

Health Care for Women and Children
in Boyle Heights:
Community Portraits of
Access, Barriers, Needs, and Resilience

by

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December 2015

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ACKNOWLEDGMENTS

Maternal and Child Health Access (MCHA) would like to thank the staff from the following organizations, communities, and institutions for the gift of their time and their contributions to this report: Clinica Monseñor Oscar Romero; Dolores Mission Parish; East LA Women's Center; Euclid Ave. Elementary School; LA Christian Health Center; Mendez High School; Planned Parenthood of Los Angeles; Proyecto Pastoral at Dolores Mission; Roosevelt High School; Weingart East Los Angeles YMCA; and Wyvernwood Apartments.

We'd like to also thank the following individuals we interviewed, as system leaders and/or as practitioners: Dr. Maritza Cabezas, Dental Director, Los Angeles County Department of Public Health; Dr. Emily Dossett, Maternal Wellness Clinic, LAC + USC Medical Center; Ellen Eidem, MS, Director, Los Angeles County Office of Women's Health; Dr. Elena Esparza, healer and activist, Just Breathe Healing; Alma Esquivel, Southern California Regional Director, Vision y Compromiso; Elena Fernandez, Director of Behavioral Health Services, St. John's Well Child and Family Center; Dr. Mark Ghaly, Director, Community Health and Integrated Programs, Los Angeles County Department of Health Services; Amy Luftig Viste, Program Director, My Health LA, Los Angeles County Department of Health Services; Dr. Breck Nichols, LAC + USC Medical Center; Dr. Monica Rado, Dental Associate Director, Clinica Monseñor Oscar Romero.

Luz Marlene Cordero, health promoter and resident leader at Wyvernwood Apartments, and Queen Victoria Ortega, transgender rights health equity leader, both contributed invaluable time and input.

Fabiola Sandoval, Community Associate of MCHA, guided the interviews, focus groups, and surveys, and wrote initial report copy. Michelle Gubbay and Lynn Kersey, Executive Director, MCHA, wrote and edited the final document. Significant support was provided by: Susana Bonis, Building Healthy Communities-Boyle Heights Evaluation and Learning Partner; Martha Escudero, Case Manager for the Perinatal Outreach and Education Program, MCHA; Joel Perez, with the Building Healthy Communities-Boyle Heights Hub; Marcela Ramos, interpreter and independent consultant; and Celia Valdez, Associate Director for the Wellness Center at Historic General Hospital, MCHA.

The California Endowment provided essential funding, support, and guidance for this project and for the community's vision of a healthy Boyle Heights. We express our appreciation for their assistance and for that of Jennifer Ybarra, Program Officer for Building Healthy Communities-Boyle Heights.

This report would not have been possible without the advocates, doctors, mothers, young women, and Boyle Heights community leaders who generously contributed their expertise, stories, experiences, and vision. We engaged with over 100 women in the course of this project; to respect their privacy, we have changed the names of those whose stories and voices are recorded here.

INTRODUCTION

This report summarizes research conducted by Maternal and Child Health Access (MCHA) in 2013-2014, as part of The California Endowment's "Building Healthy Communities" (BHC) initiative.

The California Endowment launched the BHC initiative as a ten-year commitment to fourteen underserved communities throughout California. Boyle Heights, where MCHA has been active for many years with our trademark trainings, case management, and advocacy efforts, was one of the selected neighborhoods. MCHA was funded to examine issues of access to health coverage and the quality of health care for women and children.

The BHC-Boyle Heights (BHC-BH) planning process (2009-2010) laid the groundwork for MCHA's efforts, defining priorities to expand health programs for low-income children; later, BHC members widened the target population from children to families and all community members.

Our engagement was informed by a process known as community-engaged research, defined as "working collaboratively with and through groups of people affiliated by geographic proximity, special interest, or similar situations to address issues affecting the well-being of those people." In community-engaged research, "Researchers and community members recognize each other's expertise in a bi-directional, co-learning process," and "Researchers embrace the skills, strengths, resources, and assets of local individuals and organizations."¹ This work is part of the continuum of the BHC-BH logic model and larger conversations that have taken place in the last five years in Boyle Heights.

The inquiry took place within the context of a changing healthcare coverage landscape. The changes include the implementation of the Affordable Care Act (ACA), with increased income limits for Medi-Cal coverage and expansion to single adults; the federal Deferred Action for Childhood Arrivals (DACA), which provides full Medi-Cal benefits to certain immigrants who arrived in the US during their childhood; the partial restoration of adult dental benefits in Medi-Cal; and the implementation of Los Angeles County's "My Health LA" program.

Another major landscape event that took place during this time frame was the influx into Los Angeles of migrant mothers and children from Honduras, Guatemala, and El Salvador, as well as large numbers of unaccompanied minors from these same countries and Mexico. Community clinics such as Clinica Monseñor Oscar Romero in Boyle Heights and St. John's Well Child and Family Center, with a location in the adjacent neighborhood of Lincoln Heights, have publicly committed to providing services to these populations, ineligible for more comprehensive public programs.

All of these developments have significantly impacted healthcare coverage, including some of the challenges revealed by the research. It is the hope of MCHA that the historic moment of the ACA, favorable popular opinion in California about the right of individuals to healthcare access regardless of immigration status, and local programs such as "My Health LA" will lead in the direction of comprehensive quality care for all the residents of Boyle Heights.²

¹ "A Quick Start Guide to Community-Engaged Research," Southern California Clinical and Translational Science Institute Office of Community Engagement, 2012

² "Findings of a Statewide Survey on Expanding Access to Health Coverage," by Dave Metz and Greg Strimple, September 30, 2014, reported that a majority of California voters "support expanding existing health care programs to cover all low-income Californians, regardless of immigration status." *Note added as we complete*

MCHA has worked since 1996 through advocacy, education, training, and direct services, serving people from all over Los Angeles County. To achieve our mission of improving the health of low-income women and families, we function on multiple levels:

- with individual women, assisting them to achieve healthy pregnancies and obtain quality health care for themselves and their children
- with health and social service organizations, providing information, support, and technical assistance
- with policymakers and the general public, suggesting pathways to improve health and social services systems for all low-income women and families, and the ways in which such improvements benefit the entire community

This report reflects MCHA work of over two years in the community, the collaboration of many partners, and generous contributions from residents of Boyle Heights, a predominantly Latino neighborhood but diverse, with many communities within it. In this report we focus on access to healthcare coverage and barriers to quality care as social determinants of health for the community of Boyle Heights, with the understanding that access and quality are a part of a larger picture of health equity and well-being.

this report: Popular opinion remains in flux. A more recent poll shows that 48% of California voters believe that immigration status should not determine healthcare access while a “statistically equal” 47% disagreed. See “California voters sharply disagree on low-cost healthcare for immigrants,” by Cindy Carcamo, [Los Angeles Times](#), September 15, 2015.

PART ONE DEMOGRAPHICS AND METHODOLOGY

Demographics of Boyle Heights

Boyle Heights, encompassed within zip codes 90023, 90033, and 90063, is a densely populated urban neighborhood of approximately 6.5 square miles east of downtown Los Angeles. It is one of the oldest areas in the city and home for over 40 years to one of the largest concentrations of Latinos and Mexican immigrants in the United States. In 2008, the L.A. Department of City Planning estimated the population of Boyle Heights as 99,243, of whom 94% were Latino; this compares with a 48.5% Latino population in Los Angeles as a whole. Over 80% of the Latino population in Boyle Heights is Mexican or of Mexican descent.³

The neighborhood has historically lagged behind other Los Angeles communities in indices of well-being including education, health care, income level, and public safety. According to the 2010 census, one-third of Boyle Heights families lived below the federal poverty level, and over two-thirds of adults had less than a high school education. In 2003, the U.S. Department of Health and Human Services designated Boyle Heights a Medically Underserved Area, with inadequate provider and hospital capacity.⁴

However, Boyle Heights also has many attributes that contribute to greater health in the community, including active social networks, parks and other social gathering spaces, strong nonprofit infrastructure and capacity, youth and adult organizing activity, and many cultural riches. The Alliance of California Traditional Arts, in their Boyle Heights Cultural Treasures Project, surveyed residents and found a wealth of assets. Seniors at Roosevelt High School have produced three books highlighting the resilience and pride of the Boyle Heights community, past, present, and future.⁵

The 2009 California Health Interview Survey (CHIS) found that 32% of Boyle Heights adults lacked health insurance, compared to 26% in Los Angeles County as a whole. (Percentages may have shifted with the recent changes in the health coverage landscape mentioned in the Introduction.) The CHIS found that 20% percent of Boyle Heights adults were in fair/poor health, similar to the county-wide figure of 18%. Significantly, 35% were obese – in the U.S., a disease of the poor – compared to 21% in Los Angeles County as a whole.⁶

³ Demographic data for Boyle Heights can be found at the [Los Angeles Times](#) “Mapping L.A.” website page for Boyle Heights; the Census Bureau’s American FactFinder website and their Quick Facts site (both searchable by zip code); and City-Data.com (searchable by neighborhood).

⁴ See website of the California Office of Statewide Health Planning and Development, <http://gis.oshpd.ca.gov/atlas/topics/shortage/mua/boyle-height-central,-city-terrace-w%20->

⁵ See the several articles on Boyle Heights on the website of the Alliance of California Traditional Arts, actaonline.org. The three books written by Roosevelt seniors, [In Our Global Village: Boyle Heights through the Eyes of its Youth](#) (2010), [Untold Stories from Boyle Heights](#) (2011), and [The Tomorrow We See Today: the hopes of Boyle Heights dreamers](#) (2012) are all available from the Los Angeles Public Library, and the first is accessible on the Internet. We will return to the topic of assets and strengths later in this report.

⁶ See the Boyle Heights Health Profile from the UCLA Center for Health Policy Research. We will return in our Conclusions to the topic of obesity as a disease of the poor.

A major issue affecting large numbers in this community is the question of immigration status. Lack of legal status severely restricts access to quality health care, and President Obama's health reform, the Affordable Care Act, excludes undocumented residents from coverage. In Los Angeles County as a whole, there were over 800,000 undocumented residents in 2013,⁷ of whom 400,000-700,000 were uninsured, according to the Los Angeles Department of Health Services.⁸

Within Boyle Heights, about half the population is foreign-born.⁹ Nearly one in five children in the County of Los Angeles has a parent who is undocumented,¹⁰ but in Boyle Heights, this figure doubles to 40 percent.¹¹ Our research supports the findings of Marcelli and Pastor that "unauthorized immigrants are often deeply rooted in their communities." In Boyle Heights, Marcelli and Pastor note, "about half have resided more than a decade (11 years) in the USA."¹²

Survey Methodology and Demographics

MCHA's research was qualitative in nature, and consisted of four components:

- Ten stakeholder interviews
- Sixty surveys
- Three focus groups
- Five system leader and three clinic leader interviews

Community stakeholder interviews: Health and social services providers and community leaders working in Boyle Heights were interviewed to develop questions and topics of importance for the community surveys and focus groups. This was the first stage of the research, conducted from February through May 2013. The interviews were each 25-40 minutes in length.

Community member surveys: The 57-question survey was developed from areas of interest identified in the stakeholder interviews. Women were approached at parent centers at Roosevelt High School and Euclid Elementary, outside outpatient clinics of LAC + USC Medical Center, inside Clinica Monseñor Oscar Romero, and at the Weingart East L.A. YMCA. We explained the purpose of the research and offered a small stipend for participation. The surveys were administered one-on-one at these same locations plus at Pico-Aliso and Wyvernwood Apartments.

The survey participants were all Latina, with the exception of one African-American woman and one woman who self-identified as multi-racial. All were between the ages of 18-70, and all lived (78%),

⁷ "Just The Facts: Undocumented Immigrants," by Laura Hill and Joseph Hayes, Public Policy Institute of California

⁸ "L.A. County health program for unauthorized immigrants shows promise, but challenges remain," a story broadcast on KPCC radio on May 1, 2015, plus personal interview with the story's author, Adrian Florido

⁹ "Unauthorized and Uninsured: Boyle Heights and Los Angeles County," by Enrico A. Marcelli and Manuel Pastor

¹⁰ "What's At Stake For The State: Undocumented Californians, Immigration Reform, and Our Future Together," by Manuel Pastor and Enrico A Marcelli, May 2013

¹¹ "Unauthorized and Uninsured"

¹² "Unauthorized and Uninsured"

worked, volunteered, or had children who attended school in Boyle Heights (or a combination of these characteristics).

Forty-eight out of our 60 survey respondents were mothers; 12 women had one child, 10 had two, and 25 had three children. The 2009 California Health Interview Survey found that 98% of children in Boyle Heights are insured.¹³ This high rate of health coverage for children was reflected in our research, in that respondents raised issues of children's health care mainly in relation to dental health and specialty treatments, not primary care.

