Anthropologists, Migrants, and Health Research

Confronting Cultural Appropriateness

Jennifer S. Hirsch

And if a stranger sojourns with thee in thy land, thou shalt not wrong him... The stranger that dwell with you shall be to you as one born among you, and thou shalt love him as thyself, for you were strangers in the land of Egypt.

—Leviticus, 19:33–34

In the autumn of 2000, I received a frantic phone call from an epidemiologist at the Centers for Disease Control and Prevention (CDC). She was investigating a syphilis outbreak among Mexican migrants in rural Alabama and told me that the CDC team was having trouble getting the infected men to speak with them. She wondered whether I, as an anthropologist, could suggest the best way to approach these men. It seemed that she wanted me to let her in on the secret handshake. As a putative expert not just on Mexican migrants in general but also—even better—on Mexican migrants and infectious diseases, what could I tell her that would make them trust her enough to talk?

Anthropologists who conduct research with migrant groups sometimes find themselves called on to explain the behavior or experiences of the people with whom they work, either in the court of public opinion or in official discussions about policy formation. This is true in not only the area of health and medical services research but also any area in which public policy might conceivably draw on academic research

This chapter attempts to sort through several issues involved in deciding how to respond when called on. To a non-anthropologist, it might seem obvious that an anthropologist, when asked about migrant health, would talk about culture. However, within the discipline, we have moved far from the idea that the proper domain of a cultural anthropologist is exclusively culture. Medical anthropologists Nancy Schepers-Hughes (1992), Paul Farmer (1999), and Richard Parker (2001) have argued recently that the reach of both our theoretical and our applied work has been hobbled by an over-investment in the importance of cultural difference. Critical medical anthropologists, however, have largely failed to explore the way in which the knowledge we produce is shaped not only by our own theoretical frameworks but also by the desires of the audiences to whom we are, or might be, speaking. Regardless of theoretical advances in the discipline, anthropologists in public health continue to face the fact that people call in an anthropologist when they want to hear about culture—and in particular, about culture as a barrier to complying with certain desirable behavior (as in the opening anecdote). The demand for “cultural” explanations exists independently of our willingness to produce them.

As we develop a research agenda for anthropology and migration, it is urgent to draw on recent developments in anthropological theory and practice, but it is equally urgent to consider how the knowledge we produce fits into broader political economies of knowledge, serving certain political agendas and silencing others. In this chapter, I make this point primarily through an exploration of different ways in which public health research on migrants has incorporated the concept of culture. As I discuss in the conclusion, though, this point applies more broadly to other substantive areas of the ethnography of immigration. Shweder (see Chapter 9) argues that anthropologists might “rise to the moral challenges posed by cultural migration” by using our position as experts on cultural diversity to help our evermore multicultural society “distinguish between a defensible pluralism and the indefensible position of radical relativism.” Here, I make a different point about culture and the moral challenges of migration. Without denying the critical role we can play in fighting ethnocentrism, I caution that exaggerating the importance of culture as a determinant of health outcomes can do a real disservice to those for whom we presume to speak.

In this chapter, I propose that we conduct research on migrant health within a framework of “liberation anthropology” as a way of resisting the demand for the very sort of anthropological work on culture and health that the CDC epidemiologist asked me to provide. (As I will explain, the pat answer she seemed to be seeking promotes a limited understanding of the determinants of ill health.) In *Death without Weeping*, Nancy Schepers-Hughes (1992) writes about how a variety of factors—social inequality, political oppression, the social myopia of physicians, and the poor’s own variously constituted reasons for avoiding acknowledging that they are on the brink of starvation—have created an epidemic of *nervos* in rural northeastern Brazil, in which people perceive their illness to be primarily characterized by emotional fragility, treatable by pills rather than by food. As part of an attempt to develop a “liberation medicine” that parallels Latin American experiments in liberation theology, she suggests that another option exists and that medicine can be a “critical practice of freedom” (1992:215). Doctors can work to alleviate both physical suffering and the social inequalities that produce it. As she writes, “We might have the basis for a liberation medicine, a new medicine, like a new theology, fashioned out of hope” (1992:215).

Schepers-Hughes’ work also suggests the possibility of an anthropology of liberation; a key role for the ethnographer-writer is to give “voice, as best she can, to those who have been silenced” (1992:28). Liberation anthropology, however, would involve not just a sensitive form of ethnographic storytelling and a keener ear for community members’ pain. It would also involve, like liberation theology, a commitment to social analysis that reveals the underlying causes of suffering and ill health, including the pathogenic role of social inequality (Farmer 1999:5). To contribute to the broader project of liberation anthropology, medical anthropologists must explore cultural influences on health and healing, but they must also go far beyond this.

In the first part of this chapter, I argue that the nature of ethnography in immigrant communities obliges us to embrace the role of spokesperson and advocate. Unless we agree that we should answer
when asked, there is little point in discussing the political implications of whatever response we might craft. Next, I discuss how public health has integrated the concept of culture and examine the political implications of these cultural explanations of health. I argue that when anthropologists who work on migrant health are asked to provide explanations about culture and health, we should push to reframe the question so that it explores more broadly the determinants of migrant health. In the third section, I use examples from my own research with Mexican migrants in Atlanta to demonstrate how we might do this and thus produce theoretically sophisticated research that articulates clearly with critical policy questions—in other words, how we can not only provide grist for the culture mill but also raise questions about the prevailing models of determinants of immigrant health, about the interests served by an oversimplified model of culture, and, ultimately, about the politics of knowledge about immigrant health.

ETHICS, ETHNOGRAPHY, AND RESEARCH WITH MIGRANTS

Our ethical obligations to the migrants who are the subjects of our research stem from three sources: (1) our general ethical responsibility as social science researchers to avoid harm to our subjects, (2) the ways in which the particular vulnerabilities of our immigrant subjects may facilitate entrée into their communities, and (3) the dependence of Americans on the exploitation of immigrant labor for our very high material standard of living.

