2018

STORIES OF STRENGTH: CHICAGO LATIN@S' NAVIGATION OF HEALTH, WELL-BEING, AND CHRONIC DISEASE

Lilian L. Milanés
University of Kentucky, lilian.milanes@gmail.com

Digital Object Identifier: https://doi.org/10.13023/etd.2018.279

Recommended Citation

Milanés, Lilian L., "STORIES OF STRENGTH: CHICAGO LATIN@S' NAVIGATION OF HEALTH, WELL-BEING, AND CHRONIC DISEASE" (2018). *Theses and Dissertations--Anthropology*. 33.
https://uknowledge.uky.edu/anthro_etds/33

STUDENT AGREEMENT:

I represent that my thesis or dissertation and abstract are my original work. Proper attribution has been given to all outside sources. I understand that I am solely responsible for obtaining any needed copyright permissions. I have obtained needed written permission statement(s) from the owner(s) of each third-party copyrighted matter to be included in my work, allowing electronic distribution (if such use is not permitted by the fair use doctrine) which will be submitted to UKnowledge as Additional File.

I hereby grant to The University of Kentucky and its agents the irrevocable, non-exclusive, and royalty-free license to archive and make accessible my work in whole or in part in all forms of media, now or hereafter known. I agree that the document mentioned above may be made available immediately for worldwide access unless an embargo applies.

I retain all other ownership rights to the copyright of my work. I also retain the right to use in future works (such as articles or books) all or part of my work. I understand that I am free to register the copyright to my work.

REVIEW, APPROVAL AND ACCEPTANCE

The document mentioned above has been reviewed and accepted by the student’s advisor, on behalf of the advisory committee, and by the Director of Graduate Studies (DGS), on behalf of the program; we verify that this is the final, approved version of the student’s thesis including all changes required by the advisory committee. The undersigned agree to abide by the statements above.

Lilian L. Milanés, Student

Dr. Ann E. Kingsolver, Major Professor

Dr. Sarah Lyon, Director of Graduate Studies

STORIES OF STRENGTH: CHICAGO LATIN@S' NAVIGATION OF HEALTH, WELL-BEING, AND CHRONIC DISEASE

DISSERTATION

A dissertation submitted in partial fulfillment of the requirements for the degree of Doctor of Philosophy in the College of Arts and Sciences at the University of Kentucky

By

Lilian Luisa Milanés

Lexington, Kentucky

Advisor: Dr. Ann E. Kingsolver, Professor of Anthropology

Lexington, Kentucky

2018

ABSTRACT OF DISSERTATION

STORIES OF STRENGTH: CHICAGO LATIN@S' NAVIGATION OF HEALTH, WELL-BEING, AND CHRONIC DISEASE

Health inequalities take many forms related to race, gender, socioeconomic status, ethnic, language and many other axes throughout communities around the world. Type two diabetes, high blood pressure, and high cholesterol are examples of conditions (among many others) that disproportionately affect Latino@s in the U.S.. The research of this dissertation is based on fieldwork conducted throughout several predominantly Latin@ neighborhoods in Chicago, IL. This dissertation examines how Latin@s in Chicago navigate health and well-being, and how they engage in agentive strategies in the face of chronic disease. I recorded individual life histories and semi-structured interviews, focus groups, and participant observation at various community events and settings. The stories of these Chicago Latin@s are shared here in an effort to de-homogenize the depiction of Latin@s in the U.S. by paying attention to local narratives, and especially to those related to living with chronic disease.

KEYWORDS: Health inequities, Latin@s, Chicago, U.S.

Lilian Luisa Milanés

May 3, 2018

STORIES OF STRENGTH: CHICAGO LATIN@S' NAVIGATION OF HEALTH, WELL-BEING, AND CHRONIC DISEASE

By

Lilian Luisa Milanés

__Ann E. Kingsolver, Ph.D._
Director of Dissertation

___Sarah Lyon, Ph.D.______
Director of Graduate Studies

_________May 3, 2018____
Date

Esta disertación la dedico a toda mi familia. Especialmente a Juan Andrés, Leonardo Emanuel, y Rosario Chávez, por todo su apoyo y fuerza para seguir adelante.

ACKNOWLEDGMENTS

First and foremost, thank you to each and every person who took the time to sit down and talk with me, and teach me how they navigate their health and well-being. In particular, I am so appreciative of my dear friend “Ms. Yaly”, for helping to connect me with so many residents and teaching me about living in the NW of Chicago. Thank you for helping me organize my research and watch or hold Leo when I needed an extra hand. Thank you to las muchachas del sur. You are the lifeblood of the family and have taught me so much about motherhood, being a spouse, a comadre, and friend. Thank you for opening your homes and lives to me as I began adapting to life in Chicago. Thank you to “Doña Nancy”, for sharing your heart and passion with me since day one. Your dedication to the community, to follow your dreams and your happiness for the betterment of your and your family’s life is so uplifting. To las mujeres del centro, thank you for your encouragement, suggestions and help to launch my data collection and teach me what resilience truly means.

I am so grateful and honored to have had this opportunity to work with my advisor and mentor, Dr. Ann E. Kingsolver. In the two short years under her mentorship I was able to finish conducting fieldwork, write this dissertation, apply for academic positions, and land my dream position. Thank you for all the time you have dedicated to all of your advisees, especially when running on borrowed time. Thank you for believing in me when I did not believe in myself. Thank you for showing me first-hand, how quality, collaborative, and engaged ethnography is done. You are the essence of mentorship. Your patience, kindness and prestige are what I hope to embody as an academic, scholar and activist.

Thank you to Sarah Lyon for making this mentorship relationship possible. I appreciate all of the work you have been doing to see me, along with all anthropology graduate students, succeed through this program. Thank you to Deb Crooks for remaining on my committee through retirement and opening the world of biological anthropology to me. Thank you to Ana Liberato for your mentorship throughout my time at UK, and for being a little piece of home for me when I felt most lost.

This dissertation writing experience was completely transformed by the weekly writing group meetings with my colleagues and fellow Kingsolver advisees, and I am so thankful for being part of this community. To my dear friends and colleagues Céline Lamb and Sneha Thapa for constantly reminding me and motivating me to achieve my own greatness. To Veronica Miranda for advising me through so many phases of this Ph.D. process.

To my husband Juan, for your tough love and insistence on the very best constantly propel me forward. You inspire me to do better each day. To my son Leonardo, thank you for your patience and for constantly teaching me the most important things in life. To my mother, thank you for always giving so much, for being the trail-blazer you are and for guiding me through each of these steps, especially when I did not know what to ask. To my father, an honorary medical anthropologist, words cannot express how grateful I am for everything you have taught me, and continue to teach me, in life. To all of my abuelas, abuelos, tias, tios and primos, and all my family and friends who have supported me in one form or another. This is for us. We did it!

TABLE OF CONTENTS

LIST OF TABLES

LIST OF FIGURES

CHAPTER ONE:

Introduction

Throughout my intellectual development I always questioned why there are so many health inequalities throughout the world: inequities in access to education, income, food and nutrition, health care, housing, and safe environments—inequities due to racism and xenophobia, religious intolerance, gender discrimination and suppressed self-determination and agency. Why were so many marginalized communities experiencing ill effects, especially in the U.S., one of the richest countries in the world? With the drive to combat these injustices in a holistic way, I found my place within medical and engaged anthropology. Through critical medical anthropology, specifically, I learned how health and illnesses are experienced in various contexts, how to analyze power in relation to health injustice, and—most importantly—what can be done to address these injustices. My research is in line with scholarship that traces how sociocultural processes (such as experiencing racism, xenophobia, and other forms of discrimination) become biologically embedded (Gravlee et al. 2009). Particularly, I view structural violence as a central way of identifying the purposeful creation of health inequalities among marginalized communities. Johan Galtung describes structural violence as:

> the violence built into the structure and shows up as unequal power and consequently as unequal life chances. Resources are unevenly distributed, as when income distributions are heavily skewed, literacy/education unevenly distributed, medical services existent in some districts and for some groups only, and so on. Above all the power to decide over the distribution of resources is unevenly distributed (Galtung 1969:171).

The structural violence framework helps scholars trace how both intentional and unintentional forms of violence are enacted by the structures of the state, local government, international agencies, and everyday actors. The structural violence framework is associated with political economic analyses and a focus on human rights and social justice. Following Galtung, medical anthropologist Paul Farmer has utilized and continued the development of the structural violence concept. Farmer describes structural violence as “violence exerted systematically—that is, indirectly—by everyone who belongs to a certain social order” (Farmer 2004: 307). In Farmer’s *Pathologies of Power*, he further explains how,

> structural violence is used as a broad rubric to include a host of offensives against human dignity (e.g. extreme poverty and relative poverty, social inequalities ranging from racism to gender inequality, and more apparent forms of violence that are uncontested human rights abuses) (Farmer 2005:8)

Overall, structural violence explains how “ubiquitous social structures” and institutions that are part of everyday experience, create and recreate a “machinery of oppression and marginalization” (Leatherman and Goodman 2011:40). Additionally, forms of symbolic and everyday violence are crucial to identifying the intimate impacts and reaches of violence. Philippe Bourgois distinguishes between political violence, structural violence, symbolic violence and everyday violence (2001:8). Symbolic violence, as developed by Pierre Bourdieu (1997), operates through people’s internalization and “legitimatizations of inequality” (Bourgois 2001:8) often without their awareness. Symbolic violence is a way for repressive ideologies and ways of life to be reproduced among people throughout their lives. Everyday violence, as described by Nancy Scheper-Hughes (1992, 1996), is constituted through the “routine practices and expressions of interpersonal aggression that serve to normalize violence at the micro-level” (Bourgois 2001:8-9). All these forms of violence are interconnected in terms of structural, symbolic and everyday violence. I saw many examples of this in my fieldwork; when patients were criticized for not making follow-up visits to the clinic, instead of personal irresponsibility the explanation could be structural violence: a fear of leaving the house due to aggressive anti-immigrant state policies, for example.

Bourgois solidifies these connections in the U.S. by explaining that “the fusing of structural and symbolic violence produces especially destructive but persistent patterns of interpersonal violence that reinforce the legitimacy of social inequality in the public eye” (Bourgois 2001:29). These forms of inequality, or I would argue inequity, inform the distinction of worthy from unworthy citizens (Bourgois 2001:29), wherein worthy (moral) citizens must “practice safe sex, avoid drugs, refrain from violence and toil diligently at subordinate jobs…in order to deserve shelter, food, medical care, employment and a modicum of public respect” (Bourgois 2001:29). Applying this to the narratives documented in this dissertation, in order (through this inequitable dominant lens) for people to be ‘worthy’ of healthy lives they must avoid ‘unhealthy food’, exercise regularly, and follow their medication regimens; those who ‘fail’ at these specific forms of ‘self-care’ are seen to be putting themselves intentionally at risk of amputation, heart attack, stroke or death. These biomedical definitions of self-care, conveyed to patients within clinical facilities, health outreach centers and programs, often reproduce structural, symbolic, and everyday violence through not acknowledging them. As I explain later in the dissertation, it is difficult for a parent to follow the instruction that they should make sure their child has regular exercise outside if their neighborhood has no safe playgrounds and gun violence is an everyday risk children face.

Following the scholarship of critical medical anthropologists such as João Biehl and Adriana Petryna (2013) who argue that we should place the emphasis on people rather than the disease or health condition, my research highlights the people: first and foremost, Latin@s[1] living in various areas of Chicago, and how residents navigate their health and well-being. Various medical anthropologists have contributed to our understandings of how race, and racism affect our health, especially in terms of experiences with hypertension (Dressler 1990, 1991a, 1991b; Gravlee 2005, 2009; Gravlee and Dressler 2005). This research explores similar holistic views of well-being among Latin@s in the U.S., at a moment when there is a great deal of political discrimination, following the 2016 U.S. political elections.

Throughout my dissertation research, I spoke with Latin@s living in Chicago, particularly along the Northwest (NW) and Southwest (SW) community areas, who had experiences with chronic diseases, primarily metabolic conditions. Metabolic syndrome is a cluster of risk factors for heart disease including diabetes, high blood pressure, and high cholesterol. Originally this research investigated experiences of Puerto Rican Chicagoans with type 2 diabetes. However, after further preliminary investigation, I came across more and more people, of all Latin@ subgroups, who were dealing with high blood pressure, high cholesterol, and pre-diabetes. Residents' health concerns ranged

---

[1] Among the many decisions to be made within the presentation of this dissertation was one about the use of identifying terminology. I use Latin@ instead of Latinx in order to better represent the phrasing used by local residents. The vast majority would identify across nationality lines, mostly identifying oneself as Mexican or Puerto Rican, but in terms of speaking about all Latin@s, local residents used 'Latinos' or 'Hispanos,' but more commonly Latino. Thus in my writing I use the term Latin@s to discuss both Latina and Latino stories. Additionally, I use the term black to include African-Americans, African and non-Spanish speaking Caribbean residents in Chicago. Lastly I use the term white to include "Caucasians", European immigrants, Euro-Americans and all who the U.S. Census would classify as 'non-Hispanic white'.

from the conditions I focused on (diabetes, hypertension, and hyperlipidemia) to chronic arthritis, chronic pain, cancer, or osteoporosis. The development of this research project speaks to the constantly shifting demographics within localities, in addition to the how the permeabilities and vulnerabilities of people's health is shaped by the intersections in which they stand.

The overarching question framing this study is: *how do Chicago Latin@s with diabetes, high blood pressure, and/or high cholesterol navigate their well-being and engage agentive strategies (health actions) in the face of challenges to their well-being?* I follow Nandini Gunewardena and Ann Kingsolver's notion of navigation as "the myriad encounters (people) grapple with in globalized contexts and (people's) efforts to exercise agency within constraints" (Gunewardena and Kingsolver 2008:5). This line of inquiry stems from my interest in learning from residents living with these conditions—conditions that are lifelong. Additionally, I wanted to learn about the aspects and resources helping them to lead a healthy life, in hopes of supporting and improving the lives of people diagnosed with these conditions throughout the globe within their specific sociopolitical conditions. My approach is both interpretive and political economic (Farmer 2006) as I emphasize and privilege narratives of residents and aim to translate and support their points of view in conversation with political and economic processes taking place within larger surroundings.

When I started conducting my dissertation fieldwork in 2015, I was interested in the various possibilities and impacts of community centers among people's experiences with health and well-being. I sought out the deeply-rooted Latin@ communities in Humboldt Park, Chicago and the various Latin@-driven, Latin@-run, and Latin@

community-based centers, and organizations. I wanted to grasp how Latin@s were navigating health and well-being for ourselves, on our own terms[2]. Amongst the plethora of Latin@ non-profit organizations in this Northwest (NW) area, I came across Northwest clinic, the largest free-clinic serving Latin@ patients in the country. I immediately registered to volunteer at this clinic, particularly interested in being involved with their free health education classes offered to the community at large. Almost all (non-professional) volunteers were bilingual, most were Spanish-speaking and another portion were Polish-speaking. The demand was especially high to have volunteers fill the interpreting gaps for the clinic's Spanish and Polish speaking patient populations. As volunteers, we were required to commit to serving at least two four-hour shifts each month.

My dissertation research was framed within an important time period and political climate (from 2015 through 2017). After the passage and implementation of the Affordable Care Act (ACA) in 2010, millions of uninsured Americans had a pathway to access health insurance. By 2015, the state of Illinois and city of Chicago were steadily connecting residents with health insurance options. In 2015, still, 9.6% of Chicago residents did not have access to health insurance; a large portion of those can be attributed to the many undocumented residents left out of the ACA. Towards the end of 2015 my spouse and I found out we were expecting our first child. After months of waiting, and what felt like an even longer, very pregnant summer of field work, we were blessed to welcome our son, Leonardo, in August 2016 in Chicago. On November 2, 2016 the Chicago Cubs won the World Series, lifting a 108-year drought. And less than a

---

[2] I included myself among Chicago Latin@s, as discussed later.

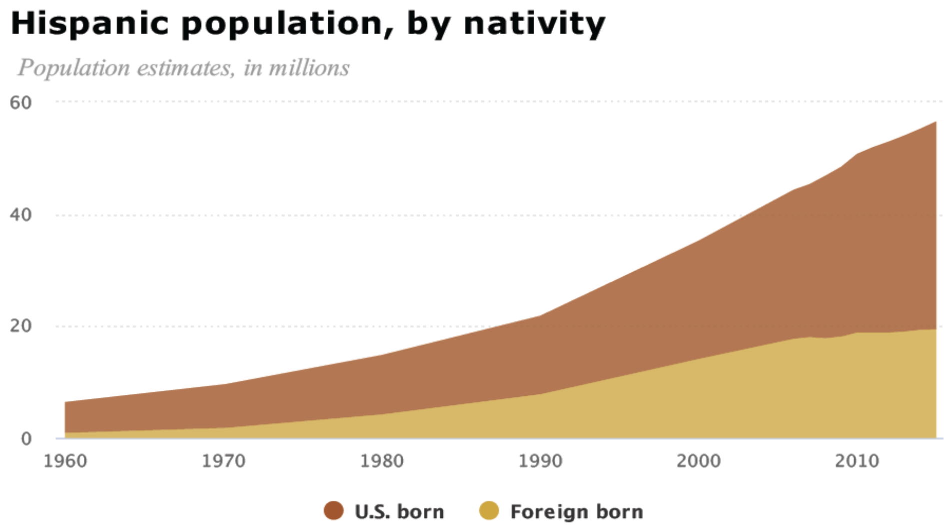
week later, Donald Trump became the 45th elected President of the United States. The looming threat grew as the 2017 inauguration neared. Each day after the 2017 inauguration was met with a different executive action that fed the festering lump growing in our throats. Despite being within the sanctuary city of Chicago, my Latin@ neighbors filled the post-office passport lines. Undocumented residents, knowing that any day they could be sent back to their countries of origin, took the necessary precautionary measures to keep their families together. My nuclear family stood in this same line as well, but in a more hopeful sense. My spouse would be going through Consular Processing and if all went well, he would be granted a green card and Legal Permanent Residency. In the summer of 2017 we celebrated our son's first birthday in my husband's hometown in Aguascalientes, Mexico where my husband was reunited with his younger siblings and family after a 16-year separation. Each of these intimate, local, national and international experiences shaped my fieldwork, and the people I met, the resources I came across, how I came to learn about different areas of the city of Chicago, and the respective impacts on health and well-being.

Dehomogenizing Latin@ representations in the U.S.

According to the U.S. Census, as of April 1, 2010, of the 308.7 million people residing in the U.S., 50.5 million (16 %) were of Latin@ origin (Ennis, Rios-Vargas and Albert 2011:2). Between the years of 2000 and 2010, the Latin@ population accounted for over half of the 27.3 million increase in the total population of the U.S.. Additionally, the U.S. Latin@ population experienced a total increase of 15.2 million within this same time period (Ennis, Rios-Vargas and Albert 2011:2). The demographics within the extremely diverse U.S. Latino population identified their ethnicities across several different countries (as seen in Figure 1.2 and Figure 1.3 below).

In attempts to further disrupt stereotypes of Latin@s in the U.S., it is important to point out the number of U.S.-born Latin@s. The most recent figures in 2015 identify a total of 37.1 million U.S.-born Latin@s, and an additional 19.4 million foreign-born Latin@s in the U.S. (Flores 2017). Figure 1.1 demonstrates the continued growth of U.S.-born Latin@s throughout the decades. With the current era of nativist rhetoric and criminalization of immigrants, it is no wonder that the number of immigrants attempting to come to the U.S. has decreased. Recent figures count the number of undocumented residents in the U.S. at around 11.3 million residents, less than four percent of the overall U.S. population (Krogstad et al. 2017). Among the number of undocumented residents, Mexicans make up 5.6 million of these residents (Krogstad et al. 2017).

Figure 1.1: *Native and foreign-born Latin@s in the U.S.* (Source: Flores 2017).



PEW RESEARCH CENTER

Latin@s in the U.S. have roots in various countries of origin throughout Latin America and the Caribbean. As detailed by the 2010 U.S. Census, over two-thirds of U.S. Latin@s identify with having Mexican origins. The next largest ethnic groups with which Latin@s identify are Puerto Rican (9.2%), Other Hispanic or Latino (6.8%), Cuban (3.5%), Salvadorian (3.3%), and Dominican (2.8%). Figure 1.2 is taken from a report put together by the U.S. Census Bureau showing the distribution of U.S. Latin@s based on regions of origin, i.e. Central America, Caribbean, and South America. From this image it is interesting to see how the U.S. Census classifies Mexico as part of Central America, even though for policies such as NAFTA, Mexico is considered part of North America. To be clear, Mexico is geographically unquestionably part of the North American continent. Additionally, in Figure 1.2, there is a miscellaneous ‘All Other Hispanic’ subgrouping that included Spaniards and ‘other general terms i.e. Hispanic/Latino’ (Ennis et al 2011).

Figure 1.2: 2010 U.S. census’ depiction of Latin@s in the U.S.
Note: The U.S. census describes the demographic shifts of U.S. territories in separate reports thus Puerto Ricans living on the island are not included in the figures below (Source: Ennis et al. 2011).

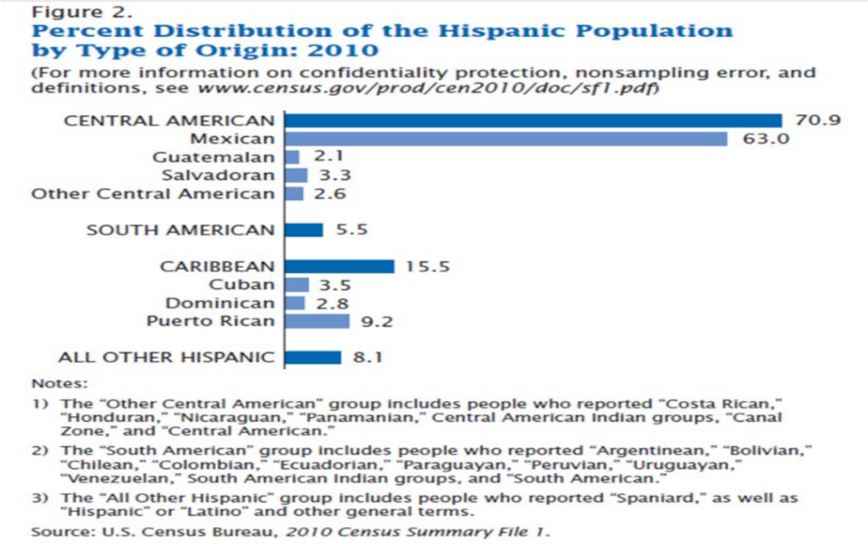
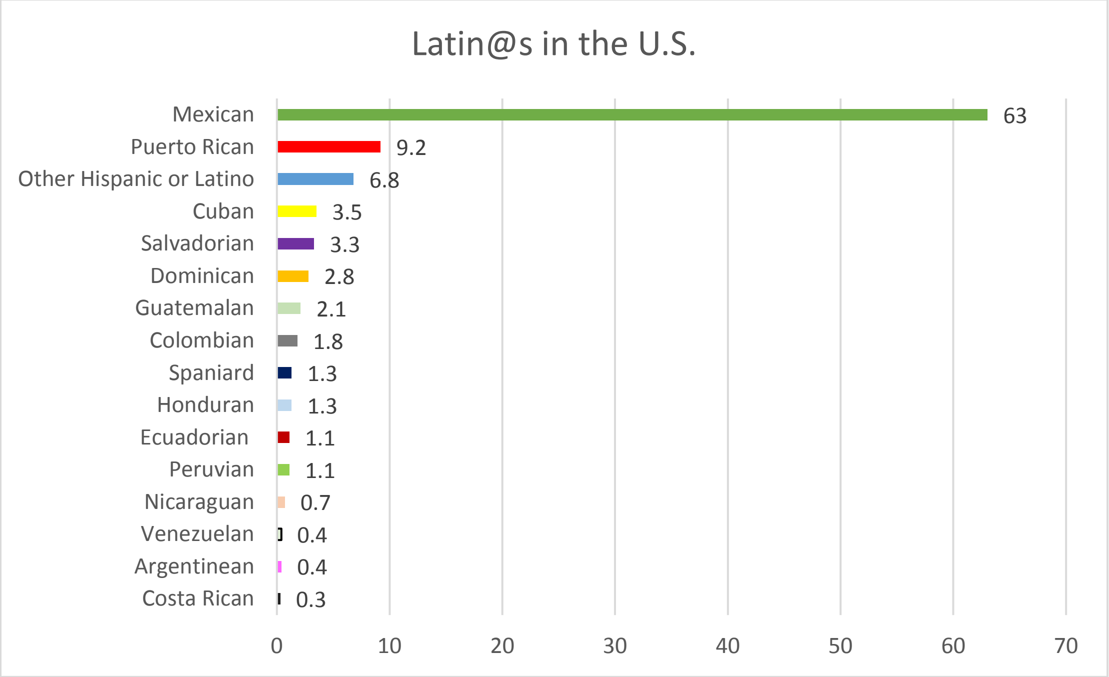


Figure 2.
Percent Distribution of the Hispanic Population by Type of Origin: 2010
(For more information on confidentiality protection, nonsampling error, and definitions, see *www.census.gov/prod/cen2010/doc/sf1.pdf*)

Notes:
1) The "Other Central American" group includes people who reported "Costa Rican," "Honduran," "Nicaraguan," "Panamanian," Central American Indian groups, "Canal Zone," and "Central American."
2) The "South American" group includes people who reported "Argentinean," "Bolivian," "Chilean," "Colombian," "Ecuadorian," "Paraguayan," "Peruvian," "Uruguayan," "Venezuelan," South American Indian groups, and "South American."
3) The "All Other Hispanic" group includes people who reported "Spaniard," as well as "Hispanic" or "Latino" and other general terms.

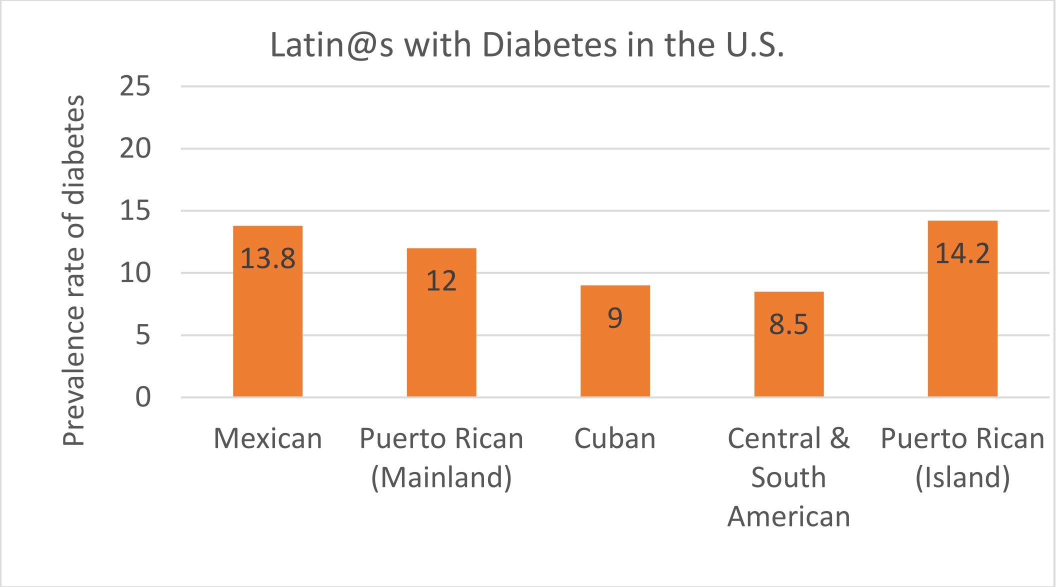
Source: U.S. Census Bureau, *2010 Census Summary File 1.*

Figure 1.3: *A better representation of Latin@s in the U.S.*.
Graph created by author (Source: Ennis et al. 2011).



The more time I spent reading the Latin@ health literature, the more I realized the discrepancies in the representation of Latin@s in terms of health research. There tended to be a homogenizing picture of Latin@s as if we were all the same: the same ethnicity, race, class, citizenship status, socioeconomic status, all factors and differences that were not accounted for under the label ‘Hispanic’ or ‘Latino/a’. I tried looking for research that studied Latinos and at the very least identified where they were born (i.e. foreign or native born) and/or their ethnicities. Puerto Ricans are one particular subgroup among U.S. Latin@s who, like other Latin@ subgroups, cannot be characterized as a homogenous group. Puerto Rico, as a U.S. commonwealth, has the unique situation of granting full citizenship rights to island natives once living on the U.S. mainland. However, access to federal and state resources does not guarantee better health, especially when examining the incidence rates of diabetes. Figure 1.4 shows an example of how the rates of diabetes affect various U.S. Latin@s.

Figure 1.4: 2014 diabetes among Latin@s in the U.S.. Graph created by author (Source: CDC 2017, CDC 2018).



In this research I gathered background information from residents I interviewed, such as time lived in Chicago and their local community area, country of origin, and reasons for migrating, among other details, in order to have a deeper understanding of who each of these Latin@s were. Yes, there were a certain number of Puerto Ricans, Mexicans, Hondurans and other ethnic groups, but these ethnic lines are a small portion of the larger picture. Listening closer to individual and local narratives, and paying attention to the intricacies of how people are navigating these conditions are what I have found to be more effective in order to understand the disparities taking place and how to address them.

Meanings of health and chronic disease

I was socialized to keep my head down, follow the rules, follow directions, not bother, not ask, and do for myself. I think it was a combination of teachings from my father and becoming the oldest sibling; I grew up learning to do things for myself for the most part, and I learned to be obedient and not to ask questions or push the envelope. It was something I prided myself on, my obedience. Years later my obedience, figuratively, hit me in the face as I accompanied a man, Pedro[3], to a doctor's visit. Pedro's primary purpose for this visit was because he believed he had intestinal worms—something he thought he had contracted more than fifteen years ago when he lived in Mexico. The doctor, in their typical ruling out all of possibilities way, asked all the questions (in English—Pedro spoke English well enough to respond and narrate his concerns) and the clinician seemed to believe that he may have had a hernia. She instructed him to undress and put on the robe in order for her to conduct her examination. When she came back into the room to find the patient fully clothed she was taken aback, and inquired what had happened. The man asked the doctor what the purpose for him to change into the robe was, and she responded that she was going to do a rectal examination. He shook his head, grinning, and said 'no, I don't think I want to do that,' and she quickly responded that that was fine and that she would go ahead with the other lab work (to do a stool sample) as he had originally requested. And just like that, the visit was over and we were sent to see the lab technician to get instructions on what this man needed to do for his at-home-stool test. Pedro glared at me, saying "¡¿Le ibas dejar meterme el dedo por el culo?!"

---

[3] This is a pseudonym I use for this resident, and for all others described within this document. In efforts to protect the identities and privacy of residents included in this study, I have created a pseudonym for each person included within this dissertation.

[You were going to let her put her finger in my butt?!] I was still shocked that he didn't go through with what the doctor had wanted to do. It was a revolutionizing experience for me to see this patient empowered with what he knew about his body and what he knew he needed to get done. A few days later, the labs confirmed Pedro's suspicion that he had worms and he was sent a prescription to pick up the same day the results came in.

This is part of the reason why in all the conversations I have shared with residents, especially in educational settings in which I am viewed as the expert, I always try to tell people that they need to know themselves and their bodies the best. I emphasize with residents the importance of knowing each of their own strengths and weaknesses, because no one was going to fight for you or care for you if we do not care for ourselves first and foremost. My efforts to speak with people who have these conditions offered residents a chance to speak for themselves and to learn from them outside of clinical settings. Focus groups often turned into support groups (or better yet were based off of support groups), as mothers shared their own strategies, which many had learned from other friends or family members, to lead a healthy life. Often these focus groups were perceived as lectures or 'classes' that I would be presenting to the parents, and often I did share tidbits of advice or health knowledge that I have acquired along the way. But I always re-iterated that these focus group conversations were for *me to learn from them* to take the conversations about diabetes, blood pressure and cholesterol outside of the doctor's office and clinical settings and engage people on a deeper level beyond the 15 minutes a doctor may be able give them.

Based on my observations with residents, many doctors emphasize pharmaceutical medicine for treating most conditions, as in the case of type 2 diabetes, high blood pressure, or high cholesterol. With these conditions, where so much seems to be based off of controlling what is consumed, doctors tend to merely adjust the patients' dosages to compensate for their lack of controlling their mouths, instead of spending the time getting to the bottom of what is or should not be eaten. Usually, in my observations, doctors tell patients they need to control their diet, but it is not really explained that the continued lack of control (from the patient's end) will only continue to contribute to the increased dosage and eventually insulin use (if not already in use). Sometimes patients and clinicians do not see improvements in lab-work or preventive examinations because going through the hassle of figuring out what is really going on cannot be address with increased prescription dosages alone.

Health, a healthy life, and well-being, are all defined differently from a clinical point of view compared to how residents described their navigations of these components. Doctors seem to be especially concerned that patients are consistent in taking their medicine, but based on the conversations I had, this is a relative practice for many Latino@s, not deemed as an important strategy for attaining optimal health. For some residents, like Miguel, his practice of drinking nopal smoothies every day has lowered his cholesterol to the point of not needing to take their prescribed medicine, and the lab work has given satisfactory results for his doctor to the extent that the doctor believed the medicine to be working. But for others, like Alicia, her inconsistency of use or misuse of insulin dosage and binge-eating has resulted in her blood sugar levels being 'through the roof,' and she often is not phased much about these elevated figures. By that point Alicia was so frustrated with her inconsistency in health insurance and health providers that each time she sought care they had a different regimen for her to follow, spurring her to blow off reliance on clinical care. Admittedly, Alicia did not adopt common strategies for watching her diet or using other natural remedies either. Rather she seemed to be more worried about her mother's diabetes than her own.

For many residents, health means not having to rely on medicine, pills, or insulin to have their blood sugar, blood pressure, or cholesterol levels be on point. In fact, these numbers are all so relative that someone may have an A1C[4] at 14 but feel fine, or have their cholesterol or blood pressure about to 'break the machine,' but they do not feel the gravity of these numbers. Often it is the symptoms, the secondary symptoms or complications from excess sugar, pressure, or cholesterol that get people's attention, to a certain extent. For one man, it was needing to rely on insulin to control his sugar levels instead of pills alone that gave him a wakeup call to care for his body better.

