as causing them to be unable to work; and, fewer individuals report suffering multiple chronic conditions. Since immigration status is not controlled for in the data or report, it stands to reason this might be a confounding variable affecting these outcomes.

An undocumented immigration status could conceivably restrict certain forms of social participation for immigrants; and concurrently manifest serious psychological distress contributing to myriad and ongoing mental health issues. Individuals reporting fewer chronic

conditions could be unaware of certain would-be diagnoses due to barriers in accessing ongoing or preventative care (a consequence exacerbated by being uninsured or undocumented). Additionally, not citing health status as preventing one's ability to work might also be confounded by barriers to unemployment stipends and other disability-oriented social services providing compensatory sources of income. Traditionally, migrant workers – such as in the Bracero guest worker program – have reported not being allowed to take time off nor receive medical care when they were ill (Mobed, Gold, & Schenker, 1992).

Results published in the available literature tend to vary regarding whether overall health outcomes are generally more positive for Latino immigrants when compared with various other ethnic and racial groups living in the United States. Per some measures of population health, such as infant and adult mortality, Latinos paradoxically fare well (Abraido-Lanza, Dohrenwend, Ng-Mak, & Turner, 1999). Yet health outcomes can vary significantly within the pan-Latino population according to factors such as: country of origin or 'sub-ethnicity'; socioeconomic status (SES); gender; education level; age; language and cultural fluency (González Burchard et al., 2005); and, perhaps most importantly, immigration status .

Given the overall variance in trends of post-immigration health outcomes, it might not be wholly surprising that quality of health outcomes can decrease for Latino immigrants in some respects once they resettle in the United States. Many of the negative health outcomes experienced by Latino immigrants at this juncture are associated with certain negative impacts of 'acculturation', and rooted in an overall shift of diet and lifestyle, but also include disruptions to identity, social support, and cultural continuity (Lara, Gamboa, Kahramanian, Morales, & Hayes Bautista, 2005). The concept of acculturation is an intersecting, complex web of influences; it

tends to be associated with an increase in certain negative health outcomes, negative behavioral changes, and a negative shift in perceptions which influences various health-related behaviors. There is clear evidence that certain hotpots of risk to Latino immigrant health – such as diet, and, alcohol and drug abuse – are especially prone to drive the more negative health impacts and outcomes of acculturation (Lara et al., 2005). Yet, perceptions of one's own health in immigrant Latino individuals seem to increase even in the face of some of these increased challenges and subsequent decreases in actual health status; and, according to one analysis, health care access – as measured by use – actually increases as well (Lara et al., 2005). The authors, Gamboa, Kahramanian, Morales, and Bautista, recommeneded a greater breadth of, and increased vigor in, future attempts to study the public health impacts of acculturation – particularly in community-based settings – explaining that the overall compounded health impacts were still largely misunderstood. Understanding the botánica's role in potentially mitigating certain acculturation factors – by offering a venue for cultural continuity in health services and health information – could help to broaden and inform this perspective.

In 2003, Gordon-Larsen, Harris, Ward and Popkin published a study entitled 'Acculturation and overweight-related behaviors among Hispanic immigrants to the US: the National Longitudinal Study of Adolescent Health' (Gordon-Larsen, Harris, Ward, & Popkin, 2003). Responding to a relatively mysterious yet significant disparity in overweight Latinos between first and second-generation U.S. immigrants, the study employed data from the National Longitudinal Study of Adolescent Health to address two clearly stated issues. Firstly, they isolated which specific indicator of acculturation – which they defined as "the acquisition of dominant cultural norms by members of a non-dominant group" – was most significant in predicting related negative health outcomes such as obesity. Secondly, they attempted to isolate

how the various processes of acculturation in turn impacted disparities in healthy weight management – and the proximate determinants such as diet, physical activity and smoking – in Latino immigrants as they became more and more assimilated into mainstream U.S. culture. Additionally, the research team attempted to define how various structural factors – such as household income and neighborhood levels of crime – intersected with specific and more general acculturation factors, such as different languages being spoken at home or amongst one's larger community, to produce disparities in successful healthy weight management. Their results were very clear. These intersecting structural and acculturation factors produced different outcomes in first generation and second generation Latino immigrants in the U.S. While first generation immigrants tended to maintain a more insular experience, embedded in a larger immigrant community even as they displayed similarly lower SES and education levels, second generation Latino immigrants tended to acculturate at an accelerated rate into behaviors which manifested in the weight outcome disparity (i.e. poor diet, sedentary lifestyle, etc.). Specifically, among certain sub-ethnic populations – in the case of this study, Cubans and Puerto Ricans – the tendency to experience health outcomes of obesity increased more, the longer amount of time the individuals spent living in the United States. These patterns were determined utilizing multi-variate analysis.

The authors cited that since these trends towards negative health outcomes in terms of weight can increase overall risk for lifestyle diseases such as diabetes even in youth, that reinforcing native or ethnic values and norms can play a significant role in mitigating the negative health impacts of the acculturation process. This is especially important since adolescent obesity has long term impacts that carry into adulthood; and, it is a major antecedent of adult obesity and the compounding negative health outcomes which can result.

Determinants and Predictors of Health Issues in Latino Immigrant Populations

Salient determinants and predictors of Latino health have been categorized by *Healthy People 2010* in terms of leading health indicators (LHI's). Other research has revealed a lack of access to proper mental healthcare, and exposure to SES related stress such as community violence, as causal to negative health outcomes. Perceptions of SES factors such as social mobility, post-immigration to the United States, may also play a role. Often relatively invisible to the gaze of mainstream health services, other health outcomes may be rooted in a marginalized existence. Lack of health insurance, language and cultural barriers, unemployment rates and workplace environmental factors compound with other SES variables to perpetuate some of the health disparities experienced by Latino immigrants. Fears related to undocumented immigration status may also be a significant barrier to accessing healthcare and maintaining or achieving optimal health outcomes.

Healthy People 2010 provided a framework outlining public health objectives for the current decade and included leading health indicators (LHI's) selected for: their propensity to influence crucial public health outcomes; and, their active role in generating behavioral change and action. According to an increasing pool of data available to measure indicators of progress (People, 2010), Namratha, Kandula, Kersey, and Lurie discussed the health issues of immigrants living in the U.S. in terms of the *Healthy People 2010* LHI's, in an attempt to anticipate what specific health needs will emerge within this population in coming years in their publication entitled, 'Assuring the Health of Immigrants: What the Leading Health Indicators Tell Us' (Kandula, Kersey, & Lurie, 2004). According to Namratha, Kandula, Kersey, and Lurie, the LHI's of the Latino immigrant population in the United States are: physical activity; weight and

obesity; tobacco use; substance abuse; responsible sexual behavior; mental health; injury and violence prevention; environmental quality; access to care; and, immunization (the latter is inarguably connected to the overall health of the U.S. population, and state and local health statuses and outcomes as well).

In the past two decades, national attention to racial and ethnic health disparities has increased, leading the U.S. Surgeon General to raise concerns about the barriers towards accessing mental health services experienced by ethnic minorities, especially regarding immigrant children. Latino children have been identified as an at-risk population of individuals in terms of barriers to accessing specialized mental health services. Latinos are less likely than other ethnic groups to experience proper access to care due to: disparities in insurance coverage; cultural and familial attitudes towards seeking out services; and, even just a general unrecognized need for such services. At the time Kataoka, Stein, Jaycox, Wong and collaborators pilot-tested a school-based mental health intervention for Latino immigrant youth – who were identified as having been exposed to some form of community violence in 2000 – little effort had been made regarding the development and evaluation of evidence-based mental health interventions for this highly vulnerable population (Kataoka et al., 2003). Their decision to operate in the context of a school helped to surmount fiscal and structural barriers to mental health services otherwise commonly experienced by Latino immigrant youth. Almost all children in their program were found to exhibit clinical levels of post-traumatic stress syndrome (PTSD); the ongoing impacts of which follow them long into adulthood and become systemic, community level factors producing compounded and cyclical negative health outcomes for the community at large. A full two thirds of the children had been exposed to ‘life-threatening violence’ in their communities; and, it is likely the adults or older youth who exhibited this violent behavior were

also carrying out calcified patterns of trauma and stress experienced during their own youth. Mental health is a community level crisis in Latino American immigrant communities; and, given the barriers to mainstream care options, alternative routes to providing services – such as in schools, and perhaps botánicas – are important.

The role in which botánicas are thought to play in reducing the gaps in access to mental health services has received, and should continue to receive, due attention because of the innately culturally tailored approach and general accessibility for Latino immigrant individuals they provide – regardless of insurance coverage or immigration status – and perhaps also importantly, because patterns of stress and violence are, in some instances, exacerbated upon arrival to the U.S. in extremely marginalized groups (notably, the violent gang culture of central America has been traced to El Salvadoran gangs which emerged from U.S. prisons in southern California).

Alcantara, Chen and Alegria described the health declines experienced by many Latino immigrants upon arrival in the United States, and related mental health difficulties, as being rooted in a loss of socioeconomic status (SES) – or an experience of downward social mobility – following their re-location (Alcántara, Chen, & Alegría, 2014). The authors note, however, that even though there is a significant amount of research which has concluded that a desire to advance SES status is one of the prime motivating factors inspiring Latinos to emigrate from their country of origin, there is a lack of research regarding their perceptions of this intended advancement and accompanying health implications once they arrive. The authors looked at variations of perceived social mobility as expressed in sub-populations of the broader pan-Latino immigrant culture in terms of perceived differences in the social status they experienced in their country of origin; perceived social mobility in coming to the U.S.; and how their status in the

U.S. compared to their perceptions of where they would be – SES-wise – had they not emigrated away from their home country.

Beyond these initial comparisons, Alcantara, Chen and Alegria explored associations between perceptions of social mobility in the U.S. and the experience of major depressive episodes (MDE's) in the previous year. The experience of MDE's was self-assessed by individuals participating in the study and compared by sub-ethnicity to see if any of the various cultural, national, or ethnic identities among the pan-Latino immigrant population in the U.S. seemed to serve as a moderator to such associations. Using weighted logistic regression analyses with a subsample of N=1561 Latino immigrants, the team discovered that Puerto Rican immigrants were more likely to hold negative perceptions of social mobility (perceived downward social mobility) when compared with Mexican and Cuban immigrants – the latter two groups perceived a more positive, upward social mobility in their experience immigrating to the U.S. The documented perceptions of downward social mobility were associated with an increase in less optimal health outcomes as well as experiences of major depressive episodes. Perhaps obviously, perceptions of upward social mobility were not associated with self-assessments of poor health. Thus, the authors concluded that perceptions of downward social mobility could possibly function as an independent correlate of health among Latino immigrants in the U.S. and further explain differences in sub-ethnic experiences of mental health and overall mental health status among Latino immigrants. They issued a call for more research focused on prospective designs capable of examining psychological and physiological costs associated with perceptions of, and changes in or disruptions to, social status experienced during assimilation to mainstream U.S. culture (Alcántara et al., 2014). It is feasible that marked sociopolitical shifts at

the local, national and international levels, in attitudes towards immigrants could negatively impact perceptions of – or realities of – Latino immigrant SES status or socioeconomic mobility.

Though some estimates have noted an increase in use of healthcare services, access to healthcare services in general remains a significant barrier to positive Latino immigrant health outcomes in the United States. Another subpopulation within this group, experiencing what could be considered intersecting vulnerabilities, is undocumented Latino women. Given the culture of machismo which permeates many Latino families, women are likely to be somewhat marginalized from adopting or exhibiting healthy or empowering behaviors even within their own communities and households. Being undocumented compounds this situation; and, the underlying immigrant experience combines with it to create a uniquely precarious situation for undocumented female Latino immigrants who are not of age to even be on the radar of the educational system. Adult immigrant Latino women comprise about one fifth of the overall Latino immigrant population of the U.S., yet because of their 'invisible' status there is not a lot of data on their overall salient health issues nor on, or regarding, access to health service barriers they may experience. Soto Mas and Coggin explored this problem utilizing secondary data to construct a cross-sectional survey examining: sociodemographic migration; access to health service issues; health status; and, other healthcare related characteristics in both documented and undocumented Latino immigrant female individuals in northern Texas (Marshall et al., 2005).

Soto Mas and Coggin reported that undocumented Latino immigrant women in northern Texas were less likely to have health insurance or experience continuity of care in the form of access to a regular healthcare provider. The team concluded these results highlight the need to provide immigrant Latino women with alternative health service options, in the forms of:

community health services; increased options to participate in federal and state programs; community health fairs; and, affordable insurance programs.

Given the overwhelming obstacles in place towards actualizing any of the aforementioned recommendations in a timely matter, especially in the political climate of Georgia and the Southeast regarding immigration right now, community health services such as botánicas ought to be explored as a viable option for reaching such underserved individuals. Any and all routes to disseminate health information to, or assess health statuses in, this overall population – and in the more potentially more vulnerable sub-populations – ought to be considered at this point. If indeed the overall marginalized population of Latino immigrants in Georgia and the Southeast, and the more vulnerable sub-populations within, are already accessing botánicas with some regularity, it follows to reason this could be an appropriate place to initiate formal or informal community health interventions or health information campaigns. As Soto Mas and Coggin noted, individual health is not uniquely determined in a strictly biological manner, but is a combined product of sociocultural factors, including: language barriers; SES; ethnicity; gender; employment status; working conditions; and, education. All of these factors, separately and combined, are important predictors of individual health and likewise influence access to health services and the overall utilization of such services. Latino women are, as a general population, less likely to self-report their health status as being good; and, even among the gainfully employed population, 30% more remain uninsured when compared with any other racial or ethnic group (according to their data set which was collected in 2003).

In 2001, Berk and Shur explored the effect of fear on undocumented immigrants in terms of accessing health care. Referencing California's Proposition 187 – which was passed in 1994 and required physicians to report any undocumented immigrants seeking services to immigration

authorities – they noted there had been a general wariness on the part of undocumented immigrants towards accessing health services even before this extreme piece of legislation was passed (Berk & Schur, 2001). Given the shifting, mutable, policy level conditions immigrants face in these matters, they sought to assess whether one's immigration status in general can serve as a deterrant to seeking care by using in-person surveys of populations of undocumented Latino immigrants in Houston, El Paso, Fresno, and Los Angeles. The duo found that 39% of adult undocumented immigrants were fearful of accessing or receiving health services soley on the basis of their status as being undocumented. Such services included everything from dental care, primary medical care, filling or seeking prescription drugs, and, even being fitted for glasses. All of these issues could impact an individual's ability to work, care for their family, and engage in overall long term healthy behaviors. The authors firmly concluded that concern about immigration status is negatively correlated with an individual's propensity to access health services; and, that specific fears surrounding state by state policies on immigration status can act as powerful deterrents for effected indviduals in terms of seeking medical care. They reiterated how this fear is always present in undocumented populations, but seems to be excaerbated by specific state to state policies and legislation targeting their immigration status. With the election of Donald Trump – and his own heavy-handed and controversial immigration platform – it is likely that fear over immigration status will continue to emerge as an especially salient theme regarding barriers to mainstream healthcare for Latino immigrants in the Georgia and the Southeast. Taking into account the current political climate of Georgia, and the previous turbulence around immigration policies here even under Barack Obama – and the relatively new trend of private prisons finding ways to profit from (sometimes indefinitely) detaining

undocumented immigrants – it holds to reason these findings would be especially applicable to Georgia's extensive undocumented immigrant and migrant worker populations.

It further stands to reason that culturally appropriate alternative health service options – such as botánicas – could help mitigate some of the negative health impacts of acculturation. It is likely that the climate of fear surrounding accessing health services in the undocumented population of Georgia and the Southeast would be eased or surmounted as well with the option of more community-based healthcare services being offered in an integrative manner with allopathic care. Given that accounts from inside the community tend to imply that even documented and insured immigrants access botánica services in tandem with more modern health services while in the U.S., it is at least important that the larger medical and public health community becomes aware of the concurrent role – and any untapped potential – that botánicas play in immigrant Latino health in Georgia and the Southeast overall.

The Role of Botánicas in Latino Immigrant Health

I gathered preliminary data on the role of botánicas in Latino immigrant health through interviewing academics, botánica proprietors, and botánica clients,

According to Hayes-Bautista, in exploring how a botánica functions, it is important to understand the history and trajectory of botánica culture in the U.S. Per Hayes-Bautista, it is also important to note how botánicas adapted and evolved according to immediate and regional influences and micro-cultures. Indigenous Latino immigrants for example, or any other subpopulation, have the option to influence botánica activity in their immediate community – regarding products and services provided – according to their own needs and traditions. Most botánicas offer, somewhere in the intersectional web of cultural influence, products and services

uniquely catered to indigenous customers and patients, as well as more specific subcultures of nationality or ethnicity.

Hayes-Bautista, who is a recognized expert on botánica culture and has conducted participant observation research with a curandero in San Francisco, cited that the botánica culture as it exists now on the west coast, moved in during the 1980's from the east coast. He explained this is how a lot of the Caribbean influence (like Santeria) became so prominent therein; the botánica culture of the east coast had incorporated various deities from different traditions, most prominently of Caribbean and African roots, and yet almost all of indigenous origin. He placed great emphasis on the indigenous roots of botánica culture as it emerged out of Mexico as well, and noted that even the Virgin of Guadalupe has indigenous Nahuatl roots. This diffusion of culture from east to west, and south to north, has not followed a completely linear evolution, however; and, he was quick to point out that barrios on the west coast had always been host to distributors of herbal remedies and spiritual artifacts – even before the more established botánica culture took root. The Caribbean and African cultural traditions filtered in from the east to these regions though, and have been adopted almost universally.

Dr. Joseph M. Murphy, professor of Interfaith Studies and Dialogue at Georgetown University has written a book entitled, 'Botánica: Sacred Spaces of Healing and Devotion in Urban America'(Murphy, 2015). In a statement I collected from Murphy in September, 2015, regarding botánica culture as a sort of buffer zone which mitigates some of the harsher aspects of assimilating to U.S. culture, Murphy confirmed that: "The botánica has played an important role as a mediating institution in this transformation, helping people adjust to new environments and challenges, and providing armor and an array of weapons in the fight to find a safe and sustaining place in the new world".

In his book, Murphy describes botánicas as a space for alternative spirituality that can allay some of the stresses of everyday life in the migrant and immigrant experience by providing culturally sensitive pathways for healing and empowerment. The importance of access to these more intangible types of healing is manifold since immigrants and migrants - practically everywhere - face numerous political and financial constraints when accessing mental health services. If an immigrant is undocumented, they may have little to no hope of accessing mental healthcare in most regions of the United States.

Juan Diaz used to run a botánica on a stretch of Atlanta Highway in Georgia called, 'Fuente De Salud'. Diaz had taken over the business from his wife after she passed away around five years ago. Both Juan and his wife originally immigrated to the U.S. from Peru; and, she had run her botánica business in Georgia for 15 years prior to her passing. Juan said that many people in the community access their botánica along with seeing a more mainstream general practitioner. Though generally amicable, Diaz exhibited a great deal of concern that he was being investigated somehow, and made it clear several times that he was on top of relevant tax issues – or would be very soon. Unfortunately, Diaz ended up closing his business due to a decrease in sales which he attributed to the election of Donald Trump – he told me people were terrified by his rhetoric and saving their money in case they had to flee or were deported.

Brenda Sandoval, from Honduras, had more recently opened a botánica right down the road from Juan Diaz, called 'Botanica La Orquidia'. She has been open to the public there since early 2014, selling a full spectrum of meticulously marked herbs, candles, incense, and other spiritual and religious paraphernalia. Sandoval did not speak English, but two men emerged from a back room shortly after I arrived, one of whom offered limited translation services. Sandoval was not recruited for the botánica sample of this study since I had already written a widely

distributed academic-journalism article including both her and Diaz (with their permission) which was originally published in *The Conversation,* and swiftly picked up by much larger outlets such as *The Associated Press* and *U.S. News & World Report*. Because of both Diaz (who was also mentioned in said article) and Sandoval's prior public connection to me via the news article, their anonymity had already been too compromised to include them in the actual study – which was approached with considerable efforts to conceal the identities (or the tracking of) any participants who consented to the interviews under the promise of anonymity.

A popular market in Georgia, about an hour away from Diaz and Sandoval's community, also hosts a number of botánicas each weekend. Those willing to navigate the crowds can there choose their preferred medicinal herb retailer or spiritual counselor, according to specific personal preferences or recommendations from within their own personal network.