In a sense, my invocation of the idea of liberation anthropology is merely a translation of anthropologists' primary ethical responsibility, as stated in the ethics statement of the American Anthropological Association (AAA): "To avoid harm or wrong, understanding that the development of knowledge can lead to change which may be positive or negative for the people or animals worked with or studied" (AAA 1998: section IIIA1, paragraph 2). The liberation anthropology framework adds a level of critical reflection, however, to the principle that we should first do no harm. It suggests that the onus is on us not merely to avoid exploiting migrants as individuals but also to reflect on how our work can be used to the detriment of their communities. Our representations of immigrant communities can shape what the American public thinks about these communities and thus cause material damage or produce real benefits for those same communities. Our history as a discipline in the area of research on race and ethnicity should remind us of the importance of thinking critically about the political implications of the knowledge we generate.

The political and economic vulnerability of many immigrant communities adds another level of obligation to our generic responsibility to consider the implications of how we represent the communities with which we work. The Code of Federal Regulations for the Protection of Human Subjects (1991) specifies that research with vulnerable populations, such as children, prisoners, and pregnant women, be subject to a higher level of review. The reasoning is that where the risk is greater, the benefit to be gained from such research must also be greater in order to justify the research. To some extent, this may be true of all immigrants who, as individuals and communities, feel apprehension related to how the stories we tell about them to the broader American public might affect their ability to find work and housing and coexist peacefully with other groups.

Some may feel more vulnerable, however, to the winds of public opinion than others. Indian software engineers in southern California have less reason to care about how their non-immigrant neighbors perceive them than do Mexican migrants in Cobb County, Georgia, where an English-only law has been debated, off and on, since the late 1990s. However, given that many of those software engineers may be in the United States on temporary visas and that the number of those visas is set every year by Congress, they also have reason to worry about making a good impression on their local and national neighbors.

The disparity in language skills and access to resources between researchers and our immigrant subjects may also make immigrants feel less able to reject our advances than they would in their sending communities. During seven months in rural Mexico conducting research on gender, sexuality, and reproductive health in a migrant-exporting community, I usually felt that those Ivisited welcomed me as a pleasant distraction but that all I had to offer them was the marginal prestige conferred by a visit from la gringa (which I inferred from the hurt looks of those who asked why I never visited them) and my willingness to serve as a courier, taking letters, cards, and small gifts between
Degollado and El Fuerie and Atlanta. As with any anthropologist from a rich country working among the poor, there was always the possibility that people spoke with me because they wanted to extract gifts or even money from a well-funded anthropologist trying to develop rapport. Occasionally, I did bring gifts to the women I interviewed, and I was usually happy to buy ice cream, some tacos, or an agua fresca for their children. In general, though, I needed them more than they needed me: They spoke the language perfectly and were the insiders.

Furthermore, when far from home, we are subject to constraints of politeness imposed upon guests. If we speak out too often, too vociferously, or against the wrong people, we may face problems with visa renewal, research permits, and access to the very people with whom we have invested so much time in developing rapport. Even in Mexico, which, although far from being a perfect democracy, is hardly a totalitarian society, one acquaintance constantly threatened to invoke Article 33 of the constitution and have me thrown out of the country. Although he was joking (and Article 33 is seldom invoked), he made it clear to me that he resented my presence, that he thought I was a bad influence on his wife, and that I was a guest in his community.

The limited usefulness of anthropologists on foreign soil stands in sharp contrast to their influence on native turf. Although I repeatedly explained to my informants in Atlanta that I was conducting research in order to complete a doctorate in public health and anthropology, several referred to my studies as trabajo social (social work). Given the tasks I performed for them, it is not surprising that they thought of me as a free, full-time social worker who had adopted several families in their immediate community. To gain entrée into the community and establish a framework for regular participant observation, I made doctor's appointments, drove women on errands, and translated in a variety of settings. My help, in and of itself, was not exploitative, but this method of establishing relationships with an immigrant community suggests a very different interpersonal power dynamic than one in which the anthropologist arrives at a field site knowing nobody, barely speaking the language, and having little sense of local norms and customs. Favors provided in the normal course of ethnographic fieldwork—even when offered with the best intentions—may influence migrants to consent to the interview process or to answer specific questions out of fear that if they do not cooperate the anthropologist would cease to offer these favors. These small gestures to ease the pain of settlement may make entry into communities in the United States easier than in places where we are visitors. Therefore, a potential for exploitation is inherent in a fieldwork relationship with immigrants such as the ones I shared with my informants—but the opportunity to do good is greater because our voices count for so much more than they might elsewhere.

A final layer of obligation is created by the ways in which all Americans, anthropologists included, enjoy the fruits of immigrant labor—every $1.99 head of romaine lettuce, $3.99 basket of out-of-season strawberries, or boneless chicken breast we buy was likely touched by the hand of an immigrant. The 4,000-square-feet mini-mansions that sprouted up across the Atlanta metropolitan area in the 1990s would have been unaffordable to the middle class were they not built largely by immigrant hands. The immigrant labor that makes goods, services, and real estate so affordable contains an infrequently acknowledged cost. In 1999, more than half of the fifty construction fatalities in Atlanta occurred among Latinos (Mundo Hispanico, June 7, 2000, Atlanta Journal Constitution, September 4, 2000b). Nationally, Latinos (many of whom are immigrants) are over-represented in our nation's most hazardous industries (New York Times, July 16, 2001). In Atlanta, a Mexican immigrant recently fell to his death during the construction of Emory's Whitehead research building, which I pass daily on the way to my office. Of course, in this age of global capitalism we can trace the relationship between the American standard of living and worldwide exploitation, and the same has been true at least since the age of Mercantilism (see Mintz 1985). Still, it is harder to look away from the damage this does to real bodies when these bodies live right next door. Anthropologists conducting research with migrants will likely disagree on the best way to discharge these ethical obligations. However, because of the political and individual vulnerability of many immigrants, together with the ways in which we benefit from the fruits of their labor, anthropologists who work with immigrants cannot easily ignore the imperative to see themselves as advocates, not just researchers.
CULTURE AND PUBLIC HEALTH

My suggestion that engaging in ethnographic work with migrants inherently commits us to advocacy does not mean that all anthropologists must engage with the legislative process or become community organizers. In keeping with my proposal for an anthropology of liberation, even those anthropologists who see their work as purely academic should consider the political implications of the knowledge they generate. In this section of the chapter, I turn a critical eye on the way the concept of culture has been applied in public health, exploring the concept of cultural appropriateness and discussing some possible reasons for the current enthusiasm for cultural explanations of health behavior. In doing so, I argue that although a real demand exists for immigration research that looks at cultural influences on health, medical anthropologists should be wary of thinking that our most valuable contribution to the anthropology of migration is to produce research on the health beliefs of various migrant communities. True, this may be the product in greatest demand from public health agencies, thus translating most easily into fundable research projects, but it seems worthwhile to distinguish between work that is valued in the marketplace and work that expresses our own most dearly held values.