Residents I interviewed ranged in age from recently diagnosed younger parents with children in elementary school or younger, to grandparents or great-grandparents living with these conditions for decades. Another interesting contribution of this research is that I sought narratives not only from people who have diabetes, high blood pressure, or high cholesterol, but also family members with varying levels of experience with these conditions. Older generations often dealt with multiple conditions, whether it be a combination of the three conditions studied here or additional diseases, the most common being arthritis, cancer, osteoporosis, asthma, and depression. For elders, health is a matter of making life more comfortable when their bodies carry many aches and pains from the years adding on. For younger generations, health and well-being is about surviving day-

---

[4] The ideal, recommended Hemoglobin A1C (A1C for short) level for a diabetic is closer to the range of 7. The A1C is the measure of the average blood sugar in one's blood stream over a two-to-three-month period.

to-day activities and responsibilities and resisting the many food-related temptations hitting us left and right.

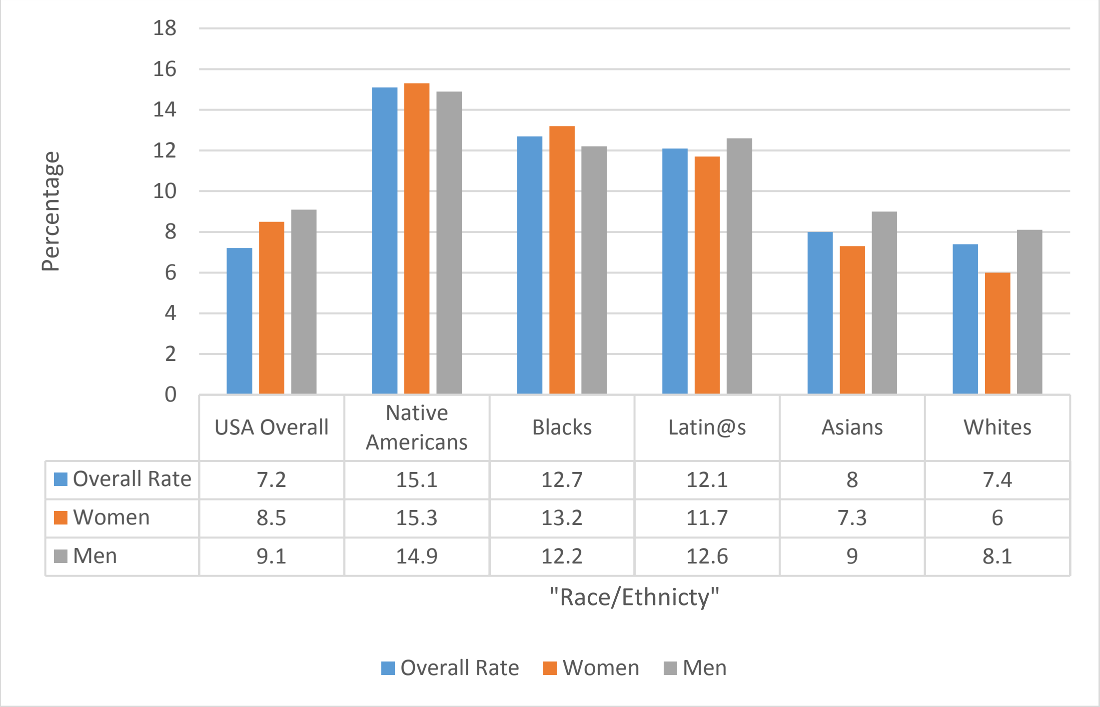
Latin@s with diabetes, not diabetics

As I began searching and reading through medical anthropology and many other health related literatures I knew I wanted to study more long-term, chronic diseases; conditions that people had to live with on a daily basis, for the rest of their lives. Diabetes is a disease that kept coming up, a disease that affects people of all backgrounds, countries of origin, ethnicities, races, classes and socioeconomic statuses, throughout the world. As an anthropologist committed to conducting my fieldwork in the U.S., the epidemiological lines of diabetes surpassed such sociocultural categories.

The more I learned about diabetes within the U.S. and about Latin@s dealing with health inequalities, I saw trends that confirmed my developing suspicions. Based on figures gathered in 2015, overall 9.4% of the U.S. population had diabetes (CDC 2017). While the prevalence of type 2 diabetes has grown across various social lines within the U.S., it continues to disproportionately affect communities of color and of lower socioeconomic status. Among Latin@s over the age of twenty, the percentage diagnosed with type 2 diabetes was 12.1% (CDC 2017:2). Figure 1.5 shows the rates of diabetes in the U.S. by "race/ethnicity and sex" (CDC 2017:4).

Diabetes is known historically as an illness of civilization, development, and/or Westernization (Swedlund 1997; Schoenberg et al. 2005). Native American nations comprise significate cases of this disease of "civilization." As the first ones to come in contact with the foreign colonists, Native American nations were the first ones to be exposed to the colonists' infectious diseases and oppression. The few Native Americans that survived enslavement and early epidemics were sentenced to a new form of oppression through the reservation system. According to Dennis Wiedman's ethnohistorical analysis Native American reservations were the "earliest socially created and built environments where the physical body was contained, where generations of humans lived almost entirely on industrially processed caloric dense foods, and where entire communities were held in chronic levels of stress from resource disenfranchisement, political, psychological, and cultural oppression" (Wiedman 2012:603). Captured Africans, enslaved and forcibly brought to the Americas, experienced the worst global atrocities. The outright violence, oppression and racism continued after slavery became illegal, and continues to take a toll and be reproduced through different hidden forms of violence upon the black community to this day.

Figure 1.5: Diabetes prevalence through "race/ethnicity and sex". These figures represent adults (age eighteen or older) in the U.S. from 2013-2015. Graph was created by author (Source: CDC 2017).



	USA Overall	Native Americans	Blacks	Latin@s	Asians	Whites
■ Overall Rate	7.2	15.1	12.7	12.1	8	7.4
■ Women	8.5	15.3	13.2	11.7	7.3	6
■ Men	9.1	14.9	12.2	12.6	9	8.1

The long history between the U.S. and Mexico established a pattern of Mexican migration to the U.S. and U.S. economic reliance on Mexican labor. Immigration policies of 1965 (Immigration and Nationality Act), 1986 (Immigration Reform and Control Act), and 1996 (Illegal Immigration Reform and Immigrant Responsibility Act) established repeated forms of exclusion of Latin American immigrants (Gomberg-Muñoz 2017). Additionally, the 2001 Patriot Act and post-September 11th hyper-vigilant U.S. climate, established a basis to systematically criminalize anyone who looked ‘illegal’, brown, or Mexican; in turn, leaving millions of Latin@s in the U.S. in stages of “perpetual limbo” (Chavez 2008) and “legal nonexistence” (Gomberg-Muñoz 2017). The fraught immigration system in the U.S. has essentially legalized a new form of slavery, of migrant workers, both legal and undocumented, who are hired to do some of the most physically strenuous work, at the lowest monetary cost (Holmes 2013).

Trends of disproportionate impacts on health in relation to the longer colonizing history with the U.S. can be seen with the above diabetes rates among minorities in the U.S. (Figure 1.5). The more time spent living in the U.S. often results in more inequality experienced and ill-health reproduced. Additional evidence has showed that for Latin@s, being born in the U.S. means an elevated risk for mental health problems (Zambrana and Thornton Dill 2006:210). Latin@s who live and grow up in the U.S. mainland have reported higher rates of depressive symptoms, illicit drug use, suicidal ideation, and attempted suicide (Burnam et al. 1987; NAHH 2000 and 2001). Higher levels of economic, environmental, and interpersonal stress are most likely linked to these psychosocial distresses reported by Latin@s (Schulz et al. 2008; U.S. Department of

Health and Human Services 1999). The lack of social receptivity in a host society among immigrants is a form of institutional discrimination (Zambrana and Thornton Dill 2006:211) and can be an explanation for why these trends are seen among Latin@s in the U.S..

Within the city of Chicago specifically, Puerto Ricans within Chicago's West Town-Humboldt Park reported a higher diabetes rate, especially in comparison with Puerto Ricans living in other parts of the U.S. mainland; see Figure 1.6 below. These diabetes prevalence rates among Chicago Puerto Ricans were collected by a collaborative, community-based research project in 2006 in efforts to address the growing concern about diabetes and its various risk factors (Whitman et al. 2006). Figure 1.7 shows the overall diabetes rate among Chicagoans by race and ethnicity, comparing those rates in 2006 to more recent figures in 2016. The overall rate of diabetes in 2006 within the city of Chicago was 10.5% (CDPH 2018).

Figure 1.6: Diabetes prevalence among Puerto Ricans throughout the U.S..
Graph created by author (Source: Whitman et al. 2006).

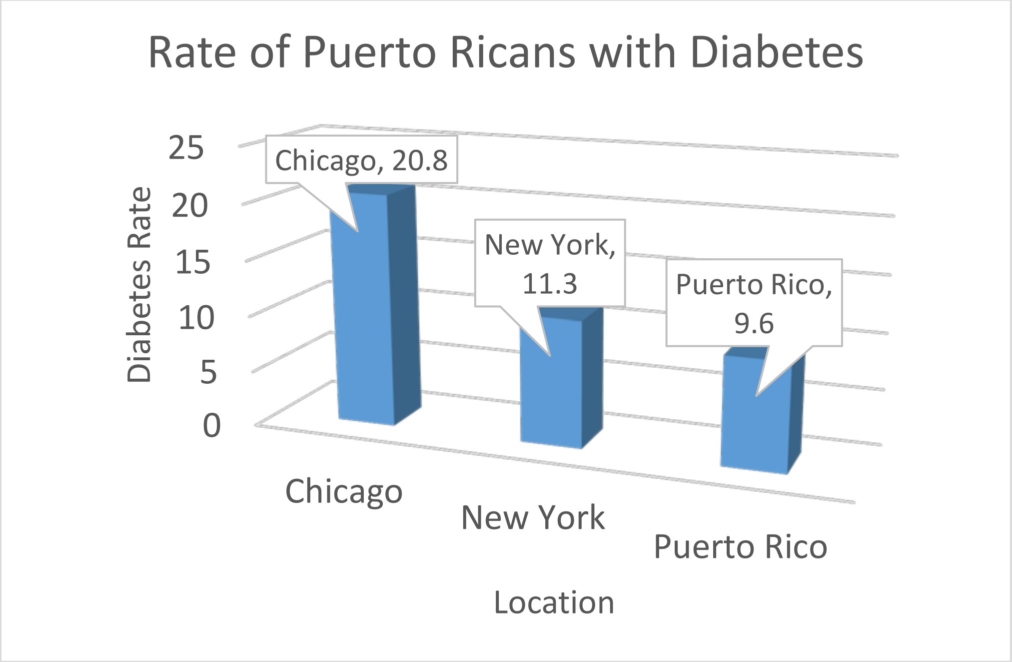
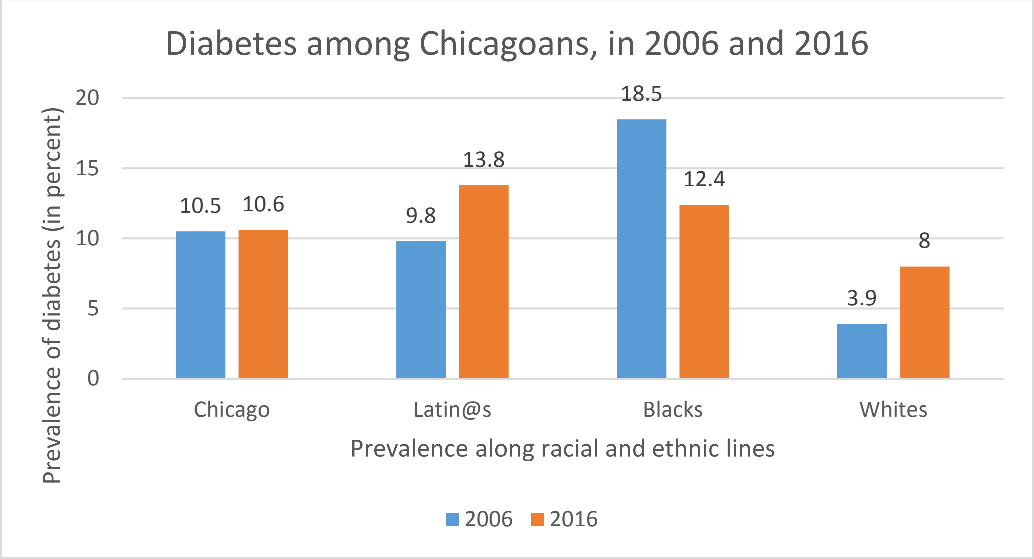


Figure 1.7: Chicago diabetes rates through race and ethnicity, 2006 and 2016. Graph created by author (Source: CDPH 2018).



In a follow-up report done in 2012, additional health conditions remained a concern for the Humboldt Park Puerto Rican community. This community-led study identified pediatric and adult asthma, diabetes, obesity, lack of physical activity and good nutrition, and consistently high blood pressure, to characterize most Puerto Ricans in Chicago and Humboldt Park (Cintron et al. 2012). Additionally, the reports noted, 72% of Humboldt Park Puerto Rican adults are overweight or obese, as are 67% of their children (SINAI 2006). One third of Humboldt Park residents had high blood pressure (SUHI 2005), and 19% of Puerto Ricans in the city of Chicago had no health insurance of any kind (ACS 2010).

Since the 1980s, medical researchers have recognized that obesity, diabetes, dyslipidemia (high cholesterol), and hypertension have similar metabolic defects (Wiedman 2012), and the World Health Organization (WHO) has defined this cluster of disorders as the Metabolic Syndrome (MetS). Within the U.S., in 2013, three of the top ten leading causes of death were related to metabolic syndrome, with heart disease being the number one cause of death, and stroke and diabetes not far behind (Moore et al 2017). This cluster of chronic conditions disproportionately affects communities of color, in particular these Latin@ communities in Chicago. Despite the high mortality of these chronic illnesses, metabolic syndrome is highly manageable in that people often live several decades without complications of these conditions. Many studies and initiatives have been implemented to prevent the condition referred to collectively as metabolic syndrome but not many studies have documented the daily lives of individuals living with metabolic syndrome, which is what this project highlights.

Theoretical positioning: translocal intersectional experiences of health

Kimberlé Crenshaw's (1989) coining and Patricia Hill Collins' (1990) further development of intersectionality theory has helped us better explain how life experiences (through race, class and gender) are complexly interwoven—relationships that are essential to an understanding of the human condition. The lens of intersectionality "conceives of categories as not distinct but as always permeated by other categories, fluid and changing, always in the process of creating and being created by dynamics of power" (Cho et al. 2013:795). The intersectional approach emphasizes "the importance of attending to the multiple social structures and processes that intertwine to produce specific social positions and identities" (Anthias 2012a:106). Thinking of intersectionality in terms of power structures implies locating the discussion within structures and processes (Anthias 2012a:107).

Social theorists such as Anthias have critiqued the use of ethnic identity categories alone for research purposes, arguing that often identity is used to describe ethnic minorities and not the majority. Anthias compared identity with ideas of belonging, whereby belonging involves making a political claim, emphasizing a process of inclusion and exclusion, because in order to belong there needs to be a separation from those who do not belong (Anthias 2012b). Lines of belonging become realities in areas such as Humboldt Park where gentrification is a constant threat. A Humboldt Park ethnographer describes this as "'intimate segregation' in which whites and nonwhites live in the same neighborhoods but in distinct and largely separate social worlds, a state that further reifies, depends and rewards white privilege" (Mumm 2014:273).

Take, for example, the infant/toddler/child play 'date' every Thursday at one public school in Humboldt Park. Every Thursday (even in the summer) there was a children's room open for members of the public to bring their children and play. Sandy, the white mother who oversaw this site, explained to me that several other schools in the area also had a play date group in order for the residents in the area to 'consider these local schools' instead of sending their kids away to private schools or to any schools other than their local public schools. As I looked around the room, the children were mostly white, although the majority of their caretakers were women of color. Most of the caretakers were Latinas, and a few Asian women, one Asian woman I had met earlier that year in a nearby library toddler playtime. There was one other white woman in the room, who stood at the front of the room with Sandy, picking up their conversation again after Sandy had given me the history of this play group.

It seemed a little surreal that the few white women congregated together and conversed while the rest of the women of color were disengaged from the play date and each other, spread out along the edges of the room. Juana, one of the parent volunteer leaders at her school, after participating in an early focus group, had helped me recruit other parents for my dissertation research. Sandy was one of Juana's recruits for my second focus group at this school. Soon Sandy inquired if I was 'going to the diabetes focus group too' and at another point I had to clarify for her that I was actually leading the focus group. A microagression? Perhaps. Within this same focus group, one of the questions I asked was if any of the participants had taken any nutrition classes to help them learn more about how to lead a healthier life. Sandy's response discussed how "In college [they] had a food science and human nutrition class that was sort of like required. It might have been an elective but most people took it." This response was definitely different from the typical responses from participants who mainly described classes their clinic or other health centers provided to help manage their diabetes. I do not know if Sandy felt that she did not belong in this focus group setting surrounded by working class women of color, or if she needed to attend to her other child playing in the other room, or maybe because the designated time that was advertised for the focus group had passed, but within 20 minutes of the discussion she excused herself from the room. For the other three participants of that focus group, the over hour-long discussion did not phase them—in fact, we could have gone longer but my always-punctual son had grown tired by that point. Such intimate segregation is a growing commonality as gentrification continues to open up housing for whiter, wealthier residents, pushing marginalized communities of color out of the Humboldt Park and surrounding northwestern areas.

Translocal impacts on health

When using transnational and intersectional frameworks, I pay careful attention to "adequately capture different axes of domination" and the "limits of using 'women of color' concepts to look across and within nation-states" (Purkayashta 2012:61-62). For example, in discussing religion Bandana Purkayashta notes that we need to pay attention to the ways in which "processes of marking religions, marking phenotypes, cultures and nationalities, act in the service of racism" (2012:61-62). Within transnational contexts, it is not always clear when and how we are to conceptualize 'race' within the intersectionality matrix if we study transnational social lives (Purkayashta 2012). Instead of simply talking about people crossing national borders, I argue that translocality in place of transnationalism is a more productive framework to use in understanding the experiences of Chicago Latin@s, which are grounded in local and not just national settings.

There have been many discussions of transnationalism (Briggs et al. 2008; Coe 2011; Duany 2011; Farahani 2013; Fernandes 2013; Basch et al. 1994; Grewal 1999; Igoe 2010; Lim 2007; Purkayashta 2012; Saldaña-Portillo 2007; Vasquez de Aguila 2014; Vertovec 2004) and cosmopolitanism (Glick Schiller et al. 2011; Glick Schiller and Irving 2015; Guner-Domic 2011; Kromidas 2011; Nusbaum 1997) as concepts to help in understanding globalized connections and power relations among people, and how these global connections are carried with people as they move across borders. In my research, as I learned more from the experiences undocumented residents about how the U.S. nation-state has systemically and violently barred residents from their countries and families of origin, which ultimately bared weight on their daily health and well-being, I searched for additional ways to theorize what I was learning ethnographically. I found that this form of structural violence that unfolds in a local context but in relation to national identities and politics could not simply be explained by using the concepts of transnationalism and cosmopolitanism I had read about. I saw some uses of those concepts as tending to romanticize people's connections with their countries of origin and their ability to easily move between countries as transnational actors, and I thought that describing identities and experiences as transnational would be missing the very violent separations residents face as a result of the U.S. immigration processes and policies (or lack thereof). I see the concept of translocation as more attentive to location, context and time (for example, when and how someone migrated to a neighborhood) as part of understanding power relations along with intersectionality. Translocality allows for scholars to analyze movement across spaces, even when movement occurs within national, state or city borders.

Floya Anthias explains translocation as "important in recognizing context, the situated nature of claims and attributes and their production in complex shifting locales and the contradictory processes in play" (Anthias 2012a:108). The term translocational denotes the ways in which "social locations are products of particular constellations of social relations, and (may be viewed) in terms of relationality and experience at determinate points in time" (Anthias 2012a:108). The translocational temporal and contextual analysis enables us to view "lives …located across multiple but also fractured and interrelated social spaces of different types" (Anthias 2012b:11). When connecting translocation with intersectionality, we can pay careful attention to time and space across various contexts and axes of power.

The concept of translocality is especially helpful in understanding the differences experienced within multiple contexts of time. For example, the collaborators of this dissertation research were residents of various generational backgrounds. I worked with elderly, especially grandmothers (abuelitas) who were actively involved—if not the main caretaker—in their grandchildren's up-bringing, as well as mothers, who cared for their parents dealing with metabolic syndrome, or their children at risk of metabolic syndrome—most of them mothers who themselves were navigating their own metabolic syndrome.

Translocality was especially productive for me to help understand the vast differences in experiences with health and well-being within city and neighborhood borders, despite having the same country of origin, gendered identities, or U.S. residency statuses. I view the concept of translocality as a way to be more grounded with the various factors residents are confronted with in their present—not implying that the past or their countries of origin are not important—but that the transnational connections people carry with them are only a portion of their lived experiences of health and well-being. Rather, there are more localized clustering of factors that impact residents' navigation of health and well-being, and it is important to understand these more local contexts' shaping of health each day. For example, an undocumented Mexican woman living in the NW of Chicago has vastly different experiences than an undocumented Mexican woman living in the SW of Chicago. This is partly due to the fact that the NW has a longer history of Latin@-led grassroots organizing and community building, which has brought about countless centers, programs and resources throughout the NW for the greater Latin@ community—especially in the Humboldt Park and Logan Square community areas. One example of this indispensable resource is Northwest clinic, where undocumented residents have the opportunity to receive primary, specialty, and pharmaceutical care (to name a few) at no charge at all to the patient. However, in the same vein, a documented Honduran woman living in the NW did not have access to this clinic because of her eligibility for the ACA and was thus struck with a situation of strategizing medication use based on her ability to afford her treatment options on a month by month basis. Another example from my research was a U.S. citizen Puerto Rican woman living in the NW who despite having state-sponsored health insurance coverage her entire life, experienced the violence of inconsistent care resulting in her health suffering because of the constant shifting of forms and rules for state-sponsored safety net insurance coverage.

What I find so interesting about using translocation as a tool of analysis, is its capacity to recognize people coming together within certain contexts, times and spaces to establish solidarity and organize around a cause. Establishing solidarity groups beyond ethnic or color lines can be seen within the context of Humboldt Park, Chicago. This site, although a historically predominant Puerto Rican community, spans various racial, ethnic and class lines, and remains a predominantly Latin@ community. However, the space of Humboldt Park also faces encroaching gentrification and its longtime residents continue to struggle against the constant threat of displacement. Such translocal intersectional solidarity struggles may be the key to framing and understanding the complexities within the context of my research. As we are all interconnected in the struggle to achieve our full potential, I believe these struggles can be highlighted with a translocational intersectional approach to studying metabolic syndrome among Chicago Latin@s.

But what of the borders and borderlines of high blood sugar, high blood pressure, or high cholesterol levels? Hastings Donnan and Thomas Wilson's (1999) use the metaphor of borders as a way of "understanding the rootlessness of many populations today," yet we would be naïve to forget that everyone lives within or between the boundaries of nation states, boundaries that are always more than metaphorical (in Duany 2011:30). In this quote's original context, it spoke to transnational communities in relation to the boundaries of countries. However, what if we applied this metaphor to risk factor boundaries for heart disease? In many ways these metaphoric lines are similar: these physiological readings and levels help clinicians understand the risks of heart disease, despite their very relative implications to several other factors—stress in particular—which tends to be undermined in its capacity to affect biological functioning. However, these elevated levels have very real consequences for those who fall on either side of these boundaries. For those diagnosed with hyperlipidemia, hypertension, or diabetes they are scripted to lives and management through medication or insulin injections. For those who are free of risk or at the borderline, their daily stress does not free them from worrying for their or their families' futures, should their health cross these risk boundaries.

I view the concept of translocality as especially useful for scholarship that may take place strictly within borders (such as within the U.S.). At the same time, I view translocality as a direct challenge to popular ideas that the global is not with us locally or that the local does not transmit globally. Feminist theories have allowed us to consider how transcendence goes across national, gender, sexual, and in this case, health borders in our daily lives (e.g. Lamphere et al. 1997). This research follows the work illuminated in Craven and Davis' (2013) edited volume, *Feminist Activist Ethnography*. In particular, scholar Iris Lopez' feminist activist approach demonstrates how fertility decisions and options among poor Puerto Rican women are "constrained by oppressive conditions … [but also] how agency, oppression, resistance, and accommodation co-exist" (Lopez 2013:148). This research has been conducted with an overtly feminist activist ethnographic approach, in search of the voices of people living with chronic disease and their responses and resilience amidst challenges. More specifically, this dissertation highlights forms in which women "exercise agency, engendering and negotiating the dynamics of globalizations from below" (Harrison 2008:24).

The city of neighborhoods

During my first encounter with the city of Chicago in 2011, I immediately noticed a vibrant activist—and community-driven—engagement throughout the city. Chicago was a place that, although divided with rigid neighborhood lines, seemed to be a city that fought for its residents. Early on, I noticed these differences in spaces, from one side of the city to another. Figure 1.8 shows all seventy-seven community areas within the city of Chicago. From the origins of the Young Lords Puerto Rican activist organization, to the push back of the Secure Communities Program to protect residents of the city and state against deportations under the Obama administration, to the more recent vows to continue to be a sanctuary city amid Trump administration hysteria, the city of Chicago was doing things to protect its residents, whether we looked undocumented or not.

When I first began doing preliminary dissertation fieldwork I sought to look for potential field sites with a large Caribbean Latin@ community. Seeing the disparities and paradoxes of illness among Puerto Ricans for example, in relation to diabetes, I began searching for the sites with larger Puerto Rican communities. Based on figures gathered in 2015, New York City's metropolitan area is the city with the largest mainland Puerto Rican community. Orlando, my hometown, has the second-largest Puerto Rican metro-area in the U.S. mainland, and Chicago has the fifth-largest Puerto Rican metro-area in the U.S. (Cintron et al. 2015). After my second year in graduate school, I began visiting potential dissertation sites in Chicago, the third largest city in the U.S., with a large overall Latin@ population.

In the summer of 2014, I visited the famous Puerto Rican neighborhood of Chicago—Humboldt Park. I started in the newly redone Humboldt Park stable which had been made into the National Museum of Puerto Rican Arts and Culture. I had decided I would tour 'Paseo Boricua' from one steel Puerto Rican flag to the other. I never made it down the first block before I crossed paths with the 'Humboldt Park Health Center[5]'. There were two young women tabling right in front of the center; they were recruiting people to get their blood pressure checked. I asked them what the center did, and they explained they were doing heart screenings. I asked if they were looking for volunteers, and they suggested I go inside and talk with their supervisor. Inside, I met Doña Nancy. She was so excited to get another volunteer, and soon I was sitting in her shared office telling her about what I was studying and how I wanted to help. She had me fill out the volunteer application and asked for my résumé, and I promised I would send it to her as soon as I got home via e-mail. I asked which days she needed volunteers and she asked if

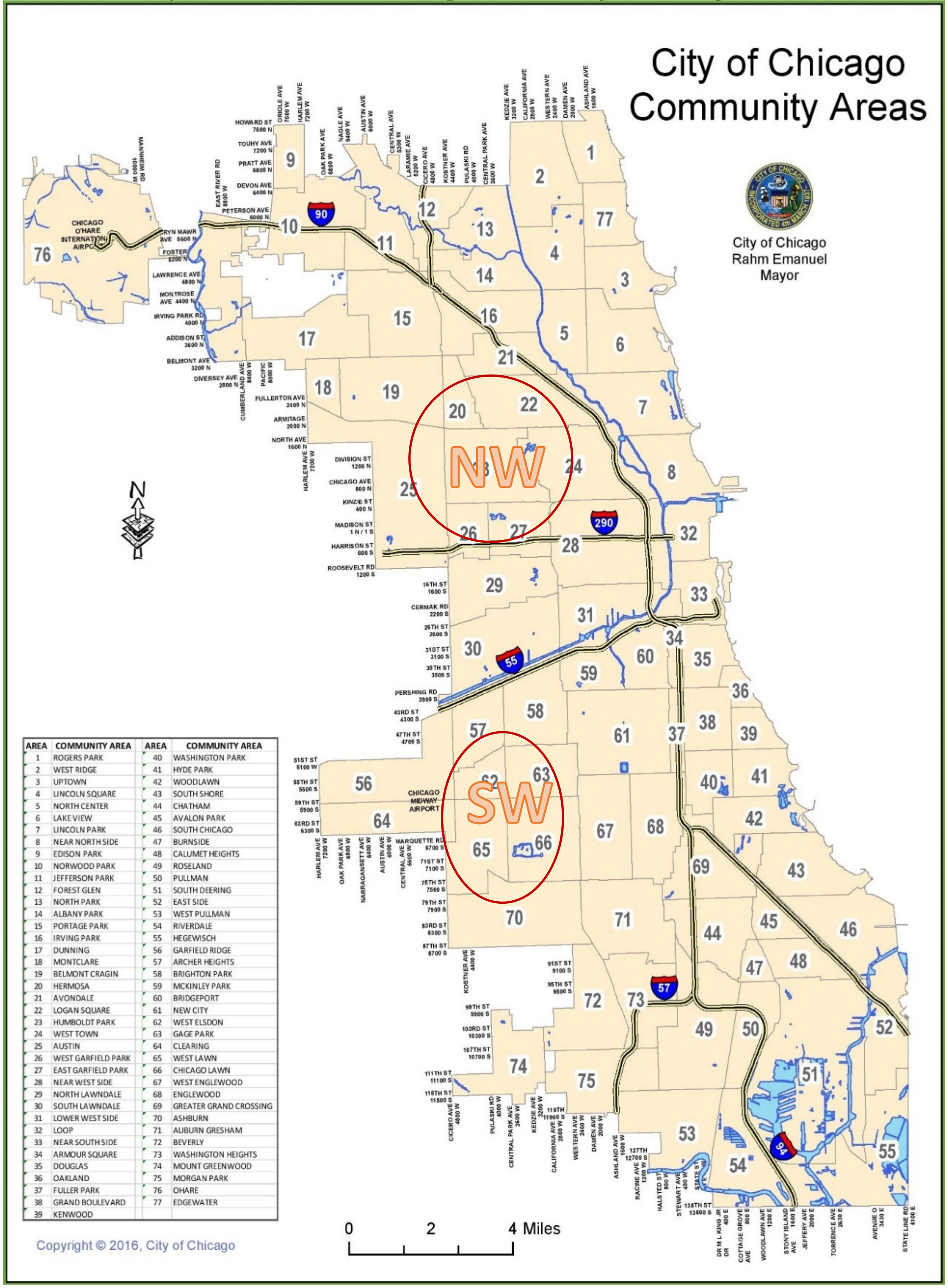
---

[5] This is a pseudonym I use for this site. In efforts to protect the identities and privacy of residents, community leaders and workers included in this study, I have created a pseudonym for each primary site discussed within this dissertation.

I was free the next day, Saturday. I promptly agreed and so began my volunteer health outreach work with the HPHC (Humboldt Park Health Center).

When it was time to move to Chicago, my family and I tried looking for apartments closer to the Humboldt Park area and surrounding northwest side of the city. But Humboldt Park and the northwest side of town had become too gentrified and too expensive for my household to afford. The southwest side of the city was the ideal alternative with easy access to a Chicago Transit Authority (CTA) ‘L’ (elevated train) line, affordable rent, and more spacious housing options. For the same price required to rent a one-bedroom studio apartment in the northwest, we were able to rent an entire single-family bungalow house in the southwest. The more time I spent traveling back and forth between our home in the southwest to the northwest for health outreach work with the HPHC, the more I realized the wealth of opportunities to collaborate with Latin@ communities in the southwest. Humboldt Park and its surrounding communities were filled with Latin@-run programs, organizations, and centers. In a survey of just the Humboldt Park area, there were a total of 71 community organizations (NCCO 2011 in Cintron et al. 2015), which range in services addressing health, education, crime, housing, religion, human services, arts and culture, youth development and community development and capacity building (Cintron et al. 2015), all within a three-by-four block radius. There was no such comparable clustering of non-profit organization in the southwest side. I began to wonder how Latin@s in the southwest were managing their chronic conditions with what appeared to be such little community support, and even fewer health services. Thus, my research expanded to include these southwest neighborhood areas. I describe more about these two neighborhood areas in Chapter Two.

Figure 1.8. The seventy-seven community areas of Chicago. Note the 'NW' and 'SW' areas of this study are identified on the map (Source: City of Chicago 2016).



AREA	COMMUNITY AREA	AREA	COMMUNITY AREA
1	ROGERS PARK	40	WASHINGTON PARK
2	WEST RIDGE	41	HYDE PARK
3	UPTOWN	42	WOODLAWN
4	LINCOLN SQUARE	43	SOUTH SHORE
5	NORTH CENTER	44	CHATHAM
6	LAKE VIEW	45	AVALON PARK
7	LINCOLN PARK	46	SOUTH CHICAGO
8	NEAR NORTH SIDE	47	BURNSIDE
9	EDISON PARK	48	CALUMET HEIGHTS
10	NORWOOD PARK	49	ROSELAND
11	JEFFERSON PARK	50	PULLMAN
12	FOREST GLEN	51	SOUTH DEERING
13	NORTH PARK	52	EAST SIDE
14	ALBANY PARK	53	WEST PULLMAN
15	PORTAGE PARK	54	RIVERDALE
16	IRVING PARK	55	HEGEWISCH
17	DUNNING	56	GARFIELD RIDGE
18	MONTCLARE	57	ARCHER HEIGHTS
19	BELMONT CRAGIN	58	BRIGHTON PARK
20	HERMOSA	59	MCKINLEY PARK
21	AVONDALE	60	BRIDGEPORT
22	LOGAN SQUARE	61	NEW CITY
23	HUMBOLDT PARK	62	WEST ELSDON
24	WEST TOWN	63	GAGE PARK
25	AUSTIN	64	CLEARING
26	WEST GARFIELD PARK	65	WEST LAWN
27	EAST GARFIELD PARK	66	CHICAGO LAWN
28	NEAR WEST SIDE	67	WEST ENGLEWOOD
29	NORTH LAWNDALE	68	ENGLEWOOD
30	SOUTH LAWNDALE	69	GREATER GRAND CROSSING
31	LOWER WEST SIDE	70	ASHBURN
32	LOOP	71	AUBURN GRESHAM
33	NEAR SOUTH SIDE	72	BEVERLY
34	ARMOUR SQUARE	73	WASHINGTON HEIGHTS
35	DOUGLAS	74	MOUNT GREENWOOD
36	OAKLAND	75	MORGAN PARK
37	FULLER PARK	76	OHARE
38	GRAND BOULEVARD	77	EDGEWATER
39	KENWOOD		

While the northwest side of Chicago is an historically Puerto Rican area, the vast majority of Latin@s in Humboldt Park and the northwest are not Puerto Rican. Although Humboldt Park and the surrounding areas have not been predominantly Puerto Rican for a long time, this is an area where a wide variety of ethnicities are embraced and intermingle with each other, allowing for different understandings of ethnicities and Latin@ representations. In contrast, in the southwest, this is a predominately Mexican-origin Latin@ community, with sprinkles of Puerto Rican flags and other Latino ethnic influences here and there. The southwest is another Mexican ethnic enclave: as one person predicted, 'another Pilsen'. The historic Mexican neighborhoods of Chicago are seen in Pilsen and La Villita. However, these areas are also battling gentrification; in Pilsen this is seen in the newer "muppie (Mexican yuppie)" (Zangs 2014:167) tenants, and in La Villita this is seen in the immense shopping district that poses threats of pushing lower income Latin@ communities out.