Dianira Cantu, a documented immigrant from Mexico weighed in concerning her own family's experience with botánica culture in Georgia on September 20, 2015. Cantu related, "All my family uses alternative medicine. We have insurance, so it's not the money, but doctors here are not so trustworthy when it comes to certain things". The same day Cantu provided this statement, she was taking her mother to a botánica run by a lady named Carmen to get her foot examined. Cantu described the treatments her mother received from Carmen, citing "…she's trying to remove the knots on the bottom of her foot so that her pain can go away". Cantu's father, she added, has a skin condition for which he seeks treatment at one of the botánicas hosted by the aforementioned market. A friend of his had recommended "a lotion that a lady [there] makes".

Another former Peruvian, Roberto Gutiérrez (a formerly undocumented immigrant who is now fully documented) has an appreciation for botánica culture but confirms that not all

botánicas are created equal, citing that, "…the catch is you need to know where to go, because some people know more than others, and some products are stronger than others as well". Roberto's mother ran a botánica in his native Peru; he reiterated claims that so-called alternative and natural medicine are much more mainstream there, even within the more formal medical community. He said that his family doctor there was a traditional M.D. "but he heals you with herbs and traditional medicine [too]". Gutiérrez described how his mother was chosen to train with practitioners in her family because she displayed the potential for joining the practice of their traditional healing methods. Regarding the spiritual element he said: "You have to have it, and frankly many of those in Peru – probably in the rest of the world as well – that have those newspaper ads, [those] are not really shamans, like they [are] called. There are real shamans, but to find them is hard, and they charge you a [lot] of money, but they can do scary [stuff]. My mom does basic stuff, like 'pasar el huevo', that is to cure babies of 'de que los ojearan'. She doesn't charge for that, and you do that on people's references; typically, you don't advertise that. You end up doing it [because] older people pass that [tradition] to younger ones; the ones that passed that to my mom [were] her aunts. They taught her how to do it [because] they saw she could potentially be good at it – she is, actually. But again, that is very basic".

Gutiérrez's assertions about the shadier side of 'shamanism' were whole-heartedly punctuated by an unnamed botánica healer working out of an undisclosed location in Georgia. He did not wish to be identified or quoted on record for fear of reprisal from some of what he described as 'darker' shamans. He took this very seriously and spoke warily of how things operated differently in the underground networks of immigrants. He, himself, preferred to work only in good magic, he assured; he provided tarot readings, Reiki healings and spiritual counseling. In his work, he drew from many traditions and during my visit he referenced Jewish

Kabbalah, Japanese Reiki, European tarot, burned incense from India, and recommended a book out of the western new age movement, called 'The Secret'. He offered up that his teachers in Mexico, where he commuted for further training – fairly frequently he claimed – mostly held medical doctorates and were fairly mainstream there.

This un-named provider seemed somewhat surprised, though he took it in stride, that a Caucasian-American (gringa) academic was interested in purchasing his services – he was also informed of the underlying exploratory research intent. Dr. Hayes-Bautista offered some insight into his initial reaction. Hayes-Bautista said that he, himself, found it funny how in L.A. he had seen the Caucasian upper-class community discover "chakras, yoga, [and] crystals". Yet, they seemed to only want to consume such things from eastern cultures which were considered more exotic, and farther removed from their more immediate experience. "Even though they have the Latino indigenous culture right here" that is basically saying and doing the same things "here, already". He lamented that, "they won't even acknowledge it". He cited "a real denigration of Latino culture" as the reason that "[botánica providers] don't get romanticized as much". The mystical spiritual powers from the east, he notes, are what people tend to get excited about, but his observation is that they refuse to look at things from Mexico and Latin America. "Why not be enchanted by indigenous culture [here]?" he questioned.

With services and products steeped in both Catholicism and pan-cultural indigenous lore – including the Caribbean and Afro-Carribean cultural influences that diffused in from the east coast – botánica providers have also appropriated other European, African and Asian spiritual traditions to offer a full spectrum of choices in alternative health and spirituality. This fusion of culture and tradition is one of the only things that is fairly standard from botánica to botánica.

Relative to individual size, which can vary greatly, botánicas usually bear host to a veritable treasure chest of well-marked medicinal herbs and provide a wide selection of choices for self and home care options. Offered along with these more tangible products, are the more intangible services such as tarot readings, spells for love, health or money, spiritual cleansings, and even psychic services. Services and products tend to vary widely from location to location.

In 2006, Hodges and Bennett described *Pluchea carolinensis* as one of the most frequently distributed or utilized plants in their survey of botánicas in southern Florida.(Hodges & Bennett, 2006) *Pluchea carolinensis* is described as a smaller shrub of the Asteraceae (the daisy family) and is common in the region, growing extremely well in areas where black mangroves grow. Another similar species found is Neurolaena lobate; however, both are commonly referred to as 'salvia' in Latin American botánicas – while Haitian botánicas in Miami commonly refer to it as 'la choige'.

Hodges and Bennett interviewed persons in a sample of 17 botánicas regarding information on various uses of the salvia plant. The most frequent ailments it is used for seemed to be sore throats and catarrh, but the herb is also used to treat a wide range of other conditions from headaches and stomach aches, to high blood pressure, to rashes and toothaches. Beyond these specific treatments, it is also considered an anticoagulant, antiseptic and an anti-inflammatory medicine. The most popular methods of application or preparation were teas and compresses. Interestingly, the herb is also known to play a role in spiritual cleansing rituals in the Santeria tradition, specifically those honoring the deity, Babalú Ayé.

Criticisms of Botánica Culture

On a more sobering note, concern has been raised by researchers about the ritualistic use of elemental mercury in many Latino and African Caribbean traditions. Believed to have great metaphysical power, elemental mercury is sometimes referred to as 'azogue' and is used in some protection spells. Ironically, it is also believed by some to attract good health – as well as money, general happiness, and positive relations. Ozuah noted how the intentional distribution of mercury on the floor of a home or business can create an atmosphere of chronic mercury vapor, affecting not just current, but also future residents and occupants. The Chicago Department of Health visited 16 botánicas in Latino communities and discovered that all of them – in 2001 – sold elemental mercury (Ozuah, 2001). Another study on folk uses of mercury in the Afro-Cuban population of New Jersey reported that 17 of the 21 practitioners interviewed using participant observation methods, volunteered information about their use of mercury compounds in terms of services provided to their clientele. Most practitioners were aware of the potentially hazardous properties of elemental mercury, but were not aware of the dangers of mercury vapor. Yet despite this common usage, an analysis of the practices did not reveal anything especially alarming in terms of folk usage resulting in extremely high exposures (Alison Newby, Riley, & Leal-Almeraz, 2006). A follow up study in Chicago by the Chicago Department of Health (CDPH) and the Center for Disease Control and Prevention did not find any association between ritualistic uses of mercury in the Latino population and hazardous exposure to mercury in children. They did express cause for concern regarding the gap in continuity of care between mainstream health providers and these underground networks, citing that healthcare providers should be aware of the potential for mercury exposure in populations and individuals who access these type of services and remedies (Schurz Rogers et al., 2007). Wendroff, however, claims the

danger of the ‘macro-religious’ uses of elemental mercury in Latino and Caribbean communities cannot be understated and laments related outcomes have not been officially connected to the large-scale folk usage. He blames this discrepancy on: socioeconomic and political factors which function as barriers to research in these communities; how public and environmental health agencies lack political mandate to effectively act on behalf of these populations; and, he further frames the long term impact of folk use of elemental mercury as a ‘latent environmental health disaster’(Wendroff, 2005). Riley, Newby and Leal-Almeraz faced off with the ethical and methodological issues involved in risk assessment and risk communication. They demonstrated the importance of delicate and well thought out approaches to risk assessment, warning of the possibility of attempts to assess the impacts of mercury use and distribution being dismissed as another chapter in a long history of cultural, religious, and medical imperialism, which could damage future potential for collaborative types of research. The team found there were different types of mercury being used in various traditions which resulted in various levels of exposure. The practices at risk for the highest amounts of mercury exposure were connected to the Santeria tradition but such usage appears to have been appropriated by Santeria from outside influences. The medicinal use of elemental mercury has also been documented in Chinese and Tibetan traditions, and is not limited to Latino or Caribbean cultures (Riley, Newby, & Leal-Almeraz, 2006).

Despite the cultural ramifications of folk use of elemental mercury, as Riley, Newby and Leal-Almeraz point out, even low dose chronic exposure can lead to chronic neurological impacts such as insomnia, tremors, memory loss and general cognitive decline. This underlying concern lends more urgency to a need for awareness on the part of mainstream medical

practitioners who work with these populations to have mercury exposure on their immediate radar for individuals who present with such potentially related symptoms when seeking care (Riley et al., 2006).

Chapter 3

RESEARCH METHODS

1) What roles or functions does the botánica play in immigrant Latino health and culture in the Georgia?

2) Is there a potential for a collaborative relationship to emerge between botánica proprietors and public health researchers and medical practitioners in Georgia?

3) What salient health issues affect the Latino immigrant community of the Georgia?

Overview of Study Approach

There was a total of 15 health service providers interviewed for this study. They included 5 botánica proprietors and 1 indigenous non-Latino health service provider (who represented the TIM, non-allopathic health service paradigm). There were also 9 mainstream (allopathic) healthcare providers interviewed. Each group was administered the same questionnaire. Results were analyzed using the constant comparison method, allowing for specific themes to emerge and be coded for subsequent overall analysis. After all the interviews were conducted, I aggregated the collected data and emerging themes to identify salient issues in Latino immigrant health in Georgia, as well as similarities and differences in perspectives between each sample community providing health services to this population. Before publication of the data, interviewees will have the opportunity to participate again in the research process by providing feedback on the findings and contributing towards deciding how the findings can best be applied in their communities, and also as to how -- and to whom-- the findings might be disseminated.

The potential for collaboration between the two sectors which emerged through interview data will be up to future research to explore. This study's research design was guided by the principles of Community Based Participatory Research (CBPR).

Research participants were recruited based on their active role in providing health services to Latino immigrant individuals and communities. It was not expected that there would be many instances where exclusion from the study, post initial contact, would occur. Once their participation was confirmed, an interview date and time was set at their convenience. Each interview took approximately one hour.

Data was stored and locked in a secure space when not actively in use. Again, data was analyzed using the qualitative constant comparison method, as acquired. Once the data was coded and analyzed, corresponding individual identities (even in the form of numbers or euphemisms) were set to be destroyed one year after the dissertation is complete.

No definable risk was foreseen for study participants; any sensitive information, including but not limited to immigration status or business license status, was not procured nor recorded in the interview process. General questions were posed regarding overall health issues of undocumented individuals who sought the health services of interviewees, but no individuals were personally identified or described in a manner that any of the interview data could be used to trace and expose their personal identity.

During the consent process it was made clear that no information deemed a potential risk to the interviewee would be sought or recorded. Likewise, if any personal information was

revealed about specific clients or patients of the interviewee, such identifying information was excluded from the preserved data.

The hope is that study participants felt somewhat empowered by the option to participate in a potential ongoing process of defining the way study results are disseminated and applied within their communities and beyond. Botanica proprietors may gain a greater understanding regarding the views of Latino immigrant health held by the mainstream health community; and likewise, mainstream health service workers may gain a greater understanding of Latino immigrant health issues from a more underground, insider, non-allopathic healthcare perspective. All potential, or willingness, for collaboration which was revealed, may be empowering towards pursuing a collaborative, integrative approach to Latino health.

Participants were not required to provide any personal information such as email or telephone numbers. Any collection of such personal information was a result of an informed choice on the part of the participant. All participants chose to participate in the potential opportunity to be contacted again for the purpose of eliciting their feedback on the results of the study, and being provided an opportunity to participate in deciding how these results may best be used in their community or disseminated to appropriate parties – yet their agreement to do this was not a requirement for participation in the initial interviews. Such activity was, however, aligned with the principles of Community Based Participatory Research (CBPR). It was completely up to each individual participant regarding whether they volunteered to participate in this follow-up at all, and whether they preferred to be approached at such a time: in person; by phone; or by email.

Audio recordings, and any personal identifiers (such as email addresses or phone numbers provided by choice and informed consent) were protected and removed from

corresponding data after it was manually coded and analyzed. All raw data will be destroyed one year after the dissertation has been completed.

Contextualizing the Nine Principles of CBPR (Minkler & Wallerstein, 2011)

Principle 1: CBPR recognizes community as a unit of identity.

The concept of socially constructed identity, in terms of community based participatory research (CBPR), is well conceived by the social ecological model in terms of units and expanding circular definitions of identity. Individual identity expands and intersects with interpersonal identity (i.e. immediate families and friendships; neighborhood, etc.) and on into a larger, in this case, pan-ethnic immigrant community identity. The community level concept of identity is constructed (and, constantly re-constructed) through: ongoing interactions; the adoption and perpetuation of mutual values and norms; common, mutual interests, and a resulting desire to nurture a spirit of collective efficacy; and, the recognition of shared common symbols of cultural significance. Though the social ecological model tends to suggest immediate succeeding spheres of influence, and in this case extensions of identity, this does not always occur in a linear or concentric geographical manner. A community of identity can transcend national borders; its members may be scattered throughout an urban or rural area, disconnected in physical space but nonetheless adopting a singular – though not necessarily completely homogenous – unit of community identity. Likewise, a community unit of identity may not be constructed in a linear fashion in terms of extending directly from family to neighborhood to a larger community; as with the instance of the lesbian, gay, bisexual, trans and queer (LGBTQ) community, it may extend directly from individual identity to community identity in a more abstract manner. The same could occur in Latino immigrant populations in Georgia and the Southeast. Though there are many regions where Latino immigrants congregate, live, and

collectively build community-oriented businesses, not all of the community members are connected in an immediate geographical sense.

In terms of this study on how botánicas function to create and re-create indigenous and mestizo Latino immigrant culture, and in turn affect health statuses and outcomes in the larger Latino immigrant community of Georgia and the Southeast, I approached it from the standpoint of recognizing a pan-ethnic Latino immigrant community that likely functions as a source of identity and cultural continuity for Latino immigrants of various generations, and from various countries of origin. The botánica is an appropriate focus for CBPR inquiry, regarding cultural identity and approaches to health, because botánica culture appropriates customs from a number of indigenous and mestizo Latino and Caribbean cultures and traditions. The botánica itself is an expression of a pan-ethnic immigrant Latino culture in the Georgia, the Southeast (and beyond) and therefore was isolated as an appropriate point of entry for research on how to better understand and serve the larger community's health needs. It is a point of social and ethnic coherence, in what can be an otherwise diverse group, in terms of social and sub-ethnic demographics.

Principle 2: CBPR builds on the strengths and resources within the community

A more tacit assumption of this study is that the botánica is an indicator of a community level adaption to various barriers to health and healthcare access which are presenting in Georgia and the Southeast at this time – perhaps mostly due to political constraints (especially around issues of immigration status) but also due to initial and ongoing cultural, lingual, insurance access, and SES barriers. Botánica culture seems to be expanding, instead of disappearing, which challenges some of the more mainstream theories of assimilation. Given that heightened degrees of acculturation have also been associated with increased incidences of certain negative health

outcomes (like diabetes) in Latino immigrant individuals, the motivation to understand the botánica phenomenon is increased. The botánica is a community level phenomenon that represents a model of autonomous Latino immigrant health services which seems to function as an alternative to, and yet also often in tandem with, more mainstream healthcare services.

Principle 3: CBPR facilitates collaborative, equitable partnership in all research phases and involves an empowering and power-sharing process that attends to social inequalities.

This offers a good point to address how CBPR principles tend to operate on a continuum rather than as a binary dichotomy – where research either 'is' or 'isn't CBPR, based on a rigid set of standards being met. In terms of this study, I conducted exploratory research in the form of numerous informal interviews and participant observation experiences with botánica proprietors, as well as with immigrants of various subethnicities in the Latino immigrant community of Georgia who access botánicas, and also with recognized academic and medical experts in the field. Based on this initial and comprehensive outreach, the interview questions were informed by this initial community input and refined by more subsequent input and feedback. After the interview questions were outlined and received initial IRB approval, I consulted on them with a few more community representatives – including two Latino immigrants who accesses botánicas, one recognized academic expert in the field, and one local public health director who is also a Spanish-speaking physician and Emory University professor, to make sure I was in fact asking the 'right questions'. As the interview process commenced, I remained flexible to community feedback in terms of following new, or emphasizing specific, subtopics which emerged in the interview process (such as the alarming HIV crisis which will be discussed in more depth later in this text). The concept of the continuum presents here, in that even with the best intentions along these lines, research conduct is subject to real world barriers and blocks to carrying out the

ideals. Specifically, regarding privacy concerns between the two sample populations of botánica proprietors and mainstream healthcare providers, it turned out to possibly be inappropriate to share all of the feedback and overall assessments made by each group with the other group, in order to reduce the potential of exacerbating any innate conflicts in ideas or cultural attitudes which arose. However, this does not serve to indicate there were major insults hurled or judgments cast, most of the censored data points were off-the-cuff remarks about how one group perceived the other group to not respect the potential contributions or work of their group. These statements, which are ultimately fears, were expressed on both sides but tempered equally with an overarching optimism that such attitudes could be surmounted, in most cases.

Principle 4: CBPR promotes co-learning and capacity building among all partners

The ideal operationalized here, in terms of this study, is for the mainstream health service community of academics and practitioners to become aware of the cultural and medicinal practices inherent to the botánica paradigm, and to be able to make an informed assessment of what this means in terms of effectively treating and assessing issues of Latino immigrant health in the region. My intention is not to try and educate botánica proprietors in terms of how to oblige with mainstream health service culture, but to ultimately raise awareness of the potential for, and to promote, a culture of mutual respect – and perhaps facilitate its emergence – between the two health service cultures in Georgia. Since I am a public health academic steeped in the mainstream institutional traditions and culture that comes along with it, my personal intent was to learn from the botánica community, and not to explicitly advise them in any defined manner. Any potential future attempts to perform an advisory role will likely be in trying to disseminate useful information which can help inform mainstream health service educators and practitioners regarding the implications of serving a community that accesses this autonomous community

health paradigm in tandem to their services. Since there was an expressed interest from a slight majority of the botánica community individual interviewees toward forming a more collaborative relationship with the mainstream health service community, this possibility can be explored more fully in time. It must be noted, however, that the botánica community is potentially extremely vulnerable to increased levels of scrutiny; and, their interests must continually be respected and protected accordingly through this (or any) research endeavor on an ethical basis.

Principle 5: CBPR integrates and achieves a balance between research and action for the mutual benefits of all partners.

This study's approach to Principle 5 is coherent with and reflected in the outlined intent regarding Principle 4. All actions taken by myself were done in the spirit of promoting an increased respect of, in addition to an increased overall awareness of, botánica community culture in the gaze of mainstream health service practitioners and academic cultures which may be concurrently serving, treating, or researching the health statuses and healthcare access patterns and barriers of the Latino immigrant community in Georgia and the Southeast. It is possible, judging from the feedback elicited from both groups, that dissemination of the results and conclusions might lead towards actions which facilitate a more cooperative, collaborative, and mutually respectful relationship between the two health-service cultures targeted for this study. However, this is not something which can be fully or accurately projected at this time.

Principle 6: CBPR emphasizes public health problems of local relevance and also ecological perspectives that recognize and attend to the multiple determinants of health and disease.

In terms of this study, I recognized how individual and community health is not singularly determined by set factors of biological influences, but instead also emerges from an

intersecting influence of environmental, social, and cultural influences and barriers. Since barriers to mainstream healthcare services can be a significant predictor of health status and health outcomes in the Latino immigrant community of Georgia and the Southeast, these factors should be assessed as the intersecting conglomeration of issues they innately represent. The population is significant enough, in terms of size, that health issues presenting substantially within it – largely beyond the gaze of mainstream practitioners – could easily become latent determinants of local and state public health outcomes as a whole. Botánica culture was assumed to be both a product of, and a response to, these broader intersecting determinants and barriers to individual and community health, and presented an appropriate point of access to study the influence and outcomes of these various factors as they present in the individual and community level health outcomes of Latino immigrants in Georgia – as well as in determining what influence or impact these outcomes and statuses might have on the public health status and outcomes in the broader region of the southeastern United States and even beyond.