Over the past four decades, international public health research and programs have increasingly acknowledged how culture shapes the success of public health programs. Often they have looked to anthropologists as experts in community structure and local beliefs (see Correll and Mull 1990). More recently, minority and migrant health advocates and those charged with serving America’s increasingly diverse population have embraced the idea of making health services culturally appropriate and health providers culturally competent. However, the simplistic models of culture employed with increasing frequency in public health research and interventions are leagues from the theoretical state of the art in medical anthropology, which emphasizes the interweaving of culturally constructed beliefs and structurally influenced access to services and living conditions (for example, see Chapter 7; Chavez et al. 2001). I argue here that to conduct unreflectively research that will be used in the pursuit of cultural appropriateness runs the risk of doing a real disservice to those whom we claim to want to help.

The intense focus on culturally appropriate health services and prevention programs cries out for critical analysis because it represents the premier policy discourse through which much of the public sector recognizes and ascribes meaning to differences in immigrant groups. An analysis of government publications promoting cultural appropriateness reveals a simplistic concept of culture, but the problem with cultural appropriateness is not only what it shows but also what it fails to highlight. It suggests that the critical problems with immigrant health relate to health services that are not offered according to the various tastes and preferences of immigrant groups, instead of acknowledging that, in all too many cases, immigrants live in unhealthy conditions, work at dangerous jobs, and have very limited access to health services.

The National Center for Cultural Competence, a federally funded center at Georgetown University, defines cultural competence as the capacity to "(1) value diversity, (2) conduct self-assessment, (3) manage the dynamics of difference, (4) acquire and institutionalize cultural knowledge, and (5) adapt to diversity and the cultural contexts of the communities they serve" (from Cross et al. 1989, cited in Goode 2001).

Training providers in cultural competence is one step towards providing services that are culturally appropriate—that is, appealing and intelligible to the target population. Inevitably, advocates for cultural competence and cultural appropriateness (for example, Bureau of Primary Health Care n.d.; Cohen and Goode 1999; Goode 2001; Office of Minority Health, October 1998, January 2000, February/March 2001) provide statistical and anecdotal evidence of the increasing ethnic diversity of the United States due to immigration and frame cultural competence as a necessary response. For example, the cover article in an OMH newsletter describes the problems faced by an elderly Bosnian woman with terminal cancer admitted to a health facility: "She doesn’t read, speak, or understand English, her Muslim faith requires modesty during physical exams, and cultural beliefs make her family members shy away from discussing end-of-life matters. Many providers are looking for guidance on how to respond to these situations appropriately," said Julia Puebla Fortier, principal investigator with Resources for Cross Cultural Health Care.

Cultural competence, then, is intended to solve the problem of cultural difference. That this draws on, at least implicitly, decades of
research on culture, health, and illness produced by medical anthropologists becomes explicit from even a cursory look at a list of reasons for the necessity of cultural competence provided by one policy brief (Cohen and Goode 1999). These include variation in ethnomedical models and patterns of resort (that is, the patterns in which people self-treat and use health-care services), the diversity of preferences regarding traditional and allopathic medicine, the effect of bias and discrimination within the health-care system, and the under-representation of culturally and linguistically diverse groups in the service delivery system. Although the last two issues have not been major topics of concern to medical anthropologists (for an exception, see Maternowska 2000), the first two have been among the field's most prominent research topics for the past several decades (see Brown 1998; Johnson and Sargent 1990).

The problem with cultural competence is not just the historically static, oversimplified concept of culture deployed in these programs. Cultural appropriateness may make services more attractive to those who are eligible, promoting a consumer-choice approach to improving the public's health, but it does nothing for those who are left out in the cold by the free market. Furthermore, it implies that cultural beliefs are the cause of ill health and, therefore, that programs catering to those beliefs or communicating in a way that acknowledges them can improve people's health. The focus on their beliefs fails to acknowledge that these groups frequently lack the power to transform the conditions in which they live, labor, and reproduce and that it is these conditions, instead of exotic cultural forms, that are the underlying causes of poor health.

Two examples of successful, culturally competent programs give a fuller idea of what cultural competence entails. Sonrisitas (Little Smiles) is an oral-health promotion program sponsored by Colectivo Saber, a school and a community-based organization in San Diego, California. As described in the OMH newsletter (February/March 2001:12), "Sonrisitas is a culturally appropriate program that relies on the traditional Latino promotoras model to change behavior and educate the community about dental health. The model uses the natural support system that exists within the Latino community. It is an informal system that helps people and families, utilizes existing resources as well as alternative sources of support, and is based on confianza (confidence) and respeto [sic] (respect). Latinos value interpersonal relationships and turn to individuals to confide in. To assure the success of our promotoras model, the community we serve has to respect and have confidence in our promotoras and our message."

It is certainly true that the Latino community may have a "natural support system," but the discussion of the program does not acknowledge the other demands that living in a low-resource community can place on this support system. It also does not acknowledge that the reason a community-based oral-health promotion program is so important for Latinos is that so few have access to dental insurance or, for that matter, to any health insurance. The article further notes that promotoras and parents worked together to design the program and that "working together in a collaborative effort is one attribute of the Latino culture. Colectivismo (working together) is associated with high levels of personal interdependence and facilitates working in unison to problem solve issues that affect the community.... Familismo, seeing the family as the primary social unit and support system, is an important Latino characteristic. The value works to keep parents open to education and information programs that will assist them in keeping the family healthy and well" (OMH February/March 2001:12).

The program review concludes by noting that "in true Latino fashion, the classes conclude with a graduation fiesta where the whole family is invited and the participants receive a diploma!" Throughout, the references to Latino values suggest a vision of culture as timeless, unchanging, and internally homogeneous. That sort of approach to culture raises a red flag for most anthropologists, but the larger problems are the lack of contextualization and the idea that fiestas and family values—instead of, say, community mobilization about lack of access to care—are the most productive approaches to improving migrant health.