By beginning my research within the historic Humboldt Park community area, I was able to talk with long-term activists and resident organizations. Additionally, the expansion of my research to the southwest allowed me to connect with more recent Latin@ activists and organizations who had recently moved to Chicago and are establishing ways to navigate a city and create community and services for themselves within it. For example, in places such as the southwest with limited healthcare facilities, Latin@s have made spaces for themselves through makeshift storefront Zumba centers and dental clinics hidden behind other businesses that value healthcare expertise that the 'official' credentialing bodies of the U.S. do not.

Sites of interest

This project's geographic foundation began in the historic Puerto Rican community of Humboldt Park and the surrounding community areas (West Town, Logan Square, and Hermosa). In 2010, there were 48,390 Puerto Ricans living in the Humboldt Park area, which accounted for nearly half (47%) of the total Puerto Rican population living in Chicago (US Census 2010). The context of Puerto Rican Chicago is embedded within development ideologies, labor history, place-making and ethnic identity construction in a transnational context (Mumm 2014; Fernandez 2012; Perez 2004; Ramos-Zayas 2003; Padilla 1987). As previously described, initially this study began with the HPHC, a branch of the Borinquen Center (BC). The BC is a community-based, grassroots, educational, health and cultural services organization created to address fundamental needs in the Puerto Rican/Latino communities of Humboldt Park, Logan Square, and Hermosa Park. One of the many programs organized through the BC is the Humboldt Park Health Center (HPHC), which at the time of this study offered free exercise and nutrition classes six days, but has since reduced those classes to five days, a week.

Another prominent center within this study is Northwest Clinic. Founded in 1993, it is the largest free clinic in the nation providing 20,000 medical and dental visits and filling over 69,000 prescriptions for their patients annually. In addition to these more clinically specific services, Northwest Clinic also provides various exercise and nutrition classes, art therapy classes, counseling for medication therapy, management for chronic conditions, and other individual social services.

In the southwest I had more difficulty finding comparable community centers and Latin@-geared programing and organizing. Among the centers and makeshift community spaces was a southwest branch of Catholic Charities located behind a prominent Catholic Church in the southwest, the Latino Southwest Organization, and the Chicago Public Libraries of the area. From the small home my family and I were renting in West Eldson, the other nearby neighborhoods of West Lawn, Archer Heights and Brighton Park became deeply ingrained within my ethnographic lens and study sample. Throughout my prenatal care and the later infant well-care visits, appointments at the WIC office, and many other daily tasks intimately shaped my observations and field notes.

Methodology

Early in my graduate career I learned of the importance of community-based participatory action research and set out to work for, and ideally with the community. I began reading Paulo Freire (1970) and learning about participatory action research, community-based research and the many derivatives of these activist, community-driven forms of doing research. I envisioned a community-based research project to be an issue or research problem that came directly from the community, where community members would be active collaborators and part of each step of the research process. This goal was daunting for a dissertation project and I set this vision aside. My priority remained to highlight people’s voices and experiences, joining Craven and Davis in “documenting lived experience as it is impacted by gender, race, class, sexuality, and other aspects of participants’ lives” (2013:1). Feminist activist ethnography allows for a more holistic analysis of the various dimensions of power and their influence on health. More specifically, there are multiple translocal intersections involved in each resident’s experience with health and well-being, and they are different in each case. One resident’s lived experience as a U.S. citizen, working poor, woman of color who was a caretaker as both mother and daughter and who was living with metabolic syndrome had vastly different experiences and narratives surrounding her health and well-being from another resident. That other resident, while sharing an identity with the first as also being a Chicago Latina, had a distinct life experience as an undocumented resident, middle class, ninth grade graduate, caretaker as mother and wife, woman of color living with hyperlipidemia. This is to illustrate that each resident's intersectional translocal contexts matter, from each resident's place of origin (across national, state, city or neighborhood borders), to their and their family's employment, social and economic status, neighborhood and household dynamics, to countless other factors. For each person, what matters most in terms of impacts on health and well-being differs, but in order to better understand the creation of health inequities, I argue that scholars, health practitioners, researchers and leaders need to learn from and listen to the people they aim to serve, and value the knowledge of each resident.

Timeline

I began working in the northwest communities of Chicago in 2014 as a volunteer health outreach worker for a local community center. In June 2015, I was granted IRB approval from the University of Kentucky, shortly after which I conducted my first focus group. From 2015 to 2016 I spent time getting connected with community organizations, attending community events, and serving as a health outreach worker in various settings, primarily in the NW. During these months of being able to recruit, interview, and conduct focus groups throughout the northwestern neighborhoods I learned how to hustle my research and do what I needed to do to get finished. When I finally got the handle of things and the relatively warmer weather allowed for more outings with the baby, I began taking Leo with me to conduct interviews, and focus groups, and completed the remainder of my fieldwork for 2017.

I am indebted to Ms. Yaly Casera for taking it upon herself to help recruit participants for my study. I met Ms. Yaly in 2014 during my first volunteer shift at the HPHC and I have maintained contact with her since then. I often saw Ms. Yaly throughout my multiple visits to Chicago before moving there more permanently in 2015. Ms. Yaly and I became immediate friends and I often came to her to vent my frustrations, concerns, and sought advice from her, just as she confided and shared her frustrations and concerns with me. When Ms. Yaly learned that I would soon be getting married she was so excited and she would proclaim this exciting news to everyone to whom she would introduce me to. As a Latina, mother, grandmother and friend she was proud of me for embarking on the higher educational journey and of the fact that I wanted to work with and for her community. She was so enthusiastic about my project that she helped me set up interviews and focus groups through her social network.

Later, through an established HPHC connection Ms. Yaly (who was looking for employment at the time) attained a part-time position for a grant on a similar health-related study. She went back to her contacts established through her previous employer, NWA (North West Association), and the many NW school programs. It was through Ms. Yaly that it was possible for me to reach out to these schools and parents (mothers mostly) and it was Ms. Yaly who taught me to stand up for myself for what I needed to do. Thanks to this shadowing of Ms. Yaly for a couple of months, I gained the confidence to recruit at the schools near me in the southwest side of town. I was starting from scratch in establishing contacts at the very end of the school year in the midst of a crisis when officials did not know if there were funds to finish the school year.

Despite these obstacles, I was able to conduct and recruit interviews and focus groups with participants from these southwest side neighborhood areas. Latin@s in this southwest side have not been tapped into as a resource and a wealth of knowledge, as I argue. The Humboldt Park and surrounding Northwest community areas have been well-studied. I suggest that we need to expand the focus of Latin@s in Chicago beyond Humboldt Park, Pilsen and la Villita. Although it is easier to study the former areas because of pre-existing contacts established through previous studies and because of other structures in place already, we still need to make the effort to reach out to areas that have not been studied to understand these other local experiences of Latin@s throughout all of Chicago—and its suburban areas, too.

Recruitment

I recruited focus group and residential interviews through various means. I had a flyer—approved by the University of Kentucky Institutional Review Board as part of my research ethics protocol—in both English and Spanish to advertise my study and to be able to leave flyers at store front businesses, community centers, schools, clinics, churches and any other public facility that gave me permission. Recruitment by means of these flyers was not very successful, but this flyer did serve as a legitimation tool for community leaders and organizers, especially as I sought to recruit parents from the surrounding schools. It was more the in-person recruitment, attending parent meetings at public schools, community fairs, making an announcement at the end of a church service, and (most importantly) growing social network connections that brought about community interest and residents' willingness to share their stories with me. Furthermore, I provided a modest monetary compensation, in cash, to each of the individual residential and focus group interviewees to demonstrate my respect and valuing of their time and knowledge.

By working with the schools and recruiting alongside Ms. Yaly my recruitment and selection of participants became more refined. Drawing from the parent groups that volunteered at ten different schools, parents were able to sign up to participate in focus groups and then I would work with the parent coordinator to set up a convenient time, during their usually scheduled workshop calendar, to conduct the focus group with the interested parents. In a few schools Ms. Yaly and I went to present our projects and explain who was eligible directly to the parent volunteers. In other instances, we spoke with the school's parent coordinator and they gathered a list of interested parents to schedule the focus group at another time. As Ms. Yaly and I presented more and more to parent volunteers, more and more parents began asking if they could invite their aunt, uncle or other relative to these focus groups, or gave me specific sites where I should go to speak with more people who have issues with diabetes, high blood pressure or cholesterol. I would not claim that my study sample is representative of the greater NW nor SW Chicago community areas, much less of Latin@s in Chicago. But my study sample is rooted among the people, residents of each of their communities, who identified with the issues I was studying and were willing to share their stories with me.

With the individual residential interviews, most were organized through word of mouth and my growing social network, especially with the help of Ms. Yaly and my adopted abuelitas. Through a social web of families, friend, co-workers, neighbors, and church parishioners I was able to gather stories of Latin@ Chicagoans' experience with metabolic syndrome.

Study sample

As noted earlier in this chapter, during my preliminary studies I set out to talk with Puerto Rican Chicagoans living with diabetes. I began working around the Humboldt Park area, since that area is known for having a larger Puerto Rican community than other parts of the city. However, the more time I spent within the Humboldt Park and greater NW area, the more I realized that the Latin@ community was very diverse including people of Mexican, Cuban, Dominican, Ecuadorian, Honduran, Peruvian and many other countries of origin. Within the same preliminary research phase, I realized the importance of listening to stories by people living with any of the conditions described together as metabolic syndrome, not just diabetes. After a few revisions to my IRB protocol, the study sample I worked with was defined as Latin@s throughout Chicago (particularly within the NW and SW areas) who have experience living with metabolic syndrome, either personally or through a family member.

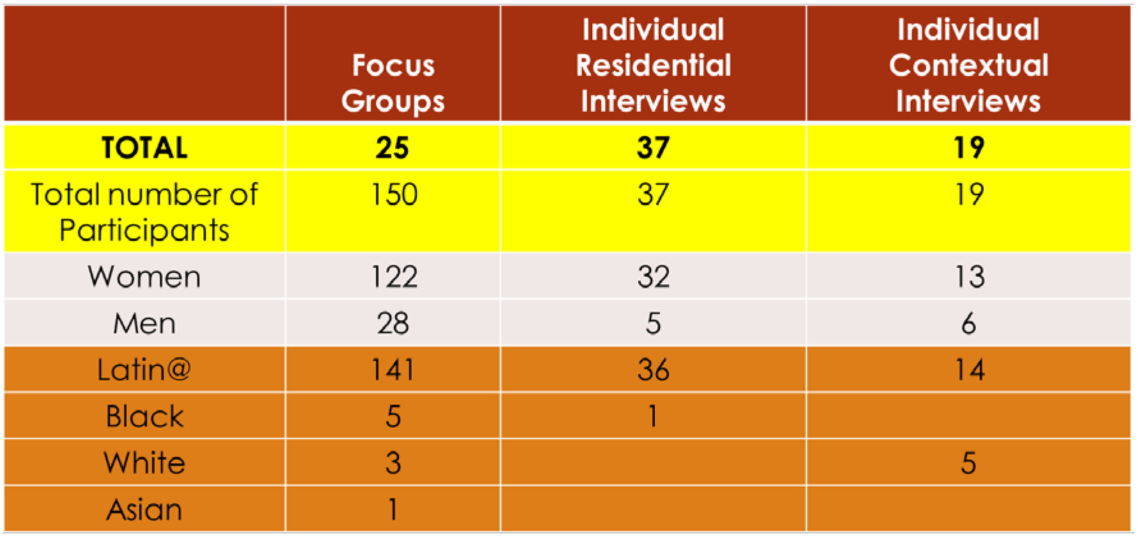
Additionally, I set out to gather narratives of those of all genders; however, the responses to my research were highly cis-gender women centered. The origins of my community involvement began with the HPHC, whose participants were 95% women. It was at the HPHC where I met a group of abuelitas who took me and my son under their wing, helping me to organize focus groups at a popular McDonalds and taking me to day-time celebrations every other Wednesday at a nearby senior center. This core group of abuelitas, just like Ms Yaly, viewed as important my project highlighting health inequities in their community, and how chronic conditions like diabetes, hypertension and hyperlipidemia were affecting almost everyone they knew—including themselves.

Table 1.1 shows the number of participants in each interview with contextual interviewees, residential interviewees, and focus groups (each further described below). Contextual interviews were conducted with local aldermen, community leaders, community workers, and healthcare providers. Residential interviews were conducted individually with Chicago residents throughout the northwest and southwest community areas. Similarly, focus groups were conducted with groups of Chicago residents throughout the northwest and southwest community areas.

Overall, I conducted a total of 25 focus groups, 37 individual residential interviews, and 14 individual contextual interviews. The focus groups ranged in the number of participants from two to thirteen. This range in focus group size was based on the interest gathered among residents in each context. Within the schools, parent coordinators were in control of those who enlisted in each focus group. Focus groups over ten were more difficult to manage, especially in terms of time to make sure everyone had time to speak. But where focus groups were organized around social support networks, residents felt more open to sharing their stories with me.

As the table below shows, there were a few participants who identified as Black, White and Asian who participated in the focus groups and residential interviews. Even though these residents were outside of my research emphasis, I did not want to silence their narratives. If any resident was interested and willing to share their stories and experiences with metabolic syndrome with me, I was eager to hear from them and learn from the knowledge they shared with me. Thus, I have included all the individuals who participated in my study, although the examples I draw on in this dissertation are from those who identify primarily as Latin@.

Table 1.1: Data summary. Table created by author.



	Focus Groups	Individual Residential Interviews	Individual Contextual Interviews
TOTAL	**25**	**37**	**19**
Total number of Participants	150	37	19
Women	122	32	13
Men	28	5	6
Latin@	141	36	14
Black	5	1	
White	3		5
Asian	1		

Health outreach work

I started volunteering at the HPHC in the summer of 2014. I was still finishing my coursework in Lexington, Kentucky until the spring of 2015, but I would come to help at the HPHC as much as I could. The HPHC's heart program (which is the area in which I primarily helped there) went on until December of 2016. In December 2016 the grant money for this program at the HPHC ran out, Doña Nancy started a new position, and the HPHC started shifting to different priorities based on the grants the Boricua Center (BC) had been awarded. As a volunteer for the HPHC, I started by recruiting people to get their blood pressure checked and later conducted blood pressure screenings myself with residents. Throughout the year I returned to the HPHC for several of their recruitment events, such as The Puerto Rican Block Party, or "Bandera Bandera" where people passing by these festivals were recruited for blood pressure screenings, another volunteer event, I recruited passers-by to get their blood sugar tested for diabetes.

As health outreach workers, we were often paired with one or two other volunteers while we conducted heart screenings in which we would do blood pressure checks, a brief health assessment, and individual consulting with residents. I had gotten to know most of the people I met in the beginning of my research through these heart screenings. The screenings were conducted primarily in Spanish and those who stopped to get their blood pressure checked often enjoyed the opportunity to check at least a basic aspect of their health for free and openly ask whatever questions they had at the time. As health outreach workers, we always made it very clear to residents that we were not clinical professionals (e.g. doctors or nurses) and if they had a specific health concern we directed them to their personal primary care provider, or connected them with a clinic if need be. Even if we as outreach workers could not answer all residents' health questions (since we were not trained health professionals), we always tried to direct residents to an answer or a resource that could be helpful for them.

In 2016 I become more involved with another center, Northwest Clinic, the largest free clinic in the country. At this center the majority of the patients are Spanish-speaking; thus, I began volunteering as a Spanish-language interpreter. Additionally, I have led several Spanish-language diabetes education courses for patients, both within and beyond the clinic walls, to help residents with their diabetes management.

In the summer of 2015, I began my IRB-approved research in which I organized the first focus group of ten participants, and conducted seven other additional interviews with community members and key informants. These preliminary interviews allowed me to see how residents with diabetes engage within various different communities and networks. In these early discussions, residents described their engagement with community centers such as Casa Puertoriqueña in their daily domino or bingo tournaments, while others described involvement with church groups, community centers (e.g. HPHC), or health education via hospital-sponsored opportunities, such as clinic or hospital-based nutrition classes or being a research participant in a research project related to nutrition. Additionally, several strategies were shared that were used to help residents manage their type 2 diabetes. For the most part, these participants described ways that they took care of their diabetes on their own, including home exercises, juicing, and walking. Despite not emphasizing an influence of community based centers in their day-to-day lives, the influence of community centers such as the HPHC actually were a significant resource even if it was limited to reading residents' blood pressure once a month.

Participant observation

By volunteering for these centers, I learned how each of the programs and services functioned, beginning with interactions with residents accessing services at these centers. Within the HPHC alone, the daily free exercise classes, weekly free health education and overall welcoming community space served as a pinnacle space for many women. Within the Northwest Clinic, not only did residents who qualified have access to primary care providers and other specialty care[6], but also patients attained all their medication needs from the in-house pharmacy to health education courses.[7] In my

---

[6] Such specialty care options include dentistry, gynecology, urology, neurology, physical therapy, optometry, cardiology, endocrinology, podiatry, and many others.

[7] Such health education courses included diabetes education, healthy eating cooking classes, art therapy, support groups, Zumba and yoga.

experience volunteering, I served as a Spanish-language diabetes educator within the clinic. As a volunteer for these programs, I saw that there were many patients dealing with either diabetes, high blood pressure or high cholesterol. I paid particular attention to the services utilized, questions asked of staff, language used, impromptu storytelling, and how residents interacted with each other.

I also attended different activities at these community centers (e.g. fitness and nutrition classes). The details collected from my participant observation at these sites are crucial to situating residents' interactions within community-based programming and among organization staff. These exploratory methods allowed me to interact with residents at these centers, and residents become familiar with me and my research project, in turn facilitating recruitment for focus groups and individual interviews.

Each day field notes were taken in two main forms, by hand and through a voice memo. Most often, field notes were taken through the voice memo function on my personal voice recorder or cellular phone. Each time I drove or walked from site to site, or meeting, I recalled notes and key observations. This voice memo function was especially crucial for me when I could not write field notes while carrying my son. In the spirit of autoethnography, for each day in the field I wrote a diary-style entry to discuss initial observations or themes that came up that day.

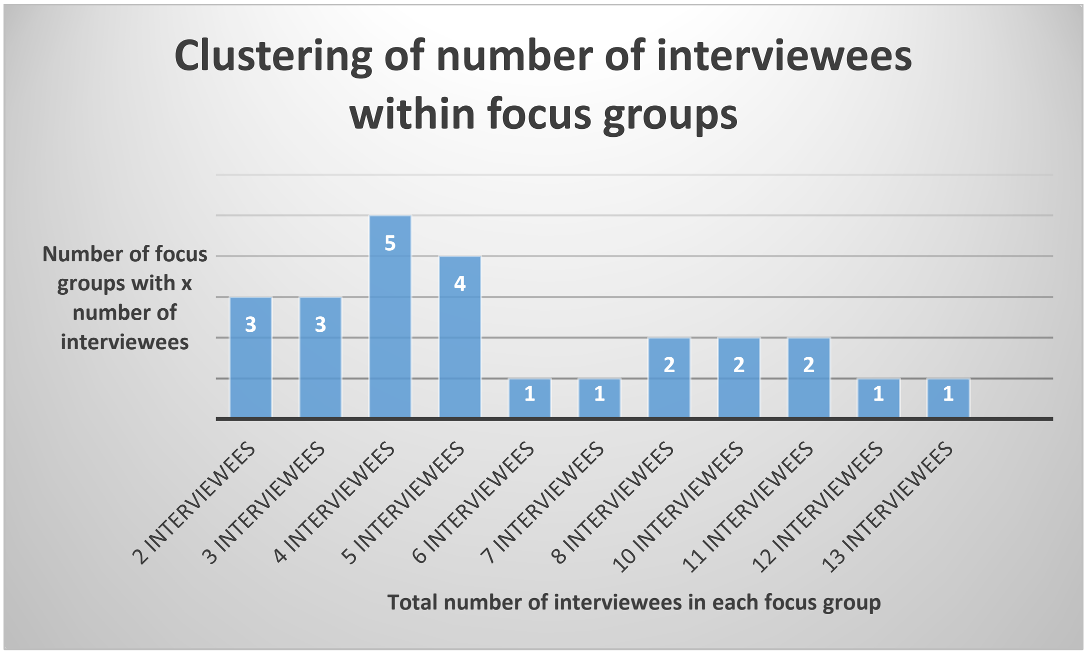
Focus groups

Focus groups were originally designed to assess the broader situation among type 2 diabetics and those with high blood pressure and high cholesterol among the various Latin@ Chicago areas of this study. However, as momentum gained in setting up these focus groups with groups of mothers at various public schools, this method developed as a supportive and empowering space for parents to share their stories, experiences and concerns along the general lines of health. They provided an opportunity for them to vent, ask questions or share grievances when their voices have not been validated or heard before. By talking with residents in a group setting, the focus groups also allowed for new topics of concern to come up and allow for conversations to flow easier given that I as the researcher was the only stranger in the room. Targeted selection was used for these focus groups to recruit Latin@s with type 2 diabetes, high cholesterol, or high blood pressure, over the age of 18, living within either the northwest or southwest neighborhood areas previously discussed. Depending on participants' preference, focus group interviews were conducted in Spanish or English, although 99% of all focus groups and interviews were in Spanish.

These focus groups aimed to broadly identify what kind of community resources residents utilized to navigate their and their families' well-being. A total of 25 different focus groups were conducted, ranging in size from three to twelve participants, and accounting for 150 different residents' stories. Figure 1.9 below shows the clustering of participants in each focus group. I sought to recruit both men's and women's narratives, although more women participated in my study. This is partly due to problematic politicized 'calls to volunteerism,' which relocate formerly state-run social services onto the free labor of volunteers who are primarily female (Hyatt 2001), especially within these public school settings.

Ten of these focus groups were organized around the public schools of each area as many parents are involved with different programs put together by these schools. The other focus groups were conducted at either residents' homes or in an apartment complex for the elderly (particularly in one of the buildings), nearby cafes or fast food sites, or other community centers (including the HPHC, Northwest Clinic, Catholic Charities Center). Most of the participants within the focus groups had either type 2 diabetes, high blood pressure and/or high cholesterol. Several participants, however, did not experience these conditions first hand, but rather had family members experiencing these conditions. Each focus group was voice-recorded, while notes were taken throughout the conversation, as well.

Figure 1.9 Focus group interviewee clusters. Graph created by author.



Interviews

In order to dive deeper into the everyday experiences of Chicago Latin@s living with diabetes, high blood pressure or cholesterol, individual residential interviews were solicited to learn more about these residents' daily lives through their own stories.

Residential interviewees were drawn from recruitment advertising (as described above) and residents visiting various public facilities. A total of 37 residential interviews were conducted with residents of Chicago over the age of 18 with either hypertension, high cholesterol and/or diabetes. These semi-structured interviews asked similar questions to those asked in the focus group, inquiring further into participants' migration stories, use of community centers and resources and general navigation strategies for actualizing their health needs. Additional conversations addressed work circumstances, living situations, environments within the home and greater neighborhood, general challenges faced in their daily lives, and the influence of chronic conditions. Such inquiries were more exploratory and open-ended in order to allow informants to tell their stories and situations as they pleased, and to allow for their narratives to be framed with their own words. The interviewees decided if they preferred to be interviewed in English, Spanish, or a mixture of the two, although most interviews and focus groups were conducted in Spanish. All interviews were recorded and later transcribed. These individually focused residential interviews allowed interviewees to speak candidly about their metabolic syndrome-related issues and general well-being. These interviews provided a means for people to speak about their daily lives outside of a clinical or socially-organized setting in hopes of further illuminating lived realities beyond these settings.

Contextual interviews were conducted throughout the many phases of this research. These contextual interviews were aimed at gathering a more holistic idea of the many dynamics of health and well-being throughout the NW and SW sides of the city, as well as greater Chicago. In the beginning of my research, I interviewed scholars and researchers based in Humboldt Park and the NW side, as well as community leaders and activists through the HPHC, BC and Northwest clinic. As I began engaging with more community centers and programs, I interviewed more community leaders and organizers throughout the SW and greater Chicago Latin@ researchers, leaders and activists. Towards the end of my research, I interviewed various aldermen from the respective NW and SW areas whose residents I had interviewed. Depending on the position of each contextual interviewee, I asked about their experience working with the community, underlying issues and challenges to Latin@ health and well-being they observed throughout their work, and changes they would like to see made within the city of Chicago. These contextual interviews provided a broader picture of the neighborhoods and community dynamics, as well as larger city structures and how power is enacted more locally, within each of the distinctive wards.

Data analysis

In August 2017, after I finished conducting all the focus groups and residential interviews I began reflecting on the conversations I had with residents. In this reflection and analysis period I would listen to the recordings of the focus group and individual interviews in order to write notes of key themes residents brought up. This preliminary analysis helped me identify additional contextual interviews or follow up questions I needed to further explore with residents. Throughout August and September of 2017 I conducted the last few contextual interviews with Chicago Aldermen and other community leaders and workers.

The transcription process for each of these interviews was to type in a word document, exactly how interviewees expressed themselves in their original language. Thus, most of my transcriptions are in Spanish. All the translations presented within this dissertation from Spanish to English are my own, and are based on the context of each conversation. I am responsible for any errors of translation and are based on how I interpreted each resident's words.

As I began bringing all of these data sets together, I gathered the hand-written field notes and voice memos and put these notes together into a more concise Word document for each day. I started an index with common themes that came up across each of my data sources. For example, if the topic of 'emergency rooms' came up I noted which source (i.e. individual interview, focus group or field note), what page number (in the transcription or field note entry), and (if applicable) which person (using pseudonyms) said or did what. After reviewing all my sources of data (field notes and transcriptions) I had a long list of themes and key terms to draw from. I began organizing and categorizing the themes to find a common ground for ways to present residents' stories. This index of themes was grouped together, organized, and re-organized to ultimately take the form of my overall dissertation outline and individual chapter outlines.

Overview of chapters

Chapter two gives deeper background into the two larger neighborhood areas that this study encompassed, the northwest and the southwest sides of Chicago. The discussion of the northwest neighborhood areas is based on research conducted primarily in four community areas: Humboldt Park, West Town, Logan Square, and Hermosa. Other nearby neighborhood areas also included Austin, Avondale, and Belmont Cragin. In the southwest, the four main community areas emphasized included West Eldson, Archer Heights, Brighton Park, and West Lawn. Other nearby community areas included Gage Park and Chicago Lawn. These two overall neighborhood areas I have clumped together and will refer to throughout this dissertation as the northwest and southwest areas. In Chapter two I look into the development of each area, migration patterns of residents that lived in each area, and additional insights from archival data demonstrating community investment based on city funding for each area. To bring a more up-to-date picture of these areas I provide information about how each of these communities is measured in terms of socioeconomic status, health and ailments, housing, and other general information I have been able to gather from federal and local agencies. Finally, I end this chapter with some ethnographic examples of residents' health concerns in each area and provide evidence to support their concerns.

Chapter three is based primarily on medical anthropological discussions and other health-related literatures such as those in public health, and health policy. I highlight previous studies of those with diabetes, high blood pressure and cholesterol, and then focus on studies done with U.S. Latino@s specifically. The contribution of this research to these literatures gives insight into the various challenges Latin@s face when confronted with managing each of their respective conditions. Additionally, this chapter suggests solutions for improving overall health and well-being for these communities based on suggestions from residents themselves in their own words.

Chapter four is more heavily ethnographically focused, demonstrating residents' various ways of engaging with biomedical discourses, practitioners and observations. To begin, I highlight the issue of health insurance in the current era of health insurance restructuring post-Affordable Care Act and how these policies translate to Latino@s both included in the ACA and those left out. Residents who have been diagnosed with any of these conditions have learned to evaluate biomedical advice and choose to follow and adapt their own forms of care suitable to their own pace of life. Residents shared various strategies and tactics with me for how they manage and attain well-being in their own terms. This chapter in particular focuses on how residents respond and engage biomedical treatment options, as they choose whether or not to take medication or shots of insulin for their respective conditions. The next chapter focused on other tactics outside of these clinical practices.

Chapter five also highlights ethnographic contexts and highlights residents' strategies outside of the clinical area of care, especially related to diet and exercise. These two topics of diet and exercise are the main sources that clinicians emphasize in order for patients to control their levels of blood sugar, blood pressure, or cholesterol. Diet and exercise have been ingrained among the residents, instructed to self-surveil their caloric intake and their physical activity. However, residents opt out of these strict, often unrealistic and frankly unspecified ways of life and develop their own strategies for managing their conditions. I divide the strategies based on condition for what residents taught me was effective for lowering blood sugar, blood pressure, and cholesterol levels, respectively. Such remedies ranged from nopal smoothies, to oatmeal, to increasing water consumption, to exercise. The strategy of exercise carries with it the misconception that the one hour of Zumba cancels out bad eating throughout the day.

The final chapter, chapter six, summarizes the agentive ways that residents navigate and strategize resources throughout the city for their own and their families' well-being. Based on my research, I suggest ways to improve clinical experiences with residents, from individual well-care visits to reaching out to Latin@s left outside of clinical reach. I also discuss policy recommendations for local and national officials, organizations, and programs. Lastly, I discuss hopes and plans for future research as I continue learning from these communities, such as ways of claiming space in efforts to create more localized healthful settings.

CHAPTER TWO:

Social landscapes of Chicago- the segregated city

Latin@s and the state in Chicago: then and now

A local Chicago scholar, Wilfredo Cruz, compiled a photographic book, *Images of America: Chicago Latinos at Work* (2009), in efforts to put a human face on the Latino worker in Chicago. Among the many faces in this book, one photo was especially memorable and related to an image that remains engraved in my memory. In this historic text, Cruz explains that one of the constant problems for some Mexican workers in Chicago is the lack of American citizenship: he provides a 1954 photo of a group of apprehended undocumented Mexican workers and their families on the 9th floor of the Chicago Post Office awaiting deportation back to Mexico (Cruz 2009:34). The left side of the photo shows a line of darker-skinned Mexicans waiting along the hallway wall. To their right is the district immigration officer (in a suit) standing next to a detention officer (in his police officer uniform with tie), both white (Cruz 2009:34). The people pictured waiting to be deported are well-dressed as well, some with long and short-sleeved button-down shirts tucked into their trousers. A little girl dressed in all-white hides behind one of the adults as she peaks towards the camera. This image is so different from what a group of apprehended undocumented workers looks like today.

In the summer of 2017 I accompanied a local resident in the southwest side of the city to his appointment to get his fingerprints registered in the U.S. system (known as the biometric screening). I was almost worried I would not be allowed to accompany him, but the guard at the front had us each sign in and warned us that we needed to turn off all electronic devices. We complied and Gus, the man I was accompanying, filled out the necessary paperwork and waited for his number to be called. The room was filled with rows of black plastic chairs and a small TV hung in the upper left-hand corner of the room to distract those waiting since everyone had their phones turned off. To the right was where the business happened: there were three different stations of workers with latex gloves processing each case. As each of the numbers was called, the person went up, turned in their paperwork, showed an ID, had each of their fingers covered with black ink from the ink pad and then had their photo taken. There were not that many people waiting, maybe five in all, and most came alone; very few came accompanied. Although there were not many people, the numbers were called slowly. When it was almost our turn, a police officer came in from the back door: a young man of color (who could have been Latino). After getting the clear, he returned from the back of the building with another older, white officer, and together they escorted a long line of detainees into the waiting area.

As these men walked into the biometrics screening room, the tension and energy of the room shifted. They were directed to sit and wait along the front two rows that faced each other at the back of the room. When I first saw these men, I thought they were prisoners. I immediately tensed up; I had never been around a group of imprisoned people in such close proximity while they were serving their sentence before. Gus was distracted, reading the papers he was given to fill out. He did not notice when they first walked in. When I subtly got his attention motioning towards the back room, he looked up and we both gawked. I quietly wondered to Gus what they could be imprisoned for. Gus knowingly corrected me that these were men who would soon be deported. My heart sank even more as more questions began to arise in my mind.

Each detainee sat with his feet chained together, hands cuffed, and each linked with one another in two different rows of detainees. All eyes were on them, and they looked around to us, too. There were about 20 detained Latinos there that morning getting their fingerprints registered in the ICE (Immigration and Customs Enforcement) registry. Each was wearing either a bright neon orange jumpsuit or neon orange pants and a gray t-shirt. Each had written on their apparel "McHENRY COUNTY DETENTION CENTER." One or two had visible tattoos or had their heads completely shaved, which made them look like the stereotypical gangster. Among the other detainees, one had a fresh hair cut that looked days new, and a couple of them looked like they had not been groomed for months, with overgrown hair and untamed facial hair.

The white officer was swift and quick, showing no emotion. He did not wear rubber gloves as he locked and unlocked the cuffs on each of the approaching detainees when it was their turn. The rhythm of the fast zipping of the cuffs—on and off—as he quickly tightened each person's hands to their detention was a sharp contrast to the method of the younger officer. The young officer of color put gloves on (I assumed) to not contaminate the fingerprint sample. The young officer made engaging conversation with the woman working the finger-print station. He took care as he unlocked each of the detainee's handcuffs to get their identities registered in the system. He was gentle as he locked their hands back into the handcuffs when they finished. The slow clicking of the cuff as the circle tightened around their hands rang in sharp contrast to the fast pace of the other officer. Maybe he was trying to be careful not to catch someone's arm or skin into the cuffs, or maybe it was with regret, guilt, or compassion that he tightened these cuffs. Did he see himself or his family in these men?