Principle 7: CBPR involves systems development through a cyclical and iterative process

As addressed more elaborately in previous sections, this study hopes to potentially open the channels of communication between the allopathic and non-allopathic cultures of health services accessed by the Latino immigrant community in Georgia, or at least the channels of communications between mainstream healthcare providers and their patients who are accessing both paradigms of health services. The ultimate goal was to gain a larger understanding of Latino immigrant health statuses and understand the role the botánica culture plays in assessing and addressing the salient health issues in this population. In the most ideal terms, a formal or informal partnership – or at the very least a mutual and respectful acknowledgment – may eventually emerge between the mainstream health service culture and the botánica health service

culture to the benefit of the larger communities they serve. Additionally, the salient health issues which presented in the Latino community via research data gathered in this study may hold implications for broader local and state level policies (i.e. interventions to stop the spread of any identified latent epidemics). Since Latino immigrants comprise a significant portion of the overall population of Georgia and the Southeast; it stands to reason that many of their health issues and service access patterns may translate into state and regional health issues or outcomes – or have the potential to develop as such in either a positive or negative manner.

Principle 8: CBPR disseminates findings and knowledge gained to all partners and involves all partners in the dissemination process

This principle is a bit more complicated to achieve strict adherence to when certain findings are of a critical nature from one group to another. Criticisms regarding accessibility and cultural appropriateness issued from the botánica networks regarding mainstream health service providers could create a better understanding of ways to benefit and improve the relationship between the two cultures overall. However, criticisms of the underground, autonomous Latino health networks issued by healthcare service providers within the mainstream service networks will probably not achieve much towards the overall goal of improving cooperative and respectful relations between the two – mostly because of the imbalance in power that already presents between the two cultures, which is unlikely to shift significantly any time soon.

Principle 9: CBPR requires a long-term process and commitment to sustainability

In terms of this principle, I remain committed to this community for the long term and have made sacrifices in the past to demonstrate this commitment, and to gain the trust of those involved. The original contact with the botánica network of proprietors and customers was

supposed to result in a health news publication, but when the publishing network pressured me to secure footage of the community without their explicit permission– including potentially and especially vulnerable undocumented individuals – I cut ties with these parties for the sake of maintaining trust in the community. I also turned down the offer of a major news outlet that wished to send a reporter to Georgia to follow my research as it exposed some potentially explosive themes (in particular, the HIV epidemic and its potential transnational impact.) The decision to not allow this stemmed from concerns that such a strictly journalistic approach might sensationalize sensitive issues and contribute to a broader stigma associated with Latino immigrants in general. I have been involved in Latino immigrant participatory action research in the past. I speak moderately decent Spanish (which I am also committed to constantly improving) and have traveled extensively and conducted participatory action research in Latin America (visiting seven different Latin America countries in total at this point, spending most of my time observing public health and human rights motifs) which has provided me with ongoing opportunities and networks which have facilitated an increasing familiarity and a personal state of comfort with Latino culture. These experiences prepared me to understand and approach the culture perhaps better than the average outsider or academic researcher might when attempting to engage with such an in-group phenomenon – as botánicas – from an outsider perspective. I am in it for the long haul and intend to deepen my own understanding, connections, and potential to collaborate towards better health outcomes in and with the Latino immigrant community of Georgia and the Southeast.

Application of CBPR Principles

Since the botánica phenomena is a uniquely community-oriented phenomenon, there is really no other way to: understand what questions to ask; to gain the trust of the vulnerable

community members enough to really answer those questions; or, to figure out how to best approach the culture and individuals in terms of spearheading a collaborative spirit geared towards potentially ongoing public health research, then by involving the community directly. The CBPR approach helped to lift the veil on an otherwise secretive practice which is manifesting in a community who have extremely valid privacy concerns. There is no reason for them to cooperate with a research process operating from a more traditional hierarchical manner as remains normative in mainstream academic culture – a group which has certainly not always demonstrated that they had the communities' or individual's best interests at heart.

The CBPR approach helped interpret the phenomena from the subjective experience of the insider culture, the ones who create and re-create the culture and botánica community through their everyday work and experiences. An outsider's sole objective assessment would never truly get to the heart of what is happening here. An outsider attempt at taking an objective look would require too many potential and detrimental assumptions regarding what the botánica truly means to the Latino immigrant community, and why some continue to access these services and seek their advice first, even when they have insurance and direct access to more mainstream healthcare models which would often be assumed by outsiders to be superior.

Since my long-term research goals are of a participatory action nature, learning and incorporating the needs and perspectives of the community itself were essential to progress forward. Also, in terms of informing the mainstream public health community and health service practitioners about the types of services being performed and received, and the medicines being prescribed – potentially concurrently with services they are providing and prescriptions they themselves are issuing – understanding the actual motivations and patterns of community access and adherence are crucial to moving forward in a unified approach. A community who is already

exhibiting some form of basic distrust towards mainstream health providers and researchers, would have been unlikely to offer up information about their own activities to these same entities, unless barriers to this trust were somehow preemptively surmounted – and CBPR was really the only approach with the active potential to surmount them.

Principle 3, which states that "CBPR facilitates collaborative, equitable partnership in all research phases and involves an empowering and power-sharing process that attends to social inequalities" was challenging due to the power inequalities present between the two interview population samples. Research conclusions distributed to both groups might not be equally empowering. There is potential for research conclusions abstracted from interview data with the botánica culture sample of individuals to be misused, misunderstood, or misapplied by the mainstream health service sample of individuals. For instance, if the mere revelation that patients are receiving concurrent health services from both cultural entities causes mainstream healthcare providers to patently discourage further use of botánica products or services to their patients, then this most certainly would not empower the botánica community. On a similar note, if tacit prejudices are identified within the mainstream health services community regarding botánica culture or the Latino immigrant community of Georgia within the results and data analysis of this study, there would be nothing empowering about disseminating the conclusions that emerged in this regard to the botánica community or the lager Latino immigrant community. In fact, such a dissemination could – and likely, would – create an even deeper divide and could exacerbate negative health status outcome disparities and issues in its wake. Luckily, no major themes emerged along these lines, and the overall tone from both groups was essentially positive surrounding the idea of increased communication and cooperation, even when a general misunderstanding of the other was admitted or somehow expressed.

Adherence to Principle 4, which states that CBPR promotes co-learning and capacity building among all partners was subject to the outcomes generated by research participants. Not everyone surveyed in the botánica network immediately expressed a likelihood of wanting to work with the mainstream health providers, at any point. In part, they feel innately disrespected by their approach – which can violate cultural taboos or disrespect cultural knowledge and practice – and some are simply affected by a seasoned distrust. Likewise, the mainstream health service practitioners' experiences had not all generated an open-minded enough state to grasp any potential for collaboration with the botánica proprietors; however, none were quick to shun any public or private connection to the largely un-regulated industry (especially if it offered them opportunities to learn about other treatments their own patients were receiving). All that being said, none of the opinions collected in the data seemed sufficient to prevent the possibility of achieving the goals of the study moving forward. And, it may be possible that once trust is built between the more pioneering individuals, that this sense of trust would ripple out into their larger respective communities as well.

Principle 5, which states that "CBPR integrates and achieves a balance between research and action for the mutual benefits of all partners", had to be applied somewhat unevenly, as touched on in the previous section. Since the study was working with two communities which can exhibit conflicting value structures and cultural norms, and in acknowledging that they inhabit separate ends of a power spectrum in terms of ultimately representing more hegemonic versus more marginalized interests, the concept of 'mutual benefit' had to be constantly re-evaluated accordingly and basically in stride during the research process.

Principle 8, which cites that CBPR research should ideally disseminate findings and knowledge gained to all partners and involve all partners in the dissemination process, may be

difficult to comply with on the most straightforward of interpretations as well. For reasons explained in the previous section, that are rooted in power discrepancies and virtual dichotomies in cultural norms and approaches, only when the data retrieval process ended, and subsequent themes emerged, was I able to make appropriate judgement calls as to how this specific study might appropriately further this principle.

The limitations of the CBPR approach in terms of this study were that the lens mitigated some of the potential for critical analysis. It stymied me from directly addressing some of the more controversial practices which have been uncovered by other researchers concerning botánica culture, such as the use of elemental mercury in ritual cleanses. (As noted, the latter was found to be extremely prevalent in assessments of botánica culture which took place in Miami, Florida; Chicago, Illinois; and New York City, New York). Given the CBPR driven nature of this study, this was not likely to emerge as an issue the community felt comfortable with self-assessing – especially in terms of potential implications which might be disseminated to the larger, mainstream health networks. I did not attempt to address the use of mercury – however, nor did I notice any indications of its presence – in any of the botánicas I visited.

In a similar vein, the obligation to disseminate findings to the community of mainstream healthcare providers presented the issue of determining how much the botánica interviewees should really be encouraged to reveal, given the increased scrutiny it could lead to from state and local policy makers and the larger health service community.

Population, Sample, Consent and Recruitment Process

Given the still limited and somewhat invisible overall population of botánica providers in Georgia, this research was at the mercy of convenience sampling and snowball sampling. To initiate the sampling process, I approached botánica providers interviewed during the exploratory

research phase of the study, which included 3 different botánica providers I had collaborated with on the previously mentioned journalistic article for initial referrals. Again, given the public ties to me which had already been established, these individuals were not recruited for this study. Initial outreach was met with measured compliance and cooperation since the terms of contact were quite different. It was cautiously assumed that other proprietors might be more comfortable and cooperative engaging in this more formal research process for reasons such as: an increased comfort due to the fact that they would be assured of their right to remain anonymous and even be given the option to help further formulate and drive the actual research process – as well as weigh in on the interpretation of results and analysis in terms of how they might later be applied or disseminated. Another sampling hotspot was a Latino market in North Georgia. Previous contacts here suggested botánica providers there might be considered more 'underground' and may not be operating with full business licenses, and thus some showed more reluctance to participating. However, given the participant observation nature of my initial contact with one of the botánica service providers there – which seemed to resolve in a heightened state of trust between the myself and this proprietor – I was able to establish a cooperative relationship within this more formal research process (given the complete guarantee of privacy). There were in total 3 botánica providers recruited for the study at that location alone. Initial exploratory research concluded there was an even more extensive botánica network within the greater Atlanta and Athens areas, and that word of mouth referrals from other participants were highly preferable to seeking out providers through advertising services – however a list of providers advertising via the internet was compiled, but ultimately not accessed for backup. Exploratory interviews with Latino immigrants who accessed botánica providers, as well as with the botánica providers themselves, revealed an assumption that the proprietors who resort to public advertising do so

because they have not developed a solid enough reputation within the Latino immigrant community of Georgia to get by on the word of mouth advertisement which is more standard to botánica culture. Therefore, these sorts of contacts were not ideal. The available academic literature on this topic has confirmed that botánica networks function as an underground cultural phenomenon and that most advertisement occurs in the context of interactions between botánica proprietors and the Latino immigrant individuals who access their services. Thus, public advertising is perceived as a break from the overall cultural code and thus may function as some sort of a red flag signifying a proprietor's role in the community is not especially secure. Given the diversity in evolution the botánica culture manifests from region to region according to differences such as sub-ethnicities in the surrounding areas and personal preferences of each proprietor themselves, it is entirely possible that public advertising – which is currently conceptualized as a break from the more standardized botánica culture – is not an overall signifier of a larger disconnect from the Latino immigrant community but rather an instance of a broader acculturation and assimilation into mainstream U.S. culture that does not place a negative connotation on public advertising of health services at all.

Concerning the sample of mainstream health service practitioners, this was also initially approached with convenience and snowball sampling methodology. Community health clinics, public health district centers, and physicians' offices who either: saw patients without insurance; or, accepted commonly held insurance by Latino immigrants such as 'Obamacare'' (the vernacular term for insurance provided through the Affordable Care Act) as well as Medicaid, and other government services such as Wellcare or Peachcare which cater to otherwise uninsured youth were points of initial outreach. Individuals who volunteered to be the initial interviewees were further questioned regarding other places, institutions, or outlets where Georgia's Latino

immigrant population sought mainstream healthcare services; and, in this way the community of mainstream healthcare providers working with this population helped to drive the research forward as well, in a community-based participatory fashion. Initial interviews also solicited feedback on whether I was asking 'the right questions' in attempts to get to the heart of salient health issues and health statuses among this population as well as gain an idea of their overall patterns of, and barriers to, seeking mainstream healthcare services in general.

Though the community-based participatory design, which was worked into the qualitative research inquiry, had to remain flexible according to feedback and collaborative willingness from the community, the initial goal had been to interview 10 botánica providers and 10 mainstream healthcare service providers who served a significant number of Latino immigrants in Georgia. It would have also been helpful to interview a sample of Latino immigrants who accessed botánicas to help fill in any thematic gaps which emerged once initial data collection from the first two groups reached a point of saturation in terms of an overall consistency of feedback, but this was also restricted due to time and resources.

Location and Sampling Criteria

Inclusion Criteria: The sample of TM or TIM (non-allopathic) health service providers specifically included individuals who served the Latino immigrant community of Georgia as botánica proprietors, along with one TIM non-Latino health service provider.
The sample of mainstream (allopathic) health service providers also specifically included individuals who served the Latino immigrant community of Georgia as a mainstream health service provider.

Exclusion Criteria: Botánica proprietors would only have been excluded if they did not primarily serve Latino immigrant populations (sparing the one exception of a North American

indigenous health service provider). There was one business, using the name 'botánica', initially contacted which seemed to cater almost exclusively to an African American community – and everyone who worked there was African American. As similar as their offerings seemed to be in terms of products and services, I ultimately decided to maintain the study's focus on TM/TIM health service providers who primarily served Latino immigrants or, in the one case, a provider who was themselves indigenous. Mainstream health service providers were uniformly excluded if they did not primarily, or significantly, serve Latino immigrant populations.

I generated a snowball sample from an initial, pre-established network in the botánica community, and the larger Latino immigrant community; and, I also eventually resorted to identifying botánica proprietors through cold contacts (seeking out venues where they were likely to operate and approaching them in person) but was not able to generate the initially desired sample of at least 10 individuals. Eligibility was established upon verification that each proprietor primarily served the Latino immigrant population of Georgia. I also generated a snowball sample of mainstream healthcare providers through existing personal and professional networks, verifying that they too primarily served the Latino immigrant population of Georgia.

For the botánica sample, I initially reached out to the proprietors interviewed during the initial phase of exploratory research, in the hopes they would offer referrals. These initial contacts do not advertise publicly. There were 3 botánica providers at one of the markets I visited that also did not advertise publicly and ended up being accessible for this study's recruitment. Beyond this, and any snowball referrals I was able to get from them, I drew from cold approaches identified through personally exploring locales where botánicas were likely to be operating.

As far as the mainstream health service provider sample, it was easier to find collaborators to engage with, and I initially relied on suggestions from community members, while also cold contacting some service providers based on themes generated by the research (which ended up including more than one HIV /AIDS specialist).

Recruitment

Recruitment took place in person, and sometimes by phone and email, mostly as established through referrals. There was not a general advertisement issued, publicly. However, a recruitment notice was drawn up for use with cold contacts or by parties participating in the referral process which was approved by IRB protocol.

Most recruitment ended up taking place more informally by email for the mainstream service provider sample, and by in-person visits for the botánica sample unless suggested otherwise by an individual providing the referral.

If an initial recruitment attempt was made by phone or email, and it was not discernible whether the message reached the targeted individual, a follow up in-person visit, or subsequent phone and email outreach, was sometimes necessary.

Consent

Consent was obtained orally – as approved through the Institutional Review Board – due to a number of contextual factors. Even though it was determined there were very few risks for participants who elected to be interviewed for this study, the main risk was conditional to protecting their anonymity. Therefore, I provided a thorough explanation of the consent process – which included but was not limited to: their right to refuse to answer any question and still receive the full $25 participation stipend; their right to stop the interview at any time; and, their

right to not reveal any information which could incriminate or bring unwanted scrutiny on any of their patients or their practice. All interviewees gave consent to be taped with the assurance that the tapes would be used only by me to revisit each interview when coding and aggregating data, to make sure there was nothing missing from their field notes.

The actual consent form approved by the IRB at the University of Georgia is included at the end of this text and labeled ‘Appendix B’. I also disclosed my personal and academic motivations for pursuing the data being gathered, as well as what my personal hopes are for any impact of its eventual dissemination.

All subjects agreed to be contacted again for any follow up questions – including, potentially, on the nature of how the results could or should best be disseminated to the benefit of their community.

Data Collection, Coding & Analysis

In their 2003 publication, ‘Beyond the Qualitative Interview: Data Preparation and Transcription’, McLellan, MacQueen, and Nedig noted that while in studies involving quantitative data, data cleanup and recoding processes are conducted before any subsequent analysis is undertaken, when it comes to strictly qualitative data, the processes usually take place simultaneously (McLellan, MacQueen, & Neidig, 2003). Given the more focused nature of this research study, I handled this as a continuous process of simultaneously transcribing and interpreting the data while employing the constant comparison method to draw out any salient themes or notable discrepancies to allow for better coding methods to emerge. All interviews followed the same standardized set of questions; unless, given the participatory nature of this endeavor, interviewees clued me in as to what questions I should ‘really’ be asking. The only

instance where a question was actually added, after the study had already begun, was after it almost immediately emerged that there was a latent HIV epidemic being nurtured (especially in rural and impoverished regions) in Georgia's Latino immigrant health population.

In instances where interviewees revealed information that was deemed sensitive about themselves – or most especially, about others – a systematic protocol was followed wherein I omitted such data from records immediately in my own notes. According to feedback and IRB protocols, the recordings of the interviews will be stored for a limited amount of time and then destroyed after a specified amount of time (one year).

McLellan, MacQueen, and Nedig presented a strategy for transcript protocol which mirrored data preparation techniques that were developed for use by various Center for Disease Control and Prevention mixed method studies on HIV/AIDS – these studies included both individual interviews and focus groups. The authors also drew from Mergenthaler and Stinson's seven principles for transcription development (Mergenthaler & Stinson, 1992). The most relevant one, in terms of this study, was preserving the naturalness of the transcription data (keeping original word forms and punctuation as much as possible while complying with standard forms of written text). Digital audio recordings were saved on un-hackable cassette tapes for easy storage and access (these are subject to the same storage limitations detailed in pre-approved IRB protocol). Overall data management included steps outlined in this text such as: maintaining and protecting field notes and recordings; organizing the copies according to chronology; and, the development of a protocol for reading and reviewing each recording and accompanying field notes. Each file was officially assigned a number that would chronologically determine which interviewee the data was collected from.

Noting that when qualitative research design involves collecting audiotaped interviews or conversations from focus groups, the authors expressed how each individual researcher must decide whether any subsequent analysis is better supported by direct transcription or by the researchers' own notes generated from reviews of the recordings. Although given that recordings do not always capture all notable aspects of an interview, the cassette tape recordings captured for this study were supplemented by ethnographic notations during each interview process. Given the various comfort levels potentially exhibited by each individual interviewee upon noticing my taking notes, these results may have varied but ended up being uniformly thorough. As noted by McLellan, MacQueen, and Nedig, any attempts at transcription should preserve background noises, nonverbal sounds (such as laughs or sighs), usage of slang or other grammatical errors, and even mispronunciations. The authors also note that for some analyses it might be sufficient to abstract only certain parts of the interview for the transcript or review, for this study – the recordings were transcribed in instances where my notes had not sufficiently captured the interviewees answers – for instance, when I found themselves typing from an awkward position and unable to transcribe the interview as quickly or thoroughly as usual. Or, in one instance, when (due to unforeseen technical difficulties) I was forced to record one of the interviews on my phone – when the tape deck batteries died – and the decision was made to transcribe this entire interview to help bridge the discrepancy.

Regarding issues of 'source labeling,' this was approached in a manner that a quick scan of the documents by an independent party could find it immediately obvious which parts were questions or comments from myself and which parts were answers or comments from the interviewee. The document header included an interviewee profile including a set of characteristics and demographics.

Potential Threats to Reliability & Validity

Pope and Mays noted in 1995 that in qualitative research, the researcher can be regarded as the research instrument. Acknowledging the inherent subjectivities involved, the researcher must constantly assess their analyses in terms of questions like: 'How well does this actually explain the phenomenon in question?' and 'Are these conclusions coherent with existing knowledge about the population or phenomena in focus?'(Mays & Pope, 1995).