Cultural Competence: A Journey, a glossy publication produced by the Bureau of Primary Health Care (1999), explains and promotes the concept of culturally appropriate services through examples of how health programs have made themselves more attractive to their target populations. The Park Ridge Family Health Center, in Sunset Park, Brooklyn, is highlighted in a passage titled "Celebrating Competence: Gold Fish
Are Lucky." The population in the late 1980s was primarily Spanish-speaking, but Sunset Park is now home to many Chinese, as well as increasing numbers of Russians, Poles, and Arabic-speaking Muslims. The report notes that most Sunset Park residents avoided the local community health center in spite of its multilingual signs. Executive Director Jim Stiles described how he reacted by doing "a myriad of things that show that we want to be a provider for our neighborhood." These included putting Chinese lettering on the signs outside the clinic and redecorating the interior: "In the center of the waiting room at the Park Ridge Family Health Center, for example, is a fish tank. It improved the atmosphere, officials thought, helped patients to relax, and provided a Feng Shui element of water and sound. But when Chinese patients came to the center, which serves a wide-ranging mix of ethnicities, they were uncomfortable with the tank. It held the wrong kind of fish—gold and yellow fish are needed for luck. So out went the tropics and in went the gold fish. But there was something else wrong. The tank was sitting under a skylight, and the sun streaming in removed the color and the fertility from the fish. A shade was installed to cover the skylight." The remaining pages of Cultural Competence provide examples of culturally competent service provision elsewhere. The Minnesota Indian Board of Health was open to "healing ceremonies, vision quests, herbal remedies, and visits to a sweat lodge." A community health center in Seattle provided Chinese patients with acupuncture and Southeast Asian refugees with culturally appropriate treatment for post-traumatic stress disorder. The local radio station broadcast a series of dramatic novellas for the Spanish-speaking community in South Dade County, Florida. Latina women suffering from hypertension could take a dance class with salsa music in Oakland, California.

The underlying logic is that cultural competence is necessary because of increased immigration, that targeted efforts towards individual migrant groups will improve the health of the nation as a whole. On one level, of course, cultural competence is hardly a bad thing. Indeed, it is an improvement over its implied alternative, cultural incompetence. Under the rubric of improving cultural competence, Latino community advocates in Atlanta have made real gains, including effective resistance to (and the eventual repeal of) an English-only ordinance for signs in Cobb County, increased access to higher education for non-citizen children who graduate from Georgia high schools, shelters for day laborers, attention by the Federal Occupational Safety and Health Administration to the high proportion of construction fatalities among Latino workers, and, most recently, a collaborative effort to increase compliance with Title VI of the 1964 Civil Rights Act by ensuring that clinics receiving federal funding provide adequate access to medical interpretation.

The emphasis on cultural competence, however, can lead to problematic assumptions about how best to improve immigrant health. For one, to suggest that people who "have culture" need special programs to entice them to use health services seems mildly patronizing. Presumably, "culture free," white, native-born Americans do not. Improving health services for those who qualify for government-funded care is praiseworthy but does little to help the millions of immigrants who are not provided with health insurance by either the individuals and companies for whom they work or the government to which they pay taxes. In Georgia alone, the thousands of Mexican women who give birth every year have not been eligible for prenatal care from Medicaid since the 1996 federal welfare reform. Another reason to be wary of overemphasizing the health beliefs of migrant groups is that popular representations of these groups can use their sexual, nutritional, or healing practices as a way of exoticizing them. For example, a recent article in the Atlanta Journal Constitution (April 17, 2002) opens by describing "horror stories" that have followed the Hmong in America: "There was the Hmong Shaman in Fresno, Calif., who chanted incantations while a German shepherd puppy was publicly bludgeoned. And the Hmong mother in St. Paul, Minn., who strangled her six children to death. And there have been many other incidents—of Hmong exorcisms and opium use, polygamy and kidnap marriages..." Of course, not all writing about migrants' health in the popular press sensationalizes their supposed beliefs and behaviors. However, articles such as this one remind us that ethnographic descriptions of cultural variability in health and healing can be used to emphasize our newest neighbors' most exotic aspects, instead of what we all have in common.

Even beyond debates about the role of culture in shaping access to
health care, focusing on health care as a determinant of overall health overlooks the role of underlying structural factors. Immigrants are typically (but, of course, not always) poor. They are also over-represented among the uninsured and in the nation's most hazardous occupations, such as construction, farming, meat processing, and garment work (see Frumkin, Walker, and Friedman-Jimenez 1999; *New York Times* July 16, 2001). Many live in substandard housing in neighborhoods with the heaviest burden of environmental contamination. Poorer health outcomes are more common among people marked by ethnic or racial difference, but acknowledging this cultural difference will not make these immigrants healthier.

The most problematic aspect of the cultural competence paradigm is that it reifies racial and ethnic differences as the key explanatory variables to which we must attend and reduces the salience of social class factors. Research that explores ethnomedical models of health so that program directors can construct a separate, appropriately decorated clinic for each new ethnic interest group does not do nearly as much to improve the health of our nation's immigrants as would some exploration of what these immigrants have in common with poor, working and non-working blacks and whites, for whom "health disparities" are the inevitable outcome of income disparities. The focus on ethnic and cultural differences makes health services an area in which ethnic groups inevitably compete for resources. The interweaving of health services and identity politics works against the recognition of the shared inequalities faced by all the poor, native and immigrant alike. This obscuring of the pathogenic role of social inequality is not just a theoretical point. Health services, along with schools and the marketplace, are critical institutional contexts in which newcomers learn about life in America. One of the key take-home lessons of culturally appropriate services is that developing an ethnic identity in America means learning to vie with other minority groups for a piece of the federally funded pie.

Those committed to an anthropology of liberation, therefore, should be wary of conducting research on the exotic health beliefs of immigrants that will be used for the development of culturally appropriate health services. Rather, the liberation anthropology response is to analyze the public health epistemologies that, for various political, historical, methodological, and theoretical reasons, have come to privilege individual behavior and individual-level risk factors over structural ones (see Krieger 2000; Watney 1999). Cultural competence is the product of well-meaning advocates for minority and immigrant health whose vision of the reach of public health is limited by the current state of the field. They attribute problems to the system's inability to serve certain groups and conceive of solutions that only change the behavior of individuals instead of the system as a whole. The cultural appropriateness framework represents an enormous amount of hard work motivated by genuine concern for and commitment to improving the health of immigrants and the under-served. My goal here is not to be superciliously critical of these dedicated public servants but to show how the current individualist bias in public health limits their efforts. Our job as critical ethnographers should be to point out the political implications of the cultural appropriateness worldview in a way that is intelligible to non-anthropologists.