This vignette presents an example of how structural, political and symbolic violence are carried out through everyday violence. Although the scene described above is not one that every Chicagoan has experienced, the reality of deportation among the few of us in the room witnessing this procession of detainees was enough to embody the violence and threat of deportation. In the months following the 2016 U.S. Presidential election, I was privy to rumors about ICE raids and arrests throughout the SW area of Chicago. In my frequent evening walks around a nearby park with Heidi, Antonia and Lorena (revisited in chapter three), they updated me on the recent ‘barrio’ word-of-mouth news. An ICE truck was seen in the local flea market style ‘Mega Mall’. The popular grocery next door to this Mega Mall sat abandoned that week for fear that an ICE truck would return. Another comadre shared the story of an undocumented single mother who was arrested at her home; her infant daughter and two older children were left alone the night their mother was taken away. These forms of everyday violence that became part of the daily gossip and concern—especially in the time following the narratives through which the 2016 election was won—were very much symbolic violence and responses to it were embodied among residents who only opted to travel when it was absolutely necessary.

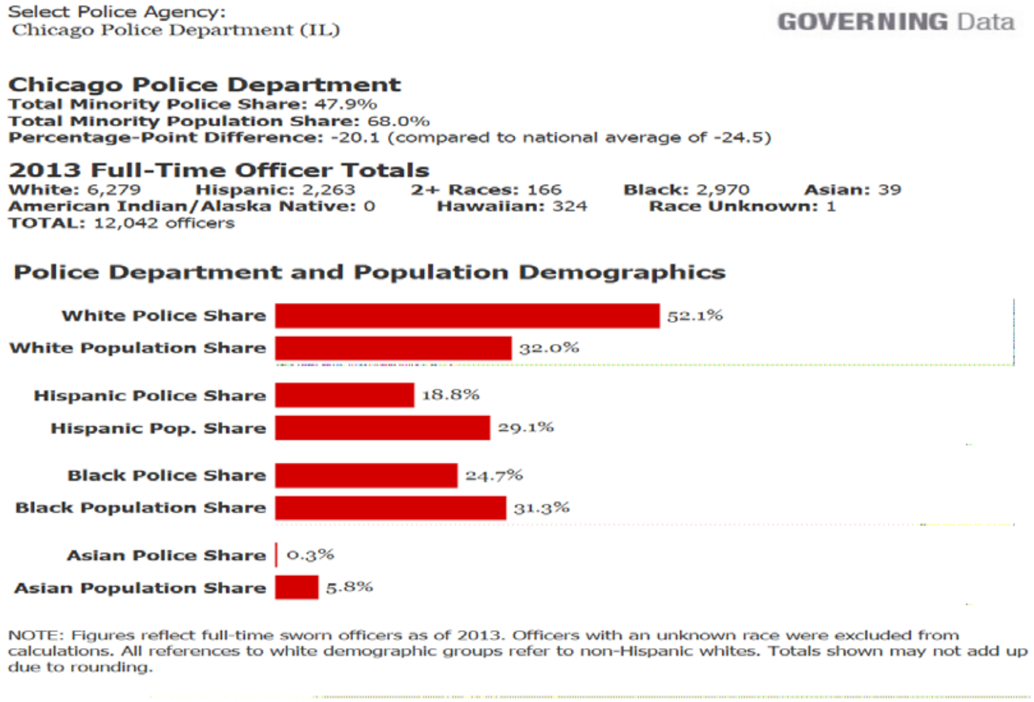
Additionally, the hyper-visibility of the above procession of undocumented and—by appearances—‘criminal’ immigrants follows Michel Foucault’s description of disciplinary power becoming obvious through state actors’ disciplining or examining disempowered subjects and through that visibility disciplining others (as in the abovementioned appearance of the ICE truck and residents' subsequent fear to occupy public space). Foucault explains that:

> Disciplinary power…is exercised through its invisibility; at the same time it imposes on those whom it subjects a principle of compulsory visibility…And the examination is the technique by which power, instead of emitting the signs of its potency, instead of imposing its mark on its subjects, holds them in a mechanism of objectification (Foucault 1979:187).

The visibility and in turn objectification of these detainees reiterates the power of the state not only among the detainees but to and within those who are witnessing this performance as well. For this is not merely an act of spectacle, but an imposition of the power of the surveilling state (Foucault 1979:217). Interestingly enough, the state played a key role in directly recruiting and bringing more Mexican and Puerto Rican laborers to Chicago. Programs such as the Bracero Program and Operation Bootstrap made migration "paradoxical as the state sought to regulate and restrict (migrants') mobility once in the U.S." (Fernandez 2012:25). These paralleled histories of Mexican and Puerto Rican immigrants to Chicago are why historian Lilia Fernandez view their stories as "intertwined, and resemble each other significantly and therefore must be told together" (Fernandez 2012:16).

In 1953, the first Latin@ police officer was killed on the line of duty, Detective Oreste E. Gonzalez, shot by a passenger within his squad car he was driving (CPD 2018). The city of Chicago did not see the first Latin@ superintendent until 1992, when Matt L. Rodriguez was appointed by Mayor Richard Daley, Jr. (CPD 2018). Figure 2.1 provides the 2013 demographic information on the Chicago Police Department. In October 2014, white officer Jason Van Dyke of the Chicago Police Department shot Laquan McDonald, sixteen times (Charles 2018). McDonald was an unarmed, black seventeen-year-old, who was attacked in the SW side of Chicago. The entire incident was recorded on CPD dashboard cameras, which were ultimately released to the public under a court order in November 2015 (Charles 2018), furthering the distance between authority and community trust. Since these events, the city of Chicago has been taking greater strides to ensure the Chicago police force is more representative of the city's population diversity. The recruitment period of 2016 consisted of 54,000 total candidates, of which 35% were black, 32% Latin@, and 20% white; yet of the 1,371 officers ultimately hired 14% were black, 36% Latino and 41% white (Charles 2018).

Figure 2.1: *2013 Chicago Police Department demographics* (Source: Governing 2013).



Select Police Agency:
Chicago Police Department (IL)

GOVERNING Data

Chicago Police Department
Total Minority Police Share: 47.9%
Total Minority Population Share: 68.0%
Percentage-Point Difference: -20.1 (compared to national average of -24.5)

2013 Full-Time Officer Totals
White: 6,279 **Hispanic:** 2,263 **2+ Races:** 166 **Black:** 2,970 **Asian:** 39
American Indian/Alaska Native: 0 **Hawaiian:** 324 **Race Unknown:** 1
TOTAL: 12,042 officers

Police Department and Population Demographics

NOTE: Figures reflect full-time sworn officers as of 2013. Officers with an unknown race were excluded from calculations. All references to white demographic groups refer to non-Hispanic whites. Totals shown may not add up due to rounding.

What a difference from the time of the 1954 image and now: over 60 years have passed, and yet lives continue to be uprooted, families separated and outright police violence continues to weigh on communities of color. The image from the 1950s at least appears to have some dignity. Those who had been apprehended were to a certain extent ‘free’: they are not cuffed, they are not in uniforms, treated as though they were not guilty until proven innocent, unlike how detainees are treated today. Forced deportation of migrants was not new to the 1950s either. Many Mexicans were deported during the 1921-1922 recession, and again in the 1930s (Arredondo 2008:9). These deportations and the subsequent federal repatriation programs only “fortified Mexican ambiguity toward the permanency of their lives in Chicago” (Arredondo 2008:9). In the more recent area of detention centers, the conditions in which apprehended undocumented immigrants are kept is nauseating. In these makeshift detention centers, immigrants are not guaranteed phone calls, the rights to a lawyer, or any other of the (few) rights prisoners are granted in other public and private U.S. prisons. Often, undocumented detainees opt to self-deport (if given the option) instead of waiting in detention for an unknown amount of time. These oppressive state policies and actions are deeply felt among immigrant communities and their extended families, resulting in a much deeper economic, political, social and physiological toll throughout the city.

Latin@s in Chicago

Among Latin@s in Chicago and the greater Midwest region, Mexicans and Puerto Ricans are the two largest Latin@ groups (Cruz 2009). These two groups make up 85% of Chicago’s Latin@ populations, and specifically Mexicans represent 70.4% and Puerto Ricans comprise 15% of Chicago Latin@s (Cruz 2009:8). By 1916, a sizeable number of Mexicans had settled in Chicago, and the first waves of Puerto Ricans came to the city in the late 1940s, peaking in the 1950s and 1960s (Cruz 2009:8). Evidence of this early Latin@ presence in Chicago can be seen with the establishment of the Mexican Consulate in 1884 in the city (Año Nuevo Kerr 1976). An influx of Mexican migrants to

Chicago can be explained by the many changes after the 1910-1917 Mexican Revolution, as well as the higher-paying employment opportunities in Chicago (Año Nuevo Kerr 1976). Many of Chicago’s major industries were benefited by Mexican labor, including the steel mills, meatpacking industry, railroads and agricultural production (Año Nuevo Kerr 1976). Chicago-area railroad companies, such as Santa Fe, Topeka and Burlington, recruited Mexican workers from the Texas-Mexico border. The number of Mexicans working for Chicago railroad companies rose from 206 in 1916 to over 5,255 in 1926 (Cruz 2009:9). By 1928, Mexicans made up 11% of the workforce in 15 of the Chicago area’s plants, which included those working in meatpacking, steel, and other industries (Cruz 2009:9).

Many Mexican enclaves were built around these worksites, with some of the original ones being found in South Chicago (specifically the South Deering neighborhood), Near West Side, and Back of the Yards (also known as New City). The Our Lady of Guadalupe Catholic Church seemed to serve as one of the earlier religious centers; it is notable in many of the Latin@ wedding photos, which date back to 1926, included in Cruz’s book (Cruz 2009:13). The Claretians (a Roman Catholic order of priests and nuns) began working in Chicago with the Mexican community in 1928 at Our Lady of Guadalupe Church (Cruz 2009:103).

By the 1920s there were roughly 20,000 Mexicans in Chicago, two-thirds of whom were men (Año Nuevo Kerr 1976). However, many Mexican migrants were sent back to their country when the Great Depression took effect, bringing the total Mexican population down to 14,000 people (Año Nuevo Kerr 1976). Those who remained in Chicago experienced much hardship, as did the rest of the city and country during these times. Due to prejudice, some settlement houses and charities refused to extend food or relief to unemployed Mexican families during the Great Depression (Cruz 2009:16). One settlement house that did consistently help Mexican families was the University of Chicago's settlement house, founded by Mary McDowell (Cruz 2009:16). The renowned Hull House was also an important resource for many migrant families, including Mexican families. In the 1920s many Mexican families lived in the Hull House neighborhood, often in overcrowded apartment buildings where outbreaks of tuberculosis were common (Cruz 2009:31). Common resources offered to Latin@ communities by Hull House are English language classes and citizenship classes (Cruz 2009). To this day many community centers, especially in the south side, provide English language classes, citizenship classes and even GED classes. These are usually provided for free or at low cost to residents. However, for the vast majority of Latin@s who are undocumented, with no path to citizenship (Gomberg-Muñoz 2017), what other services can local communities offer residents to help improve their well-being in these contexts? Perhaps it is time to reevaluate the services community centers provide and to consider what the needs of residents are in the present day, and to not continue to provide the same services as the 1940s.

In 1948, U.S. Steel brought in over 500 Puerto Rican contract workers for its Gary, Indiana plant; hundreds of Puerto Ricans labored in the steel mills of South Chicago, Gary, Indiana and East Chicago, Indiana (Cruz 2009:9). With labor recruitment and contract labor being an important catalyst in the growth of Chicago's immigrant and migrant populations, many Chicago Puerto Ricans were depicted as exhibiting "'good' migrant behavior," especially in comparison to New York Puerto Ricans, for those living in Chicago did not “cause problems” (Perez 2004). In the following sections, I give evidence from Chicago archives, and then discuss more histories within each of the Latin@ Chicago community areas researched in this project.

Chicago governing bodies

According to the 2010 U.S. Census, there were a total of 2,695,598 residents within the 237 square miles that make up the City of Chicago. On the city’s eastern border is Lake Michigan. The City of Chicago resides within the greater Cook County, which also includes the Chicago neighboring suburbs, accounting for an additional 2,499,077 residents—about 5.3 million people and 946 square miles in all (Cook County 2018; U.S. Census 2010). Figure 2.2 shows the span of Cook County below.

The governing bodies of the City of Chicago are divided into two branches, the executive and the legislative branches. The legislative branch consists of aldermen, representing each of the 50 wards throughout the city. The aldermen’s term spans four years and they make up the base of the City Council. In addition to the 50 aldermen, the Mayor and City Clerk are part of the City Council as well (City of Chicago 2018). Within the City Council there are sixteen standing committees. One of these deals directly with health: health and environmental protection (Chicago City Clerk 2018). Additionally, all aldermen are required to participate in the ‘committees, rules and ethics’ committee. The ‘budget and government operations’ and ‘finance’ committees are the most popular, each holding 35 aldermen. Whereas the ‘housing and real estate’ and ‘transportation and public way’ committees are less popular, consisting of 15 aldermen in each. Each alderman is said to be a “source of information and intermediary on behalf of their constituency about city functions and services within the ward” (Chicago City Clerk

2018). The governing actions throughout the city generally begin with the establishment of a budget ordinance in November of each year, through which the actions and decisions are made based on the passing of ordinances and resolutions (City of Chicago 2018).

The ward system in Chicago has been in place since the first municipal charter in 1837, creating six wards at the time (Knox 2005a). The number of wards has increased in relation to the population growth in each area. After major city annexations of 1889, the 35 wards remained consistent. However, state law requires that the ward boundaries be redrawn every 10 years (after each federal census) in efforts to attain "equal representation by population size" (Knox 2005a). This historian noted, "in some cases, wards have developed localized cultural identities akin to those of neighborhoods" (Knox 2005a); however in some wards, especially those in the SW, there are not close-knit identities spanning ward lines. If we look at the ward where my home at the time was located, ward 23, the boundary lines went from Cicero to Kedzi with a 5-block width along this vertical axis (see Figure 2.3 below).

In contrast to the arbitrary ward lines dividing communities, key social scientists in 1920s from the University of Chicago, such as Robert Park, advocated for the drawing of community borders along more "natural" barriers such as rivers, parks and railroads (Seligman 2005). The Chicago Department of Public Health also had a stake in developing more cohesive community divides. As a result, the 75 community areas of Chicago were created along more "natural" divides, and have remained actively in use to this day. Currently there are 77 community areas as the O'Hare community area was added in 1956, and in 1980 the Edgewater community gained secession from Uptown forming its own community area (Seligman 2005).

Figure 2.2 Map of Cook county. This map shows the city of Chicago (shaded gray area) within the greater Cook County boundary lines (Source: Orr 2018).

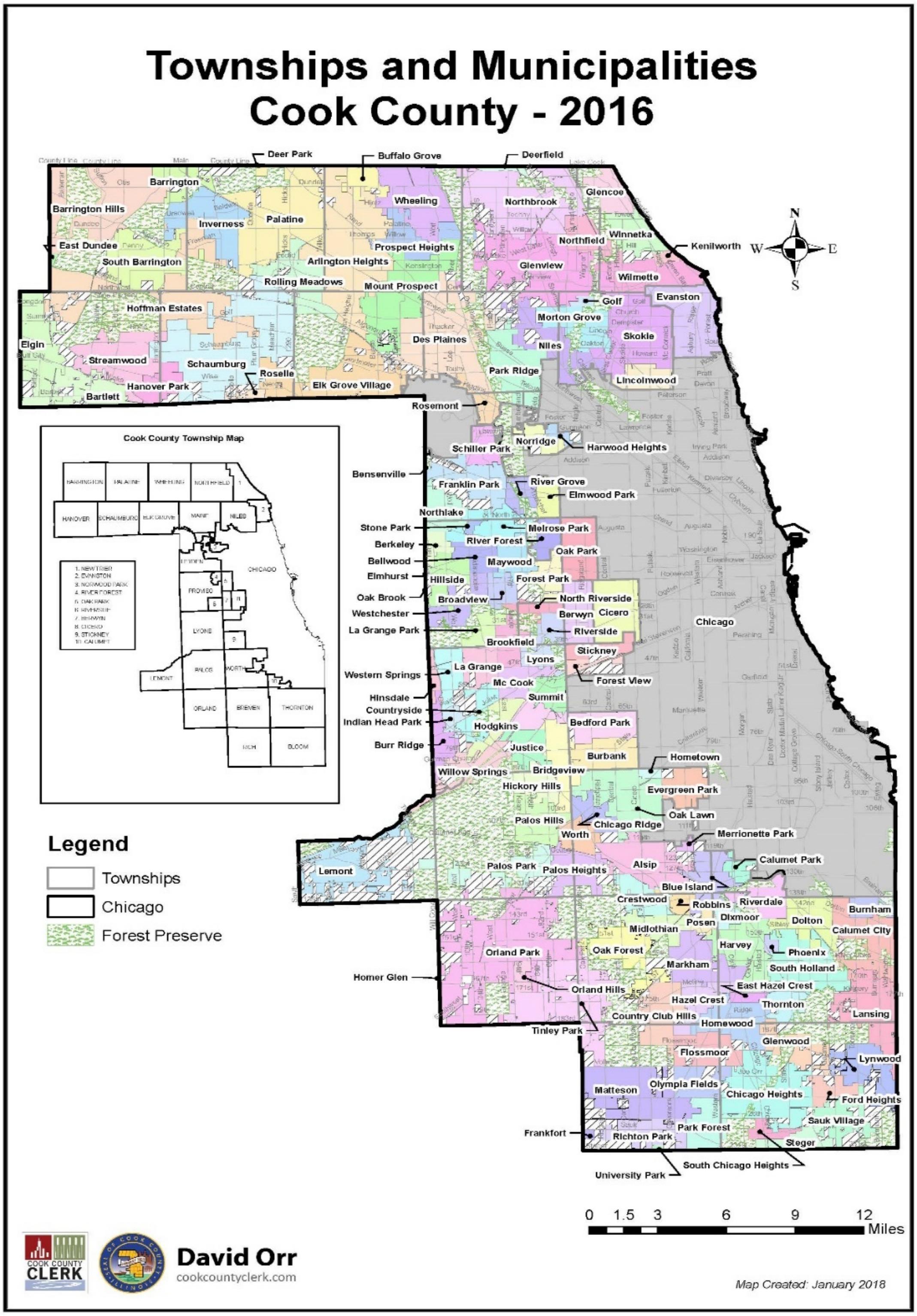
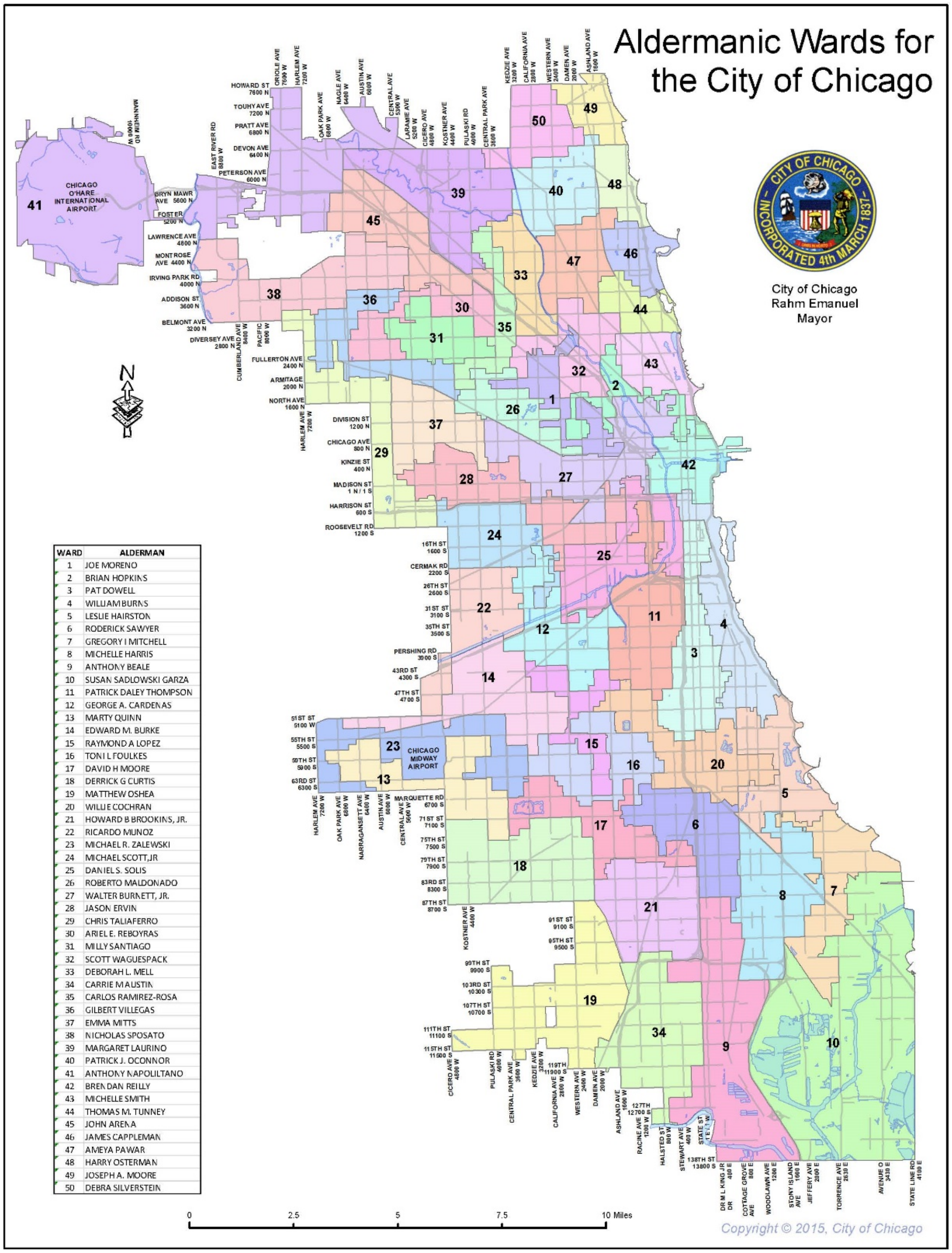


Figure 2.3 2015 *Chicago aldermanic wards map* (Source: City of Chicago 2015).



WARD	ALDERMAN
1	JOE MORENO
2	BRIAN HOPKINS
3	PAT DOWELL
4	WILLIAM BURNS
5	LESLIE HAIRSTON
6	RODERICK SAWYER
7	GREGORY I MITCHELL
8	MICHELLE HARRIS
9	ANTHONY BEALE
10	SUSAN SADLOWSKI GARZA
11	PATRICK DALEY THOMPSON
12	GEORGE A. CARDENAS
13	MARTY QUINN
14	EDWARD M. BURKE
15	RAYMOND A LOPEZ
16	TONI L FOULKES
17	DAVID H MOORE
18	DERRICK G CURTIS
19	MATTHEW OSHEA
20	WILLIE COCHRAN
21	HOWARD B BROOKINS, JR.
22	RICARDO MUNOZ
23	MICHAEL R. ZALEWSKI
24	MICHAEL SCOTT,JR
25	DANIEL S. SOLIS
26	ROBERTO MALDONADO
27	WALTER BURNETT, JR.
28	JASON ERVIN
29	CHRIS TALIAFERRO
30	ARIEL E. REBOYRAS
31	MILLY SANTIAGO
32	SCOTT WAGUESPACK
33	DEBORAH L. MELL
34	CARRIE M AUSTIN
35	CARLOS RAMIREZ-ROSA
36	GILBERT VILLEGAS
37	EMMA MITTS
38	NICHOLAS SPOSATO
39	MARGARET LAURINO
40	PATRICK J. OCONNOR
41	ANTHONY NAPOLILTANO
42	BRENDAN REILLY
43	MICHELLE SMITH
44	THOMAS M. TUNNEY
45	JOHN ARENA
46	JAMES CAPPLEMAN
47	AMEYA PAWAR
48	HARRY OSTERMAN
49	JOSEPH A. MOORE
50	DEBRA SILVERSTEIN

The executive branch consists of the Mayor of Chicago who holds office for up to four years. The Mayor’s term runs for four years but is unlimited in the times they can run for reelection. Rahm Emanuel has served as Mayor of Chicago since 2011. In 2019 he will be up for a possible re-election for a third term; his potential opponent is not yet confirmed. Thus far, Emanuel has collected $3.1 million in donations for his tentative campaign, seventy percent of which are donations are from “high-dollar contributors…who have benefited from actions (in) City Hall” (Coen and Ruthhart 2017).

The longest serving Mayor in Chicago, was Richard M. Daley who served a total of six terms, from 1989 to 2011 (Associated Press 2007). Richard M. Daley, son of Richard J. Daley, followed his father’s footsteps in longest held Mayor terms. Richard J. Daley was reelected for five consecutive terms from 1955 until his death in 1976. Daley Sr., known as the “last boss” of the Chicago Democratic Machine, controlling an “estimated 35,000 patronage jobs, the use of which ensured party discipline and relegated the local Republican Party to insignificance” (Biles 2005). Under Daley, Sr.’s reign, Chicago became “the most residentially segregated large city in the nation” (U.S. Civil Rights Commission in Fernandez 2012:8). Daley ran the city like a “feudal lord”, under which the police force also broke records, being notorious for its abuse and brutality. At one point the Chicago Police Department was reported to have killed more Chicago citizens than the police departments of New York, Los Angeles, and Philadelphia *combined* (Fernandez 2012:186). After Daley, Sr.’s death, Chicagoans elected various mayors in each term; beginning in 1977, the city saw its first non-Irish mayor since 1933, Michael Bilandic, who had Croatian origins (Holli 2005). Then in 1979, Chicagoans elected its first female mayor, Jane Byrne (Holli 2005). And in 1983, Harold Washington was elected, becoming the city’s first African American Mayor. He was reelected to a second term but within months of election passed away from cardiac arrest in 1987 (CPL 2018).

During these pinnacle moments of citywide electoral change, I wanted to get an idea of what these changes meant for residents on the ground. Thus, I searched through some of the Chicago Community Area development records to see changes taking place within each of the community areas during this time, as described in the following section.

Chicago community area archival and resource snapshots

In efforts to gather more historical information on the distribution of resources throughout the city, I gathered information from city records about how resources compare according to each of the neighborhoods discussed in this project. From the 1985 "Chicago Neighborhood and Suburbs: A Historical Guide" archives which is divided into the 77 community areas of the city, it is possible to learn a small portion of the story. These records compare population size, vacant land, unemployment rates, and community improvement funding across each community area. According to these records, the Community Development Block Grant (CDBG) was a federal grant established in 1974, which provided funds for a variety of urban community needs related to health, safety, and public welfare. Specifically, the CDBG allocated targeted funding to geographically chosen programing for housing, economic development, and community improvement. This did not, however, include allocations for human services and city-wide programing. These funds could be used to build a new community center for the elderly or for other similar projects. The amount of funds described below under the 'community improvement funds spent' are from this CDBG. To better visualize how each of the community areas studied (in addition to Pilsen and La Villita, two historically Latin@ Chicago neighborhoods) compares to one another, I provide a table based on the data collected from the 1980 archives. For each of the community areas of this study, the following is highlighted below: the population change from 1980 to 1985, the unemployment rates from 1980 to 1985, the vacant acreage rate, and the community improvement funds spent.

From this small glimpse into a few decades ago, we can see the disparities in terms of CDBG funding allocation alone in the southwest (SW) side. The five SW community areas (in green) highlighted here had a total of $181,000 for community investment *combined,* whereas in three of the four NW community areas (in blue), the amount of funds spent in each area on community improvements surpassed this sum. Just think about the number of vacant lots for example, and what just one acre of land could do for these communities to serve as an epicenter for services, resources, and information delivery for the overall benefit of local communities.

Another aspect to consider is the sheer population size of these communities. For example, in the four NW communities, the total population included 278,332 residents, while in the five SW community areas, the total population was just shy of 100,000 (97,526). The population densities for these NW community areas were almost twice that of the SW areas. Additionally, the changes in population size, unemployment rates, and vacant acreage rates in each community area are also important to compare how they appear decades later between the NW and SW, which will be discussed later in this chapter. One note briefly is that the Logan Square community area continues to have a large population, but the SW has also grown drastically from these 1980s numbers, now reaching closer to over 40,000 and 50,000 residents in each of these SW areas (Acosta-Córdova 2017).

Table 2.1: *Chicago archives by community area* (1980-1985) (Source: Chicago Neighborhood and Suburbs: A Historical Guide 1985).

Community Area	Population		Unemployment rate		Vacant acreage rate	Community Improvement funds spent
	in 1980	in 1985	in 1980	in 1985		
Humboldt Park	70,879	75,214	12.9%	18.9%	8% (180/2250)	$352,000
West Town	96,428	97,599	10.9%	16.2%	8.2% (245/2955)	$5,037,000
Logan Square	84,768	84,021	9.4%	14.1%	4.4% (100/2245)	$504,000
Hermosa	19,547	21,498	7.8%	11.7%	3.3% (25/750)	$6,000
Lower West Side (Pilsen)	44,951	49,622	16.2%	23.4%	8.9% (160/1780)	$684,000
South Lawndale (La Villita)	75,204	86,068	13.7%	20.0%	11.7% (330/2810)	$556,000
Archer Heights	9,708	8,524	6.0%	9.1%	8.0% (105/1310)	$0
Brighton Park	30,770	31,557	7.7%	11.6%	7.3% (130/1765)	$0
West Elsdon	12,797	11,950	5.1%	7.8%	6.6% (50/750)	$6,000
Gage Park	24,445	23,417	7.8%	11.8%	4.8% (70/1435)	$175,000
West Lawn	24,748	22,078	5.4%	8.2%	3.2% (60/1845)	$0

The making of the Latin@ NW side community areas

Humboldt Park is the historic center of Puerto Rican Chicago. Although this was not the first place Puerto Ricans lived upon arriving to Chicago, this neighborhood was one of the last destinations of Puerto Rican displacement efforts. In the 1950s when larger waves of Puerto Ricans arrived to Chicago, most settled primarily in Lincoln Park and the Near West Side (south of West Town and north of Pilsen). As programs for urban renewal developed, Puerto Ricans were pushed out of their originally-settled communities. First they relocated to West Town, and then continued west from there into Humboldt Park, Logan Square, and eventually Belmont Cragin.

The context of Puerto Rican Chicago is embedded within development ideologies, labor history, place-making, and ethnic identity construction in a transnational context (Mumm 2014; Fernandez 2012; Perez 2004; Ramos-Zayas 2003; Padilla 1987) and is very much placed in Humboldt Park. Activist history can be seen in the creation of various centers like the Puerto Rican Cultural Center (PRCC), Casa Central, and ASPIRA. While the neighborhood boundaries are especially fluid between the Humboldt Park and West Town community areas, many community centers and resources are concentrated within the official West Town boundaries. For example, the renowned Paseo Boricua—marked by the tall steel Puerto Rican flags on each end—is housed within West Town.

Many Humboldt Park researchers have defined Humboldt Park or re-drawn the lines of the Puerto Rican Chicago community in their own terms. For example, Humboldt Park ethnographer Jesse Mumm defines the Humboldt Park neighborhood lines along the boundaries of Armitage Avenue on the north, Western Avenue on the east, Chicago Avenue on the south, and the diagonal line of the Milwaukee District/North Line railroad embankment on the west (Mumm 2014:145). This follows the most commonly understood and shared street borders used by local Latin@ residents, and represents an area of about four city blocks in any cardinal direction from the park itself (Mumm 2014:145). Other Humboldt Park researchers and activists have outlined a “Puerto Rican

Influence Area" (PRIA), defined as the area with census tracts where Puerto Ricans make up more than 10% of the total population according to the 2010 Census (Cintron et al. 2012:16). Within these lines, which crossed the community areas of West Town, Humboldt Park, Logan Square, Hermosa, and Belmont Craign, the maximum concentration of Puerto Ricans in the PRIA and the City of Chicago was 38% (Cintron et al. 2012:16). In 2010 there were 48,390 Puerto Ricans living in this Puerto Rican Influence Area, which accounted for nearly half (47%) of the total Puerto Rican population living in Chicago (US Census 2010). More recently, the Belmont Cragin community area had the largest total population of Puerto Ricans in the city (ACS 2011-2015). However, Humboldt Park and Paseo Boricua (officially West Town) remain the "political and cultural centers" of the Puerto Rican Chicago community (Acosta-Córdova 2017:69).

The long history of Puerto Rican activism in Chicago can be traced back to the 1940s. For example, Cruz (2009) presents a 1941 photo of Puerto Rican sugar workers who worked for an American-owned mill in Yabucia and who were on strike in search of higher wages and better working conditions (Cruz 2009:35). Labor unions from Chicago helped Puerto Rican sugar workers in their attempts to win higher wages, as can be witnessed in an early 1950s photo taken of well-known Chicago labor leaders meeting with local Puerto Rican sugar workers (Cruz 2009:36). These translocal networks returned to Chicago as well; some Puerto Rican sugar workers were photographed attending a 1956 national convention in Chicago of the United Packinghouse Food and Allied Workers of America (Cruz 2009:37). This particular Chicago union helped sugar workers in their efforts to win higher wages in Puerto Rico (Cruz 2009:37).

Along with the larger percentage of Latin@ residents in Humboldt Park, there is also a large black population, with 41% residents identifying as black, 52% Latin@, 5% white, and 1% Asian (Acosta-Córdova 2017:70). The looming threat of gentrification approaches the Humboldt Park community area from the east (from West Town) as well as from the north (from Logan Square, and the Bloomingdale "606" Trail). The cost of single-family housing increased by 21% in the fourth quarter of 2016 alone according to the DePaul Institute for Housing Studies (Acosta-Córdova 2017:76).

Latin@s began moving to Logan Square in the 1970s and by 1990, over 66% of its population identified as Latin@ (Patterson 2004). Since the late 1990s, Logan Square has had a larger total population of Puerto Ricans than Humboldt Park, despite Humboldt Park being a more famous Puerto Rican enclave (Acosta-Córdova 2017:53). Logan Square is also considered one of the centers of Chicago Latin@ culture, as it is known for having a diverse Latin@ population, evident in the annual "Taste of Latin America" food festival held every summer in Logan Square (Acosta-Córdova 2017:53). Since 2000, Logan Square lost more Latin@ residents than any other community area in the city. From 2000-2014 around 19,200 Latin@s left Logan Square, while the white population increased by 10,340 residents. Out of all the other neighborhood areas in this study, Logan Square is the area with the largest white population, with 47% Latin@, 44% white, 5% black, and 3% Asian (U.S. Census 2015). One of the contributing factors for the rise in housing stock can be attributed to Logan Square's participation in the Chicago Park Boulevard System. Such historic streets as Humboldt Boulevard, Logan Boulevard, and Kedzi Boulevard compose some of the most iconic housing stock in Chicago (Biasco 2016). Additionally, within its boundaries Logan Square has three different CTA train stations. Developers have created Transit-Oriented Development (TOD) near these stations, further exacerbating the land values and housing costs of the surrounding areas (Acosta-Córdova 2017:53).