Most (63%) of the survey respondents were between the ages of 25-44 and most were married or domestically partnered. Seventy-five percent were foreign-born, a higher percentage than the estimated 50% in the population of Boyle Heights as a whole, with most of these from Mexico and six, in total, from Guatemala and El Salvador. Forty percent self-identified as undocumented. Most either spoke Spanish only (48% of our respondents) or were bilingual in English and Spanish.

Thirty-three percent had Full-Scope Medi-Cal, 20% had "restricted" Medi-Cal covering emergency or pregnancy-related services, 15% had private insurance paid by their employer, and 18% had no health insurance. The remaining 14% of survey respondents didn't answer this question.

Community focus groups: The three focus groups each consisted of about 15 women, all Latinas. Participants were recruited via the distribution of flyers and through contacts of the Youth Media Team at the Weingart East L.A. YMCA and of the *Promotoras de Salud* from East L.A. Women's Center. Participants consented to give two hours of their time to the research, and received a small stipend. MCHA provided childcare during the focus groups. Two of the focus groups were comprised of women over the age of 18 and one consisted of adolescents aged 14-17. A fourth focus group was attempted with Lesbian, Gay, Bisexual, Transgender, and Queer participants, but it became a situation of a small group interview.

System leader interviews: After conducting the surveys and focus groups, we approached community nonprofit organizations, health personnel, clinic leaders, and community residents and leaders to obtain

Needing Specialty Care

One respondent who spoke with us about the importance of a good pediatrician was 26-year-old Lorena. For her medical needs she used to go to a nearby hospital, only a short walk away from where she lives with her parents, partner, and siblings. This changed when her son was born with tongue-tie (ankyloglossia), a correctable condition affecting some newborns who have a tight piece of skin between the underside of their tongues and the floor of their mouths; infants with tongue-tie may be unable to properly breast feed. Lorena and her son did not receive the timely specialty care needed and, frustrated, Lorena had to stop breastfeeding despite her desire to continue.

The experience moved her to search for a new pediatrician, and she found one at a local community clinic. "I now get my appointment within a week," she said, expressing with pleasure how open the doctor is to hearing her questions, and how she has gained self-confidence as a first-time mother.

¹³ A reflection of the available government programs that provide healthcare for young children. See the Boyle Heights Health Profile from the UCLA Center for Health Policy Research.

a broader understanding of the challenges encountered. We asked for their recommendations for addressing barriers to quality health care in Boyle Heights.

Our findings in all areas throughout this report are augmented by existing research as well as by our ongoing exploration of the cultural wealth and human resources within the Boyle Heights community.

First Focus Group

On June 11, 2013 we facilitated our first focus group, with 15 women who live and/or work in Boyle Heights. As many children as adults were present in the room, but two childcare providers helped to ease the situation, allowing the women to participate fully.

The women spoke of their ties to Boyle Heights: most had lived in the community for at least 10 years, and they also had other bonds, such as children attending school in the area and volunteerism and/or employment in the neighborhood. Everyone participated in the lively conversation which ranged across topics from dental health to postpartum depression, and from insurance coverage to traditional herbal remedies.

PART TWO

ACCESS TO QUALITY HEALTH CARE: SOME KEY OVERALL ISSUES

“Many of our communities are in survival state, in need of living wage jobs, affordable and quality housing, and access to fresh and healthy fruits. Health care often isn’t a top priority, except in times of health emergencies.”

Paola, one of our interviewees, a Guatemalan mother of two and a passionate *promotora* (a community member who provides basic health education to her peers), expressed the above sentiment when we asked her about healthcare coverage in Boyle Heights. This perspective, that attending to health care is not an ongoing priority, was frequently voiced in our initial focus group discussions and individual interviews.

As we probed further, however, women expressed the understanding that good health is a necessary foundation in their lives. Respondents articulated the desire for a medical home where they could receive general health coverage for themselves and their families, including preventive screenings and disease management — though for many this seemed an unattainable luxury.¹⁴ Among the women who did have a regular provider, most shared with us that they had a good relationship with their doctor, a finding that points to one of the many benefits of a medical home.

For those with limited or no health insurance, access to care is a time-consuming navigation of a patchwork system for such essentials as family planning and dental health, with emergency care often the only route for injury and disease. “The wait is terrible for individuals to get specialty care for terminal illnesses,” one woman told us. Another woman spoke about being in excruciating pain from gall bladder stones; after waiting for 12 hours on the emergency room floor at LAC + USC Medical Center, she left to seek alternative care.

Four major barriers to quality health care emerged repeatedly in the course of our conversations:

1. Lack of access to quality health care (or any health care at all) for those without legal immigration status
2. Lack of access to quality health care because of limited financial resources
3. Problems of communication with medical providers who speak only English
4. Lack of information, and cultural and internalized barriers

1. Lack of access to health care for those without legal immigration status

The healthcare landscape for undocumented immigrants in California was shifting during the course of our research, and is still in an ongoing state of flux. Undocumented immigrants are not eligible to apply for President Obama’s health reform, the Affordable Care Act (ACA), and the implementation of the ACA initially made matters worse for the undocumented because in order to help pay for the expansion of Medi-Cal coverage under the ACA, the State of California withdrew \$900 million from local programs

¹⁴ The perspective that health care is a “luxury” stands in glaring juxtaposition to a 2014 report showing that 30.9% of Latinas in Los Angeles County self-reported fair to poor health, a significantly higher percentage compared to all other racial/ethnic groups. See “Highlighting Disparities For Latinas” by Angie Denisse Otiniano Verissimo, PhD MPH, Data Dissemination Project, County of Los Angeles Public Health, July 17, 2014.

that funded care for the indigent regardless of legal status.¹⁵ According to a recent projection from researchers at UC Berkeley and UCLA, undocumented immigrants will constitute about half the approximately three million Californians lacking insurance by 2019.¹⁶

Sara's Story

Sara, a native from the small town of Tepalcatepec in Michoacan, Mexico, came to the U.S. with her young son who suffered from congenital hydrocephalus (an abnormality of the flow of fluid in and around the brain), a difficult but not necessarily fatal disease. She recalls navigating the health system and the difficulties they encountered due to the limited scope of services offered with restricted Medi-Cal.

Both were undocumented and Sara's son was refused treatment at hospitals because he did not have a Social Security Number. After a year in the U.S., Sara connected to California Children's Services (CCS) and her son then gained access to the comprehensive care he needed, but he passed away at age 13.

About a third of our respondents were in mixed-status families, with frequent scenarios such as that in which one family member had comprehensive health coverage while another had only the limited coverage for residents without authorized immigration status or no coverage at all. Women commonly shared that their children had full coverage while they themselves had partial or no coverage. Some children in these families had comprehensive coverage only up to a certain age. One of our respondents, Veronica, a Guatemalan seamstress recently diagnosed with osteoarthritis, has three children eligible for Full-Scope Medi-Cal and a 17-year-old daughter who has only restricted Medi-Cal, like herself.

One of the women told the story of a doctor making racist, anti-immigrant remarks, complaining to her that immigrants were supported by the government and they "don't want to work."

Dora, a married mother of six children who immigrated to Los Angeles from El Salvador, expressed a typical scenario of encountering waiting lists and long delays at community clinics. Resourceful and resilient, she told us of navigating health fairs to get a mammogram, but whereas in the past she visited a community clinic to receive a physical exam and pap smear, by the time of our interview the program requirements had changed and she no longer qualified. She also told us of her difficulties when her son broke his leg practicing football: from the clinic they were referred to an orthopedic specialist, but then had to wait eight months for the approval of specialty care.

The changing landscape for undocumented residents

Three programs implemented or promised since the completion of our research will help undocumented residents of Boyle Heights obtain health services:

- My Health LA, launched in October 2014, is a no-cost healthcare program for low-income residents of Los Angeles County who are uninsured and not eligible for health insurance, primarily undocumented residents. Immigration status is not an issue, but income must be at or below 138% of the federal poverty level.
- The federal Deferred Action for Childhood Arrivals (DACA — the "Dream Act," implemented in June 2012 and expanded in November 2014) includes, in California, health coverage for qualified youth through Medi-Cal.
- A California state budget deal reached in June 2015 promises healthcare by May 2016 to

¹⁵ See "A Patchwork of Care by Counties" by Soumya Karlamangla, [Los Angeles Times](#), June 11, 2015.

¹⁶ "A Patchwork of Care by Counties"

children regardless of immigration status.¹⁷

In addition, the Deferred Action for Parents of Americans and Lawful Permanent Residents (DAPA) and expanded DACA programs may bring more coverage in California. However, these programs are currently blocked by a temporary order from a federal district court in Texas, a preliminary injunction upheld by the U.S. Court of Appeals for the Fifth Circuit on November 9, 2015. On November 10, 2015, the U.S. Department of Justice announced that it will appeal the Fifth Circuit decision and seek Supreme Court review of the case.¹⁸

2. Lack of access to quality health care because of limited financial resources

“We need something effective and of quality even if we’re poor.”

Among many of our respondents with at least some health coverage, issues of quality and availability of service still loomed large. One of our respondents, Laura, who has Full-Scope Medi-Cal coverage for both herself and her two children, noted the contrast between the wealthy private facility in Boyle Heights, Keck Hospital, and what she’d encountered elsewhere. Keck, a specialized treatment center, has substantial information regarding colon, breast, and intestinal cancer, she told us, but, “If they have that information there, why can't it be more accessible to others, like individuals who are low-income and cannot go to an expensive place?”

Many women spoke of the burden imposed by the combination of the poor quality of public transportation followed by long wait times at appointments; these are more than annoyances for women juggling childcare and low-wage jobs. Women spoke of needing to take a half or a whole day to seek medical care, and contrasted the long wait times before seeing a doctor with the often very short doctor visit. One woman spoke of the limited nature of her insurance coverage, not adequate for the frequent doctor visits and cost of prescriptions for her disabled child.

In some situations where further tests or treatments were necessary, women with less comprehensive coverage reported waiting up to half a year — or more — to see a specialist. Georgina, a mother of four children who works at a dry cleaners from 9:00-6:00 Mondays through Fridays and on Saturdays from 10:00-4:00, underwent thyroid and bladder surgery at LAC + USC, but had to wait eight months to be scheduled for the latter.

Nancy, a young mother, writer, and student of Puerto Rican descent, commented on the negative stereotyping of low-income women: “When you access care with Medicaid, there are always assumptions about the type of person that you are, the way your kids are, the type of mother that you are.” Another woman's comment summed up the feelings of many: “We need something effective and of quality, even if we’re poor.”

The changing landscape for low-income legal residents

The Affordable Care Act was coming into implementation as we were conducting our research, and ideally it will have a measurable positive impact on low-income legal-status California residents. It

¹⁷ See “Advocates: Extending Medi-Cal to Undocumented Kids a First Step,” July 7, 2015, on the California Healthline website.

¹⁸ For updates on this issue, see the website of the National Immigration Law Center — *here accessed 11-14-15*.

provides expanded Medi-Cal coverage for legal-status adults with an annual income lower than 138% of the federal poverty level; pregnant women are covered under Medi-Cal to an even higher level, 213%, and children even higher, 266% of the poverty level. The Medi-Cal Access Program, formerly known as AIM, covers pregnant women with income higher than free Medi-Cal allows, from 214% to 322% of poverty, with comprehensive coverage.

For low-income adults above the 138% Medi-Cal threshold, Covered California is available, with substantial subsidies for monthly premiums. Nonetheless, the lowest-priced plans have a high deductible and entail co-payments for many medical services, and health insurance alone doesn't answer the problem of finding childcare or needing to take perhaps-unavailable time from work for a doctor's visit. Further research will be needed to determine what healthcare gaps continue to exist for ACA-covered residents in a community such as Boyle Heights.

3. Problems of communication with medical providers who speak only English

"At least half the patients were not English-speaking."

An estimated one-third of Boyle Heights residents speak limited English or no English at all.¹⁹ Dr. Mark Ghaly, Director of Community Health & Integrated Programs with the Los Angeles County Department of Health Services, voiced support for the community concerns: the persistent scarcity of Spanish-speaking physicians in Boyle Heights.

State and federal laws require that medical interpreters be present for people with limited English proficiency.²⁰ Latinos are the largest ethnic group in the State of California, approximately half the population of the City of Los Angeles, and the hugely dominant majority in the community of Boyle Heights, but many of the monolingual Spanish-speaking women who participated in the focus groups or completed our survey were not able to receive medical care from people who speak Spanish. It is a glaring healthcare gap in 2015.