A second task for the liberation-minded anthropologist is to set his or her sights on the institutions with which migrants come in contact—in this case, to produce an anthropology of public health and health care in the United States. An anthropology of public health might usefully explore why culture has gained such a prominent place of late in the explanatory models of researchers and practitioners. Others have noted how the current appetite for work on cultural factors shaping health draws on material factors such as the changing demographics of the American population (OMH 1998) and on the fact that early HIV prevention efforts were widely understood to have failed because of a lack of sensitivity to cross-cultural variation in sexuality (Parker 2001; Parker and Aggleton 1999; Vance 1991). Widespread popular embrace of the idea that culture matters deserves further reflection. Anthropologists can contribute to the move towards cultural appropriateness in health services in a variety of ways. Rather than merely answer the questions people are most likely to ask us (reporting the necessary information about cultural values and beliefs so that practitioners can shape their programs accordingly), we should pose two questions of our own: Why are people so interested in culture? What else, other than culture, shapes immigrant health? Both of these questions are fundamental for a liberation anthropology approach to
migrant health. Answering the first enables us to explore critically the way in which both theoreticians and practitioners have confused cultural difference with structural violence (Farmer 1999:85). Answering the second helps us move beyond this limited vision of culture to describe more accurately the interrelationships of culture, social inequality, and ill health.

**REPRESENTING IMMIGRANT CULTURES**

That the concept of culture is misused is hardly reason to turn our back on it altogether. In the following section, I draw some lessons from my own research on US-Mexico migration, migrant health, and cultural creativity, focusing particularly on the special contributions careful ethnography can make to our understanding of the interrelationships of culture, political economy, migration, and health. In addition to generating health research that reframes questions about cultural influences, medical anthropologists can push our dialog with the public in the direction of liberation anthropology by presenting ourselves not only as experts on cultural influences on health but also as experts in community-based health research. In describing anthropological research on migrant health in this way, I suggest that we answer people's questions about health in migrant communities by asking the following four questions: (1) What do you mean by "community," and how is that community internally stratified? (2) What institutional or structural factors shape health in this community? (3) Given these external constraints, what health-seeking strategies do people craft? (4) How are things different for the people of this "community" who live elsewhere? By addressing these four questions, we can produce research that better represents the full range of anthropological contributions to health research. What follows explores these questions for one group and draws on my dissertation research, conducted in Atlanta and Mexico in 1995 to 1997, as well as on several other projects with Atlanta's Mexican migrant community.

In response to the first question, ethnography can make a critical contribution by describing the internal diversity of migrant communities and demonstrating the relevance of this diversity for health behaviors and beliefs. My dissertation was designed as a study to compare the dynamics of gender, sexuality, and reproductive health among Mexican migrants in Atlanta and their sisters or sisters-in-law in the rural Mexican-sending community. The project grew out of my long-term interest in how the social constructions of gender and sexuality shape reproductive health practices. It also aimed to contribute to the developing transnational perspective on cross-border communities and migrants' shifting and strategic constructions of identity by showing the influence of specific places and the constraints of social context, which have been often lost from view. As the data collection proceeded, I came to see that although differences in social context contributed to behavioral and cultural variation between women in the two places, a here-versus-there comparison was limited by an unexamined assumption that Mexico-US migration involved moving from a traditional setting to a more modern one. Social science research on migration has been so absorbed in the question of how things change when people move across space that we have sometimes forgotten that the places from which they come are not frozen in a distant, traditional time. Along these lines, I found that migration-related changes in gender and sexuality needed to be placed in the context of a broader, historical transformation in marriage and gender in Mexico. As I discuss in *A Courtship after Marriage: Sexuality and Love in Mexican Transnational Families*, these dual trajectories of change can be summed up by two phrases I heard repeatedly throughout the course of my fieldwork: "Ya no somos tan dejados como las de antes"—"We are no longer as easily pushed around as women of the past"—and "En el norte, la mujer manda"—"In the United States, women give the orders" (Hirsch 2003).

This Mexican transformation in the social construction of gender was reflected in generational differences in marital ideals. Women born in the 1920s, 1930s, and 1940s in rural western Mexico described marital relationships there as based on respect, obligation, clear hierarchies of age and sex, and the fulfillment of a strictly gendered division of labor. Their daughters, born in the 1960s and 1970s, described unions organized around ideals of cooperation and shared decision-making, sexual and emotional intimacy, and a less rigid (although hardly egalitarian) distribution of authority. (Even though at a disadvantage in terms of socially structured access to resources, the older women were certainly not submissive, exerting influence in subtle, and sometimes not so subtle, ways, and their daughters were not quite as
powerful as they made themselves out to be [Hirsch 2003].) The younger couples I knew, in both Mexico and Atlanta, described how sexual intimacy-created and strengthened marital bonds. Differences between the younger and older women’s stories show that mutually pleasurable sex has come to be understood as a source of marital harmony, not just a way of producing children and keeping a man’s attention from straying. Recalling question one, above, the internal diversity in this community’s notions of sexuality, then, were not only due to the rural communities’ increasing integration into migrant circuits but also to the changes in rural Mexico itself—and the family lives and relationships there. The profound social and economic changes in this region of Mexico are intimately linked to migration, but to credit migration alone for these changes would be a mistake.