Adopting a snowball method of sampling and recruitment could conceivably have limited the sample pool to a more homogenized group of botánica providers than is accurately representative of the overall population of botánica proprietors in Georgia. Given the comments obtained in initial outreach and exploration, there definitely seemed to be different approaches to botánica culture at large. It is possible, though perhaps not entirely likely, that the divisions may not truly be between 'good shamans' vs. 'bad shamans' (as was described directly, and inferred multiple times by different sources) but there may essentially be some sort of political or subethnic divide which was manifesting in such overly subjective assessments. To counter for this, I ventured outside of the snowball sampling methodology for 2 of the interviews in that population sample. I also kept track of any individual data interviewees offered up, such as: country of origin; religious preferences; political opinions or salient political views; views about casting 'spells' of protection only, versus casting spells intended to influence another person without their consent, or, to outright harm or obstruct another person's free will or personal well-being. I also maintained awareness for any other potential issues or factors that arose which might reflect a subcultural divide between various botánica proprietors in Georgia or the Southeast.

A potential threat to validity is always data collector subjectivities and data collector bias. Did my desire to see the botánica as a positive force filter or unduly influence interpretation of raw data in terms of immediate and long term public health issues? The tendency to only ask the 'comfortable' follow-up questions was of course strong, as the research was driven by community feedback and participation both within the botánica networks and within the mainstream healthcare service networks. This potential for subjectivity could have been exacerbated in the process of what has been conceived of as the temptation to 'go native'; and thus, I have tried to eliminate or mitigate any indication of coming off as defensive of the botánica networks in the face of scrutiny from the mainstream health culture, while also giving full due weight to ethical considerations that assured I was not inappropriately setting up the botánica community for a level of scrutiny they are not yet prepared to deal with.

A unique threat to reliability that might present in this research model, which consists of an outsider trying to document a veritable insider culture (especially a somewhat private and underground phenomenon such as botánica culture) is that the answers the botánica providers give to the outsider researcher may not be the same answers they would give to an insider to their in-group world. It is possible they simply told me what they thought I wanted to hear, incentivized by wanting to get the interview process over with and get back to work, or to retain a certain shroud of secrecy around some natures of their practices. This potential threat to reliability is of course not limited to the sample of botánica proprietors and could similarly have manifested in the mainstream health service professional group. Health service professionals might have wanted to over-represent the true nature of their understanding of health issues in immigrant Latino communities, either to project a heightened sense of competency or truly because they 'don't know what they don't know', as the colloquial saying goes. The mainstream

service providers might also have been prone to hide or be defensive about internalized racist or political views they may have picked up from the divisive nature of issues surrounding immigrants in the Georgia, the Southeast, and the country at large right now. I had to be careful not to take all statements at complete face value, while at the same time exercising caution not to project my own subjectivities into the analysis of the raw data obtained.

Subjectivity Statement

I opted to include a subjectivity statement, as is standard to qualitative – and especially CBPR – research methodologies. Providing such a statement can empower independent reviewers with a deeper critical faculty when analyzing the conclusions generated by this study. I became aware of the botánica phenomenon through my own personal affinity and larger awareness of Latino immigrant culture in Georgia, which stemmed in part from my extensive travels in Latin America. These travels included conducting participatory action research, and otherwise pursuing social, educational, and journalistic opportunities in Latino communities with a large focus on health and human rights – mostly among indigenous, campesino, or otherwise marginalized communities – in Guatemala, Nicaragua, Costa Rica, Cuba, and Colombia. In between these trips, and at present, I remain enmeshed in a larger network of Latino immigrant solidarity activists locally, nationally, and internationally – mostly in regard, but not limited to indigenous peoples' issues. This involvement has found me engaging in such activities, including but not limited to: a humanitarian visit to a private immigrant detention center in southern Georgia; facilitating a speaking tour in Georgia for a Guatemalan indigenous human rights activist; participating in a Latin American solidarity protest; participating in a migrant farmworkers' rights protest; collaborating and communicating with a Latino community radio station in Atlanta; and, offering ongoing general support to the Latino immigrant community

both at home and abroad. I have also published a relatively long list of journalistic articles documenting human rights and environmental health issues in Latin America.

Ethical Considerations

First and foremost, an ethical consideration which must be weighed is the idea that any attempt to bring an understanding of botánica culture 'above ground' may bring with it a level of scrutiny that the 'underground' culture is not prepared to deal with. Given that botánica providers are usually immigrants themselves, assumedly of varying statuses of documentation, it is possible they may not have had sufficient time to fully grasp or attend to matters of regional, state, or national policy concerning business codes, health codes, and other tangential or related issues. There is also the possibility there will be some controversies regarding their concurrent administration or prescription of various treatments or medicines once they come onto the radar of mainstream healthcare actors. A worst-case scenario might be if certain political actors who wished to install draconian policies around immigration and immigrants in the state saw the botánica culture as an opportunity to undermine an autonomous Latino immigrant culture from emerging or perpetuating itself in general – although, this would be extremely short-sighted of them given the role botánica proprietors fill in reducing the gaps in crucial access to care for this marginalized population, whose health statuses ultimately impact the region and state at large. The FDA has been accused at times of giving unfair scrutiny to natural health products and practices in comparison with the way they deal accordingly with the political clout pharmaceutical companies maintain, which allows them to get away with a great deal less scrutiny. However, at least two of the botánica proprietors represented in this sample – one through a direct interview, the other being her husband who ran a separate operation but affirmed

that ‘her views were his views’ – are apparently already in a quasi-working relationship with the FDA and did not describe any negative experiences or opinions of the agency.

Another possibility is that the emergence of knowledge regarding botánica culture into the mainstream could create a surge of interest in people from other cultures, ethnicities and walks of life in accessing this alternative health paradigm for themselves. Though results would likely vary and there could conceivably be both positive and negative outcomes of this – which could exist and operate simultaneously – overall, it might dilute the sense of community and hence the spirit of cultural continuity that the underground cultural phenomenon that is the botánica provides for Latino immigrants in Georgia and elsewhere at this time. A sort of gentrification of botánica services might even conceivably raise the prices of services and products in a manner which could put them out of reach for some of the more impoverished members of the Latino immigrant community. This would be a long-term projection at most, however, and would not be indicative of any immediate risks to the community represented in this study.

At any rate, an increased level of attention and awareness of the botánica culture will most definitely create some extent of increased scrutiny; and, it is hard to predict the short term and long term impacts this increased scrutiny might bring. On the one hand, it could open up opportunities for botánica proprietors to receive further training and qualifications which could increase the quality of their services and product offerings. On the other hand, any resistance to this could amount to a further debasing of botánica culture and immigrant Latino culture in Georgia and the Southeast. The increased scrutiny is, however, an explicit goal outlined by the WHO Traditional Medicine Strategy. And, the most likely outcome of this individual study is that the opposite transfer of knowledge and attention occurs, and botánica proprietors are given

opportunity to provide information about herbs and supplements to mainstream providers unfamiliar with their use. There is also the potential they could be trained to screen for more extreme morbidities and be provided with contacts to refer patients to, whose symptom had progressed beyond the scope of their services. This would ultimately be a win-win outcome for both health service communities – and by proxy, the communities they serve.

Integration of CBPR Principles in Instrument Development

The development of survey questions used in this study stemmed from the initial exploratory research and outreach. Once the questions were established, they were sent out for further feedback from: two Latino immigrant botánica accessors; one established academic expert on the botánica phenomenon; and, one Georgia public health leader who presided over a county with a dense immigrant population. It was determined not to be prudent to get feedback from the two survey populations directly but rather from the populations they serve and academic authorities including a public health leader who is also an MD.

The questions sent out for initial feedback (post IRB approval) were as follows:

1) A. How many customers buy your products or services on a daily/weekly basis? (for botánica providers)

    a. What are your most popular products/ services?

    b. What are the most common ailments, problems or concerns presented?

   B. How many Latino immigrants do you tend to see on a daily/weekly basis? (for mainstream healthcare providers)

    a. What are the most common ailments or concerns they present?

2) Are there any health issues notably present in this population that have become prominent, or gotten worse, only after they immigrated to the U.S.?

3) Are there any prominent health issues that tend to disappear or get better once immigrants re-settle into the United States?

4) A. What are the most important roles of the botánica in Latino immigrant health? (for botánica proprietors)

   B. What are the most important roles of the healthcare system in Latino immigrant health? (for mainstream health workers)

5) What seem to be the most prominent barriers to positive health outcomes in the Latino immigrant community in the Southeast right now?

6) What seem to be the most positive trends in immigrant health?

7) How does the current political climate influence Latino immigrant health, or the way Latino immigrants access health services?

8) A. Does the botánica seem to offer a sense of cultural continuity in health services for Latino immigrants re-settling in the Southeast? (for botánica proprietors)

B. Are there cultural barriers that interfere with mainstream health service providers effectively treating Latino immigrants?

9) Is there any potential for collaboration between botánica proprietors and mainstream health service providers?
A & B. What about with academic researchers focused on this population?

The first feedback received was from a Mexican immigrant living in Georgia who has regular insurance and still regularly accesses botánicas. Her feedback was extremely helpful; she also suggested a referral that would be a good candidate (and was ultimately interviewed) for the mainstream health service provider sample of individuals. She had this to say regarding the first question:

> "Sometimes we visit botánicas not just to buy but to ask for their advice on how to treat an ailment. For the most part, they will try to sell you a product in their botánica but if they know of something else that you could do to treat your ailment, they will share that with the customer. I don't think it [is] just about making a sale. Some botánica owners build a relationship with the clients where they both share knowledge and experience. So what if you say how many potential clients visit your botánica on a daily/basis? Of those that visit, how many would walk out with a product?"

For question 4 A, as outlined above, she suggested adding the follow up questions as quoted below.

"In your opinion, how do you think the Latino community perceives botánicas in the US? What role would you like to play in the Latino immigrant health?"

For 4 B, she suggested:

"In your opinion, how do you think the Latino community perceives the healthcare system in the US? What role would you like to play in the Latino immigrant health?"

And finally, in terms of question number 8, she altered the syntax a little bit and expressed that she liked the question in general. Her feedback:

"How does the botánica ~~seem to~~ offer a sense of cultural continuity in health services for Latino immigrants re-settling in the Southeast? (for botánica proprietors) (I like this question.)"

Dr. Joseph Murphy, from Georgetown, responded:

"Thanks for sharing this with me. It looks like a most worthy project. I think the survey as it is written might hit some practical problems. The questions are dense, often have multiple parts and require an educated mastery of English. Most of my botánica interlocutors weren't native English speakers and weren't attuned to the more "academic" questions that interested me. I had to "gear down" to find the conversational wavelength that would elicit the information I was after. I'm sure you're aware of these basic fieldwork issues but I wanted to prepare you for the culture gap. I wish you the very best in your fine project that recognizes the contributions of non-allopathic health workers".

In response to Dr. Joseph Murphy's advice, the plan is to keep the questions as designed and note any specific rephrasing which becomes necessary in the questions' delivery on a case

by case basis. Such a method will preserve the integrity of the academic inquiry, while also adapting to the diverse comprehension levels of each interview participant, and perhaps even introducing to them new terms or phrasings which could be useful in the future discussing their work with individuals in the academic or medical sectors.

Now former District 2 Public Health Director, Dr. David Westfall, who is an MD and Emory professor who speaks fluent Spanish, also weighed in with some advice when presented with the first draft of questions. Among other more general feedback about potential recruitment methods, in regards specifically to this survey he expressed:

> "You might want to add a question or two to ask each group whether there is currently any communication between the two "camps" (traditional healthcare providers and alternative/folk/cultural providers), and if not – what are the barriers they perceive. Also – what benefits, if any, they could envision from more open communication/collaboration".

A former undocumented immigrant from Peru – who is now a citizen, has obtained a Georgia State University college degree, and is working for an initiative which currently educates the Latino immigrant community in Georgia about the Affordable Care Act – that was reached out to (and described previously) has a unique perspective on botánicas because his mother is a botánica proprietor back in Peru and his uncle is an allopathic physician there. Coming from his both uniquely cultured and educated perspective, he expressed curiosity about how socioeconomic status and perceptions of socioeconomic mobility influenced the botánica phenomenon. Beyond that, he was very interested in finding out whether individuals preferred to access botánicas with proprietors from their own country of origin; whether there was also a correlation between education levels and accessing botánicas, both in countries of origin and,

comparatively, now in the U.S.; whether the botánica proprietors ran or worked for botánicas in their own country of origins (or if it was a family tradition, as he says it usually is in Peru); and in relation to the last point, how running a botánica in the U.S. compared to running a botánica in their countries of origin. He expressed concern about individuals who might be opening botánicas here without roots of experience or tradition in Latin America. There were specific reasons for this concern, he said, which will be explored at a different phase of the research process.

Due to the specific contexts and constraints of this study – since only proprietors and not customers were surveyed – it was not possible to deeply explore all his interests in the scope of this initial project. However, the questions were updated to gather perceptions on the differences between running a botánica in the U.S. and in the proprietor's country of origin, including whether they actually ran a botánica in their country of origin.

Through subsequent exploration, it became obvious there should be at least one pointed question regarding indigenous culture, since it is a foundation of the botánica phenomena, and also important to probing how many indigenous immigrants here in Georgia are accessing botánicas. Indigenous language speakers have been found to encounter increased barriers to health information and services in farmworker communities and elsewhere around the U.S.

Interviews were conducted face to face and generally lasted about an hour. Each interviewee was provided with a $25-dollar incentive to make up for any lost wages. This amount was deemed to be sufficient without being coercive. In some cases, a translator had to be present for certain interviews; in this case, they too were provided the same $25 stipend.

(A translator was acquired for 4 out of the 5 interviews in the botánica sample to assure as little as possible was lost in translation. Interestingly, in every single case, it ended up being the daughter of one of the botánica proprietors).

Dissemination of Results

It is anticipated that study results will add to the general body of knowledge regarding non-allopathic health services currently being accessed by marginalized populations, in a manner which aligns with goals of the World Health Organizations (WHO) Traditional Medicine Strategy 2014-2023. In service of WHO outlined goals, any potential for integrative approaches (between the allopathic and non-allopathic health sectors) to emerge were analyzed and the emergent opportunities discussed in a later section. It is further anticipated that the study results may – perhaps, most of all – be used to inform the process of training allopathic health service providers in Georgia and the Southeast to better understand the communities they serve. For example, medical students participating in the University of Georgia - Georgia Regents University partnership to produce doctors working in the state of Georgia are not currently receiving any specialized training on working with Latino immigrant populations. It is possible that research outcomes of this study could also create a network of individuals who could participate in overcoming this oversight, through activities such as guest lectures, field and participatory immersion experiences and study, and ongoing opportunities for community immersion education.

Chapter 4

RESULTS

In this next to last chapter, I will: review the sampling methodology; provide descriptions of each sample of individuals to the extent their personal identities may be confidently preserved as confidential; describe the challenges to recruitment; and, present the data collected during the study interviews as it has been aggregated and coded according to salient themes which arose through the application of the qualitative methodology commonly referred to as the constant comparison method.

Sampling Methodology Overview

The ambitious scope of this project originally aimed to attain an equal sample of 10 botánica proprietors, and 10 mainstream health providers – in the state of Georgia – within the span of time allotted for field research (about one full semester).

Through adopting the snowball sampling method initiated from inside my personal network, the recruitment momentum started off rather prolifically, and then subsequently and significantly waned. Within the first several months, 6 mainstream health providers were recruited and interviewed during recorded sessions which lasted an average of one hour. During the final months the next (and) final 3 were procured with more difficulty but were also more precisely identified based on their position of expertise regarding salient themes (in particular, the HIV crisis) which had arisen through the former interviews.

The first wave of botánica recruitments came easily, as all were recruited through previous or cold contacts at a large weekend market where more than a few operate openly. The 4th interviewee was identified at another large market in a largely immigrant section of Atlanta – each market seemed to replicate the sort of open markets one finds around Latin American cities and pueblos, but both were mainly enclosed indoors. The 5th botanica interviewee was recruited when they took over the space previously occupied by another botanica shop familiar to me through previous contacts.

A 6th non-Latino TIM provider in the Northeast Georgia area – who worked at the ongoing Standing Rock indigenous protest of the Dakota Access Pipeline as a mental health emergency therapist – was also recruited and interviewed to gain a more comprehensive look at TIM practitioners in Georgia. He has formulated his counseling methodology based on a set of pan-indigenous (northern) Native American values – common to most North American tribes. His perspective, while different, provided a larger macro narrative which promoted a natural coherency to the micro narratives which emerged from the interviews with individuals recruited for the Latino botánica sample.

Botánica Sample

The botánica sample was diverse: proprietors hailed from Mexico, Venezuela, and Ecuador (these countries all have drastically different cultures and indigenous traditions). One woman was (according to her husband who ran a separate botánica) answering for both of them as 2 separate proprietors, though he was not counted separately in the documented cumulative sample in the section above. For his part, he said, “Her thoughts are my thoughts”. I was invited to their home in a compositely immigrant neighborhood of northern Georgia – their home was immaculate and projected a level of comfortable affluence – and their daughter, while calmly

attending to her toddler, happily provided translation. The daughter was accordingly also compensated the $25 stipend awarded to all interviewees as approved in the research application and in turn adopted as Institutional Review Board (IRB) protocol. This particular interviewee was extremely open and excited about the possibilities of broadening the scope of botánica networks to work with more mainstream health, medical, research and academic communities. She was the polar opposite (as far as transparency and a desire to collaborate) of some other providers who had shunned any discussion on their work (for reasons that I was repeatedly told likely had to do with immigration status). This woman however, who spoke little English, exhibited exceptional levels of comfort at the idea of being adopted into mainstream health networks. She discussed how the FDA already visited her and her husband's stores regularly – and that if they told her to stop selling an herbal remedy or supplement, she did – and that a doctor regularly came to her shop to conduct diabetes and blood pressure screenings (both diabetes and hypertension are especially salient health issues in the Latino immigrant community in Georgia and elsewhere). She also spoke of immigrants from other regions such as Asia and Africa frequenting her establishment, which validates WHO conclusions that TM/TIM is seen as a trusted healthcare option in many regions of the world – and from this anecdotal evidence, may in fact transcend individual culture.

Another proprietor – as it turned out, everyone in the botánica sample who agreed to be interviewed, was a woman – invited me to her shop before opening hours. I provided a stipend to her daughter as well to help with translation, which she was very efficient at. Her daughter had plans to attend college and become a medical doctor. She had worked in her mother's botánica every weekend while in high school and was inspired by this experience to aim her career plans towards a more formal healthcare setting. She is the type of second generation immigrant who

may be changing the ecosystem of Latino healthcare in Georgia, even without explicit intervention, in the next 20 years or so. Unfortunately, many crucial issues still exist in the present.

Another female proprietor, whose shop was within walking distance from the last woman described, agreed to allow the daughter of the previous interviewee to translate for her as well. They seemed to be familiar with each other. The botánica networks are very intertwined, and as previously described, tend to specialize in unique services so there is not much sense of competition. It happened that this young woman earned $50 that day, for around two hours of work; and, I was able to get two diverse perspectives – the two women interviewed that day were from different countries. Each was open in some degree to working with the outside medical, health service, and academic communities. The latter interviewee described was the first I encountered who had run a botanica in her country of origin; and, she found the opportunities to make a living running a botanica in the United States more lucrative, financially. Another woman would later tell me that a corresponding downside was that a lot of the herbs Latino immigrants traditionally used – and their clients were used to buying – are not easily transported over the border into the United States, nor obtained or grown here.

The fourth TM/TIM provider was recruited through a cold visit to a previously described Latino open market in an immigrant section of Atlanta. After being rebuffed by the first one approached (the woman literally, while perhaps coincidentally, packed up and went home when a bilingual individual nearby told her what was being asked of her) I found another one operating in a different area of the market who openly (and somewhat tellingly, regarding the previous encounter) announced with confidence that she would be happy to participate, as she was a legal

citizen of the United States. This did end up being the shortest of all the interviews; however, the woman's perspective was unique and valuable, if succinct.

The fifth botanica interviewee was carefully courted through a series of visits, the initial one happening to occur within non-business hours when I could see that there were still people inside. It was at this initial encounter she first declined to be interviewed without even much apparent thought, but I was still immediately provided a chair and invited to sit down and socialize. There was a Cuban-Nicaraguan woman who spoke excellent English and I engaged with her for about an hour, having traveled extensively in both countries myself. Before I left, the Cuban-Nicaraguan visitor was able to explain more in depth my intentions, which were compounded on a visceral level by the rapport which had been established, and the proprietor agreed to be interviewed the following weekend. She identified her daughter – who was not present at the time – to be the designated translator at that date. Her daughter was there at the time of the interview – and the shop, still new, had expanded significantly over the prior week. This interview turned out to be one of the most groundbreaking in terms of reaching a true understanding of my intent for the study, and the subsequent trust nurtured may or may not have contributed to this proprietor's expressed willingness to communicate further and openly with the mainstream medical sector.