Even at the Keck School of Medicine, a private, prestigious, and linguistically diverse hospital (part of the University of Southern California's medical campus in Boyle Heights), there are insufficient translation resources. Dr. Ibrahim Busnaina, writing as a senior resident in psychiatry at Keck in a 2012 blog post for U.S. News & World Report, noted that he had been called many times to consult on "situations where medical students and residents mistook a language barrier for a psychiatric issue."

Dr. Annelle Primm, Director of the Division of Diversity and Health Equity of the American Psychiatric Association, has commented on the lack of medical interpreters, nationally, and its impact for mental health in particular: "Very often in health and mental health centers there is a lack of interpreters and a lack of bilingual psychiatrists and mental health professionals. It is really ideal to conduct the evaluation and treatment plan in the language that is preferred by the individual; there are differences in the information that can be gathered if the evaluation is conducted in English as opposed to Spanish."²¹

¹⁹ See the Boyle Heights page of the City-Data.com website

²⁰ See the website of the National Council on Interpreting in Health Care, especially the page on "FAQs for Healthcare Professionals" under the "Resources" tab.

²¹ "Mental Illness an Epidemic Among U.S. Latinos: Only 1 in 11 Seek Treatment," by Nicole del Castillo, July 11, 2014, *Fox News Latino*

Nancy, the young student-mother mentioned earlier, is herself fluent in English but nonetheless noted that when she had a clinic appointment with her primary doctor: “I witnessed that at least half of the patients were not English-speaking, and none of the doctors were Latino. The only Latinos were the secretarial staff and Medical Assistant.”

Laura, also mentioned above, is a resident of the Wyvernwood Apartments community, where she was engaged with other tenants confronting the threat of redevelopment. She told us of her experience during a medical visit when the doctor was recommending that she use an IUD for preventing endometriosis. As her symptoms and condition were explained, she struggled to understand the doctor, a monolingual English speaker. A bilingual nurse was called in to interpret but still there were misunderstandings, and Laura felt frustrated as medical advice was lost in translation.

Laura is from El Salvador but she also spoke to us about women in Boyle Heights from indigenous communities in Mexico and Guatemala who speak their indigenous languages but neither English nor Spanish. There seems to be little success in providing indigenous interpreters for these patients.²²

4. Lack of information, and cultural and internalized barriers

“I don’t have time for me.” ... “I don’t understand my benefits, what’s covered and what isn’t.”

Our research revealed informational, cultural, and internalized barriers to women developing a healthy lifestyle and seeking medical help when needed.

- In some cases there are clear demarcations between these barriers, while in other cases they feed into each other. We heard from numerous women who under-valued their own self-care, internalizing a cultural prescription that women sacrifice themselves for those they love; this in turn made them less attentive to information about adult women’s health. “I only started talking about my own health issues when you came with the survey,” we heard, “I feel that’s very secondary.” One woman put it succinctly: “I don’t have time for me.”
- The general informational barriers are of several types. One is that in the confusing and shifting healthcare landscape, many women are not aware of the health programs and services for which they are eligible.
- For women who do have some form of insurance, it can still be a bewildering task to interpret their benefits. “I don’t understand my benefits, what’s covered and what isn’t,” one woman stated (and she wasn’t alone). “I barely know what my insurance covers, let alone what it doesn’t.”
- Lack of knowledge of proper preventive care is another barrier we encountered in our discussions.

We will revisit some of these questions in later sections of this report, and in our Conclusions we will address the issue of needed education, outreach, and support.

²² Although none of our survey participants were speakers of an indigenous Mexican or Central American language, this population has been growing in California, with people speaking an indigenous Mexican language estimated currently at about 200,000 in the state. See “The Other Mexicans” by Katya Cengel, National Geographic, June 25, 2013.

PART THREE DENTAL HEALTH

"I have not been to the dentist in over 17 years; I can't afford it."

From our very first focus group, dental care showed up as an area of major concern. That remained consistent throughout our research, with 97% of our respondents stating that dental coverage was very important, although two-thirds did not have it. In our focus group with 16 adolescents, four young women in the room had dental pain at the time the group was conducted.²³

Despite the overwhelming survey responses affirming the importance of dental care, we learned that community members are not sure where to go when needing services, how often they should go, whether dental services are included in health coverage if they have it, and what some of the warning signs are, other than pain, that indicate the need to visit a dental provider.

A handful of our respondents traveled to their home countries for dental care: one woman traveled to El Salvador and a few others traveled to Tijuana for their dental care needs.

Even those research participants who did have dental coverage did not generally use it for preventive care but rather solely for treating dental problems. This finding accords with the perspective expressed to us by Dr. Maritza Cabezas, Dental Director for the Los Angeles County Department of Public Health: "There is a lack of knowledge and understanding of the importance of oral health and oral health literacy, meaning the understanding that oral health is part of general health."

Dr. Monica Rado, Dental Associate Director at Clinica Monseñor Oscar Romero, emphasized to us that dental disease is mostly preventable with basic knowledge of preventive care, and that untreated dental problems in adults, specifically gum disease (periodontal disease), are linked to both premature birth and to chronic health problems such as heart disease and diabetes. She stressed the importance of educating women about the imperative to have an oral examination during pregnancy.

Dr. Rado also underscored that parents must understand the need to take their children to the dentist by age one. Our focus groups and surveys showed that this advice is far from being realized: only eight percent of parents among our respondents took their children to see a dentist by the time the first tooth erupted. Reasons for this included lack of knowledge, inability to find a dental provider, and lack of coverage.²⁴

²³ In a 2009 study of underprivileged children in L.A. County, 73% of the children were categorized as needing dental care within 15 days of the oral exam performed by the study's dental examiners. See a summary of the study's findings, "Dealing with Untreated Dental Disease" by Beth Newcomb, USC News, February 22, 2010.

²⁴ For a broader context of this problem, see "California Falling Short in Kids' Dental Care, Studies Say" by George Lauer, March 1, 2010. Lauer reports on a study in L.A. County that found the following: about 1 in 5 children had no dental insurance and of those who did, almost 60% were covered by public programs in which access to care is often a problem; about half of the approximately 5800 dental offices and clinics in Los Angeles County do not serve children covered by Denti-Cal, and fewer than half (44 %) treat children two years of age or younger; and most parents (86%) do not follow the American Association of Pediatric Dentistry recommendation that children should see a dentist before their first birthday.

In summary, our research revealed four gaps which create barriers to dental health:

1. Gaps in qualification for dental coverage. Some gaps remain, even though the landscape is changing in major ways since our research ended and some (though not all) of our respondents who did not qualify for coverage before may qualify now. As of 2015, Covered California (the state's health insurance exchange under the Affordable Care Act) includes children's dental in their plans and adults will be able to purchase dental care in 2016. After a lapse (2009-2014) Medi-Cal again covers some adult dental, as well as the children's dental it has always covered. Thus, residents with authorized immigration status who are eligible for Full-Scope Medi-Cal are covered, but citizens or legal residents who are not eligible for Full-Scope Medi-Cal must be able to afford dental costs with an ACA plan, unless they are pregnant or immediately postpartum. Again, except during pregnancy/postpartum, undocumented residents are not covered for dental care. The latter group must seek charity care or the limited dental benefits in the county undocumented program, My Health LA.
2. Gaps in knowledge about existing programs even among those who do qualify, e.g. the restoration of dental benefits for adult Medi-Cal recipients and pregnancy coverage – as with Ana (see sidebar story), who, although without dental coverage for many long years, could have been seen during her recent pregnancy.
3. Failure to be offered dental services or failure to use available coverage for routine preventive care.
4. Gaps in knowledge about preventive self-care at home, other than the generality of needing to brush one's teeth.

Two Dental Health Snapshots

Two women's stories point to different outcomes, based on financial resources:

- Ana — the head of her household who lives with her mother, her older brother, and her three children (10 months, 7 years and 17 years old) — told us that she hasn't been to the dentist since a few years before the birth of her first child: "I have not been to the dentist in over 17 years; I can't afford it."
- Maria, a 24 year-old college student who works part-time, recounted her recent experience when she had severe pain in her mouth. She consulted a local dentist in Boyle Heights and was told that her permanent molars (wisdom teeth) were erupting in a way that would cause problems for her. Fortunately, she had the money to pay the dentist to help with the problem, and expressed the relief that this brought her. "I come from a history of having to wait hours for service, waiting almost all day at General Hospital for family members to get seen," she told us. "It was foreign to me having actual service, not having to wait a long time."

PART FOUR
REPRODUCTIVE, MATERNAL, AND SEXUAL HEALTH,
including related Mental Health issues

Reproductive and maternal health were the areas of specialized health care that came up most frequently in the focus groups and interviews.

Family planning, pregnancy, and women's health issues

“There were five women named Maria and they almost mixed up my file.”

Lacking comprehensive health coverage, many survey respondents relied on a patchwork system to obtain gynecological tests and family planning services.

During focus group discussions, women often referred to the State of California’s Family PACT (Family Planning, Access, Care, and Treatment) program as their main source of care. Administered by the Office of Family Planning, Family PACT is open to all residents, regardless of immigration status, whose income is less than 200% of the federal poverty level, and it pays for many sexual and reproductive health services, including pregnancy tests, birth control, STI (sexually transmitted infections) testing and treatment, and counseling. However, it does not pay for abortions, prenatal care, or maternity care, and since it is a service for childbearing women, three of our respondents told us of their regretful discovery that they were no longer eligible for any of its services, including a pap smear, after they’d had their tubes tied as a safe method of permanent birth control.

Our surveys indicated that most of the respondents received prenatal services as soon as they desired, once they learned they were expectant with a pregnancy they intended to carry to term. However, one of the few Federally Qualified Health Centers (FQHCs) in Boyle Heights, LA Christian Health Center, doesn’t offer prenatal services.²⁵ This is challenging because a woman who has been receiving health care there needs to either change her medical home when pregnant or split her care into separate pieces and visits.

Our respondents reported a wide range of experiences during pregnancy and when giving birth. About two-thirds reported feeling satisfied with the overall experience of prenatal care and birth; about one-third were dissatisfied with at least one of their pregnancy and birth experiences. Several women said with pleasure that they liked their doctor(s) and nurses and felt treated with respect. Others, however, reported not being treated properly or well. One woman said that her water broke early and this led to an infection, which was undetected by the doctor. Another told us that “there were five women named Maria and they almost mixed up my file.” More than one woman spoke of being unprepared for the cesarean-section delivery that occurred; in at least one case, this was due to language and communication problems. One survey respondent spoke of a doctor who rushed in when her baby was coming, upset because his schedule was interrupted and making her feel like she was an inconvenience; another described her birthing experience as “traumatic,” because the doctor was not present. One woman who wanted to be awake for the birth was given so much morphine that she was put to sleep;

²⁵ FQHC is a designation signifying funding streams received, sliding scale charges, and a community-patient Board of Directors.

other women reported long waits for pain medication, or no response at all to their requests for pain relief. In one woman's case, the placenta was not fully removed.

Our finding that a substantial one-third of our respondents were dissatisfied with at least one of their pregnancy and birth experiences contrasts with the results of a comprehensive 2002 survey of over 1500 mothers, summarized on the website of Childbirth Connection (a program of the National Partnership for Women and Families); that survey showed that "An overwhelming proportion of mothers were pleased with the care that they received" during their childbearing experience.²⁶

Abortion did not arise as a topic in our focus groups, but we cannot draw a conclusion that the participants were opposed to abortion. A recent statewide survey of Latinas/os conducted by California Latinas for Reproductive Justice (CLRJ) found that nearly 70% of survey respondents said that while they might not choose an abortion for themselves or their partners, they believed in protecting this right for women.²⁷

Other women's health issues discussed in the focus groups included menstrual problems and breast cancer. A 30-year-old woman, an undocumented immigrant, spoke about going to a doctor because she had not had her menstrual period for many months. They scheduled her for several exams, including X-rays, but she didn't return because she could not afford the cost. In one of the focus groups with women aged 18-55, a few participants voiced a concern that women in the community are getting breast cancer at younger ages than before. Several women then engaged in a conversation as to how to deal with the threat and fear.

Family History

Nancy spoke passionately about the importance both of good gynecological care and reproductive justice. She has a family history of cervical and breast cancer — her mother's younger sisters died from these cancers — "so I always worry," she said.

She also told us that her grandmother was forcibly sterilized in Puerto Rico, part of a shameful chapter in U.S. medical history that also - disproportionately - affected Los Angeles County's Mexican-American women. (See "*Más Bebés?*: An Investigation of the Sterilization of Mexican-American Women at Los Angeles County-USC Medical Center during the 1960s and 70s," by Renee Tajima-Peña.)