The vast social changes that produced this shift to a more companionate model of marriage have also (not surprisingly) produced diversity in health beliefs, such as women’s understanding of their reproductive physiology. For example, Magdalena, a forty-eight-year-old woman of great wisdom but little formal education, explained that infertility is caused by a woman’s remaining open (abierta) after childbirth, so a baby cannot stick to the inside of her womb. Isabel, twenty years Magdalena’s junior and educated at a private Catholic high school in a nearby provincial city, had markedly different views. When I asked her about women who are stuck “open” and need traditional massage to become pregnant again, she looked at me as though I were an idiot and said that women who don’t get pregnant must not be ovulating regularly and should have their hormone levels checked by a doctor. Isabel lives in Mexico, but her sisters Blanca and Patricia live in Atlanta, as does Magdalena. Blanca and Patricia’s ideas about fertility and reproduction, however, resemble Isabel’s much more than they do their neighbor Magdalena’s. A well-meaning clinician in Georgiawho studies traditional Mexican ethnomedical models, such as those to which Magdalena ascribes, in order to communicate better with his or her patients would hardly find cultural competence useful if the patient in question happened to be Blanca or Patricia. Social class and generational differences create internal diversity in a cultural group, so it is misleading to speak of a culture as a unified whole, as the cultural appropriateness approach often does.

Gender, another critical line of fragmentation in these communities, provides further reason to ask people what they mean by “community.” Gender differences in interpretation of culturally constructed beliefs about marital sexuality highlight the importance of exploring socially constructed disparities in power within cultural groups. In rural Mexico and in Atlanta, younger Mexican women have come to see infidelity not just as evidence of a lack of respect (as their mothers did) but also as a profound breach of the intimacy on which marriage is based (Hirsch, et al. 2002). Younger women call on the cultural framework of companionate marriage to question men’s right to extramarital sex and men’s supposed inability to domesticate their desire. Although many of the younger women’s husbands shared some of their ideas about marital companionship and sexual intimacy, most did not embrace the idea that men’s infidelity had become unacceptable. Indeed, many men felt that the savvy modern husband should exercise extra caution to keep his misbehavior from his wife. In a social context in which men frequently spend nine or ten months a year apart from their wives while they work as migrant laborers in the United States, gender differences in attitudes towards infidelity have critical implications for the prevention of sexually transmitted diseases, including HIV. The differences in how men and women interpret the meaning of infidelity within companionate marriage remind us that intracultural differences in beliefs are a product of both individual choice and socially structured access to power. Medical anthropologists should insist that portraits of migrant cultures seek out the tensions and disagreements within cultural groups and explore how social stratification shapes these tensions, rather than accept a socially flat portrayal of cultural influences on health. These examples about infidelity and infertility suggest that anthropological research on migrant health can make a valuable contribution by adding complexity to pat statements about what Mexicans—and other migrant groups—believe.

**Looking beyond Cultural Factors**

In addition to producing more nuanced portrayals of the diversity of health beliefs within migrant communities, medical anthropologists should explore the importance of beliefs relative to other factors in shaping actual behavior, thereby answering the second question about
how structural factors influence health. In my dissertation research, for example, although I found Mexican women’s fertility goals to be similar in Mexico and the United States, striking differences emerged in preferred ways to achieve those goals. Of the thirteen women I interviewed in Atlanta, seven relied on a modern method such as the pill or IUD. Among their sisters or sisters-in-law in Degollado and El Fuerte, only one had tried such a method, and she discontinued it quickly after being invited to be godmother to a friend’s daughter at her first communion. To be a godparent, you must take communion, and you cannot take communion unless you have confessed. No priest in this region of Mexico would allow a woman with only three children to use an IUD unless a pregnancy would mean her certain death.) The difference in contraceptive preferences is largely the product of differences in the organization of certain key social institutions (the Catholic church, the family, the labor market, the health sector) in rural Mexico and the United States (see Hirsch and Nathanson 2001). Also, a different value is attached to fertility in the two locations. In Mexico, fertility is a precious resource that women fear will be impaired by the side effects of the pill or the IUD. In Atlanta, women weigh the risk of an unplanned child more heavily, wary about the effects on their ability to work outside the home. They also feel greater freedom to choose a method to which their partner objects.5

Inevitably, an ethnography of immigrant experience is an ethnography of America. To draw a more rounded picture, we must not only work with immigrants but also include ethnographic (and demographic) studies of the institutions that shape their lives, in order to understand the context within which they make specific choices. The example above highlights the importance of institutions. To attribute the difference in contraceptive practices solely to migration-related cultural changes, such as a change in the value of fertility, would be a mistake. In terms of health institutions, this would mean an anthropology of public health, rather than merely in public health. Studying the structure, organization, and constraints imposed by the institutions with which migrants negotiate is the only way to understand their options—and we cannot reasonably interpret studies of individual choices and preferences without information about the (perhaps limited) options available.

Another example that highlights the role of structural factors comes from my research on social ties and HIV risk among Mexican migrant men in Atlanta, which explored how cultural factors (such as men’s ideas about masculinity, sexuality, and marriage) and social factors (migrant experience, social networks, and loneliness) shaped men’s likelihood of engaging in sexual relationships while they were in Atlanta as temporary labor migrants.6 The ethnographic and survey data from this pilot study suggest that both social and cultural factors shape men’s HIV behaviors (Hirsch and Yount 2001), but in the end what put these men at risk for HIV infection was that they were in the United States (the risk of HIV infection is much lower in rural Mexico). They were forced to migrate and take low-status jobs here on account of dire economic conditions in their home communities and long-standing economic and political inequalities between the United States and Mexico. I make this point not to deprive these men of any agency (after all, some men engaged in extramarital sex and others did not) but to argue that we should attend to not only the choices individuals make but also the broad social and economic forces that limit their options.

Following Paul Farmer’s (1999) lead, I have come to be more concerned with the institutional determinants of health than with cultural factors. To explore these institutional determinants of health, I am developing a project, in collaboration with the Hispanic Health Coalition (an Atlanta grassroots Latino health advocacy group) and Atlanta’s Mexican consulate, that aims to improve occupational safety and health among day laborers in the construction industry. Nationally, Latinos are over-represented among worksite fatalities (New York Times, July 16, 2001). Locally, more than 50 percent of deaths in the construction industry occur among Hispanics (Atlanta Journal Constitution, September 4, 2000).7 When I discussed plans for the project with my colleagues at the Hispanic Health Coalition, their first response was to focus on the cultural barriers to improving occupational safety and health. “You know,” some members of the coalition told me, “back home we never worry about things like that. People ride around in the back of trucks in Mexico, even little children. We are not used to taking precautions, wearing masks and things.”