The sixth indigenous medicine (TIM) provider was identified in North Georgia and was of North American, Native American descent. He is a certified medicine man within his greater tribe; and, he operates a mental health counseling center in a rather urban-adjacent area of Georgia. His clients come to him for his special indigenous-based treatment methodology, based on a set of indigenous values consistent within most tribes in North America. His perspective was valuable as it intersected with much of the data collected from the Latino American

providers also operating in the state and contributed towards overall themes on the importance of approaching health challenges at the community level and the significance of generational trauma. Although he serves mostly non-indigenous peoples in his general practice, he had played a significant role in providing mental health services at the Standing Rock reservation during the protest and occupation against the Dakota Access Pipeline; and, he was able to weave in his experiences in working directly with indigenous peoples there.

Challenges

This section will walk through three of the main obstacles to recruitment for this study. Two of these were unforeseen, while one was expected. The largely unexpected election of Donald Trump turned out to be an obstacle, as was the arrival of Hurricane Irma. Facing off with a general seasoned attitude of distrust towards academic researchers was considered par for the course but still merits discussion and inclusion here.

Election of Donald Trump

The biggest unforeseen challenge of research recruitment occurred in finding individuals willing to participate as part of the sample of botánica proprietors after the largely unexpected election of Donald Trump (which occurred after the planning and exploratory research, and just before the onset of this study). Donald Trump's heavy anti-immigrant platform and hyperbolic threats about mass deportation seemed to function as a significant deterrent in recruiting for the botánica sample. It turns out, his xenophobic propaganda did more than just cause paranoia among the botánica community, it was also bad for business in general. Two botanicas I had conducted extensive meetings with during my exploratory research phase ended up closing down because, according to one, "People are saving their money, you know, in case they have to flee,

or they get deported. They are not spending money on these types of services right now". One said it was causing him and another proprietor just down the road (who had always projected an extremely affluent front) to close. At first, I considered this could be a paranoia-induced evasive strategy of his own, but sure enough in the coming weeks, both botánicas in that region took down their signs and disappeared from public sight. The issue of Donald Trump became a recurring theme in all of the interviews, in both samples. In the botánica sample, no one liked him. Everyone thought he was crazy and cruel – although one admitted that she prayed regularly for his heart to open and see that most Latino immigrants are honest, and hard workers who deserve a chance to realize a better life in this country. Some of the interviewees were economically sophisticated and expressed how capitalist system he seemed to be a figurehead for had functionally decreased the opportunities for Latin Americans to make living wages in their home countries because of the low wages paid by U.S. factories and the monoculture crops which U.S. corporate entities had appropriated from traditional farmers, displacing them and robbing them of their livelihood.

Hurricane Irma

During one of my later recruitment cycles – which, as previously described, was more specifically targeted in relation to rising salient issues – approaching individuals in the mainstream sample, there arose a wave of new hope about an entry point through which I might gain entry into some of the really, really underground TM/TIM practices in the largely marginalized communities of Latino migrant workers in South Georgia. Referrals were given, plans were made to travel to this region, but in came Hurricane Irma which stopped everyone and everything in its tracks. As entire communities in the region were flooded, causing mass evacuations to the Atlanta area (where there will still massive power outages from the storm) I

was prevented from taking advantage of a window for travel to the region. The hope had been to leverage two connections referred by a previous interviewee who had done a lot of work in the area, into access points within the community of isolated migrant workers themselves. Unfortunately, this did not pan out. Even as the physical obstacles and damage began to subside, the referrals – especially as public health professionals – were buried under mountains of work, delayed by and/or caused by the deadly storm. Eventually, I was able to – through persistent diplomacy – schedule an interview with a public health worker in the area who had an extremely valuable perspective and close relationship with the migrant worker community to boot. Though, there was no opportunity to leverage this contact into contacts that might produce more TM/TIM recruitments, it did provide a larger than expected lens into the world of a migrant worker in South Georgia. This included in-depth perspectives on not just health but sociocultural factors which were indicators and predictors of health outcomes as well.

General Distrust

Beyond the unexpected election of Donald Trump and the unpredictable force and path of Hurricane Irma, I expected to encounter a significant level of general distrust in a population – the botánica sample – which operates largely underground through in-group word of mouth networks which likely included a multitude of undocumented individuals (both as proprietors and clients). Having traveled through seven Latin American countries, and speaking enough Spanish to communicate basic ideas, I was able to somewhat penetrate this largely secretive community with more ease than a standard ‘gringo’ academic might, but with considerably less than a native speaker might have. However, it did help that my travels through Latin America were focused on navigating the more impoverished regions and I was often immersed among the general sort of individuals who might attempt to emigrate and remain within the insular

community networks that the botánicas serve after resettling. I have observed that some more affluent Latino immigrants or politicians who might ostensibly seem to be capable of establishing a more natural rapport with these communities and individuals are still saddled with prejudices stemming from the wide chasm of class division characteristic of almost all of Latin America – even the ostensibly more egalitarian states, such as those which identify with the socialist Bolivarian revolution. On a related note, while traveling in Latin America, I have found that people are prone to dress their best every day and present themselves as perhaps more affluent than they are. If a North American dresses in some of our more typical casual attire while visiting certain communities in Latin America, it can be seen as a sign of disrespect or condescension. However, with the botánica culture of Georgia, I learned almost immediately not to show up in a blazer or button up shirt – as here, that was a sign of authority that might be perceived as dangerous or at least inconvenient for them to encounter. Obliging to this, I began toning down my appearance more and more – even adorning essential oils like patchouli, which I already owned, but would normally not wear in a professional setting because of the connotation of it being unprofessional. However, this sort of display of my more bohemian side seemed to appease the sensibilities of potential interviewees and softened the encounters to a large degree. Sometimes I would even make a point of showing my tattoos – which are considered even more anti-establishment in most Latin American countries because of their affiliation with gangs, and this seemed to help prove that I wasn't a dangerous authority figure (or agent of one) trying to weasel my way into their community. I found myself having to prove myself in some way, repeatedly – which sometimes included speaking expressly negative, if authentic, opinions on Donald Trump, ICE, and the immigration system in general – and all the more points were awarded when I was able to do it through the use of some semblance of 'Spanglish'.

Additionally, some state or local public health officials or health workers did not feel comfortable speaking about immigrant issues in the current, heated, political climate in any manner and thus declined, or were hesitant, to participate in this study.

Themes of Botánica Sample

The three most salient themes which emerged from the botánica sample included: a broad consensus on salient health issues and ideas about a more holistic and natural view of health which focuses on preventative medicine as much if not more than cures or rigid treatments; common reasons why they would or would not be inclined to increase communications or activity with mainstream health actors; and, political and cultural factors which impacted how Latinos seek, or barriers they encounter in seeking, healthcare overall.

Health Issues

Every botánica proprietor mentioned diabetes and high blood pressure or hypertension as prime health issues in Latino immigrant communities of Georgia. The first proprietor I approached immediately said, “Diabetes. And, stomach issues – ulcers, gastritis, obesity”. Stress was also a common theme, and this ranged from work stress (from an extremely physically demanding job or jobs) to stress generated from being in an environment where individuals perceive a lot of personal and politically oriented discrimination, or even the threat of persecution (i.e. deportation, detainment, etc.). As one proprietor expressed, touching on these compounding issues, “…a lot of people are being stopped w/o license, scared to drive and go out [to work or access health services] for fear of deportation, because the president is threatening to deport a lot of people. They should try and give people the chance to work and prove themselves. There are a lot of people working in the chicken plants, and they steal their hours; and, they are

afraid to speak up". Devastatingly, I quickly and unexpectedly stumbled upon a latent HIV epidemic – which a mainstream expert scaled at a 10 on a scale of 1-10 in severity when it came to impoverished or rural Latino immigrant groups. One botánica proprietor went as far as to seemingly relate this with aspects of acculturation, saying that the "HIV epidemic is as product of being exposed to liberal American values. I believe it's also harder for them to get diagnosed because it's such a taboo". She implied that those at risk might not easily submit to testing which could leave them stigmatized within their community; and, she spoke about how the lack of a diagnoses makes it impossible to seek health services for HIV in mainstream or alternative community settings. A trend expressed over and over in both sample groups, is that there is a problem where immigrant men come to the United States a few years or so before their spouses; and, there are sex workers who cater to this specific population, who are also marginalized from the type of care where they could, and would face the same stigma of having to, be officially diagnosed. Years later, when the men have saved up enough money working, and their spouses come to join them, they then procreate; and, the wife often won't seek health services until very late in her pregnancy, at which point they may find out that the whole family has HIV. One botánica practitioner noted that if someone comes to her with HIV, she tells them to, "Go to the doctor". (This is a theme which will be addressed more in the section on the mainstream health service sample). Another less, though still somewhat sensitive subject addressed by one of the interviewees was drug abuse. When asked about salient health themes, she replied, "Kidneys. Lungs. Drugs – I also help people trying to get off drugs, or to cleanse for court dates". However, she went on to affirm that diabetes was, in her experience, the biggest problem; and, she noted she also gives a lot of treatments for diabetes. "Some have it when they come; some get it here", she claimed. And finally, kidney problems were an issue repeatedly addressed by the

TM/TIM interviewees as a salient issue in Georgia's Latino immigrant population. One went as far as to potentially link it to the pesticides many are exposed to in farm-work, and the overall excess of chemicals present in the food and environment here (as per her impression). Two proprietors claimed their specialties were in spiritual cleansing, blessings, and candle magic – even including love spells.

One theme was common among interviewees in both samples: they all had encountered indigenous individuals who spoke neither English or Spanish, but in every case, they described such individuals as being escorted by family members who could translate for them, thereby these individuals seem to be insulated within their communities, if further marginalized by health services individually. It is unclear how many indigenous immigrants arrive here without families and are thus completely invisible to both paradigms or cultures of health services here in Georgia. Accordingly, it may also be more difficult for them to access services when they have to rely on other family members any time they need to access them.

The non-Latino indigenous TIM practitioner regards "isolation" in and of itself to be the most significant health challenge faced by both the indigenous communities he has treated, and also in the more mainstream populations he regularly encounters in his Georgia practice. As a mental health practitioner, his views on the health dangers of isolation and the need for community, resonate with the underlying themes of the botánica phenomenon itself and lend support for identified needs such as cultural continuity and the inherent danger of marginalizing populations from the larger mainstream health service community – which lies at the root of many of the most severe negative health outcomes in the Latino immigrant community, including but not limited to the severity of the burgeoning and expansive HIV crisis and how it has flown below the mainstream radar for this long.

Views on Increased Communication with Mainstream Health Systems

The individuals in the botánica sample were split 3-2, the slight majority in favor of working and communicating more with mainstream health providers. There was some suspicion expressed regarding mainstream providers' willingness to validate the natural treatments they provide. One proprietor was concerned, and expressed, "I believe that some of the physicians know that herbs are good and are healing but they're not going to recommend them because then they won't be able to sell their product – but some are aware of their healing powers". For the ones who tended to favor the idea, increased understanding of natural and herbal medicine within mainstream healthcare was a goal universally cited. There was excitement about the idea of an interchange where they could refer patients to appropriate mainstream facilities if they presented symptoms or conditions the proprietors were not equipped to treat; and, in turn mainstream providers could call on them to ask them about specific herbal or nutritional remedies which they might not understand and might otherwise discourage patients from taking out of fear. In the case of at least one interviewee, this was already happening. She described, "I do have some types of contact, but they are not traditional physicians, they are also into curing and healing with natural medicine. Some of them back me up, selling my products; and, I can call them for consultations about patients I am not sure how to treat. I have one of them who works with me about two Sundays out of the month to offer free glucose testing and free blood pressure testing; and, he doesn't sell anything. He'll advise lifestyle changes and ask for [customers] to quit drinking Red Bulls and Monster Energy. If there is something wrong, then he'll recommend something from the store". She also said that in certain cases, "like with someone with a serious illness coming in, I'd like to be able to contact a physician to see if I could treat them or if they needed more advanced medical care". All TM interviewees liked the idea of helping to create training

modules for medical or health students who would be practicing in the state of Georgia and seeing a significant number of Latino immigrants. There were also, as noted, more obscure lessons they could provide, such as culturally specific semantics used when describing health conditions. There wasn't much, if any, paranoia expressed regarding whether increased communications and visibility to mainstream health actors would have a downside of increased scrutiny on their practices, in the sample which was already comprised of those who agreed to be interviewed in the first place. One explained how she and her husband were already receiving visits from the FDA. "Yes. We also get monitored by the FDA, they come to our booths and take a look at everything we are selling. Sometimes they advise us to stop selling [certain products.]. They don't endorse everything, but they let us keep selling it".

Political Issues

The more specific topic of how the current political climate impacted the way Georgia's Latino population accessed healthcare services was a major theme that everyone interviewed had strong opinions about. The first proprietor I encountered, when talking about the implications current state and national politics had, relayed, "Less access, definitely – to access any kind of insurance or healthcare. Botánicas will play a greater role". She believes botánicas will come to play an even greater role in Latino health, as politics around immigration become more and more heated because, "[They're] easier for [immigrants] to access". Another proprietor noted certain effects which she identified as correlating with the election of Donald Trump. She mused "Since he was elected, all the Latinos like, they started working less…in general. [It] impacts their health; people started getting stressed…and [succumbing to the] pressure". Interestingly, in one way or another, every TM provider noted that a repeal of the ACA (or 'Obamacare') would have

a negative impact overall on the way Latino immigrants accessed healthcare here in Georgia, insinuating this would result in worse health outcomes overall, over time.

Another broad theme was the preference for natural medicine in general that stemmed mostly from the medicine immigrants had access to in their home countries. One proprietor explained, “I took nursing classes in Mexico, but it also comes down to my ancestors who would also treat each other with natural remedies and cures. So, I started getting into it”. It’s not necessarily true that mainstream medicine is wholly absent from the countries they emigrated from, but the individuals who choose to emigrate, are sometimes poor and seeking better opportunities (at least in this subset of the Latino population, who regularly seek out botánicas). Therefore, the preference for natural medicine was often presented as the combination of a desire for cultural continuity and a continuing issue of fiscal barriers to more expensive treatments, while also being an intrinsic part of their value system. One proprietor shared how she thinks botánicas “…play a major role [in Latino immigrant healthcare in Georgia] because healthcare is free in Mexico; so, they’re coming here, and they don’t have access to that; they resort back to what their ancestors do, which is with herbs and everything natural. [Natural medicine is] a very fundamental part of where they grew up”. Another proprietor said that running a botánica in Georgia may be more financially lucrative than in Mexico, explaining, “I believe that [there is] more revenue here in the U.S. since people don’t have the access to free healthcare like they have in Mexico, so I see more people. But again, there are people who would rather have natural medicine than anything else”. Obtaining the natural medicines many immigrants might prefer is not always easy; one proprietor recalled being stopped at the border for trying to bring back legal plants as requested by her customers, “They told me I’d be fined $300 if I tried to cross the border with them”. Another proprietor noted that this problem of acquiring plants and herbs

related to their indigenous traditions existed for her too. She phrased it as, “It’s a lot different here. Over there [in her home country] there are natural plants. And here, there are pills [which claim to] have natural plants [in them.] The plants here come from different countries… [there are] more chemicals in the plants here”.

Vitamins are gaining momentum and presenting almost as popular as herbal remedies in many Georgia botánicas, which lends credence to the idea that preventative medicine is seen as a financially responsible approach to health, since not all vitamin products observed are necessarily ‘natural’. Customers are actively seeking to prevent health problems which may exceed their financial capacity to seek treatment for in the future if they were to incur them; and, this was cited multiple times as a relatively positive trend. The same proprietor referenced above shared, “A lot of people don’t actually take the supplements because they are sick, but to prevent sickness”. An astute observation made by one proprietor was that she believed immigrants recognized they couldn’t afford to let chronic conditions like diabetes progress, because this could make it even harder (with a pre-existing condition) for them to get insurance in the future. When it comes to concurrent use, one botánica proprietor observed, “People might go to [a general practitioner] doctor for diabetes and blood pressure checks. They look to them for diagnoses, but [they] come here for products and treatments”.

Description of Mainstream Sample

The mainstream sample also generated from within my immediate connections and snowballed out according to referrals and from information presenting in accumulating research. This group was more aware of privacy issues which could affect their job security, so their individual descriptions will be less forthcoming. It became clear early on that it would be extremely beneficial to speak with some mainstream health workers who worked directly with

HIV or infectious disease units; and, there were certain areas of the state where there were higher concentrations of immigrants, and interviewees were specifically recruited (sometimes through cold approaches) for a representative perspective for these regions. The mainstream sample consisted of health services workers who were working with majority Latino populations either through public health services, non-profit groups, outreach services from universities, advocacy groups, or private clinics. Each one had a different role than anyone else in the sample, and some were Latino immigrants themselves. The ones who were Latino immigrants (and the non-Latinos who were very embedded in the community) had a clear sense that they were walking in two worlds which they were constantly bridging – both personally and professionally. There were several who seemed to take great joy in the idea of helping to train new or currently practicing health service workers in how to better understand and better serve their Latino patients and clients.

Themes from Mainstream Sample

Themes which arose from the mainstream sample were surprisingly congruent with the botánica sample, even though they were, of course, administered intentionally comparable questionnaires. They were no major discrepancies on salient health issues, the impact of current politics, or even some of the more negative aspects of acculturation. Of course, some members of each group were expectedly loyal to their own perspectives regarding which type of treatment or culture was the most important to the larger communities served – but there was a lot of open-mindedness, much more in fact than I expected. It was a pleasant surprise which has auspicious implications for future studies and/or interventions.