²⁶ The study, "Listening to Mothers: Report of the First National U.S. Survey of Women's Childbearing Experiences," recorded that 94% of respondents said "that they generally understood what was happening," 92% "felt comfortable asking questions," 91% said they "got the attention they needed," and 89% "felt they were as involved as they wanted to be in making decisions." Conclusions drawn from this contrast in percentages can only be speculative; however, given the particulars that some of our respondents reported, a lack of respect for low-income, Spanish-speaking mothers does appear to be an issue.

²⁷ Over 80% of respondents to the CLRJ survey strongly agreed that every woman should have a right to decide for herself the number and spacing of her children, and nearly eight in ten respondents agreed that a woman needs medically accurate information about abortion, and that it should not be coercive or shaming nor should it try to change her mind. See "Latinas/os and the 'A' Word: What Latinas/os really think about abortion," California Latinas for Reproductive Justice, 2012.

Mental health issues related to pregnancy and maternity

"I felt unnatural with my thoughts and emotions as a mother."

Our research revealed that, once given permission to open up, women welcomed the opportunity to talk about mental health issues related to pregnancy and maternity.

"During pregnancy, maybe therapy would have been beneficial," one woman said during one of our focus group discussions. "My husband was deployed and I felt alone."

Postpartum Depression

Andrea told us that for many years she believed she couldn't have a child due to her age — "In our culture, you're old if you don't have any children by the age of 30." After three years of fertility treatment she successfully became pregnant at age 31. She received prenatal care and took prenatal classes, but the topic of postpartum depression was not discussed. When she came home after birthing her son, she felt "unnatural with my thoughts and emotions as a mother."

Within a short few months, she became pregnant a second time, totally unexpected since her first birth had required the long years of treatment. Her depression was exacerbated, navigating new motherhood while pregnant. Her second son was born prematurely. "I felt guilty," she told us. "I was depressed during pregnancy and so I didn't take good care of myself." Finally, after seeking and receiving the therapeutic and medication help she needed, she bounced back to normal, with a renewed sense of purpose and determination.

"I didn't go out, I felt depressed," another woman commented. "I had classes but those were only once a week. *Me la pasaba encerrada en mi casa*, I was confined in my house. It would have been nice to have more of the classes where we speak, play, do exercises."

Martha Escudero, an MCHA employee and Boyle Heights resident, told us that most of the moms-to-be and new moms that she sees in her work in Perinatal Outreach in Boyle Heights and East LA are either depressed or have a lot of anxiety. For some, their families aren't nearby and husbands may work all day; these women lack a needed support system and speak of their feelings of loneliness and isolation.

A comprehensive 2012 survey by the Los Angeles County Department of Public Health LA Mommy and Baby Project (LAMB) found that 34.8% of Latinas self-reported feeling sad, empty, or depressed most of the day for two weeks or longer during their pregnancy, and, postpartum, 35.4% of Latinas self-reported feeling "a little depressed," 10% reported feeling "moderately depressed," and 4.1% reported feeling "very depressed."²⁸ However, only half of our survey respondents were asked about their mental health during their regular prenatal and postpartum visits.

Dr. Emily Dossett works at the Maternal Wellness Clinic, a specialty clinic inside the Adult Outpatient Psychiatry Clinic at LAC + USC Medical Center. She discussed with us the intense needs of her patients, referred to her clinic both from the Obstetrical department at LAC + USC and from neighboring clinics, including AltaMed, Hudson Comprehensive Health Center, and White Memorial Medical Center. Over 70% of her patients have a history of intense stress and trauma (previous sexual abuse and/or current trauma) before she

²⁸ "A 2012 Survey of the Health of Mothers and Babies in Los Angeles County," published by the Los Angeles County Department of Public Health, January 2015

sees them in the context of perinatal or postpartum psychiatric issues. She spoke about the vulnerable population of postpartum women who do not qualify for Full-Scope Medi-Cal and are dealing with postpartum depression without healthcare coverage.

One of our research interviewees, Laura, spoke of her personal experience some years ago with severe postpartum depression; at one point she developed such a fear of entering public places that she did not want to leave her own home. In the Boyle Heights community, she told us, she has seen a lot of moms who awaited their babies with anticipation, but then, unprepared and without warning, fell into depression after giving birth. Self-care is neglected, she told us, and a mother may even neglect or abuse her child.

Reproductive/Sexual health issues and related mental health issues for adolescent girls

“Entering into the Planned Parenthood clinic is viewed as shameful, so how many young people do not take advantage of the clinic because they don’t want to be seen going in?”

In our focus group with teenage girls aged 14–17, the two topics the girls most wanted to discuss were access to birth control methods and sexual health education, including the subject of sexually transmitted infections (STIs) such as chlamydia and gonorrhea.²⁹ Only about half the young women felt they had adequate access in their school and community to information and services about reproductive and sexual health. The adolescent girls also shared their views on the importance of mental health, mostly speaking about self-esteem, self-image, and having a reliable adult with whom to talk.

The intersection of self-image/ self-esteem with reproductive and sexual health was highlighted when we interviewed two young women who are participants in Planned Parenthood’s Peer Advocacy program in their high schools. They shared their experiences engaging with their peers, noting that poor self-image and low self-esteem are factors leading teenage girls to engage in risky sexual behavior. In their conversations and observations at school, they saw how often young women value themselves primarily through their peers and seek acceptance by whatever means.

Irma, a Peer Advocate at Mendez High, spoke to us of seeing a lot of young girls getting pregnant and dropping out of school and noted that “Since middle school, I’ve seen how girls feel wanted only when someone makes them feel wanted” – that is, they don’t get the attention needed at home and end up putting themselves in risky life-altering situations. Furthermore, young women often don’t realize they are in an unhealthy relationship, since that’s all they have seen from the adults in their lives, and “many young people don’t trust, and hesitate to share what they are going

Teen Moms

Valentina, a teen mom (her baby was two months old at the time of our interview), goes to Arroyo Vista Family Health Center in Lincoln Heights for her medical and pediatric care. She has Full-Scope Medi-Cal, and she told us that she is satisfied with her son’s pediatrician but that she feels a need for teen moms like her to have a space to get together. “We are kind of pushed away, once we become moms,” she said. “It’s important for teen moms to talk about our experiences and try and help one another.”

²⁹ For rates of chlamydia, gonorrhea, and early syphilis in L.A. County, charted by age and by race/ethnicity, see <http://www.cdph.ca.gov/data/statistics/Documents/STD-Data-LHJ-LosAngeles.pdf>

through.”

Xiomara, a Peer Advocate at Roosevelt High and second oldest in a family of five girls, stated: “I see many questions unanswered because of the taboo surrounding discussing issues of our bodies, including sexual and reproductive health. Entering into the Planned Parenthood clinic is viewed as shameful, so how many young people do not take advantage of the clinic because they don’t want to be seen going in?”

Health concerns within the LGBTQ community

“To truly create a healthy community, you need to create it for the sum of all of its parts.”

We were frustrated in our attempts to convene a focus group of Boyle Heights women who identified as Lesbian, Gay, Bisexual, Transgender, or Queer, despite a lot of outreach help from two women who are part of this community. When our third attempt brought a total of three women, including one who was to be a co-facilitator, we shifted into the mode of a small group interview.

The women spoke of feeling the “erasure” of being a brown or mixed LGBTQ woman in a working class neighborhood such as Boyle Heights, the “invisibility” of living at the intersections of being LGBTQ and of Mexican descent. “Just because you’re LGBTQ, you don’t stop being Latino,” one said.

They were articulate in discussing how women’s sexuality and gender expression in a macho culture can render shame in many women of color, and how the added layer of being Lesbian, Bisexual, or Transgender makes it even harder to navigate public spaces. With sober intensity they shared how important yet infrequent it is that healthcare practitioners (particularly those dealing with issues of sexual health) are equipped with appropriate information rather than applying hetero-normative practices to LGBTQ women. They pointed to the overall ignorance and lack of training about sexual health for gender and sexuality experiences outside normative heterosexuality.³⁰

The three women discussed the lack of readily available information about healthy relationships and safe sex for women involved with women, the importance of peer support for mental health, and their work in trying to create an LGBTQ space within the new Wellness Center at the Historic General Hospital. “When I was coming out, I wished there were a group for women questioning,” one woman remarked. “There still are no spaces for women who are older and coming out.”³¹

³⁰ As we were completing this report, a white paper entitled “Discrimination and Denial of Care: The Unmet Need for Transgender Health in South Los Angeles” was published by St. John’s Well Child and Family Center. The August 17, 2015 press release announcing the report stated in part: “St. John’s, which developed a transgender health program that has served more than 500 transgender individuals over the last 15 months, has uncovered widespread discrimination and denial of care experienced by the transgender community in their attempts to access health care services ... The white paper was written to shed light on the barriers to basic healthcare experienced by the transgender community ...[and] to ensure that the tens of thousands of transgender individuals living in Los Angeles County have access to affordable, competent and loving transgender health services.”

³¹ In October 2015, eight months after our small group interview, an LGBT center, Mi Centro, opened in Boyle Heights under the auspices of the Los Angeles LGBT Center and the Latino Equality Alliance.

Alexa, a trans woman, emphasized the need for a campaign “that calls out our health concerns or prioritizes our health inequities,” and the need for organizations in Boyle Heights that have not traditionally been LGBTQ-friendly to be educated about the imperative to invest in this direction.

One woman beautifully expressed the concept of “Building Healthy Communities” when she said: “To truly create a healthy community, you need to create it for the sum of all of its parts.”

Being a Trans Woman

“The system is confusing as a trans woman,” Alexa shared when we sat down to speak about her familiarity with the L.A. County healthcare system, “and a lot of imaging doesn’t reflect people like me.” Filling out an application during an intake process can be difficult for many people, but for those who are transgender there are challenges most don’t even have to think about: the male/female gender box is an obstacle, and then there’s the system’s inability to capture medical history from a name used prior to a transition. Alexa spoke about the countless times she has been called out of her gender by medical staff, and how she has been questioned at inappropriate moments about her sex transition: “Even if I go to get my eyes checked, I get questions about my transition.”

There is no federal standard of care for a transgender woman; co-pays are high for hormone replacement therapy and dosage is inadequate. When a transgender identity intersects with being low-income and/or having an unsatisfactory immigration status, Alexa told us, you feel even more vulnerable when you ask that your needs be met. Nonetheless, Alexa is resilient and resourceful, and she understands the power of her voice. She intends to continue to advocate for herself and for all transgender women.

PART FIVE

MENTAL AND EMOTIONAL HEALTH ISSUES

(not related to Perinatal Health)

Most of the community stakeholders interviewed during the initial process of our research expressed concern about undiagnosed and untreated mental health issues that they observe in their direct front line work.

“People in the community may not identify that they have a mental health need,” said Amy Luftig Viste, Program Director of My Health LA. “They may not realize that they are depressed and/or are stressed, although they are being impacted by depression or anxiety or gang violence. Few resources exist to help people identify that they are in need of mental health care.”

Mental/ emotional distress in itself interferes with quality of life, including at the most basic levels of functioning in the world and relationship with others, but in addition poor mental health can affect physical vitality.³² Dr. Elena Esparza, a chiropractor, holistic healer, and activist for community health in Boyle Heights, commented to us on the interrelation of mental, emotional, and physical health issues that she sees in her practice. “I’m a chiropractor and I’m seeing patients who have mental health issues,” she said. “I have people coming in here for anxiety all of the time. There’s this general sense of panic and fear and loss that is not being addressed ... [but] there’s this negative connotation to anyone being ‘crazy,’ so even seeking care is hard.”

In our survey responses and group discussions we found ambivalence and contradictions on the issue of seeking professional help for mental and emotional health problems. While many of our respondents rated mental health services as important, many also revealed a hesitation to utilize such services.

Our research revealed four interrelated reasons for this hesitation: lack of knowledge of where to seek care; fear of and/or actual experience of an insensitive practitioner; the cultural stigma attached to seeking professional psychological or psychiatric assistance; and, among those with a sensitive legal status, fear of legal repercussions. We will discuss these four interrelated reasons throughout the sections below.

Historical and environmental issues affecting mental health for Boyle Heights residents

“Necesitamos mucha ayuda con lo mental.”

Elena Fernandez, the Director of Behavioral Health Services for St. John’s Well Child and Family Center, spoke to us about generational traumas that affect communities of color. She noted that violence in home countries, the hazards of migration, poverty, and community and family violence here in Los Angeles are all factors that impact current mental health.

³² The interdependent connection between mental health and physical health has increasingly been recognized by Western medical practitioners in recent decades. See “Mental and Physical Health: A Critical Connection,” from the U.S. Veterans Health Administration, and “The Relationship between Mental Health, Mental, Illness and Chronic Physical Conditions,” from the Canadian Mental Health Association.

A cycle develops. Historical and environment traumas create wounded psyches. If untreated and unhealed, those who bear these scars may then affect the family and community life of succeeding generations, people who are themselves generally still facing challenging conditions in the wider environment.