Of course, using infant car seats, wearing seat belts, taking cholesterol-lowering drugs, and exercising daily reflect a different worldview and
ability to control one’s fate than piling into the back of a pickup for an
impromptu trip to town and eating tacos in the plaza. Such differences
in behavior are not just a product of culture, however. Latino immi-
grants readily learn to use car seats and buy car insurance when clear
institutional supports are in place to encourage their doing so. Most
day laborers have little control over the conditions in which they work
and even less opportunity to develop task-specific skills that would
make it easier for them to carry out their work safely. While the
research project is still under development, we hope to educate con-
traeristas (contractors) and subcontraeristas (subcontractors) about work-
place safety and their legal obligations to provide a safe working
environment.

Negotiating Modernity through Medicine

The third question we might ask as we map out a liberatory
approach to medical anthropology research with migrants is how indi-
vidual strategies are formed at the crucible of culturally constructed
beliefs and structural or institutional constraints. For health research,
this means looking at how people negotiate strategically through the
various systems of service provision. It also implies an open-ended explo-
ration of the goals shaping these strategies. Of course, one goal of seek-
ing health services is to achieve or maintain physical health, but we risk
missing a rich symbolic dimension of health behaviors if we assume that
this is the only (or even the primary) determinant of health-seeking
behavior.

The sight of her growing fetus, for example, fascinated Mercedes, a
young Mexican woman in Atlanta. She cajoled me into calling her
obstetrician’s office and reporting that she was having symptoms of pre-
mature labor, solely so that she could have an emergency ultrasound at
twenty weeks to learn the baby’s sex. She then had me accompany her
to the office as a translator. Her evident delight afterwards was not just
because she could begin knitting in the appropriate color. She loved
the technology, savoring her peek into the future at her baby-to-be and
her ability to manipulate the medical system (and me) to give her this
opportunity. Other Mexican women I met in Atlanta found it laughable
that some women in Georgia broke the law in order to have babies at
home (home birth is illegal in Georgia). They did not understand why
anyone would choose to have a baby as their mothers did, at home with
the partuera. For them, a physician-assisted, medicated delivery marks
middle-class status. The women who come to Atlanta want to deliver in
a hospital because they believe that it is safest and because it is the only
way to get a birth certificate. Also, they see access to technology as a
measure of their successful adaptation to American society. They are
making health-care choices that indicate their desire to be modern
women.

Learning what people are trying to achieve through their use of
specific services helps us see health-seeking behavior as an act of con-
sumption, a way of constructing and performing modern or traditional
identity. Even among the poor and uninsured, issues of identity and
belonging may be played out through the use of health services. For
example, when immigrants prefer traditional healers to allopathic
practitioners, how is this related to a preference for services that are
familiar and affordable? To what extent are these healing rituals also
rituals of identity? Conversely, what are the cultural and social factors
that lead to the sort of ethnomedical syncretism we see across the spec-
trum of American society? In exploring the weaving together of tradi-
tional and allopathic approaches, we should push for a theoretical
framework that embraces both Mercedes’ intense desire for an extra
ultrasound and many Americans’ fascination with massage, acupuncture,
and herbal remedies. Although structural factors (such as employ-
ment that provides health insurance) are one explanatory factor,
people’s desire to position themselves in relation to modernity
(expressed through medical technology) also seems important.

Discussions of culture’s influence on immigrant health-seeking
behavior often assume a fixed set of cultural beliefs that correlate
directly with a certain set of behaviors. In contrast, an agency-oriented
approach to immigrants’ use of the American health-care system sug-
gests that a preference for traditional medicine, for clinics with good
feng shui, is not inevitable. It is better to start out by investigating immi-
grants’ strategies—including the way they make health-care choices as
a way to express who they are, or who they are becoming—as they navi-
gate through the health-care system’s many barriers. Questions about
how migrants’ health-care choices express identity are closely linked, of
course, to questions about citizenship, eligibility for Medicaid, and the
broaden economic structure of the health-care sector. To the extent that culture and identity shape the decisions migrants make about how to heal themselves, however, we should also attend to the possible linkages among modernity, medical technology, and immigrant identity.

**Calling for Comparative Research on Migrant Health**

Finally, after we describe and explain how the combination of external constraints, shared beliefs, and individual goals shapes health-seeking behaviors in a specific migrant community, the fourth question I suggest would push us toward comparative research, which can highlight the influence of social context in numerous ways. In spite of the recent flourishing of multi-sited ethnographic fieldwork in migrant communities, we still do not know much about how people's lives change as a result of short-term, long-term, and permanent moves between one country and another. Also, there are real challenges to doing even this multi-sited work well. I would argue, however, that it is also crucial to "nest" these multi-sited studies of migration and social and cultural change within studies of cultural and social transformation in the places from which migrants come. My own research on the interweaving of generational and migration-related changes in marriage, sexuality, and reproduction suggests that gaining a clear purchase on how people's lives change with migration is impossible without having some idea of the cultural and social transformations underway in their home country. Given the logistical challenges of finding enough time to do extended fieldwork in one location, much less multiple sites, one solution might be to promote more cross-fertilization and collaboration between migration researchers and anthropologists (or other social scientists) who have conducted—and can conduct in the future—long-term fieldwork in the societies from which large numbers of migrants come.

Comparative studies are vital to unpack and problematize the dominance outside anthropology of purely cultural explanations of migrant health and to help us think more clearly about, and make more useful policy contributions to, the role of culture in migrant settlement. A second kind of comparative work—cross-national comparisons of immigrants, for example, in Canada and the United States (countries with related streams of immigrants but very different health-care systems)—would help evaluate the role of culture and the importance of cultural appropriateness, relative to other determinants of migrant health. Third, within the United States, comparisons of the experiences of migrant groups and non-immigrants can also shed light on the relative roles of various explanatory factors in shaping immigrant health. The studies should also be designed to bring out the role of social class among immigrants and non-immigrants alike. To do this well, of course, it is necessary to foster collaboration among anthropologists who specialize in different ethnic groups.