Health Issues and Barriers

While diabetes, high blood pressure or hypertension, high cholesterol, and stress were, as expected, among the most prominently discussed health issues presented by the mainstream health worker group, there was one issue which shook up the entire research process – which was the reported prevalence of HIV in a group largely marginalized from access to diagnostic procedures. There is no overstating the severity of the existence of a largely unknown, latent HIV/AIDS epidemic in Georgia among rural and impoverished Latino immigrants – and to some extent beyond – which has presented itself through the course of this study. Also mentioned with frequency was obesity, which is largely correlated with diabetes; and, this is often associated as a product of acculturation and the amount of processed foods in the U.S. diet. However, one mainstream health service interviewee who was himself an immigrant didn't blame weight gain solely on processed foods. When asked about health issues that tended to get worse after immigration, he replied, "Yeah, weight…blood pressure, cholesterol, diabetes. Everything related to food. We had a more active lifestyle wherever we came from. Much more sedentary here; you have AC and heaters; you don't have to have daily activities to protect from the elements…Food habits…don't change…with the lifestyle changes. I gained 20 pounds my first year in the U.S. eating half of what I was eating in [my home country]. More processed foods here…Fresh food was cheaper [there] because you have to sell it quickly; you were forced to eat healthier. Diversity of food…Under that rationale you have less processed food by far. It was easier to have access to healthier food. I never ate canned food because it was more expensive.". Being from Latin America and working in the U.S. in mainstream health, he also offered a perspective on some barriers to health. "Language barriers – when you are sick you don't know how to describe it. Being documented [or not] is a big issue; transportation – many wives

[especially] don't drive. Also, compared to [my home country] there are more tests and diagnostics, instead of touching and actual physical examination. [In my home country] it's more personal, less clinical, more physical. I took my grandma to the doctor here, a urologist, to check her kidneys. I remember the doctor asking, 'does it burn, itch or sting?' She was like, 'What? How can I tell the difference?' Doctors [in the U.S.] rely more on their numbers and blood tests. In [my home country], it's more holistic". All mainstream interviewees mentioned lack of insurance as a barrier to health services and positive health outcomes. One health service worker suggested that other than HIV – which immigrant and migrant workers seem to be contracting once they get to the U.S. – some do come here with undiagnosed infectious diseases, such as tuberculosis, from their home countries where they may have still been marginalized from healthcare diagnostics if they were living in a rural or impoverished area (and weren't able to easily access even 'socialized' or 'universal healthcare'). Living in rural and impoverished areas of Georgia, according to data collected in this study, creates a higher risk for infectious diseases as well. The latent HIV epidemic among rural and impoverished Latino immigrant populations cannot be emphasized enough, though. It has reportedly reached drastic proportions – one mainstream health service provider, as referenced previously, rated the severity a 10 on a scale of 1-10 for this subset of Latino immigrant populations. They said, "Traveling [migrant] farmworkers show up and then will participate with prostitutes and end up with HIV or STD's at camps. It's getting better here but 5-10 years ago it was bad…the [migrant] camps were bringing in lots of women from the town. I used to work directly with some of the prostitutes as well [because] HIV was prominent. We have seen that get worse within migrant worker populations as they travel between camps". This worker cited the lifestyle instability of the migrant worker as putting them at a higher risk for negative health outcomes. They described a double pronged

approach to mitigating and treating the spread of HIV within the migrant worker camps. One way they do this is through: “Targeting prostitution with jail outreach. I talk to them about safe sex, wearing condoms, and being safer. If I can get the prostitutes tested more regularly, and get the guys [in the migrant worker camps] to wear condoms…it’s a type of risk reduction/harm reduction model. I give away tons of condoms and do health education”. This interviewee said they also sometimes visited local strip clubs and bars where they knew the presence of sex-workers was high or likely, to do public outreach and education; and, they cited the lack (or lack of application) of soft skills among public health workers in really being able to immerse themselves in the communities they serve and gain their trust as an issue which should be more prominently addressed, both in practice and education. When discussing the reason that the presence and spreading of HIV seems to be more prevalent in the U.S., one interviewee, who was also a Latino immigrant, explained, “Something that’s different with sex…in Latin America… [HIV] is probably more of an issue in cities in Latin America… [In smaller communities there is] collective peer pressure to have less sexual partners. Even in the cities, it’s way more sexualized than here, so you are forced to deal with awareness of HIV. There is no HIPPA in [my home country], so if you have AIDS, everyone will know… Everyone knows your business; it’s a collective society. Immigrants who are deported after contracting AIDS in the U.S… It’s a valid concern, because people might try to keep it a secret. Access to treatment [for HIV/AIDS] is more expensive in Latin America, treatment is harder to get – you won’t last long once you get it. There are no specialized clinics…If you send someone [with HIV or AIDS] back to [my home country] and the medicine is too expensive, and there are no clinics…it’s a death sentence. Collectivism is a protective factor; it's very stigmatizing – people are more careful; it’s a deterrent. So… people who come back might not even tell anyone until they started

to get really sick. The medicine is cost prohibitive". Another service provider found mental health issues to be most prominent, even among the commonly presenting physical morbidities. When asked about salient health issues, she responded, "Basically, adjustment disorders, trying to adjust to a new culture. Lack of financial…a lot of financial issues, high anxiety, high domestic violence, high depression. Anxiety from [the] political situation. [The] main issue [is] separation from family…Stress makes domestic violence worse". She also mentioned that she believes some barriers to care can actually be relieved for Latino immigrants upon resettlement who were impoverished or living in rural areas of countries with socialized medicine, "They don't have doctors in their hometown. Even in countries with socialized medicine they still can't access [healthcare] as easily". However, a caveat to what may present as an increase in access is not met without challenges. She went on to say, "The cultural gap is a barrier. Definitely. Having low education, no elementary or high school, not being able to read or write – these are boundaries to achieving anything. They can't open bank accounts or other services. Cultural and language barriers, and education. Eighteen out of twenty have the same problem – depression and anxiety. Building a connection with a doctor – [where they] will be on the same page…If the doctor understands and is able to bridge the gaps, it will help". She also, going back to the HIV epidemic, explained that there are cultural barriers to men using condoms. "They have high rates of HIV because they are not educated, and even when they are educated, there are cultural barriers towards using condoms…This would be very bad if there was a mass deportation. Men will never get checked for HIV, same with females. If there is a mass deportation, all of these people will go [back] there without knowing. They don't have the same access to health there". Another mainstream practitioner had some more pointed comments regarding the universally expressed themes of diabetes, hypertension and high cholesterol. "I used to be a lactation

consultant; and, so many of the people would come from a culture where everybody breastfed, and it was very common. They come here and see people feeding babies bottles; and, babies are getting fat. Correlated with greasy, fatty, sugary foods here, they become overweight which brings diabetes, hypertension and high cholesterol". She also was of the mind that access to healthcare removed some barriers to positive health outcomes here, explaining, "My impression is that they don't get any or very little healthcare where they come from: Mexico, Guatemala, Colombia, Peru, all over the South American continent. Access to healthcare is easier here, and that comes with education about high blood pressure and diagnoses and referrals. They get care here. And then, there are some issues where you have to decide whether they are environmental or hereditary. Undocumented immigrants are not sedentary – they usually work at least two jobs and have a very driven work ethic". Speaking specifically about the migrant worker population, one interviewee offered, in terms of salient health issues: "Hypertension; eye issues – eye exposure to the sun while picking crops, you can't see [the crops] wearing regular sunglasses. We provide clear UV protective glasses. And also, athletes foot". Even for the younger migrant workers, she described them having health conditions related to being overworked in ranked order of: "Skeletal and muscle pain; chest pain and hypertension; and ear issues". She added, "These are young people having these issues, things you normally wouldn't see in a 20-year-old. Hypertension is a genetic issue for some. Dermatological issues are also a problem because of the sun and whatever is on the crops". On a totally different topic, a public health worker offered some thoughts on how a Latino immigrant culture of 'machismo' contributed to health outcomes and services sought by women. "Machismo has a lot to do with sterilization. They want their women to get their tubes tied; they don't want to get a vasectomy because they fear losing their macho image. It's hard to get through to the man through his wife, because he is in this culture

[of machismo] …but they women are saying, 'I'm not having any more babies'…One husband was scared of a vasectomy…'Who does not want to get pregnant again? [his wife said]. 'It's me.' That's the way women feel…He's not going to do it…What I do in my position is, they come to me and say they want a tubal but they're not sure; I mention the vasectomy, and I provide Spanish material about vasectomies. They will pay $3,000 in anesthesia, and [there will be a] 3-week recovery for the woman's procedure. [For the] husband? An over the weekend recovery; and urologists in local areas will do it for $500 to $850. The male procedure is actually done in the office; and, they're back at work on Monday. The difference is so significant".

Views of Botánicas

Views on botánicas and other more underground Latino immigrant health services varied a lot among the individuals in the mainstream health sample. Some described anecdotal experiences which had given them a bad impression, while others whose views were less critical were not as optimistic about other people in their field(s). One interviewee who expressed no critical views of her own, said, "I think they are, or would be, perceived…by mainstream health workers, negatively, unfortunately. There are issues with cultural competency, education, training – perhaps on things that in this particular culture is the norm... [Health service workers] should make more of a connection to the culture…[and] then if they feel like [botánicas] are helping, then maybe they'd decide [Latino immigrants] need both". She feels it's not just the botánica culture which is unknown, but the sub-population of migrant workers as a whole. "I think that farmworkers are a forgotten population; any contact that makes them visible is good. Spreading the word that they are here and that without them we would not have any produce". Another interviewee thinks the reason there hasn't been increased communication is a byproduct of such invisibility, which has translated to the situation where no one has even tried to initiate it.

"No one has made the effort to. Make the effort…I'm thinking there are many things that are treated through traditional medicine that are hard to explain in medical terms – but they work". One mainstream health service worker noted about their region in particular, "They don't have [botánicas] here but a lot of Hispanic grocery stores have areas within the stores. A lot of times they will get meds out of network; and, they'll have [unofficial] drugstores in the back of stores where they might give things like B-12 shots. The only thing I worry about is the re-using of needles. It's all fairly harmless otherwise. They may give flu vaccines sometimes too…or antibiotics. Mainstream providers are mostly completely unaware…Hospital and E.R. people may have heard about it… [Immigrant patients] don't always volunteer information; people have to know to ask them about it". Another provider who was an immigrant, Hispanic but not Latino, was more familiar with the phenomenon and had some more personal feelings when asked about botánicas: "My clients go there pretty often; they use a lot of natural things – which I'm good with. I don't like when they take too many pills. I honestly don't think most others are aware. Not everyone believes [mainstream providers] actually heal or help people. [Mainstream] patients want solutions quickly, if you give them an antidepressant, it might work quicker than the natural remedy, but it won't work as long. Doctors look for expediency. My concern is what happens after. If we can implement natural things…the Latino population believes in natural and spiritual things…It's easy for them to be more open-minded. They grew up with grandmothers treating them. There is a cultural gap in understanding. In Latin America [this type of medicine] is much more common; in the U.S. it's different… My [Latino immigrant] clients don't agree with taking too many medications. They believe in natural things first; the first option is never a pill…They are shocked that doctors resort straight to pills and medication. I would like for [other mainstream providers] to be more open-minded; educate themselves about the Latino culture,

like I did. Research and understand, develop cultural competency. Be more open-minded. If a patient says a natural cure is working, then listen. In my opinion there should be an educational class on everything. We think that we know things, but we don't know everything. If we can have more people coming and talking, explaining their point of view [then] in the future we can use integrative medicine. Latinos don't want to take meds; we should try new things…If you don't teach a doctor how to treat a Latino [immigrant], they won't treat them right…because I think you have to be very open-minded. It comes down to knowing that your method works but maybe there are other methods that also work. You need to at least try to be more open-minded. What barriers keep these communication lines from opening up between health service providers who are serving essentially the same populations? Attitudes…If we start coming out with meetings, classroom settings, education, then that could pave the way. We definitely need to educate from both sides. Knowing that it's not a fight between one and the other. If we work as a collaborative team, we'll know what our role is with the patient. If a patient is beyond natural treatment, let's refer [them] to a doctor for stronger medication…A culture of mutual respect". When the same service provider was asked about what benefits they could envision from collaboration, they replied, "Definitely overall better healthcare. Latino people will feel more understood. If I'm explaining to a doctor that I went to a curandero, and they think I'm crazy…? If we all collaborate and make an effort to understand the different cultures it will allow more resources, more communication, more understanding. The confidence to share will decrease taboos. It will decrease anxiety and depression levels. I'm usually the first person people can talk to about these things". Another mainstream health service worker, when asked about the ideal role they'd want to play in bridging the gaps in cultural competency with Georgia's immigrant population responded, "If I could do anything, I would be some type of liaison to every

university that has a public health or medical school program and create the partnerships with the local communities with their local clinics – and allow space for communication, be a liaison, create curriculums for every school that allows for the teaching [about] this population…Cultural competency, 'take this into file for how to find and treat the population'. "Another public health worker cited, regarding how the mainstream health sector in general felt about botánicas, "Well, if they even know about it, I think they would probably really question the safety. And, that's what we do. When we hear something that they are doing other than what they get from us, I say, 'okay, where did you get it, what does it do?' Then…I look it up on the internet to see what in fact it is. If it were to be something more in terms of the vitamin shots…they also go down to Mexico or a private provider and get a monthly birth control shot that is underground…and we don't even know what it is. The safety of it, the effectiveness of it; some of them will not come to get birth control at the department because of this – and take care of that elsewhere – but come to get an exam…The biggest problem is getting disclosure; they don't think they should let anybody know. Either they're told not to, or they see it as the medication is not necessarily better than the herb – and sometimes it's not, because it has side effects. The private sector, I'm not sure how much they know about the underground or herbs sector. Most mainstream services [providers] don't see this population because they don't accept non-insured patients or offer a sliding scale".

Political Climate

When asked how or if the current political climate was likely to impact the way Latino immigrants access health services, one mainstream sample interviewee felt the answer was emphatically negative. "Not good. Certainly, it's [getting] more complicated. I'm feeling this very much. The work is awareness. The main challenge for immigrants is to adapt to new

systems, so that transition is harder under a system that is unwelcoming and doesn't care about people that don't know the basics…The president doesn't care about immigrants. It's harder [now] for them to make the transition. More undocumented immigrants will be afraid to seek health services. Documented immigrants, such as a woman without a driver's license, it's still a deterrent. You're not going to feel inspired to go for preventative treatment. It's unfortunate because immigrant communities could do better, but it's going to get more challenging". Another mainstream health service worker said, when asked about the current political climate, "Broad answer – the crackdowns on anything…it keeps people from coming to appointments and getting out much at all if they're here illegally. If you're doing a health fair and the sheriff's department is notorious, they can scare people off and spread the word about it. When it gets ramped up, naturally it scares people. It influences their ability to access services; they're even more scared to drive with or without a license. A lot of people just pull back". Another immigrant mainstream worker who works mainly with Latino immigrants, when questioned about how the political climate might impact how Latinos access healthcare responded: "Very bad. It has [already] increased mental health issues and health issues overall. More depression and anxiety; diabetes goes higher because of stress eating; [people are] scared of going outside to exercise, living in constant fear. Very negative. [They are] afraid to come to the doctor – what happens if the doctors know that they are illegal or using an invalid social security number? Access has decreased". Another interviewee simply replied, "People are afraid. People are very afraid to come out. Just…frightened…and the further you go down south [in Georgia] …it's a very different climate". Regarding the heated environment, one public health worker said, "I really like this population because they're very appreciative and don't expect more than you can give, usually expect less, and are so happy when you provide basic services. They're afraid.

Since they've cracked down on undocumented immigrants, I'm afraid our patients, all women, are not coming in as much because they're afraid they're going to get caught up in the net…The worst part of it is, we've had a few threats from people they don't even know about…about bombs – probably about family planning, thinking they provide abortion services [here] which they don't. We ended up having to provide security; and, my fear is that they will see police presence and will be afraid to come in…Since 'you know who' got in office, it's been a big scare. I don't know how much they hear about the rest of the country, but Atlanta has been one of the areas that the crackdown has happened…They're only supposed to deport those with criminal records, but they are targeting more than that as far as I'm concerned. It is very sad". When probed a bit further about the impact of the recent election, she added, "Fear…And cost...if funding is going to be cut. We already know that both federal and state level funding is going to be cut. And it's already not easy now, so who knows what's going to happen. The problem is they want us to see more patients, but we don't have enough nurses or time, to make more money. That's going to make it harder [if they] repeal the ACA – those who had it are not going to be able to access anything else. Not a good thing".

Question 1: What roles or functions does the botánica play in immigrant Latino health and culture in the Georgia?

The botánica plays myriad roles in Latino immigrant health and culture in Georgia – socio-culturally, psychologically, and economically. On the one hand, it provides a sense of comfort and cultural continuity in healthcare, just in general, to immigrants when they arrive in the U.S. – and this culture continues to be at least somewhat embraced by subsequent generations. The botánica provides a holistic set of services where they can cater to spiritual, physical, and even mental health issues. There are consistently offered services such as herbal remedies, vitamin

therapy, spiritual cleanses, candle magic. Some even offer divination services which – suspending any disbelief in the supernatural – can cause a person to feel empowered in a place where they are not able to excerpt other kinds of power, and their future feels uncertain. And thus, it can create a sense of calm to feel that one has been spiritually cleansed or spiritually protected, even if it would be labeled a placebo effect to hardened skeptics. It is not that different from mainstream practices of pastoral counseling, common in behavioral health communities. At root, it is hard to separate such cleanses and spells from the sense of reassurance anyone feels when they pray, and why so many mainstream mental health services in the U.S. are enmeshed with spiritual traditions. Economically, the botánica is a place where medicinal diagnoses and treatments (such as herbal teas) are obtained at less expense, fiscally, than they would be going to a general practitioner – at least that is a persistent perception. Duly crediting upon them the lens of a more enlightened perspective, many immigrants – including some who have insurance – seek out botánicas for preventative medicine, because once they are sick and not able to work, they are already losing money, before they could even begin to think about paying for having an illness treated. Most undocumented workers do not get 'sick days', so preventative health care takes on a more urgent tone. Botánicas in Georgia function as a mainstay of cultural continuity in healthcare, including mental healthcare. They also provide a more fiscally accessible point to access healthcare advice or treatments. In regard to political issues, they are known to be safe spaces where it does not matter whether one is documented or undocumented – either way, they will be treated equally and with respect.

Research Question 2: *What salient health issues affect the Latino immigrant community of the Southeastern United States?*

Evidence from both camps has presented the most burdensome and worrisome issue facing

Georgia's immigrant Latino community to be a latent HIV crisis, nurtured by both political stigma and financial barriers to health services and compounded by cultural stigma around using condoms or being tested for infectious diseases such as STD's. Diabetes and obesity are correlated and were presented in every interview with both samples of individuals. Hypertension and high blood pressure were close behind, if not equal, in the overall time people spent reporting on as diabetes. The causes of diabetes are still somewhat controversial – as some are blaming it on acculturation factors such as a more sedentary lifestyle and more processed foods; while others seem to think it may just be diagnosed more here than in the rural regions where many immigrants moved from. Mental health issues related to acclimating to a new culture rate high – and the political situation, at current, is a significant compounding factor of individual stress levels. Migrant worker populations face an even larger scope of issues; while they might not present as much obesity, they are showing deterioration in other aspects of their health – such as eyesight, skeleto-muscular problems, and dermatological issues – not usually presenting in groups of similar age ranges. Because of their transient lifestyle, migrant workers also face an increased chance of remaining undiagnosed with infectious diseases, especially HIV / AIDS. The migrant workers also face the largest barriers to continuity of care, making it likely their health issues will continue to be exacerbated instead of consistently and properly treated.

Research Question 3: *Is there a potential for a collaborative relationship to emerge between botánica proprietors and public health researchers and medical practitioners in the Georgia?*

There is definitely potential for a collaborative relationship to emerge between Georgia's population of botánica proprietors and more mainstream public health researchers and medical practitioners in Georgia. Progress in this area needs to happen rapidly, but carefully and with much foresight and risk assessments concerning any potential unintended consequences. It is

important not to increase the stigma Latino immigrants already face by making a huge deal (publicly) about the fact that they are potentially nurturing a latent HIV epidemic in rural and impoverished populations of Latino immigrants in Georgia. This could easily backfire and make them even less likely to access treatment. It would seem rationale that the bilingual and bicultural mainstream providers could best pioneer initial efforts to open channels of communication and education between each group. It is entirely possible that such lofty goals as recruiting botánica proprietors as community health workers and liaisons to help with intervention campaigns, general education, and referrals in working with the mainstream sector could be achieved in the short to long term. It is also entirely conceivable that botánica proprietors could be instrumental in educating both health service, public health, and medical students, and health and medical professionals on the use of natural and preventative remedies, as well as in ways to increase general cultural competency in service providers who treat a significant number of Latino immigrant individuals. There is an open-mindedness and a willingness, while not shared equally by all, that could function as a starting point to bridge the allopathic and non-allopathic sectors into a system of integrative medicine in line with the WHO's Traditional Medicine Strategy's goals of enhancing local and national health systems through the integration of TM and CAM services.

Chapter 5

DISCUSSION

This final chapter will discuss the short term and long-term implications of the data aggregated, and the themes abstracted, from the interviews in this study. This will include a discussion on how the data can be applied in terms of predicting trends and informing interventions to change health barriers and outcomes for individuals in Georgia's Latino immigrant population, as well as suggestions for future research and specific suggestions for future interventions or program development options.

Broader Implications of Results

Results of this study made clear here are ongoing barriers to Latino immigrant health in Georgia which are poised to remain static or get worse in coming years. These barriers include: stigmatization and political discrimination based on documentation status; fiscal barriers; even language barriers as budgets for translation services are cut; as well as, other cultural barriers such as distrust in mainstream medicine and alternative values and paradigms of thought surrounding medical treatment. However, for every discouraging pattern of barriers to health care which can impact expanding negative health outcomes, there have been revealed coinciding opportunities to surmount them through carefully informed and constructed approaches.

The most evident and severe consequence of stigmatization and political discrimination seem to have manifested in the HIV crisis. This was a highly unexpected finding. Community health workers or designated thought leaders in the Latino immigrant community of Georgia

must raise awareness on ‘safe spaces’ for undocumented immigrants to receive health care which includes STD diagnostics, for example.

Another example of the consequences of politicization of health issues raised by a public health worker was that they had to hire a police officer to sit in the lobby of their office at all times because of bomb threats (which she thought were generated by the wrongful conclusion that they performed abortions there). Seeing a police officer in a public health office is going to be a strong deterrent to an undocumented individual (and, even perhaps many documented individuals who have experienced trauma from racial profiling).