Dr. Robert Ross, a pediatrician by training and President and CEO of The California Endowment, conveyed this perspective when he spoke with inmates at Ironwood State Prison in 2014. In a blog on Huffington Post after his Ironwood visit, Dr. Ross wrote about the long process of healing from childhood wounds – wounds of growing up with abuse, without present and reliable adults, and/or in an unsafe neighborhood. “The largest public health crisis in America is hidden in plain sight,” Dr. Ross stated, “and it's about the lifetime of mental and physical health problems that have their roots in something we call childhood trauma.”³³

A 2012 study on childhood trauma among incarcerated youth found that “an estimated 90 percent of youth in residential juvenile justice facilities report experiencing at least one trauma”; the list of traumas cited by the study authors include “physical or sexual abuse or neglect, family and community violence, war, captivity, and forced displacement from home and community.”³⁴ Dr. Breck Nichols, with LAC + USC Medical Center, talked with us about the Post-Traumatic Stress Disorder (PTSD) that he sees among young people, and how untreated PTSD affects a young person’s ability to focus in school, hold down a job, and take care of him or herself.

Our survey and focus group participants told us personal stories that illustrate these issues of environmental challenges and trauma. In one instance, one of our participants, a woman without authorized immigration status, spoke about stress and depression for women who are coping with issues of lack of employment and legal status. Mental health benefits are even more needed under these circumstances, she said, and are even more difficult to access. On another occasion, after we finished conducting surveys at the *Mi Vida, Mi Salud* collective at Clinica Monseñor Oscar Romero, two of the women rushed out to visit a community member who was wounded by a gunshot and was in urgent care across the street at LAC + USC Medical Center. One of the women said to us: “*Necesitamos mucha ayuda con lo mental*, we need mental health support in our community. Violence really affects us.”

Access, ambivalence, fears, and stigma

“You’re ‘crazy’ if you need help for mental health. That’s the taboo in the Latino community. If you need psychological help, then you must be crazy.”

On the written surveys we asked: “Do you ever feel sad, alone, or feel that you are overwhelmed with problems?” Forty women (69%) responded “sometimes,” six women (10%) said “often,” and 12 said “never.” Similarly, when asked if they ever felt anxious or depressed, 42 (71%) said “sometimes,” six

³³ See “Building Resilience Key to Overcoming Childhood Trauma” by Dr. Robert Ross.

³⁴ Quotes are from a summary of this study on the website of the National Institute of Corrections, “Complex Trauma Among Youth in the Juvenile Justice System: Impact and Implications,” by Lori Whitten. See also the Latino Community Mental Health Fact Sheet from the NAMI (National Alliance on Mental Illness) Multicultural Action Center: “Latinos are over-represented in the criminal and juvenile justice system. Many of these Latinos have a misdiagnosed or not diagnosed mental illness.”

(10%) said “often,” and 11 indicated “never.”

Women eloquently articulated the desire for more support services to help with anxiety and depression, “*ayuda para que no haiga tanto de los nervios y depresion.*” One woman mentioned that there had been four suicide attempts that year at the elementary school her daughter attends. “Nobody asks about your mental health, here in Boyle Heights,” she said.

When asked to rate the importance of professional psychological support, 40 respondents out of the 57 who answered this question (70%) rated it “very important.” Only two respondents said “not very important” or “unimportant.” Fifty-seven out of 60 respondents indicated “yes” to the question “If you ever have a mental health/ emotional need would you seek professional services for yourself or a family member?”

However, only two women indicated that they had ever sought professional help themselves for a mental or emotional difficulty, with 14 indicating that “I kept it to myself.” Responding to another question, as to whether either self or a family member has a *current* need for professional mental health support, six said “Yes and receiving support,” whereas 14 said “Yes and not receiving support.”

Twenty of our survey respondents said that they rely on friends and/or family when emotionally or mentally troubled, and 11 said that they turn to their spiritual community. In our focus group with adolescents, most of the girls said they’d much rather keep their problems to themselves than seek outside professional help. Martha Escudero, the MCHA employee whose work in Perinatal Outreach Education we mentioned in Part Four, told us that often a majority of the mothers that she sees with a mental health issue do not want to consult a psychologist, preferring to go to a group session or a support group.

In many cases, peer and community support may well be the best pathway to health, and in Part Six we will explore the avenues of support groups, cultural therapy, and holistic healing. Nonetheless, one or another modality of medical help – including support sessions moderated by mental health professionals – can be enormously beneficial and sometimes urgently required, especially for the intense traumas that Elena Fernandez, Dr. Ross, and Dr. Nichols refer to, above.

Obstacles to safe, easy access are one part of the problem. “How are we going to pay for a psychiatric social worker in our community?” asked the woman who told us about the elementary school suicide attempts. Almost half of our survey respondents admitted they would not know how to get psychological help for themselves or a loved one: 26 out of the 57 women who said they would seek professional mental health services if needed indicated that they didn’t know where they could go to seek these services.

For many, broaching the subject with their primary physician is not an option. “How much do you discuss sexual health and mental health issues with your regular doctor, if he’s a white male doctor?” Nancy asked. She mentioned that this has always been a big concern for her, especially dealing with the public health system as a parent: “The last thing you want to disclose is that you’re having a hard time with anything, because of a fear of Department of Children and Family Services; you’re wondering, *what will happen to the kids?*”

A woman in one of our focus groups, an undocumented immigrant, used the word “dangerous” connected with seeking help for mental health. When you’re depressed, she said, not only is it “hard to

muster the strength to seek the help,” but “it’s dangerous not having a job, not having documents, and if you have children ...” She didn’t complete her sentence.

One woman told us of a bad experience she’d had with a psychiatrist. She was in a depression for ten years and the medications given to her were not at all helpful. It seemed to her that the psychiatrist was simply going by the book, and not adjusting treatment according to her personal needs.

In addition to these external barriers to care, many women spoke about the stigma surrounding “mental illness,” a branding attached to someone who seeks professional help.³⁵

“You’re ‘crazy’ if you need help for mental health,” a woman said in one of our focus groups. “That’s the taboo in the Latino community. If you need psychological help then you must be crazy.”

“Mental health is a difficult topic in the culture, to acknowledge you’re depressed,” another woman agreed. A third woman added, “There’s stigma in the community and even in the church,” and a fourth woman summed it up: “We need more education around this.”

The desire for mental health resources

Within the supportive environment of our focus group discussions, or encouraged by the prompts of the survey questions, the women in our research sample shared their desire for greater knowledge about and access to mental health resources such as support groups, therapists, and psychiatrists; they emphasized simultaneously that they wanted to maintain autonomy to choose what they need for themselves and their families.

Women mentioned the following areas in which they would welcome help for mental and emotional health issues:

- Anxiety and depression
- Handling pressure and stress
- Dealing with mourning and loss
- Stopping the violence
- Support groups for women
- Support groups for new moms
- Support groups, counselors, and classes for

Family in Crisis

Dora, the Salvadoran mother of six mentioned in Part Two, commented on the necessity for access to mental health services. Years ago she faced a crisis in her family: her brother-in-law killed her sister and then himself. She became caretaker of her four nieces, then aged three, seven, eight, and nine. The only call that she received was from the Department of Children and Family Services about the custody of the children. The social workers told the girls about their parents, but neither Dora nor the children were offered any additional support or help. “Those of us that come from another country, without legal status: it’s very difficult to receive professional help,” she said.

³⁵ Our respondents addressed this issue as it affects the Latino community in particular, but the stigma of mental illness is widespread in North American culture. See, for example, “Mental Health Stigma: Society, Individuals, and the Profession,” by Brian K. Ahmedani, *Journal of Social Work Values Ethics*, Fall 2011. See also “Facts about Stigma and Mental Illness in Diverse Communities” from the NAMI Multicultural Action Center.

parents; help with difficulties in raising children

- What to do when one of your children is being bullied
- What to do when one of your children suffers from depression
- Help for young people contemplating suicide and help with other psychological issues affecting youth, including self-esteem for both children and teenagers; educating girls about how they can properly take care of their bodies
- LGBTQ support groups for younger and older women
- Support groups and counselors for married couples³⁶

³⁶ Thirty-six of our survey respondents replied “yes” to the question, “Do you feel that you are in a healthy relationship?” and only five women self-reported that they had an unhealthy relation with an intimate partner — but this dimension was not explored in depth in our research, and we cannot draw conclusions based on these numbers alone. As noted, some women raised the need for couples support groups or counseling, and when we mentioned the issue of relationships within a small gathering of women, one woman said, “I don’t think anyone is in a healthy relationship.” A December 2013 report on the prevalence of violence against women and girls in Boyle Heights quotes a community member who calls domestic violence a “cultural norm,” saying that it has been normalized in Boyle Heights and is “no more a taboo.” (For the report, entitled “Building Healthy Communities - Boyle Heights: Improving Community Health by Preventing Violence Against Women and Girls,” see “Boyle Heights Policy Report” on the News/Publications website page of the East Los Angeles Women’s Center.)

PART SIX

THE ROLE OF COMMUNITY AND CULTURE IN HEALING AND HEALTH

The major focus of this report so far has been on access and barriers to quality health care provided by medical professionals. We have touched on other matters, ranging from preventive self-care to larger societal problems and pressures, because it is impossible to adequately reflect on health and well-being by discussing in isolation the single factor of access to professional medical help.

In this part of the report we are shifting our focus. The question of professional medical help may enter in, but we here concentrate on pathways to healing and health that largely lie outside the jurisdiction of mainstream professional medicine in the United States. We have already mentioned one of these pathways – peer support groups – but we mention peer support again in the pages that follow because it is grounded in community, its function is multi-faceted, and issues of government funding and immigration status carry no weight in its implementation.

We will also take up traditional healing modalities and cultural therapy, two dimensions that, at the current moment, are not generally recognized, offered, or covered under healthcare plans or government health programs, but are living realities in the Boyle Heights community.

The longing for peer group support

“Let’s help one another!”

At our very first focus group session we had a rich conversation in which women spoke of the importance of faith and friendship in their lives. “My support network of friends and family has been key to my resilience,” one woman commented, speaking of both emotional and physical energy, intertwined.

“My friends have been there for me, and this is why I am where I am,” another woman said.

“I’ve had a lot of moments where I’m sad, depressed and anxious for the wrong choices I’ve made,” Raquel shared with us in her interview, and then credited both her spirituality and her children and mother as motivation, “what push me forward.”

Yet even a woman like Raquel, who feels sustained by faith and family, talked of longing for a support group. As she breastfed her 10-month-old baby, Raquel spoke of self-blame and guilt connected with her separation from her former partner. “I would like to go to a support group, if they would let us know through fliers, and free of cost,” she said. “Psychological help and encouragement that you can move forward even if you’re a single parent. How to move forward, to learn how to make things, economic entrepreneurial opportunities, whatever we would sell and not leave our children while we work.”

Many women spoke of their desire for a support group in the context of immigration to the United States, being away from their countries of origin and acculturating in a new land. Laura, an immigrant from El Salvador, met us for our interview outside her Boyle Heights church where she spoke

passionately about the need for support groups for young mothers. When she had experienced postpartum depression she could not find a support group anywhere.

In our LGBTQ small group gathering, the women spoke of their desire for a peer support group for LGBTQ women.

Teen mom Valentina (featured in a sidebar within Part Four) concluded our interview by returning to the subject of wanting a support group, proclaiming: "Let's help one another!"

Peer support groups, peer advocates, and *promotoras*

"We are socialized to integrate, to not speak up."

The ability to assert oneself with confidence can be crucial as a woman learns how to navigate a sometimes bewildering system of health programs, clinics, and hospitals. One mother told us that a doctor specifically advised her "*aprender a hablar, a expresarte,*" to learn to express herself, as she coped with finding care for her son who had a serious illness. Another woman in our study articulated the problem as: "We are socialized to integrate, to not speak up."

A Women's Support Group at Church

Sara, whose story we outlined previously, was catalyzed by the tragedy of the death of her son, born with congenital hydrocephalus. She became active with her community at Dolores Mission Church, and is part of a group called *Animadoras de comunidades de base*, "Women who encourage the grassroots." She meets with 15 other women every Monday afternoon, gathering to "*compartir el vivir, de salud, vida, familia, trabajo y milagros*" — "to share how we live, share about health, life, family, work and miracles."

A peer support group can be a tool for helping Latinas to battle together the cultural norm "to not speak up" for themselves. In addition, Latina peer group facilitators and peer advocates can model self-assertive behavior while they offer concrete knowledge and assistance.