Fourth, we need comparisons across locations within the United States. Much of what we know about migrants is based on research in Miami, Los Angeles, and New York. Newer migrant-receiving locations provide markedly different contexts (see Brettell, Chapter 6); migrants arrive at a particular historical, political, and economic moment in time. The high rates of construction fatalities among Latinos in Atlanta, for example, may be related to the low rates of unionization in the construction trades. In areas where construction work is more heavily unionized (and therefore harder for newcomers to penetrate), there may be less reliance on day laborers who do not have the chance to develop task-specific skills. Atlanta ranks high nationally in pedestrian fatalities, and pedestrian fatalities have been a particular problem among Mexican immigrants (CDC 1999; *Atlanta Journal Constitution*, September 4, 2000a). This may be less of a problem in cities that have invested more heavily than Atlanta in sidewalks and public transportation. Furthermore, the physical geography of Atlanta, with its limited opportunities for safe walking, has important implications for obesity, a critical area of Latino health. It may not be possible to disentangle all the complex differences between being the millionth Mexican man to arrive in pre-Immigration Reform and Control Act, post-recession California in 1984 and being the 150,000th to arrive in post-Olympic, pre-recession Atlanta fifteen years later. However, generalizing from one situation to the next is ill-advised without taking into account the many contextual factors shaping migrants' experiences and health outcomes.
CONCLUSION

In this chapter I have argued that the ethical obligations we incur by working with migrants in our own country require us to reflect on the political implications of the knowledge we produce. I applied this critical perspective to anthropological research on migrant health, suggesting that cultural appropriateness—and, more broadly, any research that focuses exclusively on how culture shapes migrant health—is unlikely to contribute to the broader project of liberation anthropology. To push for research on migrant health that advances the broader goals of liberation anthropology, I make two broad recommendations: first, that we turn our critical faculties toward an analysis of the questions we are asked, exploring why culture has come to hold such a prominent place in the explanatory frameworks of health professionals, and second, that we insist on portraying culture in a more nuanced fashion and view it as only one of many factors influencing migrant health. Drawing on examples from my fieldwork in Atlanta and rural western Mexico, I have illustrated how attention to internal social stratification in migrant communities, the social institutions within which migrants navigate, the ways that people use the health arena in making claims about traditional or modern identities, and comparative research design can lead to ethnographic research characterized by a more theoretically sophisticated understanding of the relationship between culture and health. Attending to these factors will also, I have suggested, guide us to produce research that contributes to a liberation anthropology agenda by highlighting, rather than obscuring, how structures of power shape migrant experience.

A conclusion that applies more generally to the anthropology of migration is that all research with migrants is political—political because the questions people ask us derive from a desire to see how migrants will fit into American society; political because the answers we give can be used to argue for or against specific programs or services that will shape the trajectories of migrant settlement. Whether we conduct research on schools (see Stepick and Stepick, Chapter 5), health services (see Chavez, Chapter 7), labor markets, or transnational social institutions or write about the theories scholars use to frame this research (see Glick Schiller, Chapter 4), we ought to frame our research explicitly as part of a larger project of liberation anthropology rather than hide behind the mantle of science to avoid acknowledging the political aspects of our work. Some might argue that, by admitting we are driven by a specific politics, we will delegitimize our findings in the policy arena. Theoretical developments in our field, such as the push for situated knowledge, make clear that conducting research free from bias is impossible. Just as importantly, critical theories provide the tools to expose the costs of research that explores, for example, cultural influences on health without looking more broadly at the pathogenic role of social inequality (Farmer 1999:5). By deliberately considering the agendas served by the knowledge we generate, we can place our research in the service of a vision of America in which we welcome not just the hands that labor for us but also the bodies for which we must care, the minds we must educate, and the hearts whose dreams may not be that different from our own.

Notes

Acknowledgments: The fieldwork on which this chapter draws was generously supported by the Andrew Mellon Foundation through a grant to the Department of Population Dynamics at Johns Hopkins University, the National Science Foundation Program in Cultural Anthropology (SBR-9510069) and the International Migration Program at the Social Science Research Council, and the Emory Center for AIDS Research. I also gratefully acknowledge support from the Fogarty International Center at the National Institutes of Health via its ongoing support for the Emory AIDS International Training and Research Program (NIH# D43 TW01042-02). I also acknowledge, in writing this chapter, my very great debt to my dear friend and mentor, Michael Francis Jiménez (August 14, 1948, to September 1, 1991), who on a chilly fall day in 1986 brought an auditorium full of naive, ambitious, self-involved Princeton undergraduates to tears as he lectured about the fall of the Allende regime. Throughout his too brief career, he taught many of us a first, unforgettable lesson about the histories of power, the power of history, and the possibility of doing academic work that matters.

1. The administrative and legal apparatus that has evolved in recent years to ensure that research is consistent with federal guidelines for the protection of human subjects is primarily concerned with the protection of individual rights, whereas here I am pointing to our responsibility to the community. On the issue of community-oriented research ethics, see King, Henderson, and Stein 1999;
8. As I discuss elsewhere, my initial impulse to look at migration and cultural change (in this specific case, migration and gender) was typical of a genre of migration research that looks at the changes associated with migration without inquiring adequately into how the places from which people come might be subject to historical transformation (Hirsch 2003). Linda Anne Rebbun, in her research on love and cultural transformation in rural northeastern Brazil (1999:2), talks about how her informants perceived modernity and geography as interwoven according to a spatial wheel of time in which more urban, centrally located places, in and of themselves, were perceived to be more modern, generating more modern modes of action, thought, and relationships. More rural locations were perceived to be more resistant to change, more remote not just in space but also in time. If we are interested in working with people as they move across space, we need to be alert to our own tendencies to subscribe to these folk ideas about space and time. We must look as hard for rural modernities in sending communities as for urban ones in the United States.

9. Women in rural Mexico have better access to family planning than do their peers in urban Atlanta. They do not face the barriers of language and transportation that immigrants encounter, and several methods (Depo and oral contraceptive pills) are even available over the counter, without the additional barrier (albeit an important one from a preventive-health point of view) of the pop smear.

10. The study "Mexican Men in the Urban South: Social Ties and HIV Risk" was supported through a pilot grant from the Emory Center for AIDS Research.

11. Without knowing what percentage of construction workers in Georgia are Hispanic, we cannot know for sure whether they are under- or over-represented among fatalities. Given that Hispanics represent only about 5 percent of the state's overall population, it seems a good guess that this statistic is cause for alarm.

12. The Immigration Reform and Control Act, which became US federal law in 1986, was intended to limit immigration from Mexico to the United States by imposing strict penalties on those who employed immigrants lacking legal permission to work.