The bureaucratic processes which surround access to care must be navigable at this point in time for any individual in Georgia willing to access healthcare particularly actively seeking HIV testing. The latent HIV epidemic uncovered in this research is by far the most alarming point of the results. Efforts must be directed towards offering HIV testing in a way that feels safe, private, and accessible to all of Georgia’s population (documented or undocumented) or else this epidemic could get out of control, fast. There is further concern the epidemic is being exported, so to speak, to Latin America – especially through the cyclical movements of the migrant workers who have been isolated as both the population most at risk of being infected with HIV while in the U.S. and also the population with the least access to care. Separate testimonies from public health workers in both the northern and southern sections of the state have officially rung the alarm about this spiraling HIV crisis which is sometimes claiming entire families at a time. The stories were repeated by several interviewees about how a man would come here to Georgia to seek work before his partner, seek the comfort of sex-workers (another stigmatized and marginalized population unlikely to seek HIV testing) and then when his wife arrived years later, she would contract it unknowingly. Because of the distrust born of

stigmatization, she would then become pregnant and not seek medical care – and thus, not discover any diagnosis – until it was deemed absolutely necessary. (Of course, we don't know how many home births may be taking place off the grid, and no one mentions that). However, it is a pattern where entire families could be found (and have been found) to be carriers of the HIV virus at the point when the pregnant mother finally sought healthcare and was subsequently diagnosed. The cultural stigma of Latino immigrants in the larger political climate of Georgia compounds an internal cultural stigma around HIV testing and has brought devastating and potentially far-reaching damage to health outcomes in not just this state, but the nation, and also Latin America where there is less infrastructure access to care to treat HIV and AIDS.

The fiscal barriers to positive health outcomes for the Latino immigrant population could be at least partially surmounted by valorizing the preventative care options presented by botánicas at much more affordable rates. Preventative care also holds a strong potential to prevent future fiscal barriers to more serious (and thus, costlier) health problems which tend to present in this population of individuals such as diabetes and hypertension. Conceivably, this could also prevent future barriers to obtaining insurance by preventing them from developing a disqualifying pre-existing condition to begin with. ACA recipients are in a precarious state at this time, and a constant theme during the interviews was that a repeal of 'Obamacare' would have devastating consequences on the Latino immigrant population of Georgia. Cuts to funding at national, state and local levels to public health operations compound the fiscal barriers of treating Latino immigrants in Georgia. If the immigrant population faced fiscal barriers to healthcare at the time these interviews were conducted (spring through fall of 2017), they must certainly be even more vulnerable to them now. The new tax plan signed by President Trump at the end of December 2017, and its implications on healthcare, is going to be reverberating through the lives

of all SES-challenged individuals and extended communities for decades to come. This undoing of an already precariously woven set of protective factors will require immediate action from the health community to circumvent short term and long term negative health outcomes. Such negative health outcomes will certainly not remain confined to a community as biology does not see nor cater to socially constructed ideas of race and ethnicity. The public health community must be prepared to seek alternative sources of funding (which is worlds easier said than done).

Thus, it now becomes even more vital to explore all methodologies and delivery modes of preventative medicine, which prove to be less costly in the short term and hold potential to generate less negative health outcomes in the long term, mitigating future fiscal barriers which might have arisen if a person developed diabetes or hypertension (for example) in the long term. It is also more crucial than ever before to invigorate and expand health education and health promotion interventions in all communities, in culturally and lingually specific manners.

Language barriers remain a significant obstacle to proper treatment. It was reported during this study that even certain mainstream health service operations which were required to offer translations services either didn't, didn't consistently, or did not offer quality services. Apparently, there is a new computer program being introduced where the translation work is in some cases now shifted to health workers themselves; and, such services are not reliable – as languages don't necessarily 'translate' in a consistent manner through such programs, or otherwise. One nurse was frustrated with this service because she could tell it wasn't picking up the nuances of the countless dialects of Spanish speakers she encountered, and that a lot of important information was falling through the cracks. Along the same vein of dialects and variances in the Spanish language, there also exist cultural barriers in terminology involved in how individuals describe or, conversely, understand healthcare communications. A variance in

education levels, typically lower, in individuals who immigrate to Georgia also means that an individual may not speak ‘proper Spanish’, and may have a hard time understanding medical jargon even when presented in Spanish. Every person interviewed recalled instances of indigenous language speakers seeking care as well; and, there are currently little to no translation services – electronic or personal – available to serve these populations. Again, botánicas are more likely to have people in their personal networks who can help when indigenous language speakers present with health problems; and, they might even be a starting point to exploring how many indigenous, non-Spanish and non- English speakers arrive here without family and remain completely and utterly marginalized by both cultures. It is rare that someone, even among Latino immigrant communities, just happens to speak an extra indigenous language – there are over twenty different indigenous languages in Guatemala alone, to give some perspective.

Given the sheer number of Georgia citizens who speak both English and Spanish at ‘native fluency’, however, there is no valid excuse not to have top notch bilingual translators at every health service intervention site. Especially noting the large numbers of both high school and college age youth who speak both languages with native fluency, this would not even have to be a particularly high wage position since it only requires informal training and could be performed by second and third (etc.) generation immigrants, relatively young, who were not having to support a family, or even themselves at this point (i.e. it could at least in a large number of capacities, be performed for minimum wage or even as a paid internship). In certain settings, it is possible that training modules might be necessary to educate the translator as to the jargon of more technical or complicated procedures; however as mentioned, many of these could also be offered as internships – they would qualify due to the on the job training and experience. The skills of second and third and even fourth generation immigrants pertaining to bicultural and

bilingual fluency remain largely unrecognized and under-utilized in Georgia. These sorts of experiences could also serve to draw Latino youth into heath service professions themselves, solving some of the long-term problems introduced or reiterated in this report involving obstacles of cultural and lingual barriers to health education and health service, not the least of such: the seasoned distrust of mainstream health service providers which serves as another barrier to seeking mainstream health services for Latino immigrants in Georgia.

Throughout the ages, minority communities have been inarguably abused by the medical community – from coerced and forced sterilizations of indigenous peoples, to injecting individuals with syphilis without their consent, to more modern tales of a global health entity using the façade of a vaccination intervention to search for relatives of Osama bin Laden in Pakistan. If these concrete examples exist, there are likely an innumerable amount of urban legends operating and impacting minority communities, concurrently.

The threat of deportation is another entirely separate source of distrust for Georgia's undocumented population – since this study uncovered claims of abuses by Georgia's manufacturing industry – such as the stealing of hours from undocumented immigrants who were hired at and working at a local chicken plant – the constant threat of deportation has been weaponized in cases such as this to the point where it is surely a source of terror. In my own personal network, I have seen social media posts from local Latino businesses disputing rumors which had obviously been terrorizing the community with reports that ICE agents had inserted themselves into certain Latino business locations – the reports seemed to be unfounded yet widely disseminated. As previously referenced, at least one Georgia health department which serves a majority of Latino patients had to hire a police officer to sit in the lobby at all times because of unrelated bomb threats which had been called in to the center. The employees

interviewed there unanimously agreed it had blunted, and at first completely thwarted, the seeking of health services from Latino immigrant patients. Again, even those who are documented have very often suffered traumatic experiences of racial profiling; and, many Latino immigrant women do not have driver's licenses or tend to not carry any immediate form of identification which could prove their documentation status if threatened.

Most Immediate Needs for Response from Health Service Community

This section will explain the most crucial information which has presented and thus warrants a most prompt response from medical, academic and health service communities of all sorts. The first, is the HIV crisis. The second, is the untapped potential of botánicas to serve urgent and ongoing needs in Georgia health. And thirdly, we'll talk about how opportunities to conduct research or interventions towards a more integrative approach to medicine must always be tempered by larger picture – defined by social, political, and even ecological constraints and potential issues.

The HIV crisis is by far the most immediate and drastic threat to individual, community, state, national and international health uncovered in this study. This latent epidemic cannot be ignored or allowed to fester any longer as it has already festered for far too long. This is a case where feedback from health professionals indicated across the board that immigrants are acquiring the virus in the United States, and not (in the majority of cases) arriving here infected with it. As previously noted, Latin America is further drastically ill-equipped to handle waves of HIV infected immigrants either being deported to, or cycling through, its borders and subsequently general populations. The key things to realize here are: 1) the marginalization from health services which presents ubiquitously in this population of individuals – although more frequently in more vulnerable subsets such as impoverished, rural, migrant, or undocumented

individuals – has led to the spread of this deadly virus in a manner which could have been prevented had there been more culturally tailored health education and opportunities for testing and access to other forms of healthcare; 2) there is an internal cultural stigma which may be of religious origins, as repeatedly reported in the data gathered in this study, which manifests as a cultural taboo around the use of condoms in this population of individuals – and again, had they not been so marginalized and stigmatized, this information could have been abstracted and dealt with through personalized and culturally appropriate interventions and education in time to prevent the crisis it has spiraled into today; 3) Latino immigrants and migrants are, as reported in the data collected for this study, acquiring the virus once they come to, or through, the United States; however, there exists the very real possibility of any information about this epidemic in Georgia becoming public having the unintended consequence of increasing cultural and political stigma against Latino immigrants in Georgia and therefore this information must be handled with the utmost care and with acute attention to the delicate nature of the issue and the impact it could have on further marginalizing an already marginalized population; 4) an issue of this sort of sensitive nature must be approached in a manner that immediately transcends all currently presenting barriers whether fiscal, cultural, lingual or otherwise – hence a cooperative effort with community health leaders such as botánica proprietors, who already surmount these barriers and have the trust of the most vulnerable and marginalized among this population of individuals, may be a potential initial intervention point; and, 5) it may be past time to necessarily warn and coordinate as best as possible with Latin American health authorities and services about the unavoidable exportation (at this point) of HIV to Central and South America – it is in fact crucial this is done without delay, pretense, or any other measure of avoidance or attempts to downplay the potential for deadly impact and initiating new epidemics.

Global health authorities must also be warned of the transnational implications of this latent epidemic in Georgia and petitioned for funding and help building infrastructure in affected Latin American communities and countries; and furthermore, to be prepared to approach this issue from a variety of other angles such as health education and outreach in at risk areas.

The botánica should be taken seriously by the mainstream health service community for the following reasons: 1) it already serves as an active presence of culturally, lingually, and fiscally accessible health services for Georgia's Latino community who are or feel marginalized by mainstream health services and is thus a point of intervention to reach these individuals which exists in virtually no other conceivable context; 2) the botánica proprietors are actively providing affordable preventative care to individuals who would face fiscal barriers, or future problems acquiring insurance, if various identified and unidentified propensities for negative health outcomes such as diabetes and hypertension were not being treated preemptively by botánicas – this is thereby lowering the long term cost of healthcare for individuals and the tax payer funded public health systems (and hospital emergency rooms) who serve them; 3) botánica proprietors have an inherent level of trust within this community of individuals which can never be matched by the mainstream health service system and is thus a unique perspective on the health issues presenting in this population which is out of reach of the mainstream health service and research community's gaze – opportunities to open channels of communication and mutual education by (some already identified) willing members of the botánica proprietor community are thus invaluable in terms of staying abreast on the most salient health issues of this population and identifying emerging issues before they become acute; 4) there exists a gap in awareness perpetuated by a culture of fear in which patients tend to not disclose treatments provided by mainstream health service providers to botánicas, and alternately, services provided by botánicas

to mainstream health service providers.

The opportunity to raise increased awareness and to nurture and open channels of mutually respectful communication between Georgia's allopathic and non-allopathic health service cultures serving Latino immigrants is also critical to making sure the treatments often received concurrently are not contraindicated to one another (even if such treatments are mostly innocuous on their own). One example of this which emerged in the collection of data for this survey was the potential for certain herbs to overwhelm an HIV patient's liver, which was – if receiving treatment – already compromised by the strong medications prescribed to control the HIV virus inside of their bodies once acquired. This potential alone – for contraindicated concurrent treatments – has led many mainstream providers to tell patients to stop taking herbal remedies which have been prescribed by botánica providers, merely on the basis of uninformed risk assessments, because the mainstream providers are not educated about herbal remedies.

Unfortunately, there exists a wide gap in available evidence-based research and recommendations regarding natural and herbal remedies due to a lack of funding. There is also a commonly held notion that there are even intentionally misleading studies published on natural and herbal remedies either directly or indirectly funded by pharmaceutical industry interests. After all, if an herbal remedy could prevent or mitigate the chances of an individual developing diabetes, then when introduced in the current climate of spiraling costs of insulin and other diabetes related medications, this could result in drastic losses of income for corporate shareholders. Furthermore, indigenous, herbal, and so-called folk remedies are more difficult, if not in many cases impossible, to patent so there is less interest in funding studies to prove their effects by manufactures and distributors of medicine.

However, since the spiraling costs of medicine is a global problem – as discussed (and referenced in this text previously) within the World Health Organization's (WHO) Traditional Medicine Strategy – it becomes imperative that these health modalities be studied, and assessed for safety and effectiveness and their potential as preventative and less costly treatments, so that they can be incorporated into national health care systems which can thereby operate in a more sustainable economic fashion. Such studies which produced truly informed assessments of quality and value in terms of health treatments – preventative or otherwise – could ripple out into a composite result of increasing standardization of quality in the herbal medicine industry which does not currently exist. This would naturally expand their use and evidence-based integration into local and national health ecosystems.

One potential issue here would be in making sure that this did not supplant the access to, and the ability to treat patients with, such remedies for the already TM/TIM practicing community level providers such as botánicas. There is a risk that more standardization and mainstream integration of such indigenous, traditional, and natural medicines could lead to a more clinical, but ultimately less accessible model of distribution for the communities who stand to benefit the most from their increased availability, standardization, and safety.

The health and medical research community will also likely also have to come to terms with an uncomfortable Achilles' heel which exists in the current gold standard of clinical randomized controlled trials (RCT's) in researching the safety and effectiveness of a treatment. There is a tremendous margin of error when it comes to understanding long term effects – it is very difficult to conduct longitudinal RCT's, but this is an idea which might be entertained – of pharmaceutical or herbal treatments. There might have to evolve a reframing of views regarding indigenous medicine (TIM) which has (in some cases) been applied for thousands of years, and a

collective recognition of the limitations of RCT's in understanding or assessing their impact and safety.

Practitioners and researchers of so-called allopathic or 'western medicine' must approach the wisdom of traditional healers (non-allopathic medicine) and the treatments which are utilized with a less standardized clinical view and a more open-minded lens of what exists as a separate but potentially equal paradigm of thought, practice, and medicine. The opportunity is ripe for this call to become less of a platitude and more of a practice right here in Georgia, as Georgia is uniquely situated with the designation of being the 'public health capital of the world' (due to the presence of the entities such as the CDC, The Carter Center, CARE, and a number of other leading public health agencies and NGO's) as well as being home to a growing culture of botánica proprietors who are steeped in ancient remedies from their own cultures as well as other countries. The latter point is a point unto itself which is that the botánica is an example of transnational appropriation of indigenous remedies which is occurring outside of the mainstream health networks across the United States. Again, according to the WHO, this is markedly a positive trend and holds potent potential to be integrated into a larger, more fiscally sustainable, culture of integrative medicine. Reports from Latino immigrants collected in the course of this study have included numerous remarks of how integrative medicine is already practiced more widely by general practitioners in their home countries. Here in Georgia exists both the drastic, undeniable need to explore these networks in the name of mitigating already critical issues such as the HIV crisis, as well as the long-term potential of living up to the WHO's call for creating local and national healthcare systems which utilize the vast potential of integrative medicine. The political climate of the state acts as a barrier to this; however, the critical nature of the initiation of such exploration and integration should logically surmount this.

Moving from Vision to Reality

During the course of this study, particular individuals in the botánica and mainstream health community have actively volunteered and agreed to future contact in initiating a number of potential programs. In this section, we'll discuss how this could be applied in mainstream educational programs, as well as how the botánica community could be embraced by a more inclusive health culture in Georgia, helping to actualize their latent potential and draw upon the contributions they already have to offer as well.

I was admittedly disturbed during the exploratory research phase of this dissertation to learn that a particular program and partnership explicitly designed to produce physicians and health workers to stay in the state of Georgia to serve the state's population through their practice here, was at the time of initial exploration and outreach (spring of 2017) offering no specialized training modules or classes in regards to educating future doctors about treating Georgia's large Latino immigrant population. It was inconceivable to me that such an oversight has been perpetuated – and, this sentiment was echoed, not defended against, by relevant people I spoke with, even those involved in the program. There seems to be an overarching agreement regarding the unacceptable nature of the present state of medical and health service education in the state of Georgia towards this end. The fact that this study's results found this particular oversight to be rather easily surmounted compounds the surely unintentionally negligence of its current absence, while offering a clear path to resolution. During the interviews conducted with the relatively limited sample of individuals working in both the allopathic and non-allopathic sectors of Georgia's health service community, it became clear that there is a desire at every level and in each community for this educational oversight to be remedied. Mainstream health services workers who were themselves Latino and/or Hispanic immigrants and therefore not only

bilingual but bicultural volunteered with zero persuasion to perform as guest speakers. They were further excited by the idea of assisting in creating educational modalities to update the education of medical and health service workers in the state of Georgia to include the need of providing basic knowledge of the unique issues and challenges facing the state's significant Latino immigrant population. There was also expressed the desire to develop educational opportunities or varying degrees of specialization for people who might wish to serve particular communities such as the migrant workers in the south but – as with much of the general population – potentially be previously and wholly unaware that they even existed.

There exist potentially innumerable possibilities depending on the will and creativity employed by cooperating institutions which include but are not limited to: 1) guest speakers from the mainstream health service community who are also Latino immigrants to speak from their unique perspective on the issues, challenges (and ways to surmount them in practice) faced by Latino immigrants in Georgia; 2) entire modules – in class or online – which could be taken voluntarily, for extra credit, or as part of another class on community health or some other relevant course; 3) entire classes taught by guest lecturers who could be compensated and incorporated into degree program requirements or presented semiregularly to provide availability for each degree cohort; 4) immersion experiences in the botánica, migrant, or other designated Latino communities for students who had exhibited, cultivated or otherwise developed a sincere interest in collaborating or conducting community based participatory research as in, but not limited to, participant observation experiences either for a class paper or as the main course content and research for an independent course; 5) health service workers already serving in the industry could attain CEU credits for attending special training modules which could be offered evenings, weekends, online or in some combination and designed with the input of the botánica

and Latino immigrant mainstream health service worker community – the latter group would likely serve as a bridge in actualizing many of these offerings; 6) classes taught by members of other departments and colleges within a University which specialize on the Latino experience, with a focus on Georgia; 7) townhall style meetings or panels at universities where members of the botánica community and the mainstream health community could come together to discuss challenges, offer solutions, and take input from any interested community members – the event could be advertised at a variety of settings, including: botánicas, mainstream health service outlets, and colleges and universities; 8) study abroad trips for students and health service workers to explore the home countries of Georgia's Latino immigrants – and relevant places such as health clinics, and relevant people such as traditional indigenous healers – could help practitioners and students both align with the background and experience of Latino immigrants in Georgia; 9) delegations of volunteer / pro bono practicing health service workers could spend vacations doing a sort of 'backyard voluntourism' such as one university already does with migrant workers in South Georgia and officials within have claimed more such programs are needed; 10) colleges and universities could host visiting professors, scholars and teachers from countries where integrated medicine is a more normative value and practice – ideally these individuals would come from Latin America, and although this has not special bearing on the botánica community, there is a wealth of integrative medicine practiced in Cuba out of necessity due to the constraints on medical imports under the embargo, and this would be a great country to partner with on such endeavors as this and medical study abroad, internships, or residencies; 11) dissemination of literature and research conducted with and on the Latino immigrant population of Georgia into classrooms and health service venues could be crucial in generating

enough initial interest to manifest the previous suggestions into reality – it would be a sort of health education intervention for health educators and workers.

Other opportunities for actively planning health interventions aimed at the more immediate needs of Georgia's Latino individuals – such as in concern with the HIV crisis – would be to identify and train community health workers (CWS's) through engagement with the botánica community proprietors and affiliates. There also exists the potential for identifying community thought leaders (CTL's) for the purpose of designing health education strategies and interventions. The vast wealth of opportunities detailed in the previous paragraph are but one side of the proverbial coin. During the course of this study the willingness of botánica proprietors to engage with and collaborate with mainstream health entities was much higher than expected – though, these results may have been muted by the obvious limitation that I was already interviewing only those who had agreed to be interviewed. However, it still produced solid results proving some modicum of opportunity exists there.