A group may offer peer support and yet nonetheless be led by a professional. MCHA employee Martha Escudero told us about a program she interned with, in the Latino community of Huntington Park, the Project Return Peer Support Network (PRPSN).³⁷ Some of the support groups were led by a psychologist and others by peer facilitators, but in all cases everyone in the group was encouraged to develop solutions, and the words "mental health," considered culturally

inappropriate within the Latino community, were seldom used.

While a peer facilitator or peer advocate is not a licensed professional, she has usually received training in communication and support skills as well as in information and resources; these complement the vital element of her own life experience and wisdom.³⁸ Trained peer advocates can work in either group

³⁷ The mission of PRPSN is to promote "wellness, personal growth and self-determination for people who have experienced mental illness." See their website for a discussion of "The Power of Peer Support."

³⁸ The website of Peers for Progress, a program of the American Academy of Family Physicians Foundation, has information on training peer supporters, the core functions of peer support, and how to start a peer support group.

settings or in one-on-one encounters, and in both situations offer empathy, encouragement, experience, knowledge, resources, and advocacy. Planned Parenthood's high school Peer Advocacy program (mentioned in Part Four) is an example. Xiomara, whom we interviewed at Roosevelt High, spoke of her role in breaking myths and taboos about reproductive and sexual health, and always "knowing who to ask for help when you don't have the answer." She told us that many more Peer Advocates are required on campus than they currently have, to make the full impact that is needed.

Another illustration of peer advocacy is the work of *promotoras/ promotores*, neighborhood residents who, grounded in their own wisdom, passion, and cultural traditions, are trained to be experts on critical issues facing their community (often one or more particular health concerns) and on accessing available resources.

Promotoras are an important part of the Boyle Heights health landscape.³⁹ In our research we met women who became *promotoras* after personal experience of setback and struggle, and they are now devoted to helping their peers on a pathway to better well-being for themselves and their families.

Promotoras: Three Stories

- We introduced Andrea earlier, telling her story of postpartum depression following a long-desired pregnancy. Her primary care physician was instrumental in helping her with referrals to a psychiatrist and therapist, and after a few years not only did she feel back to her "normal" self, but she felt a strong sense of purpose and determination. One day she met a *promotora*, and her avocation became clear: she trained to become a *promotora* herself. "Being a *promotora* has been my salvation," she told us. "I make sure that my jobs allow for my *promotora* activities and involvement. It heals me when I am able to give information, when I can help another. I am good friends with many of the other *promotoras*, and sometimes many of us get together just to laugh."
- Dora is the woman who has been raising her four nieces ever since the murder-suicide committed by her brother-in-law. She found a support group in Hollywood which helped her gain strength. Later, she became involved with the Children's Bureau, an organization which aids children and families throughout southern California. She trained to become a *promotora*, and commented: "It's been beneficial to be involved in the community groups, the workshops about health. I have gained strength, united with other people."
- Paola has been a dedicated *promotora* for several years. In our interview, she spoke about the importance of having a space for women to come together — *convivir* — to build on the solidarity that is often born between women and girls. She advocates support groups and workshops on the subject of self-worth and healthy relationships. An immigrant herself, she finds herself encouraging other immigrant women to speak up: "*Tienes voz — no tienes dinero o papeles, pero tienes voz,*" "you don't have money or papers, but you have a voice." "Health is everything," she said to us, "mental, physical and spiritual."

³⁹ See the February 2013 report from Vision y Compromiso entitled "A Landscape Analysis of the Promotor Model in Boyle Heights." The original term "*promotora de salud*" – promoter of health – has been shortened more generally now to simply *promotora*. The terms *promotora/ promotoras* refer to a woman/ women in this role, while the terms *promotor/ promotores* refer to a man/ men, or, for the plural, a mixed-gender group. (The same applies to *sobadora/ sobadoras and sobador/ sobadores*, in the next section.)

Home remedies and *sobadores*

“My mom thinks she can heal everything.”

In our survey we asked, “Do you rely on home remedies?” Out of our 60 respondents, 37 (62%) said “yes.” By far the most common conditions for which our survey respondents sought relief with home remedies were stomach aches (20 women) and colds/coughs/ flu/ fever (19 women). (Many listed more than one ailment.) Only one, two, or three women specifically mentioned other disorders: muscle aches, headaches, asthma, diabetes, earaches, and burns.

Similarly, in our focus group discussions many of the women spoke of visiting a *botánica* (a store selling medicinal herbs, incense, and oils) in Boyle Heights, or the larger *Hierbas de Mexico* store (Herbs of Mexico) in nearby East L.A. One young woman said, “My mom thinks she can heal everything; she never takes me or my siblings to the doctor.” Another woman told us that her father-in-law was a traditional healer in his hometown in El Salvador; there were no doctors there at all. Some of the women relied on home/ herbal remedies because they trusted these more than medical prescriptions; for other women it was an alternative used because they lacked health coverage to pay for doctors’ visits and/or prescription drugs. One woman shared that she had healthcare coverage only when she was pregnant; she relied on herbal remedies the rest of the time.

Responding to another question, a third of our survey respondents said they accessed medications without a prescription. Similarly, in our focus groups and interviews women spoke of knowing places where they could get medicine, including antibiotics, without a prescription.⁴⁰

Another healing modality that has come to the United States along with immigrants from Latin America is the traditional massage therapist, the *sobador/ sobadora*. The Boyle Heights community newspaper *Boyle Heights Beat/ Pulso de Boyle Heights* wrote of the phenomenon in an article in May 2012 entitled “Many in Boyle Heights look to *sobadores* for relief from pain.” The article’s author, Stephanie Baylon, writes of the “many Latinos in Boyle Heights who go to *sobadores* instead of doctors”; some “chose to visit a *sobador* because they don’t trust doctors and prefer to follow tradition,” whereas others may choose a *sobador* (who may dispense herbal creams and remedies and offer nutrition advice, in addition to performing massage) because of lack of health insurance for a doctor’s visit.

We asked on our survey “Do you consult with a *sobador/* massage therapist?” and about a quarter of our respondents said that they did. In addition, just over a fifth of our survey respondents said they consulted other forms of alternative medicine, a topic that also came up in our focus groups and interviews. The woman we mentioned in Part Two, who had waited in excruciating pain on the emergency room floor at LAC + USC Medical Center, ended up going to a naturopath for treatment of her gallbladder stones. It was costly, she told us, but she was healed.

⁴⁰ It was well beyond the scope of our research to either compare the effectiveness of home remedies with prescription medication, or to investigate the quality of “prescription” drugs obtained without a doctor’s authorization.

Perspective of a holistic healer: Interview with Dr. Elena Esparza

On her website, "Just Breathe Healing," Dr. Elena Esparza (the Boyle Heights holistic chiropractor and health activist quoted in Part Five) writes that "My chief healing influences come through the great women of my family who have carried on the traditions of their grandmothers and family healers: my mother Ofelia Esparza, my grandmother Guadalupe Avilez, and our beloved Maya ancestor, Mama Pola, who never forgot the connection and lessons of the plants for healing." We interviewed Dr. Esparza at some length, and the comments below are brief excerpts:

"Often the relationship with the body is a relationship of fear. Part of what I do is a re-education about the relationship with yourself. People say to me, 'I have diabetes' and 'I have high blood pressure' and 'I have cholesterol,' 'I'm bipolar.'" And I say: That's not who you are, those are symptoms. The body is not a mystery. But it takes retraining to look inside and learn the language of your body and learn the language of what these symptoms are saying to you.

"Internally we have a knowing but we don't trust it. It's a knowing that comes from generations. We go to the doctor but we're not completely satisfied. That's why *botánicas* survive, because they fill in the empty space. But we have pushed it so far back, mainly out of fear and trying to fit in.

"I don't know how to address all this specifically as a community, except to provide lots of exposure and lots of education on how to address stress in life in creative ways, within the body, the family, within the community. I feel the number one way to heal a community is to teach people to understand, listen, and be in connection with themselves above all else. And exercise, and creative ways of expression could help change the tide of what we're seeing. There's this whole problem, too, about separation, people not being connected, and I feel that's part of the mental health thing.

"We can't do it alone."

Cultural therapy

"La Cultura Cura" — "Culture Heals"

Reviewing the psychiatric literature on the mental health of Latinos in the U.S., the National Alliance on Mental Illness (NAMI) found that there are higher rates of mental illness among U.S.-born Latinos or those who have been long-term residents, compared to the rates among recent Latino immigrants to the U.S. One study "found conclusively that long-term residence in the United States significantly increased rates in mental disorders, with particularly dramatic increases in the rates of substance abuse." Another found that Mexican-Americans born in the U.S. are at significantly higher risk of depression and suicide than those born in Mexico.⁴¹

⁴¹ See the Latino Community Mental Health Fact Sheet from the NAMI Multicultural Action Center. See also chapter 6 in the 2001 report of the Surgeon General on "Mental Health: Culture, Race, and Ethnicity." This chapter, on "Mental Health Care for Hispanic Americans," highlights a "consistent pattern of findings" suggesting that "factors associated with living in the United States are related to an increased risk of mental disorders."

Some researchers have concluded from these findings that “acculturation” is the causative factor associated with increased risk.⁴² The authors of the chapter on “Mental Health Care for Hispanic Americans” in the 2001 Surgeon General report propose that no one factor can be singled out as alone responsible. An interwoven set of compounding factors differentiates the lives and psychological landscapes of long-term resident or U.S.-born Latinos compared with recent immigrants. These include: possible delayed symptoms of post-traumatic stress disorder, due to trauma and terror experienced in the home country and/or in the perilous migration journey; persistent poverty, discrimination, and violence in the midst of “the American dream”; the fear of deportation for those without legal status; and acculturation tensions between the generations that increase, rather than decrease, over time.

Yet, while “acculturation” alone may be too unitary a concept to explain the correlation of rates of mental health problems with years in the United States, (re)connecting to ancestral culture as an expansive, living entity has been shown to play an important role in healing and health. A phrase has come into currency in Latino communities across the United States, “*La Cultura Cura*”/ “Culture Heals,” signifying an understanding of the need for inclusion of cultural dimensions within pathways to mental and physical well-being. The curative power of reconnecting to cultural roots arises both from individuals relating to each other in community, and from the individual realigning her- or himself with cultural traditions that give grounding and depth, a reminder of the continuum of which one is part.⁴³

Mujeres de Maiz – “Women of the Corn” – was founded in 1997 in the Boyle Heights-adjacent community of Highland Park, and reflected in its name a grounding within the concept of “*La Cultura Cura*” while simultaneously challenging the reality that, although “over thirty years had passed since the height of the Civil Rights and Feminist Movements,” “women’s voices were continually absent from the established platforms of representation.”

Promoting the arts, holistic healing, and women’s social justice activism, Mujeres de Maiz is one of the many women-led Boyle Heights cultural resources we encountered in the course of our work. Another is the theater and cultural arts center Casa 0101, founded in 2000 by Josefina Lopez, author of “Real Women Have Curves.” Theater productions at Casa 0101 through the years have showcased works uplifting and empowering the culture of the community, including “Real Women Have Curves,” “8 Ways to Say I Love My Life,” “The Imaginary Life of the Street Sweeper,” “Locked Up,” “An L.A. Journey,” and a “Brown & Out” Theater Festival.

In 2011, the Building Healthy Communities initiative incorporated the Alliance for California Traditional Arts (ACTA) into its programming and implemented the Activating Cultural Assets Pilot Project in four communities, including Boyle Heights, with an aim “to incorporate community-based cultural assets into the work of the BHC initiative.” This led to the establishment of the Boyle Heights Cultural Treasures Project, “which aims to facilitate a space where the community engages in its own process of looking to its cultural resources for the purpose of defining self-health and sustainability.”

⁴² The Merriam Webster dictionary defines “acculturation” as “cultural modification of an individual, group, or people by adapting to or borrowing traits from another culture.”

⁴³ See the discussion of the work of Albino Garcia in Albuquerque, New Mexico with Latino gang members , “Albino Garcia/ *La Cultura Cura*” by Karen Muktayani Villaneuva: “‘For me to change,’ Garcia says, ‘I had to journey past all those ugly identities that were placed upon me—that I accepted and adopted—and go back to that real sense of who I am, to the original spark that connects everything...’” In San Francisco, *La Cultura Cura* program of the Instituto Familiar de La Raza uses “a combination of services and innovative cultural arts programming” to teach and motivate youth.

Over 100 Boyle Heights cultural treasures, including *Mujeres de Maiz* and *Casa 0101*, were identified via a community survey. Organizations included Self-Help Graphics & Art, with its year-round programming, exhibitions, trainings, and outreach, including its month-long *Día de los Muertos* (Day of the Dead) celebration, when, each year, one of the named individual cultural treasures, Ofelia Esparza, exhibits one of her signature altars. *Danza Azteca* (Aztec dance) was identified as one of the general culture treasures, and the storefront arts, education, and action center where Aztec dance classes were sometimes held (among many other activities), *Corazon del Pueblo*, was also recognized.⁴⁴ The list ranges from muralists to musicians, gang intervention workers to neighborhood landmarks and gathering places.