Additionally, the renovation of the "606" Bloomingdale Trail between Logan Square and Humboldt Park have further accelerated gentrification on either side of this trail (Vivanco 2016). The 606, a title given to this trail representing the zip codes of Chicago—all the zip codes within the city limits begin with 606. Before 2015, the 606 was an abandoned elevated rail track and was restored in the summer of that year into a bike trail and small park. The effects of the renovation of the 606 were noted as a community concern by many community workers and activists as seen in protests during the aftermath of its renovation (Vivanco 2016). For example, one long-time community resident who has also worked for and with the community for many years shared with me:

> The 606, I know that before they started doing-and this is great because not only does it beautify the community but this incentivizes the community to be active! I mean this is fantastic. In that sense it's (the 606) fantastic, however bringing this 606 to the community has led to increased property taxes, and has led to a lot of-again people that have lived in their homes for forever, to have to move out. And whether they rent or they own- it's just too much rent-the taxes in itself, it's a lot. So the people that have been living here for a long time are really struggling to keep their homes-if they're still here.

On the surface Logan Square residents appear to have high household incomes, low homeownership rates, low rates of foreclosures, low unemployment rates, as well as a higher overall educational attainment (see Figure 2.6). However, when looking more closely into the economic and educational attainment statistics for the neighborhood, there is clear indication that the overwhelming majority of socio-economic issues in the area disproportionately affect Latin@s, which is a trend that exists in Latin@ neighborhoods where there is a significant white population. Thus, Logan Square is a prime example of the socio-economic inequalities that exist where whites and Latin@s are living in close proximity (Acosta-Córdova 2017:60).

The making of the Latin@ SW side community areas

The Brighton Park community area is located just south of Little Village, across the way of the South Branch of the Chicago River. It is one of the areas in Chicago to more recently become predominantly Latin@ (Acosta-Córdova 2017:101). Brighton Park has always been a working-class community, and it held some of the first stockyards in Chicago: it housed a live-stock trading center in the 1850s, although it did not see as much success as the stockyards in the New City (Back of the Yards) community area (Acosta-Córdova 2017:101). When the Brighton Park stockyards closed in the late 1860s, the economic focus in the area turned to the railroad industry, becoming a rail hub, and attracting many rail workers. Many Germans, Irish, French, Eastern European Jews, Poles, Lithuanians, and Italians inhabited this area. Through the 1960s—1980s, there was still a larger presence of ethnic Europeans and thus Brighton Park did not experience the same “white-flight” as seen in other south and west neighborhood areas of Chicago. The racial migration patterns seen in Brighton Park can be explained by a ‘not as economically mobile’ white working-class population, or the fact that area did not experience the same “block-busting” other areas did (Acosta-Córdova 2017:101).

“Blockbusting” was a common tactic by real estate agents to scare white property owners to sell their homes before it was ‘too late’ and their property values fell due the perceived integration of black residents (Hirsch 2005). Another name for this was ‘panic peddling’ and real estate agents often hired blacks to simply walk or drive around potential areas of turnover in order to further provoke white fears of black encroachment (Hirsch 2005). This tactic was common around white ethnic neighborhoods, especially along the SW and NW sides.

Neighborhood organizations took matters into their own hands in response to real estate manipulations, such as the Save-Our-Neighborhood/Save Our City (SON/SOC) coalition. The SON/SOC coalition was based out of two white ethnic Catholic organizations in the NW and SW, the Northwest Neighborhood Federation (NNF), and the Southwest Parish and Neighborhood Federation (SPNF). The SPNF began in 1971 in two SW side Catholic parishes, St. Gall (Gage Park) and St. Nicolas of Tolentine (West Lawn), “with the help of the Catholic Charities of Chicago” (Green 1988:25). The SPNF fought the manipulative ‘panic peddling’ real estate tactics, and the city of Chicago for designated the SW as the battle ground of integration. In 1974 the SPNF took on Talman Federal, the leading community realtor through which the SPNF was able to gain the lending data of Talman (Green 1988:25). Then in 1976 the SPNF took on Talman Federal again in efforts to fund redevelopment proposals for the 63rd Street (white) ethnic homage and commercialization; and for “new moderate-income housing” east of Western Street (Green 1988:25)—the border between the Chicago Lawn and Englewood community area.

On the NW side, the Northwest Neighborhood Federation (NNF) took form in 1976 within the home to two residents in Logan Square (Green 1988:26). The NNF worked to fight the Daley (Sr.) administration in the ‘Crosstown Expressway’ which would have put thousands of residents out of homes. Both NW and SW neighborhood organizations linked together 1984 under SON/SOC and held the “first-of-its-kind white ethnic convention to be held” on the anniversary of Mayor Washington’s inauguration in 1984 (Green 1988:26). As one leader explained, this convention was in efforts to “show the mayor that we could organize to defend our neighborhoods, tell him that we wanted to be part of the city and at the same time let him know that we were not 'sheet people' [supporters of the Ku Klux Klan]” (Green 1988:26).

The other side of ‘block-busting’ tactics was redlining, the “selectively granting (of) loans and insisting that any property insured be covered by a restrictive covenant—a clause in the deed forbidding the sale of the property to anyone other than whites” (Coates 2014:37). Ta-Nehisi Coates’ historical and political tracings of redlining practices in Chicago demonstrate the role of private corporations, the federal and city governments, as well as local community residents were pivotal in these discriminatory and inhumane policies succeeding. More recently, there have been cases of ‘reverse redlining’, or “predatory lending, where banks reserve high-interest loans almost exclusively for people of color” (Mock 2015:2). Other forms of spatial marginalization include a company’s refusal to deliver services to black and brown neighborhoods (Mock 2015). Services such as utilities, and internet more specifically have been turned “FioS redlining” (Mock 2015:4), similar to “broad-band deserts” seen in eastern Kentucky (Kingsolver 2016:42), each products of uneven infrastructure distribution.

Within the Brighton Park neighborhood there was never an “influx of African-American residents to the area” (Acosta-Córdova 2017:101), and it can be argued that Brighton Park did not have the same racially-motivated limits to economic development many other black south and east side neighborhoods had, nor did Brighton Park experience the extent of urban decay as seen in other south side neighborhoods (Acosta-Córdova 2017). By 1990, Brighton Park was roughly 37% Latin@, but still more than 63% white, one of the only areas left on the south side that was majority white (Stockwell 2005). By 2000, Latin@s made up 77% of the population. More recently, Latin@s made up roughly 83%, with the white population dwindling to 8%, and the Asian population marked at 7% (ACS 2011-2015). Brighton Park is one of the only community areas on the south side that did not lose population between 2000 and 2010 (Acosta-Córdova 2017:101). Like the majority of predominantly Latin@ Chicago neighborhoods, income and educational attainment are the two main socio-economic challenges facing Brighton Park. Brighton Park's working-class character has not changed in over 150 years. With this community area representing the largest Latin@ community south of the South Branch of the Chicago River, how well it does can have a "ripple effect" on the many other predominantly Latin@ communities around it (Acosta-Córdova 2017:108).

Just south of Brighton Park sits Gage Park, sharing many characteristics with its neighbor. Gage Park is bordered and enclosed by railroads and is also connected to the Chicago Park Boulevard System along Western Avenue and Garfield Boulevard. In 1990 this community was still predominantly (70%) white, but by 2000 Gage Park was 79% Latin@ (Acosta-Córdova 2017:109).

During the 1960s, Gage Park and the neighborhood directly south, Marquette Park (also known as Chicago Lawn), were used for testing integrated and open housing for blacks (Acosta-Córdova 2017:109). This brought with it many racial tensions to these areas. In 1966 when Martin Luther King, Jr. led a march to Marquette Park, he was met with violent resistance from counter-demonstrators. In 1972 when Gage Park High School was integrated, this historic moment was also met with major resistance by the majority-white community in the form of a boycott. To help ease these tensions several community groups were formed during the 1970s and 1980s to “stabilize” the area (Acosta-Córdova 2017:109). Organizations such as the Southwest Community Congress were formed to improve local race relations, and the Southwest Parish and Neighborhood Federation was aimed at stopping the blockbusting tactics by the real estate industry. This led to the creation of the Southwest Community Development Corporation, which was intended to work on commercial revitalization in the area (Acosta-Córdova 2017:109).

These efforts by the community maintained the middle-class character of Gage Park, even as it grew more racially diverse (Acosta-Córdova 2017:109). Currently, Gage Park boasts one of the highest percentage of homeowners (46%) among the predominantly Latin@ Chicago neighborhoods (see Table 2.3). In comparing average household incomes in 2015, Latin@s in Gage Park earned about $49,172 per year, while whites and blacks in the same area earned $37,247, and $30,677, respectively (Acosta-Córdova 2017:112). These averages are still well below the overall city and county average of $52,450 per year (see Table 2.2).

As late as 1990, the West Lawn population was still predominantly (88%) white, with only 11% of the population identifying as Latin@ (Knox 2005b). By 2000, the white population had decreased to 44%, and the Latin@ population had risen to 52%. Over the next 10 years, the Latin@ population rose further to 80%, and the white population decreased to 16% (US Census 2010).

Table 2.2: *Latin@ households across community area* (Sources: Acosta-Córdova 2017 and ACS 2015).

Community Area	**Median Income Latino Households**	**Average Income Latino Households**	**Percentage of Latino Households below Poverty Line**	**Percentage of Latino Adults 25+ with Bachelor's Degree or Higher (2010)**
City of Chicago (Total pop.)	**$48,522**	**$74,003**	**22%**	**34%**
City of Chicago (Latino pop.)	**$41,513**	**$54,696**	**24%**	**16% (2016)**
Humboldt Park	$34,417	$45,273	29%	11%
Logan Square	$34,329	$50,239	26%	11%
Lower West Side	$33,054	$42,498	30%	10%
Brighton Park	$36,639	$45,234	28%	6%
Gage Park	$40,284	$49,172	22%	5%
West Lawn	$52,824	$60,682	15%	6%
Chicago Lawn	$41,262	$48,570	25%	5%

West Lawn did not experience urban growth until the 1920s when settlers from neighboring Chicago Lawn settled the marshy West Lawn lands. German, Irish, Czech, Polish, Italian, and Lithuanian migrants had all settled in this area as employment was abundant because of the growing influence of nearby Midway Airport (Acosta-Córdova 2017:117). Industrial development and a large bomber engine factory during WWII (later to be a Ford automobile manufacturing plant) all contributed to the growth of West Lawn

Acosta-Córdova 2017:117). The area around the intersection of Pulaski Road and 63rd Street also became a major commercial and retail center (Acosta-Córdova 2017:117).

Although the median income of Latin@s in West Lawn is higher than that of whites, 40% of Latin@s in this area lack a high school diploma, and only 6% have a Bachelor’s degree or higher (ACS 2011-2015). While this community is more middle class than other neighboring south side communities, the issue of educational attainment remains pertinent (Acosta-Córdova 2017:117). Apart from the central core of Chicago, West Lawn saw the biggest percentage increase in population at 14% (Acosta-Córdova 2017:118).

Chicago Lawn began to grow rapidly throughout the 1920s and 1940s when many ethnic European groups such as the Germans, Irish, Lithuanians, Poles, and Bohemians all arrived to the area then known as a “thriving urban neighborhood.” During a 20-year span, the population grew from 14,000 to nearly 50,000 people (McMahon 2005). Chicago Lawn became infamous after the 1966 march Dr. Martin Luther King, Jr. led pushing for integrated housing, after which neighborhood residents violently opposed these Civil Rights marches. In 1990, the neighborhood’s demographic composition was 52% white, 27% black, 28% Latin@, and 2% Asian (Acosta-Córdova 2017:125). By 2000 the white population had decreased to 24%, with the black and Latin@ populations growing to 53% and 35%, respectively. By 2010, the Latin@ population had grown to 45%, while the black population slightly decreased to 50%, and the white population dwindled to 4%. In 2015 Latin@s surpassed blacks as the predominant group with 48% of the population compared to 47% (Acosta-Córdova 2017:125).

Table 2.3: *Latin@s homeownership rates and land vacancies across community area* (Sources: Acosta-Córdova 2017and ACS 2015).

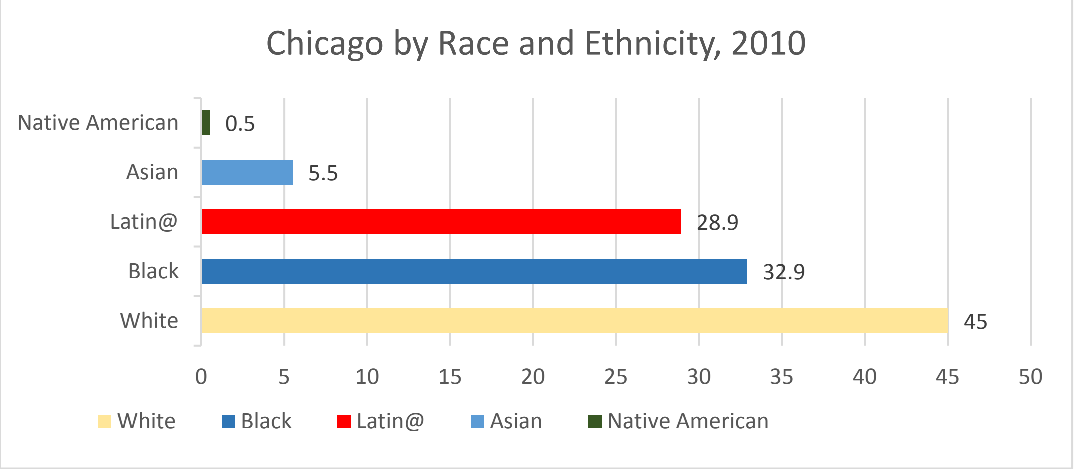
AREA	**Homeownership rates**	**Owner-occupied**	**Vacant Housing Unit rates**	**Long term vacancies**	**# Housing units**
CHICAGO	**44.0%**		**13.2%**		
Logan Square	**36.6%**	**30%**	**10.1%/13.2%**	**93%**	**<33,000**
Humboldt Park	**36.2%**	**27%**	**15.9%/12%**	**67%**	**>20,000**
Lower West Side	**26.6%**	**26.6%**	**13.5%/13%**	**86%**	**<14,000**
South Lawndale	**35.7%**	**26.2%**	**16.0%/11.1%**	**88%**	**>21,000**
Brighton Park	**46.2%**	**36%**	**14.0%/4.5%**	**77%**	**>14,000**
Gage Park	**55.6%**		**8.7%**		
West Lawn	**72.2%/69%**		**7.2%/10%**	**84%**	**9,362**
Chicago Lawn	**44.7%**		**16.2%**		

Where these communities are today

In the following sections, I will provide snapshots into demographic and statistical information for each of these neighborhood areas in order to set up a general context for how these communities look today. I rely on secondary data for this portion, especially a report by Jose Miguel Acosta-Córdova—based on US Census data—comparing 12 different predominantly Latin@ neighborhoods in Chicago (2017). This report gathered details within specific neighborhood areas about racial and ethnic demographics, household income, homeownership and house vacancy rates, educational attainment, and health insurance rates. Although not all the community areas I have studied were included in this report, it still provides key insight into broader issues that continue to challenge Latin@ communities in Chicago. In particular disparities in terms of educational attainment and income levels are consistent barriers for Latin@ communities throughout Chicago.

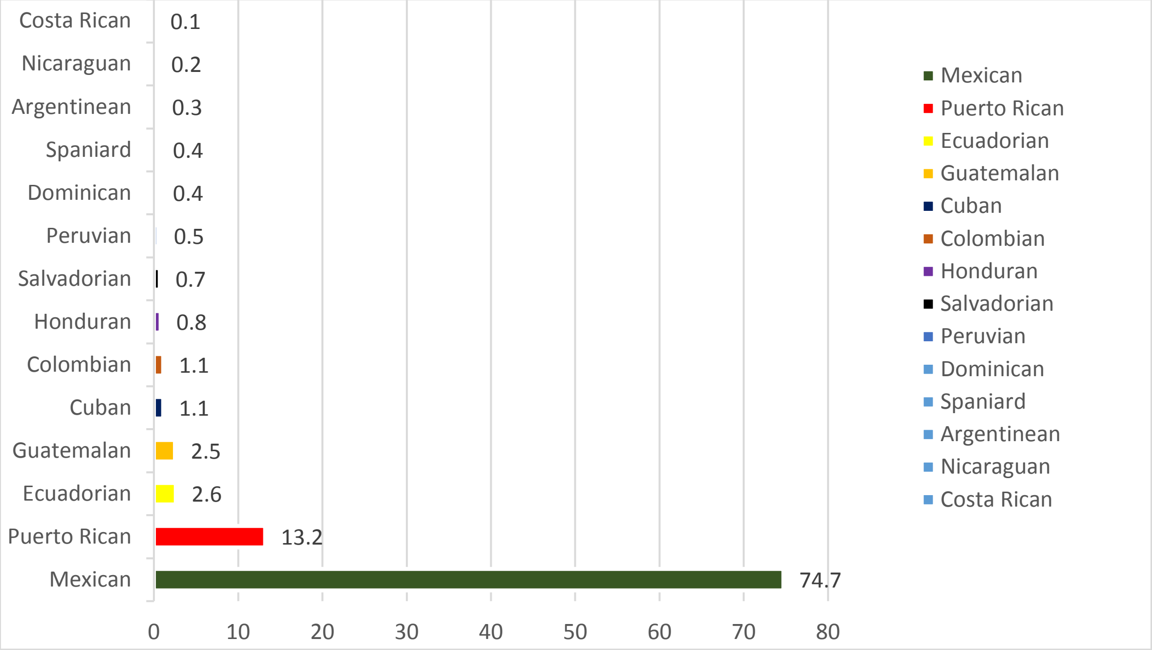
In Chicago the number of Latin@s has grown from 19,362 in 1930 (Reisler 1970:101) to 803,476 in 2016 (ACS 2016). As of 2016 Latin@s became the second largest racial/ethnic group in Chicago (ACS 2016). According to this survey in 2016, 32.6% of the Chicago population identified as non-Hispanic white, 29.7% identified as Latin@, 29.4% identified as black, and 6.3% identified as Asian (see graph below). Between 1970 and 2004, Latin@s accounted for 96% of the Chicago metropolitan region’s population growth (Ready and Brown-Gort 2005). Not only are Latin@s on average the youngest residents of Chicago, Latin@s are also the largest group of students in Chicago Public Schools, accounting for 46.8% of the CPS students, compared to 37% black, 10.2% white, and 4.1% Asian.

Figure 2.4: 2010 Chicago population by race/ethnicity (Source: US Census 2010).



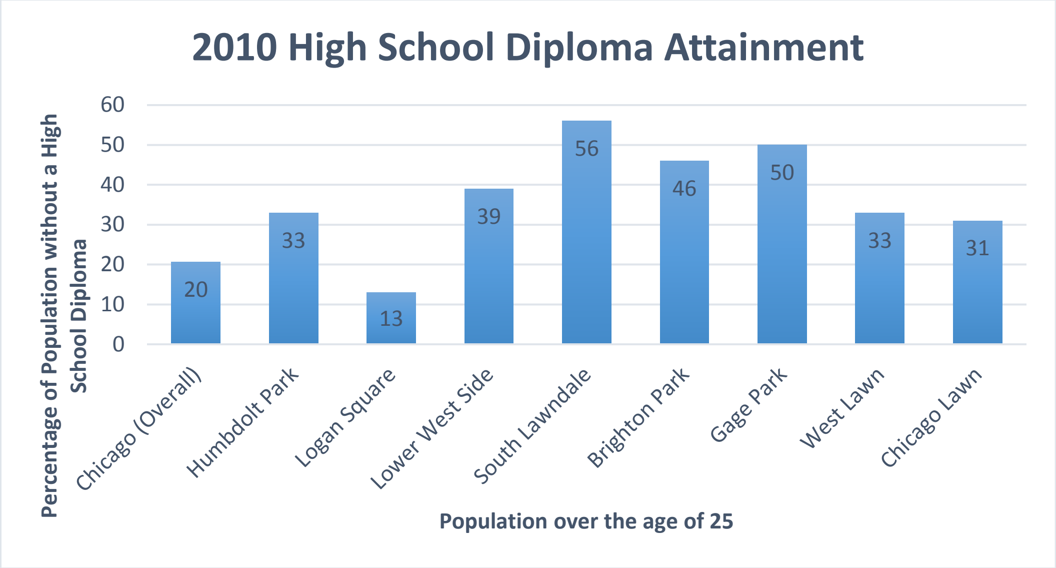
Additionally, the various Latin@ countries of origin are vast across the community areas in this study. Throughout all Chicago community areas, people who identify as having Mexican origins are the majority. More diversity across country of origin is seen in the NW areas with 52% identifying as Mexican and 37% as Puerto Rican in Humboldt Park, and in neighboring Logan Square 55% of residents identify as Mexican and 31% as Puerto Rican. In the SW areas, the percentage residents with Mexican origins is closer to 91%-94%.

Figure 2.5: Latin@ Chicagoans by country of origin (Source: Acosta-Córdova 2017).



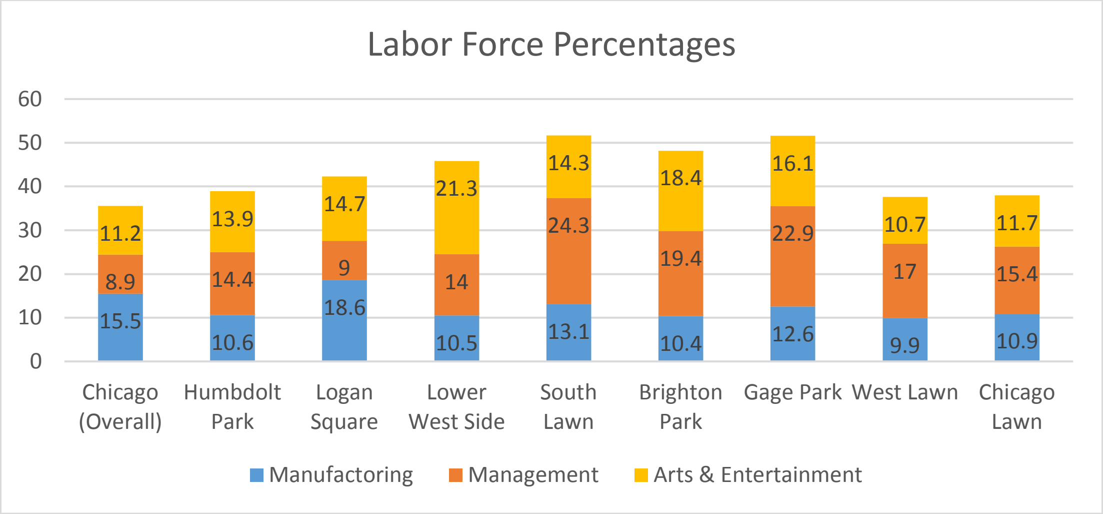
Acosta-Córdova also noted that overall education is one of the biggest disparities seen among Latin@ neighborhoods as seen in high school diploma rates:

Figure 2.6: Chicago rates of high school diploma attainment by community area (Source: Acosta-Córdova 2017:33).



In terms of the workforce within these predominately Latin@s neighborhoods, Latin@s have higher concentrations of their labor force in manufacturing and other typically low-paying service industries and lower concentrations in higher paying service industries (see figure below).

Figure 2.7: Latin@ formal labor force across community area (2011-2015) (Source: Acosta-Córdova 2017).



Differences throughout NW and SW community areas

Health care facilities

Throughout the city, aside from the slew of private practice/clinic facilities, there are also several big-name healthcare facilities with various dispersed satellite clinics, such as Erie Family Health Clinic: in the NW area, there are two different branches of this clinic located just blocks away from each other. The Northwest Clinic, where I volunteered (from 2016-2017), was a huge resource for the community, especially for undocumented residents. Near the corner of Western and Division streets, there are two big healthcare and hospital providers, St. Elizabeth and St. Mary. Additionally, Norwegian Hospital is nestled within Humboldt Park and opened a Diabetes Center for its patients.

The SW side of Chicago has been known as a 'clinical desert' as the options for emergency treatment are limited. As far as hospitals with emergency capacities, there is just one, Holy Cross Hospital. This is a disparity that its Southside neighbor, the University of Chicago (located in Hyde Park), is beginning to address. The university is planning on turning the hospital into a level 1 trauma unit by partnering with Mount Sinai hospitals to add more hospital beds and a whole new hospital wing. For primary care, I observed that Access Health was a popular healthcare facility residents utilized. There was a local branch of the Mercy Hospital facility, where my family and I went for our personal well-care visits, and it was also noted as a resource by some residents of the SW side. There were also several pop-up sliding scale clinical facilities that residents identified as places where they sought care. One of the local schools even provided their own clinic that parents could use to attain primary care. One of the mothers I met who seemed to never stop took advantage of that clinic in order to facilitate accessing her primary care needs.

Another trend I heard from residents was their use of healthcare facilities that traditionally served Latin@ communities such as Alivio Medical Center, founded in 1989 by Mexicana Carmen Velásquez, which serves residents of Pilsen, La Villita and Back of the Yards, regardless of their ability to pay (Alivio 2018). Velásquez' father, Arturo Velásquez, was a successful businessman and is commemorated in a mural at Arturo Velásquez West Side Technical Institute, a branch of the City Colleges of Chicago also named in his honor (Cruz 2009:54). Another center, the Dr. Jorge Prieto Medical Center (located in La Villita), named after one of the first Latino doctors to practice in Chicago (Cruz 2009:51), was also a site utilized by residents living in the SW.

Community centers and resources

Throughout the 1950s and 1960s many Latin@ Chicago neighborhoods established important resources: the Humboldt Park area and surrounding areas witnessed the founding of several Latin@ organizations at this time. The centers I came to learn from throughout my research include the BC's branch of the HPHC and Northwest Clinic (both are technically located in West Town). There are many other centers such as Association House, Casa Central, Casa Puertoriqueña, LUCHA, Hispanic Housing Development Corporation, and the many other branch programs of the PRCC. Casa Central was founded in 1954 by a multi-denominational group of churches in order to provide social services to the Hispanic population of the NW area. Since then, Casa Central has evolved from an organization with three employees and a $26,000 annual budget to an acclaimed model agency with over 550 staff members and a $17-million-dollar annual budget (Casa Central 2018). Casa Central is now the largest Hispanic social service agency in Chicago and arguably in the country, providing programs for all ages (Casa Central 2018). The 1966 Division Street riots resulted in the establishment of the Borinquen Center (BC) in efforts to address fundamental needs in the Puerto Rican/Latino communities of Humboldt Park, Logan Square, and Hermosa. The BC is a community-based, grassroots, educational, health, and cultural services organization founded on the principles of self-determination, self-actualization, and self-sufficiency and is activist-oriented and continues to be pillar of the community today.

Other community centers like Casa Puertorriqueña offer a place for residents to play weekly bingo or dominos. They have also held job fairs in the past to help Latin@s fill out job applications and find employment (Cruz 2009). This space is also the headquarters of the People’s Day Parade, the annual Puerto Rican parade that takes place each June in Chicago. The HPHC *Activate* Founder and Director also led the Parade organization committee and often had her most committed *Activate* ladies kick-off the parade with their unified new shirts of the year. Floats were often represented by the PRCC (usually one of the first floats), and many of its branch programs each had their own floats, including the Chicago Park District, Chicago Water Management, and a couple of the local high schools, among others. After the floats came the waves of motorcycles, later followed by the various kinds of cars — a fleet of shiny nice lowriders, then all the differently colored jeeps, and then the rest of the cars brought up the tail end of the parade. There is not any particular brand or model of car being promoted, just the Puerto Rican pride evident in the various paraphernalia decorating each of the vehicles that passed, for example. Many people come from the surrounding Midwest areas for this annual event, jumping on the opportunity to be with family and to have summer cookouts under the hot sun.

Association House, another center, was established in 1899 and served initially as a ‘port of entry’ for new immigrants. Today Association House continues to provide a slew of services for the NW areas including counseling, educational, athletic, and vocational programing (Association House 2018). Before the school year started they held a back-to-school fair where they offered free school supplies and the first 100 kids received a brand-new backpack. Each summer also they held a health fair during which they had instructors teach different ways of keeping one’s body in motion, offered free healthy snacks (apples, bananas, granola bars, and water bottles), and had local community organizations “table” along the edges of the parking lot where the fair took place. Each hour they raffled off three different items, keeping residents interested—who would stick around with the hope of their luck landing them a prize. When I attended this health fair in 2017, one of the services being offered at one of these side tables was the Association House’s very own ACA enrollment assistance counselor. The Latina counselor was handing out flyers with her contact information. She had added in sharpie her personal cell phone number above the extension number advertised in the flyer—in case anyone had trouble reaching her at the office. I later used this number to connect a resident with this counselor since they explained their frustration after years of applying for medical coverage to no avail.

In terms of housing, other organizations such as LUCHA have been extremely influential in combating gentrification in the NW areas. LUCHA was founded in 1982 to stabilize the neighborhoods of the northwest side of Chicago and to champion the housing interests of community residents (LUCHA 2018). The Hispanic Housing Development Corporation (HHDC) since its founding in 1975 has helped create affordable housing throughout several Latin@ Chicago neighborhoods (although primarily in the NW). The HHDC President and CEO, Hipolito (Paul) Roland, a Puerto Rican, has been the executive director for more than 30 years and has led the way in developing over 1,900 affordable apartments and townhouses for Latin@ families (Cruz 2009:108). In 1998 he was awarded a $250,00 MacArthur Foundation Genius Grant and used $100,000 of that grant to establish a college scholarship to attract Latin@s to the field of community development (Cruz 2009:109). Among the 26 different HHDC properties displayed on their website, there is only one HHDC building around the SW side of the city, in the Englewood community area, whereas the other 90% of the properties are clustered around the NW side of the city.

In the southwest side of Chicago there are some community centers and resources organized by grassroots efforts. Among the organizations that I interacted with are the Latino Organization of the Southwest (LOS), the Metropolitan Family Services, and the Southwest Organizing Project (SWOP). Among these it seems that SWOP has more reach and connection to the community, especially given the sheer number of grants this organization manages, compared to LOS.

The Greater Southwest Development Corporation’s (GSDC) primary goal is to improve the entrepreneurial, commercial and residential real estate development in the SW. This organization was formed in 1974,

> …as a result of organizing efforts to hold banks accountable for the growing disinvestment in the Chicago Lawn neighborhood. At the time,

> the area was experiencing violent racial conflicts and GSDC’s early efforts were largely focused on easing racial tensions and stimulating economic investment. Today, the Chicago Lawn neighborhood reflects a diverse community and GSDC’s work over the years has contributed to the area’s continued level of economic investment (GSDC 2018).

They describe the neighborhood history as follows:

> Chicago Lawn experienced tremendous growth during the early and middle parts of the 20th century and by the 1950s, much of the area was surrounded by many working families. As the years progressed, however, the entire Marquette Park community gained notoriety for the racial strife imposed by outside groups. Open housing marches drew the ire of local residents and resulted in rock throwing and protests. The turbulence continued until the 1980s, when committed residents finally began to win the fight. Today the area is truly ethnically and racially diverse with a heavy population of Eastern European (many Lithuanian), Hispanic, Middle Eastern and African American residents (GSDC 2018).

I found the history told on SWOP’s site to be more accurate, as they stated:

> Once known for the race riots that erupted when Martin Luther King, Jr. marched here in 1966 for open housing, Chicago’s Southwest Side neighborhoods are now very diverse. No longer white-ethnic and predominantly Catholic, there has been a dramatic increase in the Latino and African American populations in these neighborhoods since the 1990’s. These large and rapid demographic shifts resulted in the breakdown of institutional and neighborhood cohesion, as long-term residents moved out and new residents moved in. Families no longer knew one another – the old networks were gone and new ones needed to be created (SWOP 2018).

The GSDC founding executive director, James “Jim” Capraro, is the son of Italian Catholic immigrants and grew up in the Chicago Lawn area during the 1950s and 1960s. Under Capraro’s direction, GSDC achieved over $500 million in community development projects and created or retained over 6,000 jobs for his neighborhood (Headley and Krol 2015:106). His development projects included the $300-million expansion of Nabisco, the world’s largest bakery under one roof (Headley and Krol

2015:107). Under Capraro, GSDC was designated the National Neighborhood Reinvestment Corporation as a national model for commercial revitalization and selected as the recipient of the Outstanding Community Development Organization award (Headley and Krol 2015:107). With these funds they have also established 248 units of senior rental housing, rehabilitated abandoned single family homes to sell to first-time home buyers, generated $100 million in retail development, and cleaned a 60-acre brownfield site to allow construction of a manufacturing site. In February 2016 they transformed a former Chicago Police Department Station and empty lot into a 40-bed domestic violence shelter (GSDC 2018), one of the few in the southside (Bennet 2016).

Betty Gutierrez is another longtime community leader. Since she moved to her West Lawn bungalow with her husband, Francisco, and three daughters in 1984, she has "never stopped working as a fervent advocate of her neighborhood" (Headley and Krol 2015:120). She has served on the parish council of St. Mary Star of the Sea, served as the president of the Our Lady of Guadalupe committee, acted as team mom for the West Lawn Little League, served on the advisory board of the Southwest Youth Collaborative, and served meals to the homeless at the Pads shelter for the past 18 years. Within the GSDC, Betty Gutierrez served as the director of housing, coordinating three housing programs including the Housing Resource Center, the purchase and rehabilitation of foreclosed properties, and home repair (Headley and Krol 2015:120).

SWOP was originally formed in 1996 by a group of local Catholic priests to encourage a multi-racial and multi-cultural response to the growing racial, cultural, and economic diversity seen in the SW. As time passed, these priests realized the importance of establishing a broad-based, multi-faith community organization to represent the diversity of interests in the SW. Now SWOP consists of 34 different institutions spanning across Christian, Muslim, and Jewish faiths, public and private schools, and other institutions in the SW. Their service areas are concentrated in the Chicago Lawn, Gage Park, West Lawn, West Elsdon, and Ashburn community areas. SWOP is particularly known for their efforts in ending predatory lending and foreclosures, reducing community violence, advocating for the rights and protecting the civil liberties of immigrants, and improving achievement in public schools through parent, student, and school staff engagement (SWOP 2018).