There are a number of ways this could produce collaborations including: 1) special training for botánica proprietors or their employees to become certified in conducting particular screenings and issuing referrals to appropriate health agencies; 2) identifying CTL's as crucial points to initiate health education and public safety interventions such as around destigmatizing the use of condoms and emphasizing the importance of their use (this might be especially potent if some of the more spiritually oriented botánica proprietors were recruited); 3) since one of the goals was to move towards a standardization of indigenous and traditional medicine, botánica proprietors could attain certification in certain modalities (bodywork, nutrition, herbal medicine) through existing accrediting bodies and scholarships to further valorize the industry and lay the groundwork for collaborations and an overall re-branding of the culture into a separate but equal

framework – and eventually towards holding space for community workers in a fully integrative medical paradigm as called for in the WHO publication; 4) inviting botánica proprietors to private meetings with a bicultural and bilingual moderator to discuss ways of improving relations, respect, communication and collaboration between health service communities; 5) arranging meetings between academic botanists, biochemists, and pharmaceutical students and botánica proprietors (again with a bicultural and bilingual moderator) to discuss the nature, use, and potential ways to raise awareness and possibly even production and availability of certain powerfully medicinal herbs; 6) establish education or medicine-based lobbying or advocacy groups to petition for more rights to bring legal medicinal herbs across the border into the United States – leveraging the increased power aligned with the medical and public health establishment, this could enhance botánica proprietors' practices immensely; 7) conduct collaborative meetings to discuss ways that expanded scrutiny, attention, and standardization could be done in a way that did not exploit, gentrify, or displace botánica proprietors from their own rightful places in the current healthcare landscape of Georgia and elsewhere; 8) collaborative meetings with botánica proprietors and law advocacy groups, professors or students to discuss any potential challenges or opportunities to move towards the ideal paradigm of integrative medicine in a paradigm which does not exploit, gentrify or displace key and current members and patients in the botánica proprietor's communities and in the communities which they serve; 9) colleges of public health students and faculty, and, or as well as public health officials, could collaborate on health education interventions and campaigns in the nature of visible posters inside operating botánicas on topics such as condom use, HIV awareness and testing, and vaccination opportunities – this could be a starting point to merge the collective interests in community health shared by both botánica proprietors and mainstream health

communities; 10) identify trained Latino immigrant medical professionals to perform diplomatic outreach in cooperation with botánica proprietors to conduct health screenings and distribute health education materials inside botánicas; and 11) in general, give the botánica community a voice – there is a lot of knowledge here, thousands of years of compounded knowledge accumulated longitudinally in a manner which can surpass some of the limitations of the best designed clinical RCT's in many cases; let this become a point where this is given due respect in alignment with WHO findings and stated goals.

Potential Issues

The importance of protecting the access to, and the freedom to use and prescribe, herbal remedies for botánica proprietors cannot be understated. Increased attention and scrutiny must be accompanied by carefully designed, informed, executions of any intervention, with special care placed in making sure increased awareness of these operations – or the health issues identified within the population of individuals who access them – are not co-opted by political forces which might harm their continued operation or ability to access supplies. Likewise, any evidence-based validation of natural remedies or cures dispensed by botánica proprietors should be protected from circling vultures of pharmaceutical monied interests that might try to swoop in and patent some form of treatment, or even overharvest and create a scarcity of a certain source of herbal or natural treatments utilized by botánica proprietors.

It must also be kept in mind that because the political climate in Georgia remains heated – and in many cases, seeks to criminalize (especially) undocumented Latino immigrants in general – that any attempts to move forward in alignment with WHO goals, as the ripe opportunity here in Georgia presents at this time, must be partaken with an utmost of discretion and caution to this regard as well. This may mean in some cases effectively choosing to err on

the side of caution concerning activity which held the potential to create risk through increasing scrutiny, or further stigmatizing or marginalizing Georgia's population of Latino immigrants any further, and in any way. Their health, and the trends in their future health outcomes remain precarious; and, this reality must remain central to any future activity involving or concerning this population of individuals.

Beyond the realm of heightening or introducing educational opportunities for botánica proprietors and public health, health service, and medical students, there is vast untapped potential for future research, especially when some of the challenges unearthed by this and other studies are reframed as opportunities. Some of the immediately proposed actions might require further study to protect an already vulnerable community and preemptively, hopefully resolve any unintended consequences of any such further activity. Although, some activity – such as in mitigating or reversing trends in HIV incidence rates – may warrant more immediate and uninhibited, while still conscientious, modes of action.

Suggestions for Future Research

Now that opportunities for active participatory interventions have been outlined and explored, it is important to highlight certain themes and specific topics which should be considered by medical and public health communities in terms of recommendations for future research.

Despite some of the generalizations this report may seem to have made, the community of botánica proprietors in Georgia is, like most groups, not completely homogenous. Individuals come from countries with drastically different cultures and traditions, from all over Latin America. Because of this, certain botánica proprietors will be able to actively participate in or

inform various types of research modalities, according to their own specializations. For instance, there are some botánica proprietors who specialize in herbal remedies and research such as clinical RCT trials (conducted with an obligatory humbling recognition of the innate limitations of RCT's when compared with longitudinal cultural experiments which have lasted, in some cases, thousands of years) could possibly be a good fit for them. In this vein, there is also a lot of room for opportunities in continued qualitative and participatory observation research – especially for individuals who already exhibit certain levels of bicultural or bilingual competency.

There is the need for experiments confirming quality and moving towards a universal standardization of herbal remedies involved, yet this must be conducted discretely – and, it is my suggestion that if a chemist were to conduct experiments on the quality or potency of any operating botánica proprietor's products that this must be considered and categorized under the jurisdiction of experimentation on human subjects and the experimental design must meet the standards associated with such to protect already vulnerable individuals operating in an already vulnerable culture. Furthermore, this should be conducted under the standards of community participatory research, as defined in this report and elsewhere. Hence, ownership of the research findings would not, ultimately belong to just the university, industry, or institutional researcher, they should to some degree also belong to the botánica proprietor who provided the remedies with permission solicited from them on how and where to disseminate the nature of the findings. At the very least, there should be some shared ownership of the findings, but the botánica proprietor should ideally have ultimate input into how they are disseminated. If there are negative findings, it should be taken on as a responsibility of the researcher to help the botánica proprietor access better medicines or to use their findings to educate the proprietor for the health

of the community. The findings must not be used to publicly and needlessly debase natural medicine nor allowed to be co-opted by other interests, such as pharmaceutical companies who offer medicine for similar ailments as the remedy was used to treat – even though, those are usually accompanied by an exhausting list of potential side effects themselves. These corporations are not suffering from the publications of their products' side effects because they have the political, social, and financial capital to surmount them. A botánica proprietor, conversely, could have irreversible damage caused to their business and livelihood if similar findings were published since they lack the political and financial capital to mitigate the damage. Hence, the main consideration of research moving forward is to inform, reform, or validate the already existing network of botánica proprietors, and not gear towards exposing weaknesses or limitations. If, for example, a singular proprietor refused to stop distributing elemental mercury, after a series of scientifically based but not authoritatively intimidating warnings, then this might alter the paradigm slightly regarding taking action towards informing their larger community and consumers about this practice at the local level. Resistance to abandoning the documented practice of some botánica proprietors (but not all, and none observed in this study) of distributing elemental mercury must be approached through internal education and communication first and foremost and not sensationalized in a manner that demonizes the entire culture or industry.

Regarding the phenomena of pharmaceutical companies attempting to appropriate and patent indigenous and natural medicines, a quick Google search reveals countless examples and complaints, as well as active and pending legal cases. This is a very serious potential unintended consequence to be considered when researching the actual herbal remedies themselves, in efforts

towards validating or standardizing them, because the potential for further marginalizing botánica proprietors from their own cultural legacies and ancestral traditions and medicine is very real and exists with a tragic trail of precedence.

An opportunity which could further the probe conducted in this study would be further qualitative, quantitative, or a combination of, inquiries with patients or customers who access botánicas in Georgia and the Southeast. Some special trends or relative populations of individuals to target might involve recruiting Latino immigrants who are documented, have insurance, and still access botánicas either concurrently, initially before accessing mainstream services, or subsequently to mainstream services as a second opinion or to obtain more affordable medicine after receiving their diagnosis (a trend one botanica proprietor claims exists). Trying to narrow down the reason that the number of botánicas in Georgia and across the nation seems to be rising even as immigrants are becoming more assimilated and acculturated would be an informative lens to approach a study. It would take a very careful approach, but the right researcher, or team of researchers, might even focus a study on the undocumented population towards determining how large of a role botánicas played in achieving positive health outcomes in relation to ways they are marginalized from other basic services.

Critically needed, are hyper-focused studies on the HIV crisis. At this point, it is crucial to gather concrete quantitative data on the HIV epidemic and to also supplement and better frame the context and compounding variables of vulnerability through concurrent or follow-up qualitative interviewing both of diagnosed patients, identified at-risk individuals and populations of individuals (such as migrant workers, rural, and impoverished Latino immigrants) and health service workers (allopathic or non-allopathic). Human geography and epidemiological approaches could be employed to try and track the spread of HIV among Georgia residents,

residents of the Southeast and the United States, as well as tracking its inevitable journey back to Latin America. It may be crucial to partner with existing, or even to create or co-create, organizations who can prepare, inform, and provide more accessible diagnostics and treatment provisions for at-risk individuals who either return to Latin America having unknowingly acquired HIV in the United States, or who return home (willfully, or through deportation) knowing they have the virus and are seeking treatment. Education efforts abroad must also be increased, which must also at least partially focus on reducing stigma of diagnostic testing as well as reducing the cultural stigma of using condoms in general. Again, the latter may be most effectively approached through health promotion campaigns which partner with religious or otherwise spiritual authorities from which these cultural stigmas may have unintentionally or even originally intentionally manifested through.

The consideration of the potential unintended consequences in disseminating information about this HIV crisis within Georgia's Latino immigrant community must remain a central concern in all subsequent research designs. It is worthy to repeat, that research, and even more clinical research involving the effectiveness of herbal remedies, the chemical properties of herbal remedies or the effectiveness or placebo effect of so-called spiritual remedies, or anything which is generated from or can be traced back to the botánica community must pass through the Institutional Review Board lens of research on vulnerable populations. Accordingly, any results must also be disseminated with this in mind – the main and first concern should always be to do no harm.

The data and subsequent abstracted themes and revelations produced through this study deserve to end on a positive note. Every person interviewed was enthusiastic and extremely motivated in one way or another to bridge these gaps in communication and understanding to

better serve Georgia's Latino immigrant individuals and approached their work through a value-based paradigm concerned utmost with producing positive health outcomes physically, psychologically, and spiritually for Georgia's Latino immigrants. Every single interview conducted was a joyful experience for me, as passions of altruism and devotion to health exploded during the conversations with each individual, as diverse as each group truly was. There is a common thread of devotion to creating a culture of health for Latino immigrants in this state and beyond. And there exist here tools, options, and evidence which can inform future studies and interventions to aggregate towards the outlined goals of the WHO Traditional Medicine Strategy and further strengthen the utility and ethics of the community based participatory approach to research with vulnerable populations in general.

Closing Statement

Truly, there is so much untapped potential in the state of Georgia towards becoming a national and even global leader in moving towards a fiscally and socially responsible paradigm of integrative medicine which serves the best interests of all residents of our state, regardless of ethnicity, race, documentation or insurance status. This potential transcends partisan politics and can combine the best of all intentions across the board to create an economically sustainable, preventative medicine-based, inclusive for the sake of all, health care paradigm which can serve as a model for other states, as well as other nations. Georgia has what it takes as far as political will to resolve health care crises in a manner which reduces cost, as well as serves all citizens to the ultimate benefit of every citizen. It should be Georgia's goal to become a model example in the next version of the WHO Traditional Medicine Strategy as a state that had the resources, the political will, and the ability to harness the power of our elite academic and health institutions into creating the future of health care in a bipartisan spirit, bridging ethno-political divides in the

process. It would not take a miracle, it would only take an activation of a pre-existing, latent collective will and purpose. The data abstracted in this research shows that this state may have exactly what it takes to achieve such a lofty goal and emerge yet another sort of leader in public and global health.

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APPENDICES

Appendix A

IRB Approved Recruitment Form

Individuals working as botánica proprietors serving the Latino immigrant population of Georgia; and, individuals working in the mainstream health service sector primarily serving Latino immigrant populations of Georgia, are invited to participate in a study with the University of Georgia.

The purpose of this research is to better understand the health issues and needs of Latino immigrants in the Georgia. Specifically, we would like to better understand the role of botánicas in immigrant health.

If you agree to participate, you will be asked to:

- Sit down for a face-to-face interview, about an hour in length; you can stop the interview at any time.
- With your permission, you may be contacted at some point within the following 6-12 months to confirm that the researcher properly understood the data collected in your

- interview. At this point, we might also like to hear your opinions about what other interviewees (names withheld) had to say, and how you feel the study results might best be applied to serve your community.
- The interview will be guided by a pre-determined list of questions; you may answer any or all of them per your personal comfort level.
- You will not be asked to provide personal information about your immigration status, nor personal health or medical issues. Likewise, you will not be asked to provide personal information about any of your clients or patients.
- The researcher would like to create an audio recording of the interview if you are comfortable with this. This is not a requirement for participation.

Potential Benefits of Participation

- $25 incentive
- The opportunity to make a positive contribution to culturally appropriate health services in your community by offering your own useful feedback.
- The opportunity to help determine how the study conclusions can be used to better serve your community.

Potential Risks of Participation

- There are no foreseen risks regarding your participation.
- All participation is voluntary; and, you have the right to stop participating at any time without incurring any penalty (i.e. loss of stipend) if you decide your participation puts you or your community at risk in any way.

Appendix B

IRB APPROVED CONSENT FORM

Allopathic and Non-Allopathic Health Service Providers for Latino Immigrants in the Georgia: A Comparative Survey on Botánica

Researcher's Statement

We are asking you to take part in a research study. Before you decide to participate in this study, it is important that you understand why the research is being done and what it will involve. This form is designed to give you the information about the study, so you can decide whether to be in the study or not. Please take the time to read (or listen to) the following information carefully. Please ask the researcher if there is anything that is not clear or if you need more information. When all your questions have been answered, you can decide if you want to be in the study or not. This process is called "informed consent".

Principal Investigator: Dr. Jessica Muilenburg

University of Georgia

College of Public Health

Department of Health Promotion and Behavior

jlm@uga.edu

706-542-4365

Purpose of the Study

The purpose of this study is to better understand the health issues and needs of Latino immigrants in Georgia. Specifically, we would like to better understand the role of botánicas in immigrant health.

Study Procedures

If you agree to participate, you will be asked to …

- Sit down for a face-to-face interview, about an hour in length; you can stop the interview at any time.
- With your permission, you may be contacted at some point within the next 6 months to confirm that we properly understood the results of your interview; and, we might also like to hear your opinions about what other interviewees (names withheld) had to say.
- The interview will be guided by a pre-determined list of questions; you may answer any or all of them according to your personal comfort level.
- You will not be asked to provide personal information about your immigration status, or personal health and medical issues.
- We would like to create an audio recording of the interview if you are comfortable with this.

Risks and Discomforts

- We do not foresee any risks to your mental, emotional, spiritual, or physical well-being regarding your participation in this study. You may stop the interview or withdraw from participating at any time.
- We will not share your personal information or answers with anyone, at any time, without your explicit and informed permission.
- We will not share your answers to the survey questions, your identity, or any other information obtained during our contact with you with any authorities or institutions regardless of what information is uncovered.

Benefits

- We are committed to finding ways to help you, and the community you serve, benefit from any and all results of this research. We are open to any feedback you have on what we can do to make this possible.
- We expect the valuable knowledge, wisdom, and perspective you share with us to benefit the field of healthcare as a whole; and, we also expect it to help health service providers better understand your positive role in the community, and to better understand how to serve your community in general.

Incentives for participation

We will be providing you a small financial incentive of $25 to cover any lost wages you might incur by taking the time to participate in this study. An additional $25 will also be provided to an interpreter upon request and/or need.

Audio/Video Recording

We would like to make an audio recording of your interview in order to review it at later dates, in private, to make sure we understood all of your answers to the best of our ability.

You may still participate in this study even if you are not willing to have the interview recorded.

Privacy/Confidentiality

Your privacy will be protected with the utmost of care. If you do not wish to provide your real name for our records, you may use a pseudonym; or, we can assign you a combination of numbers and letters that will not allow anyone to trace the information you provide to us back to you at any point.

Your answers to the interview questions will be guarded and protected in the personal residence of the interviewer, and then analyzed and compared to the answers of the other participants. From all of your answers, we will draw certain themes that will then in turn be

shared back with you and other study participants, with your permission. You will not be individually identified in this process.

Researchers will not release results of the study that would easily identify you to anyone other than individuals working on the project without your written consent unless required by law.

Taking part is voluntary

Your involvement in the study is voluntary, and you may choose not to participate or to stop at any time without penalty or loss of benefits to which you are otherwise entitled.

If you decide to withdraw from the study, the information that can be identified as yours will be kept as part of the study and may continue to be analyzed, unless you make a written request to remove, return, or destroy the information.

If you have questions

The main researcher conducting this study is Dr. Jessica Muilenburg (a professor) and Courtney Parker (a doctoral student) at the University of Georgia. Please ask any questions you have now. If you have questions later, you may contact Dr. Jessica Muilenburg at jlm@uga.edu or at 706-542-4365; or, contact Courtney Parker at irissmom@uga.edu or at 678-316-8025. If you have any questions or concerns regarding your rights as a research participant in this study, you may contact the Institutional Review Board (IRB) Chairperson at 706.542.3199 or irb@uga.edu.

Research Subject's Consent to Participate in Research:

Your participation in this study, or any of the above actions, is considered a clear indication of consent.

Appendix C

Survey Instrument

The revised survey instrument, after integrating community feedback, is provided below.

1) A. How many potential clients visit your botánica on a daily/basis? Of those that visit, how many would walk out with a product? (for botánica providers)

    a. What are your most popular products/ services?

    b. What are the most common ailments, problems or concerns presented?

    B. How many Latino immigrants do you tend to see on a daily/weekly basis? (for mainstream healthcare providers)

    a. What are the most common ailments or concerns they present?

2) Are there any health issues notably present in this population that have become prominent, or gotten worse, only after they immigrated to the U.S.?

3) Are there any prominent health issues that tend to disappear or get better once immigrants re-settle into the United States?

4) A. What are the most important roles of the botánica in Latino immigrant health? (for botánica proprietors)

    a. In your opinion, how do you think the Latino community perceives botánicas in the US? What role would you like to play in the Latino immigrant health?

    B. What are the most important roles of the healthcare system in Latino immigrant health? (for mainstream health workers)

    a. In your opinion, how do you think the mainstream health service community perceives botánicas in the US? What role would you like to play in the Latino immigrant health?
    b. In your opinion, how do you think the Latino community perceives the healthcare system in the US? What role would you like to play in the Latino immigrant health?

5) What seem to be the most prominent barriers to positive health outcomes in the Latino immigrant community in the Southeast right now?

6) What seem to be the most positive trends in immigrant health?

7) How does the current political climate influence Latino immigrant health, or the way Latino immigrants access health services?

8) A. How does the botánica offer a sense of cultural continuity in health services for Latino immigrants re-settling in the Southeast? (for botánica proprietors)

   B. Are there cultural barriers that interfere with mainstream health service providers effectively treating Latino immigrants?

9) In your experience, there currently any communication between botánica proprietors and mainstream health service providers? (Both groups)

   a. If not, why do you think this is so? What barriers keep these communication lines from opening up between health service providers who are serving essentially the same populations?
   b. What benefits (if any) could you imagine coming from increased or initiation of communication?

10) Is there any potential for collaboration between botánica proprietors and mainstream health service providers? (Both groups)

   a. What about with academic researchers focused on this population?
   b. What benefits could you envision from more (or any) collaboration?

11) Did you operate a botánica, or provide similar services, in your country of origin? (For the botánica group only)

a. If so, how did this experience differ from operating a botánica in the United States?

    1. Do immigrants make a better living running botánicas in the United States?

12) Do you encounter many indigenous language speakers – people who speak neither Spanish nor English?

a. If so, would you say there is a significant number of immigrants or migrants in the Southeast at a given time who only speak an indigenous language?

After the first two interviews an additional general probe was added regarding any information or feedback individuals in both samples might have on the prevalence of HIV in Latino immigrant communities of Georgia.