Writing about the Boyle Heights Cultural Treasures Project, Quetzal Flores, the Program Manager and founder of another cultural treasure, the Grammy-award winner band Quetzal, summed it up by saying that Boyle Heights is “a community where art and culture provides hope and health for the future.”⁴⁵

⁴⁴ In December 2014 *Corazon del Pueblo* had to give up its storefront space, but maintains itself as a collective and holds events in venues in Boyle Heights and adjacent neighborhoods.

⁴⁵ See the website of the Alliance for California Traditional Arts for the methodology of the project and a link to the Boyle Heights Cultural Treasures map. The article by Quetzal Flores can also be accessed via searching the website.

**IN SUMMARY AND CONCLUSION
CHANGING THE NARRATIVE AND THE REALITY: SOME POSSIBILITIES**

The Big Questions

We are finishing this report, in October 2015, within a larger historic moment that has brought to the fore with renewed intensity the question of migration across borders, a dimension that profoundly touches the community of Boyle Heights in general, and many of the women and families in our research in particular.

The MCHA research project took place within the landscape of the larger questions about health and community posed by the Building Healthy Communities initiative.

Resonating within this global and national landscape are the large questions posed by The California Endowment’s Building Healthy Communities initiative: What is health and wellness? What is community? What is the narrative we tell ourselves as a society about how we live together, and who thrives and who does not?

Many Boyle Heights service providers and activists we interviewed addressed the concept of “health” as something more than “access to health care,” though of course access is important. This perspective corresponds to the vision of the BHC initiative which stresses the importance of a “narrative change,” that is, “changing the way people think about health and why some people have opportunities for health and others do not,” “developing community residents’ capacity to effectively drive the local dialogue on health away from conventional debates about access to health care to include addressing the social determinants.” To be healthy, “one has to have opportunities to make healthy choices – to be able to afford healthy food and housing, good jobs that sustain a family, quality schools, breathe air free of pollution, and so on. No amount of health care coverage will compensate for people who don’t have access to these essential opportunities for health.”⁴⁶

The MCHA Research Project

MCHA is active in the Prevention workgroup of the BHC-BH initiative and some of our recommendations here reflect the ongoing efforts of the workgroup before, during, and after the research project. Other recommendations reflect concerns that moved to the fore during the research process itself.

The MCHA research project of surveys and interviews with women in Boyle Heights focused primarily on access and barriers to health care provided by mainstream medical practitioners. While this is not everything needed for health, it is, nonetheless, one key element.

In these Conclusions we wish to revisit the four major barriers to quality health care for women in the Boyle Heights community that we discussed in Part Two of this report, and in addition explore some aspects further.

MCHA is active in the Prevention workgroup of the BHC-BH initiative and some of our recommendations reflect the ongoing efforts of the workgroup, before, during, and after the research project. Other recommendations reflect concerns that moved to the fore during the research process itself.

⁴⁶ All quotes here are from the Building Healthy Communities pages on the website of The California Endowment.

**Changing the narrative in the larger society around health care access:
issues related to legal status and income**

The first two major barriers we discussed in Part Two are (1) restricted healthcare access because of undocumented legal status and (2) restrictions in quality of care because of limited income. Both MCHA and the BHC-BH initiative identified these barriers before this particular research project, and our project interviews and conversations amplified these understandings. Both these barriers need revisions in government policy to bring about change.

For undocumented residents, many holes remain in the emerging patchwork of services for which they qualify; we have catalogued these throughout this report. MCHA stands with The California Endowment and BHC-BH in asserting the narrative that health care is a human right, and that just as the State of California now provides healthcare for pregnant mothers and young children, so can resources be found to provide quality physical, dental, and mental healthcare services to all residents of our state, regardless of income or legal status.

It is unlikely that a comprehensive solution will be reached without the needed education and engagement of the wider public, an effort that touches on the big questions we raised in the opening paragraphs of these Conclusions. Nonetheless, the successful passage of SB 4, providing healthcare for all California’s low-income children regardless of immigration status, gives impetus to the movement for universal coverage.

In the meantime, steps along the pathway can be taken. These include the BHC-BH’s focus on increasing the number of people eligible for programs such as the county’s My Health LA (MHLA) by expanding the numbers allowed to enroll as well as increasing the MHLA budget. Part of this recommendation speaks to MCHA’s expertise with other insurance programs covering the undocumented that may help extend the MHLA funds. BHC-BH also recommends allowing enrollment off-site, not just within the four walls of the clinic, to increase access to this enrollment-required program. MCHA expands on that recommendation by requesting that all trained enrollers for Los Angeles County programs have the ability to enroll people in MHLA, so that mixed-status family members may all be enrolled in the appropriate programs at one session.

For low-income legal residents and citizens, who are eligible for the Affordable Care Act, we repeat what we stated earlier: “The lowest-priced plans have a high deductible and entail co-payments for many medical services, and health insurance alone doesn’t answer the problem of finding childcare or needing to take perhaps-unavailable time from work for a doctor’s visit. Further research will be needed to determine what healthcare gaps continue to exist for ACA-covered residents in a community such as Boyle Heights.”

Summary of recommendations
Changing the narrative in the larger
society around health care access: issues
related to legal status and income

Grounded in the recognition that healthcare is a human right, and as part of preparing the way for the more extensive government policy change that is needed, we recommend:

- increasing the number of people eligible for programs such as My Health LA and increasing the ease of enrollment
- expanding the healthcare narrative to include access issues crucial for low-income mothers

In addition:

- further research will be needed to determine what health care gaps continue to exist for ACA-covered residents in Boyle Heights

The descriptions we received from women about the obstacles on the path to “simply” arriving at a medical appointment need to become part of discussions about access to health care. The testimony we recorded could inform the BHC goal of “engag[ing] the local media and local messengers influential with elected officials and other leaders in weaving a compelling and new narrative ...” We can help empower a vision that includes paid leave for medical appointments, flexible clinic schedules, alternative transportation options, and child care at clinics and hospitals. As the BHC initiative emphasizes, much depends on the common social narrative about the desirability, or not, of expanding opportunities for health and well-being to all.

Expanding the health access narrative to include the importance of language

The third major barrier to quality health care that we discussed in Part Two is “problems of communication with medical providers who speak only English.” This resonates with the BHC recommendation for “cultural competency and language access programs” for healthcare students and professionals. In addition we’d suggest the following: an active medical career recruitment program in the high schools and/or colleges for Spanish and indigenous-language speakers; that medical schools be encouraged to take into account bilingualism in an underserved language as one important criterion in choosing applicants; and that Boyle Heights clinics and hospitals engage in targeted programs to recruit providers who speak Spanish.

Competent medical interpretation is the second pillar of the solution to this problem, but the lack of adequate Spanish medical translation in Los Angeles remains a glaring healthcare gap in 2015. Many factors contribute to this gap: lack of sufficient numbers of people who are certified (or at least qualified) to be medical interpreters; a failure of clinics and hospitals to budget adequately for this need; and medical interpretation not always presented as an essential part of the broader picture.

<p>Summary of recommendations</p> <p>Expanding the health access narrative to include the importance of language</p> <ul style="list-style-type: none"> • A multi-faceted approach to training and recruiting higher numbers of Spanish-language medical providers • Affirming the necessity of expanding the health access narrative to include medical interpretation as an essential aspect of healthcare • Outreach to bilingual speakers in Boyle Heights to make them aware of medical interpretation as a possible career choice
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At LAC + USC Medical Center, MCHA has stepped in to fill one gap, breastfeeding support for pregnant women getting prenatal care and for new moms visiting the pediatric clinic with their babies. Our Spanish-language group is offered one day a week at The Wellness Center.

Programs and certificates in Spanish/English medical interpreting are offered both at California State University, Los Angeles and the Extended Education program at California State University, Fullerton. Outreach to bilingual speakers in Boyle Heights could make them aware of medical interpretation as a possible career choice. There may be funding sources that could support tuition for community members and job placement assistance for paid employment following certification.

AB 635 requires the Department of Health Care Services to seek federal funding to establish a program that will support medical interpretation services to limited-English proficient Medi-Cal beneficiaries. The bill failed to pass this year but will continue on as a two-year bill into 2016.

Expanding the health access narrative to include the importance of cultural sensitivity

Language is the most blatant but not the only cultural sensitivity issue that emerged in our research.

We recorded in Part Two the racist, anti-immigrant remark one woman heard from her doctor. This extreme case was not something frequently reported to us in this project, but it is at the far end of a continuum of more common situations, including the childbirth experiences we recorded in Part Four, in which immigrant and/or low-income women were not treated with dignity and respect.

In addition, the question of cultural sensitivity pertains to level of formal education and familiarity and ease with filling out forms. “There is a lot of paperwork involved, *exigen mucho*, they demand a lot in our community,” one woman said to us. Even a multi-page form in a woman’s native Spanish can feel intimidating, adding the stress of paperwork difficulty to the stress of health concerns. Efforts are currently underway at the state and federal levels to simplify application forms and reduce the number of questions asked; more scrutiny may be needed at the clinic level to see whether simplification is possible there and how assistance can be more readily provided when needed.

Cultural insensitivity and discrimination are dominant issues for the LGBTQ community. Alexa, the trans woman whose interview we wrote about in Part Four, suggested a needs assessment survey – something that might perhaps bring in resources from allies but be created and directed by the Boyle Heights LGBTQ community itself, with women at the forefront. “We do exist,” she said. “It takes a little more work, more attention and more resources to get us to the table, because we’re dealing with an onion, a plethora of issues. But we are here. We have to build some trust. Once we are at the table, we feel comfortable. There’s definitely an opportunity to create a needs assessment with our input.”

Summary of recommendations Expanding the health access narrative to include the importance of cultural sensitivity

- Encouragement of open discussion on cultural sensitivity issues as part of the narrative on health care access
- Support for efforts to simplify medical application forms, including at the clinic level, and advocating for assistance to be easily available if needed
- A survey assessing the needs of the LGBTQ community, created and directed by the Boyle Heights LGBTQ community with women at the forefront

“Cultural diversity education” is now part of the course curriculum for many undergraduate medical students, but according to a 2010 article in the Journal of General Internal Medicine there is still a distance to go in adequately meeting the need. The authors of the article document the many challenges that remain unresolved, including conceptual clarity, curriculum subject matter, faculty support, and attitudes of both staff and students.⁴⁷ Yet questions of cultural sensitivity are not insurmountable problems, once this dimension is recognized as essential and becomes part of the common narrative on healthcare access.⁴⁸

⁴⁷ “Teaching Cultural Diversity: Current Status in U.K., U.S., and Canadian Medical Schools,” by Nisha Dogra, Sylvia Reitmanova, and Olivia Carter-Pokras

⁴⁸ For an overview of key issues encompassed by “cultural sensitivity,” see “Table II-2: Summary of Core Competencies” in “The Asian Pacific Islander Population Report: In Our Own Words,” from the California Reducing Disparities Project, Asian Pacific Islander Strategic Planning Workgroup, December 2012. See also the website of the San Francisco-based Instituto Familiar de la Raza, for a discussion of “culturally illiterate

Changing the narrative within the community around female self-care and female sexuality

In Part Two, we listed a fourth barrier to health care that emerged repeatedly in the course of our conversations with women in Boyle Heights, a multi-dimensional category we labeled “lack of information, and cultural and internalized barriers.” This broad category encompasses many aspects of both external barriers (lack of sufficient outreach and information) and internalized barriers.

As we noted in Part Two, often the external and the internal feed into each other. One recurring example is how women internalize a socialization to sacrifice for those they love and devalue self. They therefore pay scant attention to resources available for their own well-being, and this then necessitates a stronger outreach effort.

To address this situation, the Office of Women’s Health (OWH), part of the Los Angeles County Public Health department, launched a media campaign in July 2015 with the slogan “Putting your health last is not putting your family first.” The press release announcing the campaign stated: “The campaign is a Call to Action for LA County moms to take time out to focus on their own health and well-being for the benefit of their whole family.” The campaign advertises a multilingual hotline with information and referrals to health services available for all women, regardless of income or legal status.

One of the women in our study summed up a sentiment similar to the campaign slogan when she stated: “It’s always been easier to get healthcare coverage for my kids than it has been for myself, but if I am not healthy, who is going to take care of the kids? Moms need to be healthy, emotionally, mentally, eyesight, dental. If I’m not [healthy and] able [to be aware enough] to see that my daughter is getting bullied at school, how is she going to succeed?”