In 2012 members of SWOP joined together to walk with Lisa Madigan—the first female attorney general in Illinois—to tour the eastern end of the neighborhood. Madigan diligently fought against predatory lending practices within Chicago Lawn and West Lawn and was willing to hold major offenders of those practices accountable. Her visit to SWOP in 2012 was to discuss housing issues in the area (Headley and Krol 2015:121). In 2013 SWOP won the John D. and Catherine T. MacArthur Foundation Award for Creative and Effective Institutions, highlighting the anti-foreclosure work and the quality of community organizing they had carried out. Among the local public schools and their parent programs I have observed through this study, SWOP is the only one that provides a stipend to the parents serving as volunteers in their children's schools in the SW, and SWOP ensured that undocumented parents did not have to worry about providing a Social Security Number in order to get paid. A similar neighborhood organization in the NW provided this same opportunity for their local Chicago Public Schools (CPS) parent mentor programs.

LOS was founded in 1992 by Hector Rico. I had the opportunity to interview one of LOS's original leaders, Guillermo, who started working for LOS in 1995 and has been with this organization since then. He re-told the LOS history to me (as told by founder Hector Rico): their director started the program in a nearby church basement. Each Sunday he would set up in an empty desk and listen to the concerns of local residents and try to find ways to help them in each of their cases. After gathering enough momentum, support, working hands, and funding, LOS was able to get situated in its own community center. Now three different locations later, they are still situated in the SW but funding—and subsequently the volunteers—are scarce. Guillermo told me that, when the money came in, everyone would come and the place would be full, all the offices in full motion and volunteers waiting to be put to work. But when the money had yet to drop, hardly anyone could be seen in the center. He said that there are certain people, three or four, that would always be there regardless, whether he and the others were getting paid or not. He was very vocal about his critiques of the governor at the time, who he faulted as the reason why their organization—as well as other nonprofit organizations—were 'muertos de hambre' [dying of hunger] waiting for their funding. Among the people who are the backbone of LOS, ensuring that their services are still being offered despite 'working for free,' were Guillermo, who taught the citizenship classes and English language classes, and Gwen. Gwen, another Latina, helped residents apply for benefits such as the medical card, SNAP assistance and other city and federal programs. Another Latina was in charge of accounting and occasionally helped residents with taxes and assistance in paying for gas and electric services in their homes. Guillermo mentioned that although they had been stationed at their current center since 2002, they were looking to move to another site because their current space was not big enough. They had their eye on another building, but it was just a matter of having the funding available to pay the rent—funding they were still waiting on to 'keep the lights on' in their current site as of August 2017.

Metropolitan Family Services began in 1857 and was originally named the Chicago Relief and Aid Society. Soon after its founding, this organization was crucial in rebuild Chicago after the Great Fire of 1871 by administering relief in the form of money and goods. Throughout the years this organization's name and services grew from poverty prevention, free legal services, and food services during the Great Depression, to spanning services focused on "education, economic stability, emotional wellness, and empowerment" (Metropolitan Family Services 2018). They have various community centers throughout the city and in several nearby suburbs.

One of their centers is just down the street from where I used to live, off 63rd street, and is known as the 'Midway' satellite site. When I came to this center to inquire more about their services, I was asked if I had an appointment with someone as the receptionist seemed to debate whether or not she should 'buzz me in.' It was a windy day and Leo was not happy about how I had covered him and blocked his view in the stroller. After passing the heavy black metal-framed glass doors, I asked the young receptionist more about the services they offered at this site. She proceeded to share their general flyer with me and directed me to their central phone number, which she told me to call so that they could tell me more about the services offered. This center was more like a set of cubicles where individual staff met with residents based on what they needed. When I was in need of assistance with child care, I called this number and was transferred to the staff person in charge of child care. She was on vacation so I left a voicemail; we played phone tag for a few weeks before we were finally able to connect. She was very helpful and informative: she answered all my questions and concerns and went over my options with me. She was particularly interested in recommending to me their Head Start program, which—if we qualified—was free; parents could drop off their children at nearby centers (they worked with other day care facilities, not only other Metropolitan Family Service sites). Some programs even offered dual classes such as cooking demonstrations for both the parents and their children. When I inquired where the nearest child care center was that I could take my 1-year-old to, the options were slim. There was one somewhat nearby, but the openings for that age group were not certain. The sites that did have openings would have required a 20-30-minute drive to the south, or a 40-minute drive to the north.

Chicago Public Schools

The Chicago Public Schools were a tremendous resource for the community in both the NW and the SW communities in which I worked. Many of these schools had volunteer programs for parents whereby they offered a small stipend for volunteering throughout the school year. Additionally, schools (especially the public elementary and middle schools) offered parents English classes, GED classes, or even computer training. Weekly leadership workshops, health education, or other general education classes were often offered to all parents at these schools (within both areas). Not all schools had the same resources but most had some base of parent volunteers actively involved in the volunteer work at their child's school.

Just as the history with the community organizations in the NW, many of the schools in the NW had deep-rooted connections with the surrounding Latin@ residents who had resided in the area since the 1960s. For example, a local principal of one of the elementary schools in Logan Square is the daughter of parents who migrated from Puerto Rico: she was born in Chicago and raised along with her six siblings in a nearby well-known housing project (Cruz 2009:108). Two master's degrees later, and after years of working with the Chicago Board of Education, this principal remains engaged with her school and community to this day. In the Parent Advisory Council (PAC) meeting I attended for this school, she translated each of the reports done in English for the group of Spanish-Speaking mother volunteers who were always actively involved in school initiatives. This principal was known to be very involved with her school community by making a point to attend each PAC meeting and be present in various school initiatives.

Botanicas

A botanica is an "herbal and natural medicine store" (Schwartz and Pepper 2009: 350) and are commonly used as a form of alternative medicine or complimentary medicine among some Latin@s. Botanicas were seen in both the NW and SW sides of the city, although seen in greater quantity in the SW. Just on Paseo Boricua there is one botanica. When I visited, a large-bodied woman sat behind a glass shelf waiting for people to come in. Her cat laid curled up in its bed next to her feet. The side walls were filled with large statues and patron saints. Similar to the more Catholic-affiliated botanica, this botanica stocked mostly momentous for practicing faith outside of the church and building shrines at home.

In the SW, within a couple of blocks from where I lived, there were three botanicas. But what is considered a botanica should not be taken at face value. For example, the three botanicas near my home were each completely different: one was (unofficially) affiliated with a nearby Catholic parish and sold crosses, saints, bibles, rosaries, candles—material items to accompany any devoted Catholic in making their own shrines at home. The other one was much larger and had a glass case with several rosaries, candles, bracelets with their own purpose, and other such items. Behind the glass case, the wall was well-stocked with different remedies (herbal, powders, pills), bottles, teas — all within reach for the person behind the counter attending customers as they walked in. The store-front was a bit dark; only the sunlight seeping in from the large windows in the front of the store allowed for the contents of the room to be visible. As I walked in, a bell rang and a thin man came to attend me from the back of the room. He asked me in English how he could help me, and I responded in Spanish, asking about what they offered at their site. Immediately he explained that they offered ceremonies to find someone, caracoles, limpieza and the like. I inquired if they did anything specifically for people who have diabetes, high blood pressure, or high cholesterol and he said yes, that the doctor can treat people who have these conditions, but that it was on a case-by-case basis. I asked if I could possibly meet with this doctor as I was interested in studying these topics, and he said no—that was not going to be possible. He said that if I wanted to see the doctor, I would have to pay for an appointment. I thanked him and left.

Another more popular botanica in Gage Park, located off another well-trafficked street, was more like what one would envision as a ‘traditional botanica’ (or at least in my mind). In the front was a table with 40 different containers of different dried herbs. Draped along the front end of this table was a poster with the original signage of this botanica from its original site in Pilsen. A U-shaped glass casing framed the edges of the store displaying rosaries, bracelets, and small saint statues. Behind the glass casing the back walls were covered with shelving with larger statues, crosses and saints on one side. The opposite side appeared more like a pharmacy covered with different pill bottles and powders for the specialist to mix together based on requests. There were a couple of shelves in the middle stocked with various teas, seeds, and such.

On one of the occasions when I came here, I asked the owner/specialist if she had recommendations for people who have diabetes, high blood pressure, and high cholesterol. She seemed surprised or overwhelmed by the question, and asked if I expected her to explain what she recommended for each one. I recanted, expressing that perhaps I could set up a time to talk with her one day when she was not too busy to discuss these topics. She said she did not think so, and brushed me off as another customer walked in. I continued looking around hoping to convince her otherwise. An older man had come in walking with a cane and a couple of plastic bags in hand. He asked the specialist what she could offer for the kidneys. He had diabetes and wanted to clean his kidneys. The specialist asked a few more questions inquiring about his symptoms and his desired outcomes and soon got to work gathering and mixing together items from the front containers and the powders along the back shelves behind the glass container—pivoting between different corners of the store. In the midst of her mixing and gathering, the man disclosed that he was having night sweats, and the specialist responded, noting the crucial tidbit of information that was just added to his diagnosis, and adjusted her treatment accordingly.

Immediately following this rejection, my protective, intimate Cuban familial explanation came to mind, ‘ella era una vieja equivocada’ [she was a misdirected lady] who did not want to give me the time of day and it was her loss in denying the engagement of this dialogue. But after further reflection, maybe she was just unsure of who I was, perhaps fearing the worst, for example an undercover reporter trying to uncover illicit activities (which to my knowledge do not occur). Or perhaps she was disinterested in having an apprentice that particular day, or because she did not see the investment of her time and experience to benefit her in any way—about which she was right.

Another botanica I had been to made more business with their services than their products. For example, one botanica in the SW had a man who performed ‘soba’, a kind of massage done to an affected part of the body. I accompanied a man who had injured his ankle playing soccer, Pedro. His ankle had been bothering him for weeks, and a comadre recommended this man ‘que sabia como sobar bien’ (who knew how to massage well). This comadre instructed us that the hours of this service were broken into two parts of the day, between eight to eleven in the morning and three to six in the afternoon. We arrived just before the three o’clock shift, and there was already a line outside of the botanica of others waiting to be treated. I estimated us to be around fifth in line. It was chilly outside, and even more so as the winds picked up. A white minivan with its engine running stood parked towards the front door of the botanica. As we approached someone came out of the minivan reclaiming their spot towards the front of the line. I thought they were waiting in their car because they were cold.

When the botanica doors finally opened just past three o’clock, we soon learned that the person who needed to be treated from the minivan, an elderly man, was waiting in the car because he could barely walk, much less stand or sit in the waiting area. You could feel the effort this man was making -as he was escorted by each hand -to walk to the back of the room. When this man walked out, you could tell his whole body was so much more relaxed, and he only held on to his assistant by one arm as he walked out (mostly) on his own. Soon it was Pedro's turn to be seen and he limped in alone.

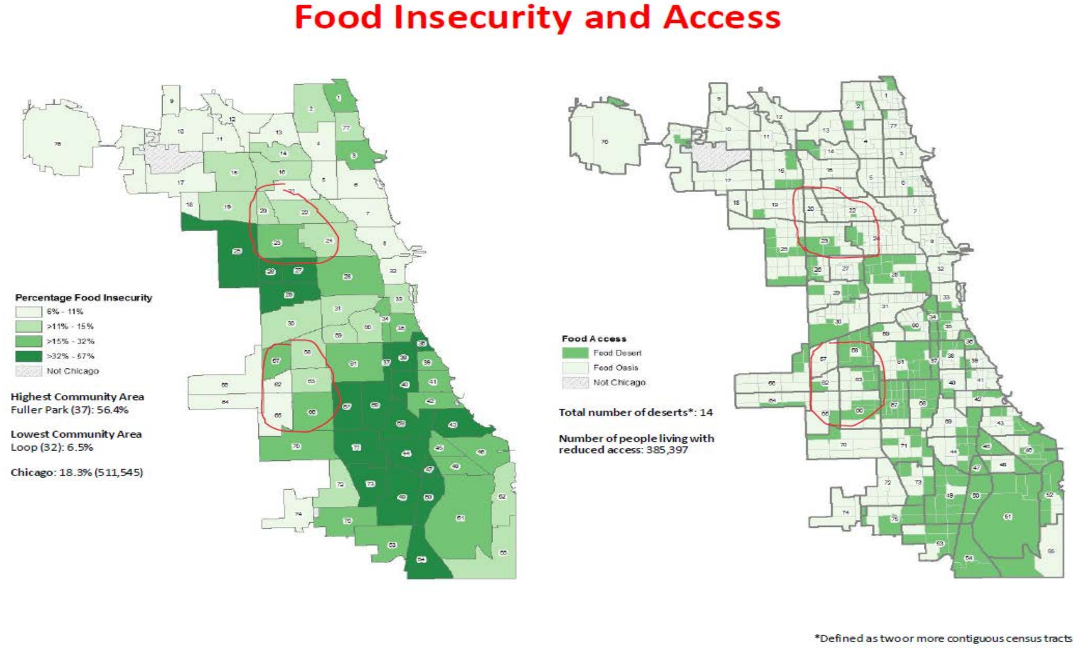
Once Pedro came out of the room from his treatment, he was escorted towards the front counter to the wife of the sobedor, who was charging customers. The sobedor would come out with the customer/patient and tell his wife what each charge was. She noted the charge in a notebook she had handy and rang each person up as she stood waiting behind the glass case with their share of rosaries, bracelets, and such. Opposite the glass container were various dried herbs, teas, and other healthful items for consumption. Upon returning to the car, Pedro disclosed 'no, ese si sabe mucho!' (no, that guy knows what he's doing!), noting that the man had identified the various muscles and ligaments causing his pain and treated areas aside from his ankle. He was really happy with his treatment. The sobedor had put some ointment along the affected region, wrapped his ankle up, and instructed him to not play soccer for the next couple of weeks. Of course Pedro did not follow these recommendations: he felt ready to play again in the game scheduled for that weekend a few days later. He still had a little pain in his ankle, but not as much as before.

Narratives and challenges

NW dealing with serious gentrification issues

The effects of place, built environments, and foodscape (among various other factors) have a direct influence on health and well-being. In a report compiled for the 'Healthy Chicago' initiative, the Chicago Public Health Department maps out such foodscapes illustrated in Figure 2.8.

Figure 2.8: *Chicago foodscape by community area* (Source: Prachand 2015).



The growing gentrification of the NW side of the city means that not only are more white residents living in the area, but also the services to communities are changing. For example, one mother noted the unique geographies within grocery stores, and in particular she compared the Aldi near where she lived with the one near her mother and how the merchandise changed:

> The Aldi's right here they're actually putting more of fresh fruits and more vegetables. But my mom (where) she lives … there's one right there … You hardly see any vegetables or fruits in that place! It's all like processed food, boxed food and stuff like that. And you come here and they have more selection of vegetables and everything. Why, because there are more people, like you know white people shopping here than that area over there.

This Latina's residence was situated in the Avondale neighborhood, just north of Logan Square, while her mother's home and Aldi were both located in the Hermosa neighborhood, west of Logan Square.

Another support group of mothers noted the encroachment of gentrification as "it's because the neighborhood is upgrading, and they're pushing the poorer people out." These mothers speak to the growing trend that exists in their Logan Square community and many other neighborhoods, where there are both Latino and non-Hispanic white residents, noting that socioeconomic disparities disproportionately affect Latin@s. As noted earlier in this chapter, Logan Square is one of the community areas with the highest percentage of whites, and overall this neighborhood had high household incomes, low homeownership rates, low rates of foreclosures, low unemployment rates, and higher overall education attainment (Acosta-Córdova 2017:60). But when these rates were broken down into racial/ethnic categories, there were clear distinctions between the privileges of white residents versus those of Latin@ or Black residents (Acosta-Córdova 2017:60). These mothers went on to explain how gentrification was affecting the growing prices of produce:

> M*:* You usually--(at) Cermak you can get an avocado for $0.99, now they're $2.49. For one avocado.
>
> J: $0.69, $0.79, now its $1.99, I'm like, for one lettuce?

They further explained:

> J: I think it's pushing a lot of the Hispanics out of Humboldt Park. Because the prices are horrible, rent's horrible. It's basically moving us out. That's what it is. Technically a lot of people are out west. Most people are moving out south, because people are losing their buildings, rents are going up, for a two bedroom rents are like $1500.
>
> M: $2060.
>
> J: If you don't own your own building. In Cermak, the prices are ridiculous. Everywhere we go, the prices are horrible.

> M: And people always tell me why do you shop where you shop. I shop the way I shop because I need to save. I have too many people to feed. Not enough money to feed them with. So I'm-a shop sales and then get-like I said if I can get the meat I need and the side I need as opposed to the $2.99 zucchini or squash or whatever it is that I like, I'm gonna buy for my family. Before thinking about okay I'm diabetic I really shouldn't be eating that, no 'cause my family needs to eat too. And yeah I know you should feed your family healthy stuff, but if they're not gonna eat it, they're not gonna eat it. I ain't gonna sit with you and fight two hours telling you to eat something you're not gonna eat.

These mothers were well aware of the healthy food that was best for them as diabetics, but the fact remained that they had to cook for their entire families, and often what their families are used to eating does not always match up with sale prices or nutritious foods. They knew that a 'diabetic' diet was simply a healthier way of eating, and that it was a method that the entire family should adapt, but it was a change that required a lot of energy to gather: strategize sales prices, to prepare, cook, and convince family members to eat. This all accounted for additional stress that these mothers did not have time for. Also, although these mothers were technically situated in the Logan Square community area, they still identified with the Humboldt Park neighborhood. Testimonies like these further justify the importance of ethnographic accounts in determining community lines and boundaries as previously described by Mumm (2014).

<u>SW residents wanting more resources within the community</u>

In the SW, many residents expressed desire for more resources to be accessible to them. Another mother who relied on public transportation noted the disparity in fast, healthy food options between the north and the south neighborhoods:

> Pero en particular consumimos más eso porque tenemos cercas. Porque no voy a ir en el bus hasta el norte para una ensalada. Entonces los

> restaurantes que tenemos alrededor de nuestro hogar son de comida chatarra. (Banging on table) No queremos eso! *[But in particular we consume more of these [foods] because we have them close. Because I am not going to go on the bus all the way to the north to get a salad. So the restaurants that we have close by our homes just offer junk food. (banging on table) We don't want that!*]

Another topic that parents brought up and wished there were more of was community gardens, noting that there are barely any community gardens in the south. However, within this same discussion one of the mothers noted that in their very own school they had a community garden, which offered the produce for parents to take freely, but also that it was not fully taken advantage of: "Como aquí, pues aquí nos tenían de lechugas (y todo). Y te aseguro que ningunos fuimos a agarrar" [*Like here, here they had lettuce (and everything). And I guarantee you that none of us went to get some (free produce)*]. In response to this comment, just because the parents may not have taken advantage does not mean that the produce went to waste, as the parent coordinator mentioned how one of the pre-school teachers took produce from this same school garden to make a salad for her classroom and the kids ate it all up. In speaking with local aldermen, there were mixed reviews about community gardens. One noted that he was not going to focus his attention on a community garden that would result in displacing or gentrifying his community. However, this same alderman noted that if a community garden was something that local residents wanted, that they would maintain, then absolutely he would support it, as did another alderman who served the neighboring ward.

This brings up the point that just because something is accessible does not mean that people are going to take advantage of it. This group of parents noted the growing vegetarian and ‘lower cholesterol’ foods offered and restaurants and even fast food sites:

> A: En los restaurantes, en el menú viene comida para el colesterol, cuando uno parece del colesterol. Porque vienen con los huevos, pero sin la yema, nada más la clara. [*In the restaurants, the menu comes with food for cholesterol, when you have high cholesterol. Because it comes with eggs without the yoke, egg whites only.*]
>
> F: Bajo en calorías. [*Low in calories.*]
>
> A: Y para-vegetarianos también. Comida vegetariana. Viene rápida, comida rápida que a veces no lo pedimos, pero porque venimos , arrachera (everyone laughing). [*and for-vegetarians too. Vegetarian food. It comes fast, the fast food that sometimes we don’t order, because we’ve come for the steak (everyone laughing).*]

Thus it is one thing that certain healthier foods are not even accessible to begin with, and then another thing that they are not very desirable or appealing to some people. As another mother noted, when you’re hungry you don’t crave a salad:

> A: Y si allí vienes tu bien, tienes mucha hambre y vas viendo los platillos, y pero los más que se te antoja son los que tiene como dicen, las carnitas. [*And if you come really, you’re really hungry and you’re seeing all these options, and what you really crave are like they say, the fried pork.*]
>
> MC: La grasa. [T*he grease.*]
>
> A: La barbacoa-ah todo eso. Y por entonces vas tu por eso envés de un plato simple de ensalada o pollo a la plancha. [*The barbequed-all that. And for that reason you go for these options instead of a simple plate of salad or grilled chicken.*]

On the topic of local representatives, some of these SW side representatives had their offices far away from their constituents. For example, one alderman has his office on the second floor of the Lithuanian Heritage Museum (with no signage on the outside for his office), and to enter this office, one has to be buzzed in and needs a reason to be there, justifiable enough to the receptionist who is protective of the alderman’s time. Several aldermen did attempt to make themselves accessible to their constituents by offering weekly/bi-weekly/monthly town-hall style meetings whereby they had a set time either weekly or monthly, to speak with anyone who wanted to speak with them. However, in visits to several aldermen’s offices, I was often told ‘oh no this week he won’t have his town-hall because he has something else scheduled’ or ‘oh no he can’t be at the town hall this time.’ I don’t know how often there were these scheduling conflicts, but it seemed to be a common claim from these offices. On the other hand, I did notice that many aldermen instead did their own reaching out to the community by going to local school meetings and talking with families there, or by stationing themselves at different sites such as senior centers to hold ‘office hours’ in places that are closer for constituents on the opposite side of the ward. When I asked each office what were some of the services provided to residents by these offices, the common response was that if anyone wanted to hold a block party or a block yard sale, then the local alderman was the one they needed to get permission from. And for those communities where residents do not have the ability to vote for their representatives, the services one can access are even more limited. In terms of health, one alderman did HIV and sexual and reproductive health campaigns; another hosted a senior’s fair that provided flu shots, access to physicians and specialists, a free meal, and other resources to those over the age of 65; and another alderman offered a flu clinic when there were funds available, as the receptionist noted the importance of the flu shot as ‘someone in our very own ward died from the flu not too long ago’.

In the SW neighborhood areas some communities are still dealing with a lot of gun violence. As one focus group of parents explained:

> Y: Tiene mucha razón porque en sí, mucha gente no va al parque por los niños y miedo de la seguridad. *[You are right because yes, a lot of people don't go to the park for the kids because they fear for their safety.]*
>
> F: Es que ahorita aquí salió … en este lado el sur, la criminalidad estuvo, no 'por el roof' como dicen, pero se pasó, sobre paso 'el roof'. Las matanzas y— [*And it's that now it came out…in this side of the south, the crime was, not 'through the roof' like they say, but it 'passed the roof'. The killings and*—]
>
> A: —y luego dicen que bajo. [—*and then they say that it went down.*]
>
> LM: El año pasado (2016) fue uno de los peores. [L*ast year was one of the worst.*]
>
> F: No, y este año va por lo mismo. [*No and this year is going the same way.*]
>
> G: Por lo mismo. [T*he same way.*]
>
> F: Todo este año…En este año yo creo que fue el más que… casi no tuvo recreo afuera, todo el recess todo el tiempo fue aquí afuera y es tiroteo y ya fuimos con los niños pa' dentro. Y pues allí lo tenía toda la semana. Los otros días adentro. Salir a la semana, y otra vez (tiroteo). [*All this year…this year I think it was more…there was barely any recess all this time it was here outside and the shots fired and we'd go inside with the kids. And there we were a whole week. The rest of the week (we stayed) inside. We'd go out after a week and once again (gun shots).]*
>
> LM: ¿Entonces cuando oigan algo por allí van pa' dentro? [*so when you hear something you go inside?*]
>
> F: Si pasan cerquitas por aquí … en esta área siempre porque se escuchan bajito. Porque la última vez yo estaba afuera con los niños. Yo sentía que casi, al lado mío estaban tiroteando alguien y a correr se ha dicho. Pa' dentro. [*Yes they pass close by here …in this area and they are almost always are heard really low. Because the last time I was outside with the kids. And I felt like they were shooting someone almost at my side, and to run. Inside.*]
>
> Y: Yo estuve una semana adentro. [*I was inside one week.*]

> T: ¡Fuimos pa’ ya (pointing to corner of school yard) y fum! ¡Vamos pa’ dentro! [*We went from over there and fum! Inside we went!]*
>
> F: Y nosotros nos encerrara arriba …Si los niños saben. Ya están, ya cuando escuchan, ya saben ya. [*And they lock us in upstairs…yeah the kids know. They are already, when they hear, they know.*]
>
> T: Si desafortunadamente que (saben). [*Yes unfortunately that (they know).]*
>
> F: Entonces este año fue peor para…mucho más que el año pasado…El año pasado no nos pasó eso. [S*o this year was worse for…much more than last year…last year this didn’t happen to us.]*

The fact that these families cannot even go to their local parks or count on having an hour of peace during the school day without gun shots threatening them blocks away is a devastating reality. Such threats are often not taken into account when health recommendations call for residents to ‘take a walk’ in order to get them to spend some time outside, stay active, and lose weight.

CHAPTER THREE:

Azúcar, presión y colesterol: 'Yo no tengo problema ninguna' [*sugar, pressure, and cholesterol: 'I don't have any problem'*]

This chapter is inspired by the Latina mothers who are constantly overworking their bodies to serve their families' needs—often neglecting themselves in the process. The first section of this chapter weaves together the implications of diabetes, hypertension, and hyperlipidemia, with the pathologization of being overweight, and provides suggestions from residents themselves on how to improve the health of Latin@s in Chicago overall. Diabetes, hypertension, and hyperlipidemia were described as health concerns that many residents themselves were experiencing or in some cases—especially for the mothers I spoke with—experienced by one of their family members. For some mothers, worrying about relatives had turned into an embodied stress that appeared to be more detrimental than the medically diagnosed high cholesterol (or blood sugar or blood pressure) levels that clinicians often emphasize.

The second section of this chapter presents an overall analysis table of the various strategies and tactics utilized by residents that came up throughout the individual interviews and focus group discussions. Strategies are divided in line with chapters four and five, along clinical and non-clinical engagements. An overall analysis and discussion is provided to synthesize table findings in preparation for the remaining chapters.

In the third and final portion of this chapter, I highlight stories of Latina mothers amid the current healthcare atmosphere of creating disease, pathologizing obesity, and turning risk factors into dis-ease. Many people may experience 'high" readings in terms of blood sugar, blood pressure, or cholesterol levels, but the back story of those high numbers should be challenged in light of the actual foci of people’s stress, and the physical consequence of their political and economic climate. This is my main argument and I use the lens of intersectional translocality to challenge these rigid lines and borders of health and illness and to instead consider matters that are more important for residents.

The pages that follow are primarily based on medical anthropology and other health-related literature such as public health, health policy, and other clinical literatures. I begin by briefly discussing how Latin@s are represented within this literature and the state of Latin@ health in the U.S. Next, I highlight how health is being defined in the U.S. and the medical and biocultural anthropological contributions to studies of diabetes, hypertension, and hyperlipidemia. Additionally, I discuss the growing issue of fat shaming within U.S. society and how being overweight has become pathologized. I relate the pathologizing of obesity to the conditions studied in this research project to further challenge the creation of risk factors into disease. Then I discuss prominent themes from these focus-support groups to demonstrate the various economic, social, and healthcare concerns of Latina mothers. Lastly, this chapter provides solutions for improving overall health and well-being for these communities, based on suggestions from residents themselves in their own words.

The dangers of Latin@ homogenization

Studies of Latin@s’ health in the U.S. are difficult to decipher because only recently have health researchers begun defining Latin@s and separating us in terms of our ethnicities (i.e. Mexican, Puerto Rican, Cuban, Dominican, Venezuelan, etc.). Therefore, while there have been increased efforts to study Latin@s health within the

U.S., homogenizing Latin@s as one group “overlooks the effects of the intersection of race, ethnic group, and socioeconomic status” on Latin@ health (Zambrana and Thornton Dill 2006:198). Glossing diverse communities of people under static racial and ethnic categories “obscure(s) differential risks within population subgroups” (Anglin 2006:318). Although the U.S. Latin@ population continues to shift across ethnic, racial, national, class, gender and generational lines, studies of Latin@ health still struggle to understand and integrate the heterogeneity of U.S. Latin@s (Abraído-Lanza 2015:565). This research’s tracing of Latin@ Chicagoans’ intersectional translocal experiences and navigation of health and well-being demonstrates this vast heterogeneity among Latin@s within city and even neighborhood limits.

Health studies have found that despite the “disproportionate representation among the poor, [Latin@s] have demonstrated lower all-cause mortality and higher life expectancy” rates than might be expected (Dubowitz, Bates and Acevedo-Garcia 2010:106). This term ‘Latin@ health paradox’ is used to refer to observations that, “foreign-born Latin@s overall have better health outcomes than expected, given their low socioeconomic standing” (Dubowitz, Bates and Acevedo-Garcia 2010:106); however, the key fallacy to this theory is that it is based on *foreign*-born Latinos. This paradox does not explain the disproportionate morbidity among Latin@s from diabetes, HIV/AIDS, liver disease, cervical cancer and breast cancer (American Cancer Society 2012); as well as the high morbidity of Puerto Rican women from serum cholesterol and asthma (Delgado and Trevino 1985; Ledogar et al. 2000). Additionally, it should be noted that “immigrants of other racial/ethnic groups (from non-Latin American countries) have also been shown to exhibit better health than their U.S.-born counterparts,” yet this phenomenon is not considered a paradox (Dubowitz, Bates and Acevedo-Garcia 2010:108). Framing Latin@ health disparities as a paradox creates the sense that Latino health issues are not salient.

From my readings, I found it was better to identify specific location-based studies to learn about different Latin@ sub-groups throughout the country. For example, studies based out of New York and other northeastern cities were more likely to have a predominately Puerto Rican Latino study sample. One study, based in New York City, compared all five boroughs throughout the city and found the Bronx to have a "high portion of total persons below the poverty level (30.7%), a high percentage of residents were Puerto Rican (24.2%), and the highest number of asthma hospitalizations for children under age 15 (9.16 per 1,000 children)" (Acosta et al. 2008:51). Another study "assessed the relative impact of race, ethnicity, and neighborhood poverty on the rate of cervical cancer incidences and mortality in New York City" (McCarthy et al. 2010:1645). In this study, black and Puerto Rican women were at "an increased risk of being diagnosed with late stage cervical cancer and of dying from their disease" (McCarthy et al. 2010:1654). Blacks and Puerto Ricans "younger than 65 had higher mortality" than whites, while blacks and Puerto Ricans "aged 65 and older—eligible for Medicare—had similar mortality to whites" showing the link between access to care and mortality risk (McCarthy et al. 2010:1654).

Cancer is another detrimental disease, that among Latin@s nationally, is the leading cause of death, accounting for 21% of total deaths and 15% of child deaths (Foster 2013:3). "Latinas experience the highest cervical cancer rates (64% higher than white women) of any racial/ethnic group in the U.S." (Foster 2013:3). The most common cancers within Latin@ subgroups are: “breast and cervical cancer among Mexican Americans, and Central and South Americans, breast and prostate cancer among Puerto Ricans and Cubans, and breast and lung cancer among other Latin@s” (Sheinfeld Gorin and Heck 2005:516).

Scholar Paula Braveman points out, “socioeconomic inequalities cannot be reduced to racial/ethnic differences alone” (Braveman 2012:665). However, socioeconomic status is one of the aspects most “strongly linked (to) access to health insurance and health care services” (Zambrana and Thornton Dill 2006:202). And of those who have access to health insurance and health care services, “Latinas are the least likely to have insurance” (Zambrana and Thornton Dill 2006:202). In the early 2000s, over 40 million people in the U.S. did not have health insurance, or 15% of the U.S. population (Becker 2004:258). Within the distribution of uninsured ethnic minorities, Latin@s made up the majority with 33% (Becker 2004:259). The lack of access to health insurance can be attributed to many structural factors such as lack of accessibility to education, and employment in industries that do not provide health benefits (Zambrana and Thornton Dill 2006:202).

Careful research has shown that low rates of preventive screening behaviors are associated with low socioeconomic status, discrimination from clinical providers, low literacy, and psychosocial distress (Zambrana et al. 1999). These aspects, combined with structural factors that limit access to health care and provide poor health services, limit opportunities for prevention and management of chronic medical conditions (Zambrana and Thornton Dill 2006:212). This evidence demonstrates the intersection of race, ethnicity, poverty, gender, and institutional context (Zambrana and Thornton Dill 2006:214).

Metabolic syndrome and definitions of health

Medical anthropologist Joseph Dumit (2012) has described the current U.S. healthcare system as illness redefined by treatment as risk, and health as risk reduction. The lines of risk, such as recommended cholesterol levels, is determined by clinical trials and pharmaceutical companies. This approach, which Dumit terms surplus health, has been molded to fit into corporate research agendas—health that is valued only in terms of treatment growth because only that translates into corporate growth. Or in other words, the healthcare system is invested in and has prioritized medication and expensive tests rather than treatment beyond pill bottles and corporate contracts.

The narratives shared here are by people who have been told they have high blood sugar (diabetes), high blood pressure (hypertension), and/or high cholesterol (hyperlipidemia). Whether or not they have been told the significance of what these bodily measurements are is an additional problem this chapter touches on. In the following section I explore a key argument within the critical health literature in the "creation of disease," whereby risk factors are deemed and diagnosed as diseases themselves.

Montoya's *Making the Mexican Diabetic* demonstrates the "empirical claims that scientific practices shape and are shaped by the social context of their production and explains the role of genetic research in the persistent use of race to divide populations in society at large" (2011:12). In this book, Montoya claims that type 2 diabetes is framed as a racialized disease, which reflects the unequal weight given to the incidence rates of diabetes at the expense of prevalence. This in turn transforms the political and social conditions for Mexican@s into attributes of the Mexican@ body itself (2011:141). These critical anthropologies of the clinic, labs, and biomedicine overall provide key insight into the framing of healthcare in the U.S. This chapter provides real life examples of how Chicago Latinas (many Mexicanas) are responding to these pathologizations.

Hyperlipidemia, hypertension, and diabetes—creations of dis-ease?