MCHA is actively promoting this important effort from the OWH, and we wholeheartedly welcome its campaign slogan as what is needed to capture the attention of mothers in the target populations. Yet not all women are mothers, and the slogan still poses the value of women’s health in terms of women’s ability to be present for other people. Our research made us keenly aware that self-esteem remains a critical problem for both adult women and teenage girls, affecting both emotional and physical health, and we want to advocate what Paola, the *promotora* we quoted in Part Six, stated without qualification: “Women need to stop feeling guilty about putting self first.” She emphasized in our interview that women need to learn to value themselves and to practice nourishing self-care.

Our interviews and focus group with adolescent girls brought home

Summary of recommendations Changing the narrative within the community around female self-care and female sexuality

- Full support for the Office of Women’s Health “Call to Action for LA County Moms”
- Educational initiatives to boost self-esteem and self-care for both adult women and teenage girls
- Recruitment of more teen advocates for school-based Planned Parenthood health centers, advocacy for comprehensive wellness centers at all area high schools, and encouraging interested teens and adults to investigate possibilities for becoming involved in the 2016 expansion of the sexual health curriculum in the schools
- Full support for the annual Women’s Conference sponsored by Proyecto Pastoral at Dolores Mission

practices [that] assaulted resiliency factors that encouraged healing” and conceptualizing and putting into practice “culturally integrated” interventions.

the importance of Paola's message. For teen girls, stronger efforts at empowering self-esteem are definitely needed, along with more sexual health education outreach, including recruiting more teen peer advocates. Ideally, there could be wellness centers at all area high schools, with the Planned Parenthood clinics as one part of a larger whole that addresses also mental health concerns. At Roosevelt High, a multi-million dollar Modernization/ Renovation plan has been projected, and the activist group Inner City Struggle is advocating for a full-service wellness center to be included in the Renovation Plans, a concept we support.

Above all, we want to contribute our voice to the principle that a narrative around health and Building Healthy Communities, including what the BHC initiative calls "Healthy Youth Opportunities," must include the dimension of sexual health education, presented with the goal to help girls feel at home in, rather than shamed by, their bodies. The Peer Advocates of Planned Parenthood and the youth programs of East L.A. Women's Center are currently working towards this objective, and more such programs are needed. "Health" includes education in healthy sexuality and healthy relationships, with vibrant adult role models, both female and male, to guide teenage girls and boys towards self-respecting and mutually respecting understanding and behavior.

The California Comprehensive Sexual Health & HIV/AIDS Prevention Act states that sexual education in the schools should "encourage a pupil to develop healthy attitudes concerning adolescent growth and development, body image, gender roles, sexual orientation, dating, marriage, and family." The law was amended in October 2015, with sexual health classes moving from the current voluntary status to mandatory unless parents object, and we encourage interested teens and adults in the BHC-BH project to investigate possibilities for becoming involved in discussions around curriculum and presentation.⁴⁹

One project in Boyle Heights that has a perspective of deepening healthy living and self-esteem for both adult women and adolescent girls is the annual Women's Conference sponsored by Proyecto Pastoral at Dolores Mission. The day-long conference consists of workshops addressing challenges of single mothers and poor working families. Workshop topics include parenting, stress management, diabetes, mental health, and menopause, and there are interactive workshops for young women and girls on self-defense, sexual health, goal-setting, and self-esteem. The high level of enthusiasm for the Conference each year points to the eagerness within the Boyle Heights community for events such as these.

**The need for outreach and education:
primary care, reproductive health, dental health, and preventive self-care**

It is clear that more resources are needed for education and outreach in the Boyle Heights community within the two large fields of (1) information about existing programs and (2) preventive self-care. MCHA has long been involved in these efforts with mothers throughout Los Angeles County, and both our daily work and this research project reinforce our recognition that more is needed on both fronts.

As detailed in several places throughout this report, the landscape of healthcare programs in California and Los Angeles County is in a process of shift and readjustment, with program eligibility requirements changing and new programs coming into being. It was the experience of MCHA even before these latest changes that, for example, women might believe that they only qualified for restricted Medi-Cal when in fact they qualified for more. With today's bewildering array of shifting programs, there is

⁴⁹ See website of the California Dept. of Education, <http://www.cde.ca.gov/ls/he/se/>

greater need than ever for outreach and education. The campaign from the Office of Women’s Health, mentioned above, is one important outreach effort, and more are needed, especially as services received during pregnancy-related care have been expanded and women have more rights to all needed services.

Equally essential are community education initiatives on the topics of healthy living and preventive self-care. We briefly discussed this in relation to dental health in Part Three, and we want here to re-emphasize the importance of dental health, especially during pregnancy when all adult services are available regardless of one’s immigration status.

Summary of recommendations
The need for outreach and education: primary care, reproductive health, dental health, and preventive self-care

- Continue and expand all ongoing efforts at outreach and education, so that women are fully informed about existing programs for which they and/or their families qualify
- Community education initiatives on preventive self-care in all areas, including dental health
- Community education initiatives on topics of healthy living, including diet, nutrition, and exercise
- Increased outreach efforts by The Wellness Center, so that its multi-faceted offerings are better known in the community, and possibly a survey to discover what barriers might hamper participation from those who would benefit

In relation to primary care and self-care, we wish to return to something mentioned in this report’s Part One on Demographics, the 2009 California Health Interview Survey finding that 35% of Boyle Heights residents are obese, compared to 21% in L.A. County as a whole, and the reality that in the United States, obesity, which can lead to diabetes, heart disease, and cancer, is a disease of the poor.

The Centers for Disease Control and Prevention recently released its data from 2014, mapping obesity across the United States, state by state and by “race” (White/ Black / Hispanic). There are 33 states in which African-Americans have an obesity rate of 35% or higher, nine states (not including California) where this is true of Hispanics, and one state where this is true of whites.⁵⁰ Commenting on these latest figures, Dr. Donald Lloyd-Jones, chair of the department of preventive medicine at the Northwestern University Feinberg School of Medicine, stated: “It is the largest epidemic of a chronic disease that we’ve ever seen in human history.”

“It is not about one group doing something wrong,” Lloyd-Jones said, noting that race and ethnicity are often an indicator of low socioeconomic status. “It is about the environment that we have built that sets people up to fail” — less choices of healthy foods and fewer places to safely be outside and walk, run or play to burn off calories.

Even when the environment has begun to change, with more stores selling fresh fruits and vegetables (and there are a few such

supermarkets currently in Boyle Heights), change in longstanding eating patterns does not happen automatically, especially when unhealthy food choices are inexpensive and even more widely available. Shifting towards healthier eating may happen as a gradual process and programs that promote such a shift are crucial. In addition, larger questions of self-esteem, hope for the future, and general emotional and mental health play critical roles in influencing what diet a person chooses to follow.

⁵⁰ See “Obesity Maps Put Racial Differences on Stark Display,” by Jane Greenhalgh, [NPR](#), September 23, 2015. The quotes from Dr. Lloyd-Jones that follow are from this article.

The desire for more information and programming about healthy living already exists within the Boyle Heights community. In our focus groups many women spoke about wanting to know more about healthy eating and healthy lifestyles. Exercise/Fitness and Nutrition were among the top three topics (numbers 1 and 3) in a survey taken at the 2014 Proyecto Pastoral conference, when the adult women were asked to rate topics of most importance to them. (Diabetes was second, Mental Health fourth.)

In March 2014, The Wellness Center opened in Boyle Heights, on the premises of the Historic General Hospital, with the mission “to inspire and empower residents and patients to take control of their own health and wellbeing by providing culturally sensitive wellness and prevention services and resources ...” It is an exceptional asset in the community, with free weekly support groups and fitness classes for all ages, and several organizations (including MCHA) offering workshops and services on the premises. However, it is our experience that many women we encounter have not yet heard of The Wellness Center. This was true not only during this research project, which took place within the Center’s first year (47 out of our 60 survey respondents did not know of its existence), but it continues to be true today. The Wellness Center offers tremendous education and services for the community, and we hope that outreach efforts will increase as it goes forward. One idea is to conduct neighborhood surveys to find out what barriers might hamper those who would benefit from its innovative approach and many programs.

**The need for education, outreach,
and programming:
mental health and peer group support**

Our research revealed the enormous need within the Boyle Heights community for mental and emotional health services of all kinds, from professional medical providers to peer group support. We dealt with this subject at length in Part Four, where we covered mental health issues related to pregnancy and maternity; in Part Five, on emotional and mental health in general, including the stigma attached to seeking help for emotional/ mental difficulties; and in Parts Five and Six, both, on peer support groups.

We have little further to add here except to underline everything we wrote earlier, and to note especially that the extent of unacknowledged perinatal depression and the hunger for peer group support (including but by no means limited to pre-birth and postpartum) were two of the major findings of our work.

Currently, there are a number of weekly peer support groups at The Wellness Center, including for mental health self-advocacy, for those with HIV, and for fathers. Such groups are a start. MCHA works in partnership with Maternal Mental Health and the Office of Women’s Health, and we hope that the Building Healthy Communities initiative will assist the Boyle Heights community to find pathways to more group and individual support.⁵¹

**Summary of recommendations
The need for education, outreach,
and programming:
mental health and peer group support**

- Education and outreach to (1) help erase the stigma of seeking help for mental or emotional distress, and (2) make better known available community mental health services
- Pursuing avenues of response to our research findings on the extent of unacknowledged perinatal depression and the hunger for peer group support during pre-birth and postpartum
- Pursuing avenues of response to our research findings on the hunger among women in Boyle Heights for peer group support in multiple areas

⁵¹ Peers for Progress, mentioned in a footnote in Part Six, has teamed with the National Council of La Raza to form

Building Healthy Communities: Boyle Heights today and tomorrow

“Integrative medicine” or “integrative health” is a new and evolving concept, founded on the principles that the patient and the practitioner are partners together in the healing process, that health and wellness are paramount, not alone the treatment of illness, and that body, mind, spirit, and community are all factors influencing wellness or disease.

It is an approach to medicine for the 21st century, and the outlook of the Wellness Center at the Historic General Hospital in Boyle Heights.

It is a theme reflected in many of the organizations named in the Boyle Heights Cultural Treasures Project.

In our research we discovered the ways in which Boyle Heights is a pioneer in the evolving field of integrative medicine. All of Los Angeles and California could learn much from the creative approaches opening up within its borders and from the wisdom of the immigrant and low-income women who call Boyle Heights their home.

It is the vision that informs the mural across the street from Francisco Bravo High School in Boyle Heights, a magnet senior high school within the Los Angeles Unified School District geared for students who plan to study in the healthcare field. The mural portrays high-technology open-heart surgery alongside an indigenous healer, and a depiction both of a starving child and a space explorer: all dimensions of our world that demand attention from those concerned with our common humanity and well-being.

It is the concept that emerged naturally and fluidly in our conversations with the women of Boyle Heights, as they discussed their appreciation both for a good clinic doctor who recognizes the importance of a patient-centered healthcare model, and the effectiveness of traditional home remedies of their mothers and grandmothers – herbal treatments, we note here, that now are widely being re-investigated and used, and accorded a new respect.

With all its challenges, Boyle Heights remains a dynamic community, simultaneously impoverished and enriched – alive in its “vibrant uniqueness,” in the words of the Preface to the 2010 book In Our Global Village: Boyle Heights Through the Eyes of its Youth. Within Boyle Heights there are very real problems of inequity, injustice, and dysfunction that cannot, and should not, be ignored. At the same time, there exist wells of creativity, intelligence, and perseverance.

There are individuals who feel isolated – hence the longing for peer support networks – and there are existing networks of affinity and relationship, a foundation of what the Building Healthy Communities initiative names as “strong and dense relationship networks” that help an underserved community remain able to face and overcome adversity and “drive policy change today and beyond.”

Although our research mandate was to investigate access and barriers to conventional health care for

The National Peer Support Collaborative Learning Network. See their several publications, including “Peer Support in Health: Evidence in Action,” accessible from the Publications page of the National Council of La Raza website.

women and children in Boyle Heights, we could not contain the discussions within narrow bounds. The women, brought together in our focus groups, brimmed with stories they wished to share with each other and confidences about wanting more spaces and support for themselves as women. They found themselves daring to want access to comprehensive primary care and a healthcare home, and laughing together as a shared consciousness unfolded of wanting to know how to care for their bodies, minds, and spirits as one, and what total wellness might mean, for themselves and their families and community.

Among the results of our research, we would name our discovery of the ways in which the neighborhood of Boyle Heights is an integrative medicine healthcare pioneer. All of Los Angeles and California could learn much from the creative approaches opening up within its borders and from the wisdom of the immigrant and low-income women who call Boyle Heights their home. These women already contribute richly to the daily existence, identity, and culture of our city and state, and will contribute so much more when further paths to wellness and opportunity are available to them.