Metabolic syndrome is a constellation of risk factors for heart disease in which a person must have three out of five conditions to be diagnosed with the syndrome. These five conditions include: a large waistline, high triglyceride levels, low HDL cholesterol levels, high blood pressure, and high fasting blood sugar. Many of the residents I talked with had one, three, or all five of these metabolic risk factors, although usually one particular condition was of more concern for them at the time. Although diabetes is a chronic disease, a person diagnosed with it can live a long life if it is controlled. However, does this mean that high blood pressure or high cholesterol are diseases *per se*?

High cholesterol (also known as hyperlipidemia) is by itself only a risk factor for heart disease, yet has been promoted, evaluated, and treated to the level of the disease-making-state and many believe this is a condition that requires immediate action (Jovanovic 2014). High blood pressure, or hypertension, is another important risk factor for heart disease. Often these three conditions run together and if a person is diagnosed with one condition, it is not long before they develop the other conditions as well.

As described in chapter one, diabetes has been associated with communities' transition to Westernized livelihoods (Swedlund 1997; Schoenberg et al. 2005), as seen among Native American nations. The U.S. reservation system and physical containment of Native Americans established environments where entire communities experienced chronic levels of stress (Wiedman 2012), expressing symbolic and structural violence through everyday violence in the embodiment of diabetes and metabolic syndrome. Margaret Everett and Josef Wieland argue that the interaction of burdens (childhood undernutrition and infection, adult obesity, and metabolic changes) and the social conditions that have dismantled local food systems (a form of structural violence) have increased migration rates to the U.S. and best explain the growing rate of diabetes in the Oaxaca, Mexico region (2012:295-296). Additionally, they argue that the high mortality rate associated with diabetes in Mexico is attributed to a lack of optimal care and the frequent comorbidity of hypertension and dyslipidemia (a type of hyperlipidemia) (Everett and Wieland 2012:296-297).

A literature review of food and beverage marketing among Latin@s identified marketing strategies—especially through Spanish language television—as "less likely to promote healthy eating and more likely to encourage the consumption of low-nutrient, calorie-dense foods and beverages, especially for Latino children" (Adeigbe et al. 2015:577). This differential exposure and the various Latin@ neighborhood foodscapes in turn may impact BMI (Adeigbe et al. 2015:578-579), although my dissertation research has not traced the built obesity-producing landscapes such as the Dunkin' Donuts, McDonald's and other fast food sites on what appears to be every main corner of the Latin@ neighborhood areas. This dissertation does provide narratives of how Latin@s navigate these landscapes, attempting to avoid these constant temptations and pressure from advertising, peers, social settings, or even their children. As one particular mother support network noted:

> A: But the corner stores open here at six o'clock. Every store is just candy full. Ain't nothing healthy.
>
> M: Candy, chips, quick like little pound cakes—which are full of sugar and we understand it but it's just so hard, cause again where you gonna get healthy breakfast in the morning that you're not gonna have to wait in a line?

These mothers, both diabetic, with diabetic parents, were well educated on how much sugar content was in the labels of the sweet breakfast treats offered at every corner store. These working mothers sought convenience when searching for meal solutions, especially for busy week-days. This group of women also noted the irony of the exorbitant cost of these quick trips to McDonald's or Subway. Those trips meant not only purchasing the five-dollar foot-long sub, but also the bag of chips and drink, or the fancy drinks from the McCafé, none of which comprised a healthy meal. Alicia pointed out how much financial strain this on-the-run lifestyle was costing them:

> In one week we did it (stopped buying McDonalds every morning). Each of us saved $100. Because we have teenagers who want the Taquis, the chocolate frappe, the other ones—it's like sometimes we spend $30 every day. Breakfast and lunch for these kids.

Understanding obstacles to treatment and health care access requires an examination not merely of immigrant cultural representations of health and illness, but also of the culture of biomedicine (Sargent and Larchanche 2011). For example, Borovoy and Hine explore the management of diabetes among elderly Russian Jewish émigrés, and how patients typically understand the need for self-care and attempt to comply with it (i.e., regularly measuring blood sugar levels). Their research highlights how the medical model of diabetes management is premised on the importance of risk assessment and reduction (Borovoy and Hine 2008), with which patients continue to come into conflict. In a context in which the management of risk is inseparable from continual ‘regulation,’ ‘management,’ and ‘control,’ the failure of Russians to actively and vigilantly manage their care regimens was often misinterpreted as the result of a lack of understanding, or as a cultural trait (and inability to self-regulate) (Borovoy and Hine 2008:7). There are similar misconceptions about U.S. Latin@s. Many preventative programs opt to educate Latin@s about nutrition and health, when many residents, especially those in the northwestern neighborhood areas, have already been exposed many times to these health teachings about what they should or should not do to lose weight or prevent heart disease.

In conversation with this scholarship, Guell (2011) cites Borovoy and Hine (2008), Rock (2003), and Mendenhall et al. (2010) to describe medical anthropology accounts of social diabetes that assume “inert populations with diabetes, quietly enduring such experiences of marginality, rather than responding to and negotiating such experience” (Guell 2011:378). Guell originally set out to shed light on illness at the margins, but upon further research developed an exploration of Turkish Berliners’ social, political, and economic practices of diabetes care as “biosocial” engagements (Guell 2011:377). The sociality of Turkish Berliners with diabetes and their decision to put together self-help groups placed their group members at center stage to show that such active healthcare practices are part of experiences of health inequality and are significant in individual and communal lives (Guell 2011:391). This chapter speaks to such agentive health strategies by highlighting the support networks Latina Chicagoans have created despite social, political, economic, and, in this case, healthcare landscapes often fraught with challenges.

Schoenberg and colleagues' (2005) study on the influence of stress on diabetes expansion revealed the fluidity and overlapping nature of etiologically ascribed stressors. The multi-ethnic narratives linking stress to diabetes onset defies simplistic stress-disease modeling or neat categorizations of explanatory models, calling researchers and health professionals to redirect attention to the processes and mechanisms underlying the stress-diabetes interface (Schoenberg et al. 2005:181). The role of stress and embodied stress is a common theme among Latina mothers and other Chicago Latin@s with whom I have spoken. Embodied stress can be seen in the rise of blood pressure levels or cholesterol levels when Latin@s go to the doctor, when a traumatic life event takes place, or in the withering of bone density for one mother, all of which will be discussed later in this chapter.

Pathologizing obesity: 'it's not real about the weight'

Medical anthropologists have long added to the critique that the obese world is often imprinted with (im)moral connotations, including; various forms of stigma, treatment barriers, poor self-image, and health problems that arise from socially constructed barriers, rather than the *biological fact of fatness* (Weaver 2015). More recently, biological anthropologists have approached obesity by exploring the metabolic basis of weight regulation and are specifically looking at the combined effect of fructose and glucose within metabolism. This is significant because the combined effect of ingesting fructose and glucose is metabolized in the body differently than fructose and glucose consumed separately (Wells 2012:267). When such sucrose, or corn syrup, is metabolized, the fructose is converted into triglycerides within the liver, and the glucose stimulates the secretion of insulin (Wells 2012:267). This results in the insulin transporting the triglycerides to fat deposits in the body, and in the process temporarily inducing a state of ‘‘cellular starvation’’ during which the individual feels both hungry and lethargic (Wells 2012:267). It is no wonder that there have been lawsuits claiming that certain foods cause “addiction.” While the evidence is too sparse and complicated to claim addiction to these high-caloric, high fructose corn syrup and vastly accessible processed (mostly sucrose induced) foods, understanding such fundamental biological interactions is important within the consideration of the life history of obesity, as well as metabolic syndrome.

In one of the focus-support groups, I was asked to give an overview presentation/health education prevention discussion about the topics that I was studying. I discussed the diseases I am focusing on (type 2 diabetes, hypertension, and high cholesterol). I was expecting to just introduce myself as I had done in the many other public schools to let the parents know about the study I was conducting in order to recruit the people who qualified for my study. I wanted to gather stories and experiences of people directly or indirectly dealing with these three conditions. Instead, the parent coordinator asked me to give a more in-depth presentation of these conditions. The presentation took the form of a round-table discussion in which mothers asked questions, justified, or disproved health myths they had heard or took the opportunity to engage health discussions in this non-clinical space. By the time I explained my study and desire to organize a focus group, the mothers suggested we do the focus group right then and there. I had already spent a little more than an hour with these women in their parent meeting. We all agreed, and some got up to have some coffee, snacks, and of course soda, which was splayed out along the side of the room as I prepared to lead the focus group.

One of the mothers, severely overweight, got up to pour herself some Manzanita apple soda. She had made some very informative comments about diabetes earlier and I was sure she herself had diabetes. When it came time for her to express her experiences with these conditions she explained that the condition she had was anemia. I remember thinking, 'Anemia? Really? You don't have any other health condition you're worried about?' She went on to describe her family history and how her father was a smoker but died naturally, her mother had high blood pressure and cervical cancer, grandparents had high blood pressure, and as far as diabetes, maybe her aunts had diabetes, but she was not sure. Her husband had high blood pressure and was currently taking medication to manage this, and her mother-in-law was a diabetic. The last thing she noted was that she had recently been told, one month ago at the time, that she was pre-diabetic. I jumped on this and asked her more about her pre-diabetes diagnosis—how long she had been diagnosed, what she was advised to do as a result, and what she was doing to manage. She shared some of her health strategies:

> Y pues en mi casa si entra la soda pero na'mas el fin de semana y nada de…porque de lata no! Nada de durritos porque si no, ya es sábado y domingo y ya el lunes que entrar y es pura agua natural, pepino. [*Well, in my house we do have soda, only on the weekends, and nothing…because cans no! None of (the) Doritos, because if not, maybe on Saturday and Sunday but come Monday and it's only natural water with cucumber.*]

Yet here we were on a Monday and she was on her second cup of Manzanita soda. The point here is not to highlight the contradiction that this mother was not practicing her rules outside of the home. The point here is that *I, as the researcher* or ‘health expert,’ had written this woman off as unhealthy and assumed she surely had at least one of the three conditions I was studying. At moments like these I could not ignore the unearthing of my own fat stigma. I began to think more about how overweight women (which, according to BMI standards, is most of us Latinas) navigate their healthcare needs and well-being if they are constantly being told their weight is the issue, yet they feel fine. My preconceived stigma of fatness and subsequent pathologizing of obesity is an example of what often happens in the current war on fat. Such assumptions are common of healthcare providers for larger-bodied women, as noted in the literature below.

In a review of the obesity literature, Fikkan and Rothblum examine the weight-based stigma experienced by women in North American throughout multiple domains including: employment, education, romantic relationships, healthcare, and the media (2012). In terms of healthcare, various examples show how “fat women’s” healthcare is being compromised because of the bias of various healthcare professionals. Subsequently, larger-bodied women were more likely to delay care or avoid certain types of facilities entirely to avoid these stigmatizing experiences, “yet this impact on the health of fat women has received very little attention” (Fikkan and Rothblum 2012:587). These authors agree with Emsberger’s argument (2009:26), citing that “although there is some evidence that poverty is fattening, a stronger case can be made for the converse: *fatness is impoverishing*” (Fikkan and Rothblum 2012:587).

These scholars also cite Harley (2001), arguing that ‘the fat body has largely been ignored in feminist studies that attempt to theorize the female body’ (61); “whereas anorexic bodies have been conceptualized as a metaphor for cultural proscriptions on women, fat bodies too often get interpreted in terms of poor health, with blame placed squarely on the individual (LeBesco 2009)" (Fikkan and Rothblum 2012:588). Girls with anorexia are often portrayed as white, from affluent families, victims of a terrible illness beyond their and their parents' control, while fatness is associated with poor girls of color, caused by bad lifestyle choices, including, in the case of children, parental neglect (Fikkan and Rothblum 2012:588). I would argue that to add a feminist analysis of larger-bodied women, using an intersectional analysis to include the experiences, in this case, of Latinas, would provide a more in-depth understanding the impact of health of these women's bodies who continue to be pathologized.

Strategies and tactics: overall data analyses and discussion

Below there are a few tables in efforts to summarize and group together some of the overarching themes I heard from residents. This first table (Table 3.1) is separated by participants who I interviewed individually. Just like the chapters, I have separated each resident's strategies according to the more clinical (biomedical) strategies, and the more non-clinical (dietary-natural-home remedy) strategies.

Table 3.1: Non-clinical strategies among individual interviewees

	Diabetes	**High Blood Pressure**	**High Cholesterol**	**Cuidándose / Portion control/ Occasional indulgences**	**Exercise**	**Avoidance**	**Cooking Techniques**	**Item Specific[1]**	**Teas/ Aguas / Smoothies**	**Actions**
Grand Total	**17 (+3 pre-diabetes)**	**6**	**12**	**19**	**22**	**11**	**5**	**8**	**10**	**22**
Alba	X				1					
A.M.	Pre			1	1	1				1
Andrea	X			1			1			
Antonia				1	1	1	1		1	1
Antonio			X	1	1					
Augustin	X		X							1
Carmela			X	1	1	1	1	1		
Cecilia					1					1
Cynthia	X		X		1					1
Elfia										1
Elvia	Pre				1					1
Genesis	X			1				1		
Gina									1	1
Gisel	X			1						
Grisette	X	X	X							1
Hiedi					1					1
Ines	X			1	1	1		1	1	1
Irene	X	X		1	1	1				1
Isabel	Pre									1

---

[1] Specific items included moringa, coconut oil, garlic, nuts, artichoke, salads, meat, wine, Coca-Cola, and glucose candies.

Table 3.1 (continued): Non-clinical strategies among individual interviewees

(cont.)	**Diabetes**	**High Blood Pressure**	**High Cholesterol**	**Cuidándose / Portion control/ Occasional indulgences**	**Exercise**	**Avoidance**	**Cooking Techniques**	**Item Specific**	**Teas/ Aguas / Smoothies**	**Actions**
Jorgina		X		1	1	1		1		
Jose			X	1		1			1	
Josefina				1	1	1	1			
Judy	X	X		1		1				
Lorena	X				1					
Lupe				1	1			1	1	1
M.A.			X	1	1			1	1	1
Mabel	X		X	1		1		1		
Maria	X			1	1				1	1
Mario					1					1
M.E.			X						1	
Mirta			X							1
M.S.			X	1	1				1	1
Ms. Yaly	X				1					1
Rosario	X				1		1		1	
Roberto	X	X								1
Victoria	X	X	X	1	1	1		1		1

Table 3.2: Non- clinical strategies among focus group interviewees

	Diabetes	**High Blood Pressure**	**High Cholesterol**	**Cuidándose/ Portion control/ Occasional indulgences**	**Exercise**	**Avoidance**	**Cooking Techniques**	**Item Specific**	**Teas/Aguas/ Smoothies**	**Actions**
Grand Total	**36 (+20 pre-diabetes)**	**38 (+2 pre-hypertension)**	**31**	**92**	**53**	**47**	**27**	**40**	**17**	**37**
FG 1	10			3	8	1		5		6
FG 2	2 (+2 pre)	2	2	3	4	2	2	2	1	4
FG 3	2	2		2		2		1		4
FG 4	2	3	1	4	2	1		1		1
FG 5	2	2	2	2	1	1		1		2
FG 6	2 (+1 pre)	1	1	1				1		1
FG 7	1 (+2 pre)	1	1	8	2	3	4	2		
FG 8	1 pre	3	1	6	4	5	2	7	1	5
FG 9	2 (+1 pre)	4	2	3	2	1	2	5	1	2
FG 10		1			1					
FG 11	1 (+1 pre)	1	1	3	3	3				
FG 12	3 (+2 pre)	5	3	10	3	6	8			3
FG 13	2			1	1	1	1			
FG 14	3 (+1 pre)	3	3	6		4		3	1	
FG 15	1 pre	3	2	4	3	2			2	2
FG 16	1 (+1 pre)	1	1	4	2	1	1		1	1
FG 17		2 (+1 pre)		3	3		1	1		
FG 18	2									
FG 19	2 (+ 3 pre)	1 pre	3	6		4	2	1	4	2
FG 20	2		1	3	1	2	2	4		3
FG 21			1	2		1		1		1
FG 22	1 pre	1		1		1	1	2		
FG 23	1 (+3 pre)	1	2	5	11	2		3	2	
FG 24	1 pre	1	2	8						
FG 25	4	1	2	4	2	4	1		4	

Discussion of non-clinical strategies

Individual interviewees

Table 3.1 shows the 37 residents I interviewed, and how each person had his or her own tactic. The single most popular trend was exercising, with walking being the easiest, most accessible form of exercising. Of the 37 individual interview participants, 22 engaged in some form of exercise, 18 of which mentioned walking as a go-to exercise—in addition to other forms of exercise. Eleven relied exclusively on walking.

The next most common strategies I have named as 'cuidándose' [*taking care of one's self*] include more specific practices like portion control, occasional indulgences and other practices. Of the 19 participants who emphasized how they took care of themselves, ten used portion control, or in other words were constantly being careful to not over-do it with the amount of food they consumed. Eight residents mentioned how every once in a while, they allowed themselves to indulge, or enjoy that ice cream sundae or those chuletas [*pork chop*], but always came back to their careful diets afterwards. Seven residents were sure to drink plenty of water throughout the day, especially if they were drinking a little something sweet like soda or juice. Other forms of taking care of themselves included a mixture of eating more fruits, vegetables, exercising, following their medical treatment regiments, and listening to one's body.

Of the individual interviews, ten residents used teas, or fresh waters, homemade juices or smoothies to help manage their health and well-being. Each specific health condition had its own remedy or recipe, and the instances these tips were brought up were not limited to treating diabetes, hypertension or hyperlipidemia specifically. Of the ten residents (from the individual interviews) who used this tactic, oatmeal was one of the most common ingredients, especially for treating high cholesterol.

Additionally, residents had particular items that they regularly consumed to help with their overall health and well-being, relying on items like garlic and coconut oil. Other items ranged from ginger, and eating more salads, to one person attributing her frequent consumption of meat to being saved from a diabetes diagnosis. In terms of particular items that were good for lowering blood sugar levels, residents' responses ranged from artichokes to wine. Items that helped to raise low blood levels, according to interviewees included nuts (almonds and pecans) for low blood sugars, and one interviewee said she used Coca-Cola to raise her low blood pressure.

Lastly, I have added direct actions that many residents engaged in to help navigate their health and well-being. These actions ranged from researching general health information on the internet, or in printed books or pamphlets, to more social practices. For four residents, their respective churches were their refuge to reflect, pray, be connected with their congregations and engage in the resources provided through their churches. For another two residents, bingo was their therapy, and for another it was the weekly domino tournaments. Other philosophies residents shared with me were to enjoy life, not staying locked up in their homes, and for others, their part-time or volunteer work was their therapy for getting their minds off of stressful situations, like one mother whose son was battling leukemia.

Table 3.3 Clinical strategies among individual interviewees

	Natural Medicine	**Healthcare Professional**	**Check blood levels**	**Pills/Insulin**	**Regular Check Ups**	**Medical Disrespect[1]**
Grand Total	**1**	**1**	**4**	**22**	**24**	**10**
Alba						
A.M.					1	
Andrea				1		1
Antonia				1	1	1
Antonio						
Augustin			1	1		
Carmela				1	1	1
Cecilia				1	1	
Cynthia	1			1	1	
Elfia				1		1
Eliva						
Genesis				1	1	
Gina						
Gisel					1	
Grisette		1		1	1	
Hiedi					1	
Ines			1	1	1	1
Irene				1	1	
Isabel				1	1	
Jorgina						
Jose				1		

---

[1] Residents who felt they had experienced disrespect in a medical encounter.

Table 3.3 (continued) Clinical strategies among individual interviewees

	Natural Medicine	**Healthcare Professional**	**Check blood levels**	**Pills/Insulin**	**Regular Check Ups**	**Medical Disrespect**
Josefina			1	1	1	
Judy			1	1	1	
Lorena					1	
Lupe				1	1	
M.A.					1	
Mabel						
Maria				1	1	1
Mario					1	
M.E.						1
Mirta				1	1	1
M.S.						
Ms. Yaly			1	1	1	
Rosario				1	1	
Roberto				1	1	1
Victoria				1	1	1

Table 3.4 Clinical strategies among focus group interviewees

	Natural Medicine	**Healthcare Professional**	**Check blood levels**	**Pills/Insulin**	**Regular Check Ups**	**Medical Disrespect**
Grand Total	**10**	**7**	**27**	**64**	**52**	**43**
FG 1	1	1	3	2	1	
FG 2				2		5
FG 3		1	2	2	2	1
FG 4	1		2	1		
FG 5		1	2	1	3	1
FG 6					2	1
FG 7			3	4	4	1
FG 8	1		1	6	5	2
FG 9	2			4	1	3
FG 10				2		1
FG 11			1	2		2
FG 12				3	2	1
FG 13			1	2	1	2
FG 14		2		2	2	2
FG 15	2			5	2	1
FG 16	1		2	2	5	2
FG 17				2	1	2
FG 18						
FG 19	1		3	6	4	3
FG 20	1		4	4	1	2
FG 21				1	1	
FG 22			1		1	2
FG 23		1	1	3	6	5
FG 24				2	3	
FG 25		1	1	6	4	4

Table 3.5 Detailed clinical strategies among individual interviewees

		Biomedical Strategies				
	Condition	**Natural Medicine**	**Healthcare Professional**	**Regular Check Ups**	**Check blood levels**	**Pills/Insulin**
Alba	Type 2 Diabetes			N/A		
A.M.	Pre-Diabetes			with same doctor of over 20 years		
Andrea	Type 2 Diabetes			No		no longer used medications
Antonia	Family (T2D)			X		inconsistent use of medications
Antonio	High Cholesterol			N/A		
Augustine	Type 2 Diabetes, High Cholesterol			N/A	Used to check with glucometer	used medications
Carmela	High Cholesterol			X		stopped taking medication
Cecilia	Other Chronic Condition			X		used medical treatment
Cynthia	Type 2 Diabetes, High Blood Pressure, High Cholesterol	ginseng (for constipation)		X		no longer used medications
Elfia	Family (T2D)			No		not happy with medical treatment
Eliva	Pre-Diabetes			No		
Genesis	Type 2 Diabetes			Good endocrinologist		used medications
Gina	Family (T2D)			N/A		
Gisel				X		
Grisette	Type 2 Diabetes, High Blood Pressure, High Cholesterol		Insurance Health Coach			used medications

Table 3.5 (continued) Detailed clinical strategies among individual interviewees

		Biomedical Strategies				
	Condition	**Natural Medicine**	**Healthcare Professional**	**Regular Check Ups**	**Check blood levels**	**Pills/Insulin**
Hiedi	Family (HC)			X		
Ines	Type 2 Diabetes			Specialists	knowing own sugar levels	used medications
Irene	Type 2 Diabetes, High Blood Pressure		Dialysis Center	X		used medications
Isabel	Pre-Diabetes			X		medication dependency
Jorgina	High Blood Pressure			N/A		
Jose	High Cholesterol			No		no longer used medications
Josefina	Type 2 Diabetes			X	knowing own sugar levels	strategic use of pills, cutting pill
Judy	Type 2 Diabetes, High Blood Pressure			X	knowing own sugar levels	injecting insulin turning needle certain direction
Lorena	Type 2 Diabetes			Often but irregular		
Lupe	High Cholesterol			X		used medications
M.A.	High Cholesterol			Every 3 months		
Mable	Type 2 Diabetes, High Cholesterol			N/A		
Maria	Type 2 Diabetes			X		used medications
Mario	Family (T2D)			X		
M.E.	High Cholesterol			No		never prescribed/used medications

Table 3.5 (continued) Detailed clinical strategies among individual interviewees

		Biomedical Strategies				
	Condition	**Natural Medicine**	**Healthcare Professional**	**Regular Check Ups**	**Check blood levels**	**Pills/Insulin**
Mirta	High Cholesterol			X		used medications
M.S.	Family (HPB)			No		
Ms. Yaly	Type 2 Diabetes			X	knowing own sugar levels	used medications
Roberto	Type 2 Diabetes, High Blood Pressure			X		used medications & insulin
Rosario	Type 2 Diabetes			X		used medications
Victoria	Type 2 Diabetes, High Blood Pressure, High Cholesterol			X		constantly had to change medications

Discussion of clinical strategies and engagement with biomedicine

Individual interviewees

Additional strategies and tactics residents used included various forms of engagement with biomedicine, or what I term more ‘clinical’ strategies. For most residents, this direct engagement with biomedicine is especially determined by whether or not a person had access to health insurance and the need to access primary care. Generally, residents who had access to health insurance, even if they did not have any of these conditions (diabetes, hypertension or hyperlipidemia) visited their primary care doctor at least once a year. However, even though residents did not have access to insurance, this did not mean they did not receive medical attention nor have a primary care provider. Of the 37 individual interview informants, ten did not have access to health insurance. Of these ten, only three did not go at least once a year to see a primary care provider (PCP). The other six did have a clinical home where they often received medical attention on an annual basis or more frequently when emergency situations arose. Additionally, one interviewee, although he had access to health insurance, had not been to his PCP in over six years. Despite being diagnosed with high cholesterol, he was treating it on his own, by ‘cuidándose’ (as described above).

Table 3.2 shows the overall number of participants. From the 37 individual interviews I conducted, 24 of these interviewees mentioned visiting often with their primary care physician, specialists, or a combination of these clinical visits. Of the remaining 13, their seeking of consistent clinical care was not brought up in the interview or alluded to throughout the conversation, thus I cannot assume that these residents did or did not have a PCP or clinical home. Of the 37 individual interview informants, 17 had diabetes, and five knew off-hand their average fasting blood sugar levels. Those who had diabetes were more likely to check their blood sugar levels using a glucometer. Residents who closely monitored their blood sugar levels took note of how high or low their sugar was to gauge what they should or should not eat before a meal or at times when their body felt ‘off’.

Another clinical strategy individual interviewees engaged in was the way medications were taken. Similar to the conversation about primary care providers (PCP) and having a clinical home, not all residents described their use of medications. Twenty-two specifically cited their medications during our conversation, whether it was their use, strategic use or non-use all together. Thirteen used their medications or treatment prescribed to them. Four needed additional treatment for particular conditions such as osteoporosis, kidney failure, leukemia and schizophrenia (two of which were describing their family members who needed this treatment). One woman had developed a dependency on morphine after many years of living with mercury in her bloodstream. At the time of our interview (in 2017) she was recovering from a cervical cancer surgery she had one month before, and was having a really hard time adapting to a medication change her recent doctor had made; needless to say, her recent pre-diabetes diagnosis was insignificant compared to all the other things she was dealing with. Another four residents admitted to no longer following their medication regimens, three by choice and the other was a forced decision (for financial reasons). Three mentioned strategically using their medicines such as physically cutting their pills in half to have one half in the morning, and the other half at night. This strategy was enacted when residents felt like they did not need a full dosage. This cutting down of dosages was used for injecting insulin as well, and was also based on how residents felt, their blood sugar level readings, or how soon they had to meet with their PCP.

One resident, Judy, found a way to place her insulin needle in a certain direction such that it did not hurt her as much each time she needed to inject herself. Judy was new to living with diabetes. She had been diagnosed about one or two years before I interviewed her (in 2017), but she had also been dealing with hypertension for over 13 years. Judy was having a really hard time adapting to the changes diabetes made to her body, and the increased price tag of the medication and insulin supplies prescribed for her care. For these reasons, Judy also strategized, checking her blood sugar levels to determine whether she should or should not use the expensive and limited insulin she had. She noted:

> Si yo veo que mi azúcar está a 200, 300, yo no me inyecto, prefiero dejar esa para cuando me sube un cantito más…me la gasto después. yo digo como mi diabetes es de 400 y fracción, 500. 300 es normal—cosa que no lo es porque es altita, pero de 300 no me inyecto. Me inyecto de 400 para 'riba, pero es la economía. Porque se me acaba y no puedo. [*If I see that my sugar is 200, 300—I don't inject myself. I prefer to leave it for when it increases a little more…I use it later. (The way I see it) since my diabetes is from 400 and parts, (to) 500. 300 is normal (for me)—of course it is not (normal) because that (number) is high, but from (around) 300 I do not inject myself. I inject myself from 400 and up, but it's the economy. Because it runs out and I cannot (keep up).]*

Judy, originally from Honduras, had been living in Chicago for over 20 years, and had always resided in the NW side of the city. Judy was living in the U.S. under a Temporary Protected Status (TPS) and could have applied for health insurance through the ACA but she did not get around to enrolling during the previous enrollment period. She was looking for help in getting access to more affordable or free insulin, and for a medical home where she could attain all her healthcare needs under one roof. She needed a better solution aside from breaking her budgetary needs each time she needed to refill her medical regimens.

Lastly, as seen in Table 3.2, ten individual interview participants noted some kind of medical disrespect (being disrespected during medical encounters), general frustrations, or concerns they had experienced that ultimately altered their engagement with biomedicine. Residents had their own specific concerns, but of the ten individual informants, two described issues with their insurance provider, one expressed how frustrated she was trying to find the right insurance provider to cover the same pediatricians and dentists her children had been treated by since birth. Another woman spent three years going back and forth trying to apply for the ACA or public insurance, only to find herself and her family constantly left to fall between the gaps of insurance coverage. An additional three residents described the lack of medical attention received, causing them to seek alternative doctors in hopes of a proper diagnosis. Two residents identified more hurtful medical treatment whereby one woman went to seek care for her eyes, and found herself leaving the optometrist walking back, basically blind, to her home because her eyes had been dilated and she did not have protection for her eyes. Another woman cited a medical surgery as the cause of her chronic back pain, restricting her mobility and quality of life. Another mother, who spoke of her experience with her son who had been diagnosed with schizophrenia, critiqued the way mental health is treated in the U.S. and the automatic prescribing of medications. This mother sought a more holistic method for helping her son's mental health that included talking, emphasizing a vast future, and actively working through concerns. This was the ideal treatment this mother envisioned which was very different from the 15-minute, dismissive visits she witnessed with her children.

I highlight this last point about medical disrespect because it is part of a larger argument of this dissertation. One of the overlying issues I continue to receive and interpret from residents, is the miscommunication that occurs between the clinician and patient. Medical anthropologist Carolyn Rouse points out “by not taking patient resistance to medications and treatment seriously, the medical community misses an opportunity to reflect on what may be wrong with the science, the clinic or even with their approach to wellness” (Rouse 2010:195). Rouse furthers the case of the importance of communication, especially in terms of what is considered ‘compliant’ and ‘noncompliant’ patient behavior and how these forms of open communication are essential to improving “patient outcomes” (Rouse 2010:194). These kinds of open, trust-building conversations cannot occur within a 15-minute session with a primary care physician or clinical specialist. Nor can they flourish if a patient is being uprooted from one clinician to another within a short span of time. Furthermore, we cannot assume that all medical advice, knowledge, or treatment is absolute or static.

Drawing on the anthropology of biomedical literature, Rouse notes “All medical knowledge does not have the same level of legitimacy or authority, as the evidence-based medicine and comparative effectiveness movements attest” (Conway and Clancy 2009; Keller, Chapin and Soule 1990; Inglehart 2009; Volpp and Das 2009 in Rouse 2010: 194). The clinician-patient relationship needs to be viewed as just that, a *relationship*, that calls on *both* parties’ to give and take, listen, understand, trust, and accept their responsibilities and roles in the development of health and well-being. This clinician-patient relationship is essential to the experience of consistent, quality care, and inclusive healthcare. Lupe, one of the elderly ladies who I claim as one of my field-abuelitas, advised me, "De eso deberías escribir tu tesis. Del mal trato de los doctores con los pacientes." [*You should write your thesis(dissertation) on that. On the abuse of patients by doctors.]* There is much evidence from the conversations I have had with residents of abuse endured pertaining to medical treatment. My aim is not to denounce clinical practice, but to find ways of improving care, especially for residents who consistently feel left out, not taken into account, or disrespected.

Latina mothers' navigation of health and well-being

The *herstories*[1] highlighted in the last portion of this chapter are examples of care *outside* of clinical spaces; spaces and support networks tapped into when medical and clinical settings lacked support or were negligent. This section further showcases the misinformation and obsessions over weight loss, fat shaming, and assumptions about BMI and ill health that assume that we eat too much or "eat bad", supposing that all overweight people can be given the same standard answer that they need to lose weight through diet and exercise. Most, if not all, of the mothers participating in these focus groups suffer from diabetes, high blood pressure, or high cholesterol personally or tangentially with their family members. Many of these mothers put everyone else in their families first, while their own personal health often falls behind in the long list of priorities.

---

[1] I use the term herstories, instead of histories, here because this chapter uses feminist theory to inform such terminology and is part actualizing intersectional stories. These stories are of women, Latina mothers specifically, and their navigations of health and well-being for their and their families' needs.

This section is based on the focus-support groups I have conducted with Latina mothers throughout Chicago. Of these 25 focus groups, ten were conducted at public schools and the participants were recruited through various parent programs provided by these schools. Within the ten focus-support groups conducted at the public schools, a total of 84 parents participated, 79 of whom were women, and five of whom were men.

The focus groups were originally designed to assess the broader situation among people living with type 2 diabetes, high blood pressure, or high cholesterol, throughout the various Latin@ Chicago areas of this study. However, as momentum gained in setting up these focus groups with mothers at various public schools, this method developed into a supportive and empowering space for parents to share their stories, experiences, and concerns along the general lines of health. They provided an opportunity to vent, ask questions, or share grievances when their voices had not been validated or heard before. Talking with residents in a group setting allowed for new topics of conversation/concern to come up and for conversations to flow easier given that I (the researcher) was the only stranger in the room.

Many of these schools have volunteer programs for parents where they are offered a small stipend for volunteering throughout the school year. Additionally, schools (especially the elementary and middle schools) offered parents English classes, GED classes, or even computer training. Weekly leadership workshops, health education, or other general education presentations were often offered to all parents at these schools. Not all schools had the same resources, but most had some base of parent volunteers actively involved in the prospering of their child’s school and future. The focus groups discussed here were organized around these social networks.

This dissertation highlights the difficulties families face in dealing with these conditions, and how these health conditions are embodied among Latinas. Despite structural violence's capacity to have "obscured … everyday violence that in turn propagates a symbolic violence … convinc[ing] the dominated that they are to blame—at least partially—for the destitution and destruction visited upon them" (Bourgois 2001:29), this chapter demonstrates how Latinas are engaging in agentive health strategies to both engage and challenge biomedical and other health systems. Lastly, I highlight their hopes for the future to better the Latin@ social, political, economic, and health landscape in Chicago.

Insight into difficulties people face dealing with these conditions

The communication of care and treatment were problems that almost all residents described, especially the Latina mothers highlighted here. A woman whose husband was dealing with all three conditions (he had been diagnosed with diabetes for ten years now) still could not get past feelings of 'pena' [*shame*] to disclose with his provider what was concerning him at the time. As his wife explained to me:

> Ahorita, apenas fue al doctor y el tenía unos hongos en los pies …a él le daba pena decirle al doctor la verdad. [*Recently, he recently went to the doctor and he had a fungus on his feet…and he felt shame telling the doctor the truth (about the fungus).*]

This speaks to what another mother, Gaby, talked about; not having "la confianza" [*trust*] to talk with providers after changing doctors so often. She explained:

> Si estoy entre doctor y doctor, no tengo la confianza para hablarle y decir, sabes que doctor esto es lo que me está pasando. Quiero que me haga una revisión o algo. Entonces a mi lo único que me queda es irme a la sala de emergencia y todo pa' que me digan que es estrés. [*If I am between*

> *doctors, I do not have the trust to tell them and say, you know what doctor, this is what is happening to me. I want you to do an examination or something. So the only thing I am left with is to go to the emergency room and all for them to tell me that it is stress (what I'm dealing with).*]

One retired Uruguayan humanitarian doctor, Dr. Paz, went above and beyond to make sure her patients were following treatment recommendations. She would go to the pharmacy to check to see if her patients had recently come to pick up their prescriptions and when they did not, she would confront them. Dr. Paz also noted the time it often took patients to disclose concerns or practices having to do with their care, often taking two or three visits to be upfront and honest with her. Not only is language, translating from English to Spanish and vice versa, a continued issue in seeking healthcare in Chicago, but also translating from clinical discourse to more understandable, 'layman' language. As these examples show, even when patients speak the same language as their healthcare provider, a certain level of trust needs to be built before patients feel able to share their health concerns. Although for some, trust can only go so far.

Insurance coverage instability and inconsistent care were additional points of contention for many mothers. Gaby, in line with her issues with building trust, expressed her fears with changing doctors four times in the past year:

> …a mí me han cambiado el doctor muchas veces, ya no puedo hacer constante con uno porque en un solo año ya me han cambiado 4 doctores. Porque me mandan las cartas de te toca tal doctor…Voy, hago la cita en un lado, un doctor … (para) volver a empezar otra vez. Entonces a mí me da miedo por todo eso. […*they have changed my doctor many times, I can't be constant with one (doctor) because just in one year they have changed 4 doctors. Because they sent me the letter that I was assigned a certain doctor, and then I did not want this doctor, I wanted another. I go to make an appointment in this other place with a (new) doctor …to begin all over again. So I am afraid because of this.*]

The inconsistent care she was receiving because of this back and forth between providers scared her because of her recurrent family history of diabetes, in addition to a recent episode she experienced of low blood sugar, although she herself was still on the borderline considered pre-diabetic.

Inconsistent care was the factor that pushed Alicia's diabetes self-management over the edge. She explained how she dealt with so many different insurance plans and doctors:

> (now it's) County Care…it was Blue Cross and Blue Shield, then it was regular medical card, publicaide- (it) just switches…I think I've seen 100 doctors for the last 9 years. Like it's changed so fast… and each one has a different method. Like 'alright here we're gonna do (this), here we'll give you pills, here we'll give you—I'm already tired, I don't even care.

The last treatment plan given to Alicia was to use a combination of oral medication and injecting insulin. But, by this point, Alicia was 'resignada' [resigned or numb] to this medical treatment, often forgetting her insulin at home while working and noted blood sugar levels through the roof (whenever she did check them, which was usually because of her close friend, Malory's, persistence). I view the structures and processes of power within these clinical domains as dominant in imposing definitions of ill health, pathologizing bodies that need attention, treatment, and mostly to lose weight. The stories of Latinas navigating these landscapes for their and their families' well-being reflect the strength and resilience Latinas enact when confronting these challenges.

Challenges faced when accessing healthcare

Those who have more consistent care shared the critique that "los doctores no te dicen nada ni te hacen nada" [*doctors don't tell you anything nor do they do anything*], touching on the recurring issue that patients are not given enough time within their individual consults/medical visits to discuss their concerns. The 15 minutes a doctor dedicates to the clinical consult is not enough time to talk about everything needing to be addressed. In my experience as a health outreach worker taking Latin@s' blood pressure and spending a little time talking with each person and inquiring about their clinical treatment, the vast majority of residents were still confused about what blood pressure numbers meant, how to eat healthily, how to lose weight, or how to remain outside of the risk category for heart disease.

The fact that not enough attention is dedicated to nutrition can be seen in the trend in many of the health education classes I taught and witnessed, often resulting in questions or concerns about nutrition. Residents often begin questions with the fact that they heard that such and such remedy was bad for such and such condition, or that such and such herb was good for lowing blood sugar levels. Most of these focus groups with mothers spent a lot of time sharing their health strategies or asking for clarification of any lingering health concerns they might have had. Sometimes, if I did not direct the discussion towards other topics, the mothers could spend hours obsessing over dieting and the challenges of eating healthy.

Gaby discussed her recent hospital visit, telling us how she was told about her pre-diabetes and how to treat it:

> Fui al hospital y me dijeron, sabes que aquí tenemos todo tu registro y tienes pre-diabetes. Tienes que bajar de peso, tienes que—y les digo 'ok yo puedo dejar de comer esto y el otro' pero eso no me va garantiza de que vaya a bajar rápido. A veces si bajo de peso, que parezco de hipoglucemia, entonces yo ya me da miedo de bajar de peso porque si bajo muy rápido es, se están temblando. [*I went to the hospital and they told me, you know what we have records and you have pre-diabetes. You have to lose weight, you have to—and I'd tell them 'Ok I can stop eating this and that but that is not going to guarantee that I will drop weight fast. Sometimes I do lose*

> *weight, because I have hypoglycemia, so I am scared to lose weight because if I lose weight too fast, (my whole body) trembles.*]

In the clinician's recommendation for her to lose weight she was instructed to:

> Comer más sano. Dejar muchas cosas, helado, lo que básicamente dicen, el doctor me dijo, sabes que te quiero ver en tantos meses otra vez porque quiero ver que bajaste de peso. Cuando fui a la cita me dijo si bajaste dos libras, que subí al siguiente día. [*Eat healthy. Stop (eating) lots of things, ice cream, what they basically tell you, the doctor told me, you know what I want to see you in so many months again because I want to see you lose weight. When I went for my appointment they said yes, I did lose two pounds, which I gained the next day.*]

The sparse holistic health recommendations given to patients on the 'health' border line, or deemed within risk lines, are not sustainable and do not address key issues in leading a more healthful life.

The standard recommendation when someone's blood pressure, blood sugar, or cholesterol is too high is that they need to lose weight, diet, exercise and/or if already prescribed continue taking medication (many doctors opt to increase the doses as well). Some patients will stand up for themselves and say that they don't want anything to do with that cholesterol pill, or disclose to their clinician that they want to see about lowering these concerning levels on their own, without adding more or higher doses of medication. But not enough time is spent on the importance of nutrition. This is evident in the lack of dietitian consults within medical care. A dietitian disclosed that physicians can charge Medicare for an individual consult in teaching a diabetic patient how to eat healthily, but a dietitian cannot. If 70-80% of weight loss is based on what we consume, why are we not dedicating more time and attention to this aspect? Because, briefly telling a patient that they need to eat more vegetables and less fatty or fried foods is not really socially, economically, geographically or culturally sensitive to what is going on in Latin@s' lives. Even if a clinician did spend an additional 15 minutes discussing how to eat a healthier diet, this one-time visit will usually not have lasting or sustainable results.

Embodiment and self-care

Social epidemiologist Nancy Krieger defines embodiment as "how we literally incorporate, biologically, the material and social world in which we live, from conception to death" (Krieger 2005:352). Medical anthropologists such as Clarence Gravlee (2009), Seth Holmes (2013), Clara Han (2012), and many others have incorporated embodiment within their work to explain how daily stress is manifested into ill effects in our bodies. Han's *Life in Debt: Times of Care and Violence in Neoliberal Chile,* provides vivid pictures of how embodiment is experienced among people. Throughout Han's ethnography residents of La Pincoya, Chile embody the stress that they face in their daily lives, particularly exhibited through mental illness. Han presents embodiment of depression, schizophrenia, anxiety, and nerves, and as a result we see the reliance on alcohol to deal with struggles in daily lives. More specifically, embodiment is manifested in Señora Flora's weight gain because of her loved one's failure to listen to her advice and later her broken heart in relation to her broken home (Han 2012:39, 52); in Susana's absorbing of another woman's pain and sickness because she can't pay her monthly debts (Han 2012:79); in the toll of daily stress expressed in Ruby's eye swelling and Hector's continuous neck spasms and early diagnosis of osteoporosis (Han 2012:125-126); in Jorge's nerves getting eaten away and Gladys' inability to use her wrist from her labor of sewing and her subsequent inability to leave the bed (Han 2012:207). Where before there was economic and social deterioration, in this context, people in Chile are physically deteriorating, experiencing a human deterioration. The stress imposed by debt was embodied in each of these cases, although manifested differently each time.

Embodied chronic disease is represented among New Orleans Hurricane Katrina survivors who, by the two-year mark post-hurricane, experienced a threefold increase in heart attacks (Adams 2012:198). Vincanne Adams' research also demonstrated the continued neglect of communities of color and the vicious cycle that is reproduced to create and maintain these inequalities, such as when the Army Corps stopped picking up trash and rubble post-Katrina (Adams 2012:197).

The Latina mothers I spoke with experienced various forms of embodied illness, mostly stress in worrying about other family members or traumatic life events. Every time I saw Ana Lucia, her nerves were shot from worrying about her husband not waking up from his sleep because of his uncontrollable health. She explained:

> …a veces en la noche le da una tos-cuando está bien tomado--una tos que como que se pone morado, como ahogado. Entonces yo le digo, yo amanezco develada porque pues estoy pendiente, porque a rato le da un infarto, un ataque y yo no voy a saber. Entonces yo siempre estoy pendiente. Yo vengo despierta desde las una o dos de la mañana por estar pendiente de que se pone mal. *[…sometimes at night he gets a cough--when he is really drunk-a cough that he gets purple, like suffocating. So I tell him, now begin the early awakenings because I am mindful, because then he will get a stroke, an attack and I won't know. So I am always on the lookout. I am awake since one or two in the morning looking after him to make sure he does not take a bad turn.*]

Ana Lucia was so frustrated with her husband's lack of attention to his self-care and his negligence in drinking, that she teared up as she voiced her worries about something happening to him because of his nonchalant attitude in managing these conditions.

A younger mother, Maribel, noted the stress her body endured in one of her pregnancies during which her father was undergoing cancer treatment. Maribel explained:

> Mucho estrés para mí en el embarazo. Yo no comia, na'mas me tomaba las pastillas y yo andaba, lo que pasó a mi después de 6 meses que me, empese a perder pelo…. Perdi el hueso, yo no tenia mis dientes chuecos, yo tenia una dentadura perfecta. Empeze a ver como iba transformando ah, me dolia las rodillas, me dolia la cadera. Y … todo el estrés. Me hiceron estudios de ni se que tantas cosas. No tenia nada. Todo era el estrés. Puedo acasionar que el estrés cuando uno lo tiene, mata. [A *lot of stress for me in the pregnancy. I didn't eat, only took the (multivitamin) pills and I would go. What happened to me after 6 months, I began to lose hair, I lost bone (density), I didn't have crooked teeth, I had a perfect dentition. I began to see how I was transforming, my knees would hurt, my hip would hurt. And all the stress. They did I don't know how many studies. They didn't find anything. Everything was the stress (I was enduring).]*

Embodied illnesses from life experiences turn into elevated numbers for many residents I spoke with. Another young woman, Diocelina, was worried about her recent diagnosis of high cholesterol. This diagnosis coincided with the traumatic divorce she had been going through around the same time. Or the father of a woman I interviewed, who "…le da miedo ir al doctor, y entonces la presión la tomaron y salio muy elevada. Mas de 200." *[…he gets scared going to the doctor and so they took his blood pressure and it came out really elevated. More than 200*]. Another man's cholesterol diagnosis came after the time his father had passed away; his body expressed the pain of this loss in the elevated LDL and triglyceride levels in his bloodstream.

For countless mothers, health always ended up on the back burner. In the earlier case of Alicia, rather than worrying about her own diabetes management, she was more concerned with her mother's health. She explained:

> It’s been real (hard) for my mom. ‘Cause she had high blood pressure and she had a stroke, and diabetes. Then she got a stent put. So it’s like everybody like you’re gonna take care of her, but you’re not taking care of yourself. I’m like yeah because, I’m to a point where I’m like, I get fed up…. She’s still in and out the hospitals…She still has feelings in her legs but …her legs are black and we’re constantly telling her you gotta take care of yourself and she doesn’t listen to us… But mom, she’s off and on. Her, blood pressure, her blood pressure be like 275. And I’ll be like ma, your heart rate, your iron’s high, you know your iron.

Alicia could easily dictate the levels and readings of concern in her mother’s case but was not as familiar with her own numbers.

Juana, a very actively involved mother in her child’s school, had not been attending to her own health and admitted to slacking on her own self-care:

> ... de salud-digo de cuidado personal pues, fallo… Voy aquí, aquí a la clínica. Aquí me hago mi estudio cada año. Pero de, de ejercicio, no. Allí sí fallo. [*…regarding health-well taking personal care, I fail…I go here to the clinic. Here I do my annual checkup. But regarding exercise, no. I fail.*]

Granted, exercising is not the only way to be healthy. In fact, Juana did well in still maintaining her annual checkups. But this further speaks to the fact that for many Latinas, confessing about lacking in exercise or diet was something always on the back of one’s mind as the mythical solution to all health problems.

Hopes for the future for a better Chicago and Latin@ Chicago

These support-focus groups shed light on the growing importance of support networks outside of clinical settings. Many community centers have developed support groups not only for diabetics but people dealing with hypertension and domestic violence as well. For many of these mothers, these support networks are key to holding each other accountable and bolstering each other when so often the odds are stacked against them.

Erika and Ms. Pérez held each other accountable when they were trying to stop drinking soda and often counted on one another to keep each one in check. Alicia, Malory, and Yanelis had developed a friendship that for someone like Alicia was the only way she made strides in managing her health. Because both Alicia and Malory had diabetes, they often reminded each other (mostly Malory getting on Alicia) about taking their insulin, and Malory was teaching Alicia which fruits had especially high sugars, or how to bargain shop. Yanelis' husband was recently diagnosed with diabetes and although she herself was not diagnosed with any of these ailments, she took it upon herself to adopt healthy cooking strategies for the entire household. In fact, Yanelis' house and healthy strategies were a tremendous resource not only for Malory and Alicia, but other school staff members who didn't have time to cook. Alicia described:

> It's hard because what's good for me I won't cook for my family. Because my family is not overweight like me. My family is you know, so they want their fried protein, their pork chops and their chicken and their rice--so I stopped cooking. So it's that now I'll go to her (Yanelis') house, I'll eat at her house (M), I eat at her house (Y). And I take my husband a bowl or plate.

Heidi, Antonia and Lorena are another household (each of their three families live in the same house, one family for each floor) that support and rely on each other to maintain their health and sanity. Heidi and Antonia were always ragging on Lorena and being vigilant of her consumption of Coca-Cola. Especially now that Lorena has been diagnosed with type 2 diabetes, their care of Lorena has been more attentive to her needs, perhaps even more than Lorena takes care of herself. Lorena gives everything for her children and husband. She waits hand and foot on her three sons and husband. After a health presentation I gave—emphasizing the importance of nutrition in managing these conditions—Lorena approached me asking about the levels at which one was considered diabetic. She still wasn't convinced that she was under the margin to be diagnosed diabetic. After I took her blood pressure she shared with me "es que no sé cómo hacer para que los vegetales saben buenos" [*it's just that I don't know how to make them (vegetables) taste good*]. The constant battle to eat healthy within her immediate family was not supported by her spouse or children, a fight that she often gave into by cooking what her family liked and was accustomed to eating.

On the topic of dietary changes, it would be more productive to emphasize what patients *can* consume instead of limiting everything they have grown up consuming for over 30 years. In many ways I interpret the way people have adapted their diets as forms of resistance to the strict dietary regiments imposed on them by health care providers. For example, a man I met while doing health outreach work had just had a toe removed from gangrene. Shortly after leaving the hospital from this procedure he and his wife stopped for a McDonald's hamburger and french fries "para acabar con la diabetes" [*to do away with the diabetes*]. There are many narratives like these in which residents are constantly picking and choosing their battles every time they eat—choosing to die happy instead of hungry. On the other hand, there are many narratives of residents attempting to approach health on their own terms by becoming actively involved and learning more about their conditions and what strategies could be adapted to curtail negative side-effects. Victoria, a woman in her 50s who had just lost her son to diabetes, was especially careful about everything she ate to the point that her self-surveillance even became a stressor in her life. In her time of need, this woman began attending a local community center where she found a support group of women (over the age of 60) and eventually found strength and purpose in her life again.

Additionally, we may consider educating *health care providers* on how to communicate better with their Spanish-speaking and other Latino patients. Not only is communicating with monolingual doctors still an issue, but the quality of care Latin@ patients receive as a result of this lapse is disconcerting. One woman pointed out the frustration within doctor's appointments:

> Los Latinos le afecta mucho la medicina y a veces los doctores también... Porque vas a veces hay unos doctores que no te ponen atención… después de 25 minutos no me explicas nada (laughing), me vas a dar un papel que no entiendo, ¿cómo está mi colesterol? ¡Tú tienes que darme una explicación! ¡Y todo eso te decepciona! [*For Latinos the medicine and sometimes the doctors too affect us…because sometimes you go and there are doctors that don't even pay attention to you…after 25 minutes you haven't explained anything to me, you're going to give me a paper that I don't understand-how is my cholesterol? You have to give me an explanation! And all that disappoints you!*]

Another support group of mothers was full of suggestions for clinicians. These women emphasized the faulty lines of preventive care in such cases as breast or cervical cancer. Their exchange follows below:

> J: …porque yo fui a la clínica y me dijeron que no (no le podían hacer la mamografía) que la recomendación es 35 y para arriba. Y (yo digo) no debería ser tan (tarde). *[…because I went to the clinic and they told me no (that they wouldn't do the mammogram), that the recommendation was beginning at 35 (years of age) and up. And (I mean) it shouldn't be so (late).]*
>
> A: No. Porque, porque también mi mamá si tuvo una conocida de allí mismo de donde es ella. Que toda su familia sufrió de cáncer de mama y ella no se revisó. Ella decía, no a mí no me va dar y, la vergüenza también. La muchacha murió de 28 años. [*No. Because, also my mom had a friend from where she is from. All her family suffered from breast cancer and she didn't get checked. She would say, no I am not going to get cancer, and the embarrassment, too. She died at 28 years old.*]

> J: Sí yo fui a pedir la revisión, exactamente, yo fui a pedir la revisión del cáncer (de mama). Pero me dijeron que no, entonces como que debería hacer un poquito más amplia (las edades para revisar). [*Yes I went to ask for a screening, exactly, I went to ask for this cancer screening. But they told me no, so (I think) that (the recommendation) should be wider (more inclusive).*]

This exchange speaks to the limits of standard screening guidelines, the copious definitions and lines of risk for cancer prevention and their lack of adapting to immigrant stories, especially if people come from communities with histories of being environmentally poisoned with cancer. Such preventative screening needs to be informed by patients' more personalized biographies instead of only following national guidelines.

Another clinical fallacy these mothers pointed out were the more frequent gynecological visits. As their exchange continued:

> J: Pero de la matriz también tiene. Se dice que si tienes tanto tiempo viviendo con su pareja, si te lo hacen porque lo están haciendo cada dos años o cada tres años. [*But for the uterus too they have (issues). They say if you have so much time living with a partner, they will do it (the check-up) because they are doing it every two or three years.*]
>
> *B:* Cada dos. [*every two*]
>
> M: Ah ha. Y en cambio, vamos a decir si eres una esposa de una pareja ahorita, otros seis meses si te lo hacen cada año, y ahora ya. Dicen, 'oh no, es que tu vives con tu pareja.' Yo si lo exijo porque yo tengo ansiedad de cáncer de matriz por mi mamá. Y yo se lo exijo, de hecho, en mi experiencia, te apuesto que cada. [*Ah ha. And then, let's say if you are a wife with one partner now, (but then) another 6 months, if you do it each year, and then that's it. They say, 'Oh no, it's that you live with your partner.' I demand the check up because I have the anxiety of getting cervical cancer because of my mom. And I demand this check-up.*]
>
> A: Cuando va uno, que le hagan el examen del papanicolaou, preguntan a uno si estabas con otras personas y preguntan del esposo y yo digo, 'pregúntenme de mi, yo no sé de eso'… ¡Seguramente mi esposo va llegar y 'sí, sí estuve con otras' no! [*When you go, that they do the Pap Smear, they ask you if you have been with other partners and they ask about your*

> *husband and I say, 'ask me about me, I don't know about that'…Of course my husband is going to come and (say) 'yes, yes I was with another woman,' no!*]

These and many other mothers and residents provided many suggestions for how they hoped to see the city of Chicago change for the betterment of their and their communities' health, as described in the final section below.

Improvements suggested by residents to be made throughout the greater City of Chicago and Latin@ Chicago communities were vast. Some residents saw the growing costs of living in the city to be especially burdening: from the traffic lights and speed radar cameras to the forbidding housing prices. Additionally, residents spoke of the limited credit opportunities that push communities of color out of neighborhoods sought for urban redevelopment projects as seen in the northwest and other areas of the city. Other residents, especially in the southwest side of the city, saw the limited resources and scarce opportunities provided to their local communities as a burden, such as the lack of guitar or other extracurricular lessons for their children, and the skimpy parks in the south as compared to the north, richer, whiter neighborhoods.

Many mothers, knowing the importance of their local schools for the greater community, suggested utilizing the school systems already in place to create more healthful environments. One mother suggested bringing a weekly farmers market to the school so that parents could access fresh produce. Another mother suggested more community gardens, citing the success of the school garden and how the vegetables produced were used for a salad snack in one of the classes and the kids loved it and ate it all. Overall, many parents cited temptations on every corner to eat poorly, the hiked-up expenses of purchasing fresh produce (especially if attempting to buy organic), and the cheap and convenient price of fast foods. Such landscapes promote over-consumption of dietary poor foods and many residents hoped to see their communities have an abundance of healthful food options instead of the poison constantly promoted to them from every direction.

Conclusions

To bring this discussion full circle I provide a final snapshot from one of these focus-support group discussions; in this context, we were in the middle of sharing experiences of clinical care being sought:

> L1: ¡Ni me dicen nada, dicen que estoy bien! ¡Pero me sigo sintiendo mal! [T*hey don't even tell me anything, they say I am fine! But I still feel bad!*]

When I inquired where her doctor was located she disclosed,

> L1: Estoy ya cambiando por lo que dije, o no me saben atender o no sea (laughing) pero todo--ahorita me estoy dando allí a la South y este-ya porque na más voy a ir a pagar dinero y siempre dicen que estoy bien, estoy bien. [*I am going to change doctors because of what I've been saying. Either they don't know how to treat me or I don't know, but all--right now I am going there on South and I only go to pay money and they always tell me I am fine, I'm fine.*]

Another woman jumped in affirming her testimony,

> L2: Uno va al doctor y le dan un diagnóstico. Okay. Vuelvan a regresar y es un diagnóstico diferente. [O*ne goes to the doctor and they give you one diagnosis. Okay. You go back and it's a different diagnosis.*]
>
> L1: Pero como dice la señora, cuando va al doctor, no me den nada ni dicen na'…de la diabetes no sé si…. A veces no voy porque también no tengo dinero. Y el dinero na más voy para darlo entonces me dice mi marido, pa' que voy, con eso, mejor lo uso para algo que necesito. No te dicen nada. [*But like the lady was saying, when I go to the doctor, they don't give me anything nor say anything…if I have diabetes I don't know…sometimes I don't go also because I don't have money. And the*

> *money I just go to give it away, so my husband (says) why go, with that (money) better to use it for something I need. They don't tell you anything.*]

This exchange speaks to the various aspects this chapter has addressed about Latinas' experience in navigating chronic dis-ease. For many residents, doctors' visits are often fraught with unclear diagnoses, unexplained numbers or readings or evaluations, and abstract treatment and recommendations. The root reason for visiting the doctor, in this woman's case a splitting headache, is left unexplained by the medical treatment sought. She almost wished for a diabetes or hypertension diagnosis in order to finally get to the bottom of her pain. Instead she kept gifting the sparse money she had to this medical establishment that continued to provide unsatisfactory care.

Intersectionality can help us understand how people with the same ethnicity are classed differently within the healthcare arena. The stories above demonstrate the common narratives and frustrations with clinicians. However, not all Latin@s thought this way about their healthcare providers. Some Latin@s have had consistent quality care and established long histories with their clinicians. Surely other Chicagoans of different races, classes, or ethnic groups can relate to one or more of these experiences. Just as someone in a rural context can be classed similarly by the healthcare system, and may experience the same fat shaming and pathologization of risk factors. For Latin@s there are additional discriminating factors in terms of language barriers between monolingual clinicians and the racialization and association of Latin@s identity being synonymous with metabolic syndrome.

Anthropologists such as Marilyn Thomas-Houston have added to our understandings of intra-ethnic diversity (2005) and argue for the importance of learning these local histories and experiences. This study does not aim to speak for all Latin@s, nor all urban Latin@s, nor all Chicago Latin@s. The context of Chicago and each of the neighborhood areas shape each resident's experience and is specific to these sites. Translocality shapes the clinical encounters people have and shapes the classed healthcare experiences. As a result, many have created their own form of social support and engaged in agentive strategies. These narratives have been gathered from select Chicago Latin@ residents in order to give insight into the obstacles faced and how to improve the clinical, social, political, and economic landscape of these communities.

In my many encounters with residents through health outreach work, I found that for most the answer to the question of whether or not they had been diagnosed with blood pressure was no, but when I asked if they were currently taking any medication for blood pressure they would answer yes, or vice versa. So although some residents were taking medication for blood pressure or cholesterol, it did not mean that they saw themselves as suffering from the particular problem. A clinician would cringe at this explanation, and I did too at the onset of this research. But residents are in the right that "no tengo problema ninguna" [*they don't have any (health) problem*]. The problem is the rigid medical system and scales of comparison that continue to minimize health to specific numbers, numbers that are strategically lowered to fill the pockets of pharmaceutical companies and other pharmaceutical stakeholders.

CHAPTER FOUR:

Engagement with biomedicine

This ethnographic chapter explores the various ways that residents engage with biomedical discourses and practitioners. Residents diagnosed with these conditions (diabetes, high blood pressure, or high cholesterol) have learned to evaluate biomedical advice and many choose to adapt it to their own forms of care suitable to their individual pace of life. Some residents shared their various strategies and tactics, expressing how they manage and attain well-being on their own terms. This chapter focuses on how Chicago Latin@s respond to and engage with biomedical treatment options as they take (or do not) medication or shots of insulin for their respective conditions. I open with a description of the clinical facilities available to the locals, with an emphasis on their experiences with emergency rooms. Next, I draw on the physician-patient relationship, including the kinds of strategies patients engaged throughout these interactions, and describe ways to improve the clinician-patient relationship. I follow this with examples of how the residents adapt biomedical practices to their own liking, from requesting certain screenings to taking pills and insulin as they see fit. Lastly, I describe experiences with ‘natural’ medicines, such as the growing trend of Herbalife use and other similar products.

Shifting health policies in the post-ACA climate

A trip to the dentist: Lorena was experiencing enduring pain from an unbearable toothache that had become a migraine, preventing her from getting any sleep in almost a week. A comadre of hers had been to a nearby dentist “que cobraba poquito” [*that* *charged very little*] and was easy to be seen without appointments. She mentioned the coordinates and I remembered seeing a sign for a dental office in that vicinity and offered to take her. We hopped in the car. Lorena kept monitoring the storefront address numbers to where the dental office was located. Traffic was holding us up. A power cord had fallen; there had been an ugly storm earlier in the day, and the winds kept howling threats. I took a short cut to where I remembered seeing the dental sign but the numbers didn't match up. We put the address in our GPS and were just blocks away from the facility. No dental signs, no advertisements, just a clothing store that looked closed. We parked the car along the side of the busy street and ran in between traffic to the storefront across the way. All the lights were off and the open sign remained unlit, but when we attempted to enter, the door was open. We hesitantly looked around to the dark room filled with clothing displays but no one was in sight. A glimpse of light peeking through the side hallway led us to plastic chairs, one occupied by a man waiting cradling his jaw. Another man behind a bare desk looked at his phone, waiting to attend walked-ins. He asked how he could help us and Lorena proclaimed "me dijeron que aquí me pueden atender por un diente que me tiene molesta" [*I was told that I could be attended to here for a tooth that has been bothering me.*] The receptionist nodded, but that it would be a couple of hours. Lorena inquired if after three in the afternoon she could come back and they both agreed. Lorena went back that afternoon and was able to get the two teeth bothering her removed. She was so happy with the treatment and the price that she even had the dentist take out a baby tooth from each of her younger sons (ten and eight years old) who had cavities that were bothering them as well.

This beginning section discusses experiences and narratives in the shifting landscapes after the implementation of the Affordable Care Act (ACA) and the looming threat of repeal. Many public, medical and policy anthropologists have called for the importance of anthropological studies in the implementation and results of such historic policy as the ACA. This discussion responds to these calls to action by addressing how these policy changes are experienced by people and their responses to the changing U.S. healthcare landscape post-ACA. Highlighted here are the uninsured who continue to be uninsured, people who benefited from this legislation, and the limits of the ACA.

Who was left out of the ACA and where can care be sought?

The 2010 ACA was an historic moment for millions of uninsured Americans to have access to health insurance. In 2011 there were nearly 48 million uninsured Americans (KFF 2012), and another 25 million under-insured (Schoen et al. 2008). In 2016 there were still 28.1 million uninsured in the U.S. (Barnett and Berchick 2017). In 2015, 9.6% of Chicagoans were still uninsured (Schencker 2016). However, in the community areas where I have conducted my research, the 2012 insurance rates range from 14-27% in the northwestern community areas, to 21%-37% in the southwestern community areas (ACS 2012). These larger uninsured percentages are of those people left out of the ACA, in particular undocumented residents (mostly Latin@). In addition to undocumented immigrants, others left out of the ACA included prisoners, those who do not have to file taxes because their income is too low, people who would pay more than 8% of their income on insurance premiums, and members of certain religious groups and Native American nations (Horton et al. 2014). The ACA also obligated states to expand program eligibility to the new income threshold or forfeit all federal funding for

Medicaid (Horton et al. 2014). However, the Supreme Court ruled the ACA's federal-state partnership to expand Medicaid as "economic dragooning" (Pear 2012) thus limiting the reach of this clause. Illinois was one of the states that opted to expand Medicaid, thereby expanding the reach of health coverage.

Among the Chicago residents I talked with, a large portion were undocumented immigrants and had subsequently been excluded from the healthcare marketplace. Some undocumented Latin@ are able to attain healthcare insurance through their or their spouse's employer. Besides these options, uninsured residents seek care at clinics that offer treatment based on ability to pay. For more routine care, such as dental work, some residents may access informal businesses of health professionals whose home country credentials are not recognized in the U.S (as seen in Lorena's story). For the most part, those who remain uninsured seek care in emergency situations. Revisiting Lorena's case, although she and her husband were uninsured, her three sons were U.S.-born citizens and had health insurance through the Illinois All Kids medical card, which included dental care. Many uninsured residents are part of mixed-status families, whereby often the children are U.S.-born citizens covered through state-sponsored insurance.

A rare outlet for uninsured residents to seek care are free clinics, like Northwest clinic. After the ACA was instated, Northwest clinic has dedicated its services to those who do not qualify for the ACA. Registering at the clinic was simple enough; applicants just had to present some form of ID (e.g. a matricula or foreign passport), and proof of address and income (paystubs, income taxes or a letter from employer). Northwest clinic is entirely funded by private donations and is the largest free clinic in the nation, providing 20,000 medical and dental visits and filling over 69,000 prescriptions for their patients annually. Surely, “esta clínica es única,” Dr. Paz, a retired, humanitarian Uruguayan doctor shared with me. She wished for clinics like these to be in each neighborhood throughout Chicago. Where else could you find primary care, lab work, pharmacy, dental care, psychiatric counseling, health education and a slew of specialty care (including podiatry, cardiology, gynecology, urology, neurology, and ophthalmology) under one roof? Unfortunately, geographic dispersal makes these vital community centers difficult to access--a south side branch of this clinic, for example, was forced to close due to lack of funding.

Lorena in 2017, at the age of 43, had been diagnosed with diabetes. She had been deemed pre-diabetic for a while but had reached dangerously high blood sugar levels. Her 35-year-old husband had been dealing with diabetes for 7 years. He treated his diabetes through prescription medicines. According to him, as he showed me the pill bottles, the Metformin was for his diabetes and this other pill to protect his liver from the Metformin. I have continued to offer my help to Lorena and others in navigating their needs for well-being as reciprocity in my fieldwork.

Benefits of the ACA

For some, the ACA was their saving grace when in need of health insurance. For Ingrid and her family, they turned to the healthcare marketplace when her husband retired early. Ingrid was a diabetic, and her husband was diagnosed with high cholesterol, both requiring medication they depended on daily.

> I was insured through my husband’s insurance because he worked. But when he retired he couldn’t get Medicare yet because he wasn’t at the age and I needed to have some sort of (insurance), so we went under the Obamacare. To us it was good. I think we paid less than $300 a month for the three of us. It was me, my husband and my son, who still lived at home. But now it has gone up a lot.

Ingrid explained that since her husband now qualifies for Medicare, she and her son are still relying on the ACA. While Ingrid was grateful for the ACA, she expressed concern about the growing premiums she and her son had to pay. Because she and her son have to purchase insurance separately, they are now paying over $200 a month for each plan, totaling $600 of household health insurance expenses a month for coverage for all three family members. While Ingrid was not charged in excess for having a pre-existing condition such as diabetes, the baseline cost for her son, a healthy young adult, was still steep.

Thankfully, many of the residents I spoke with were managing their conditions to their standards and overall in good health. Yet there were also extreme cases like Irene. A young woman in her 30s, Irene has had diabetes since she was 13, was dealing with hypertension and depression, is going on four years' remission from breast cancer, and is currently on dialysis three times a week. She was still not eligible for a kidney transplant because, in order for her to be considered a candidate, she needed to be cancer free and without cancer treatment for five years (she still had one more year of oral medication). Irene's life depended on access to health treatment facilities, such as the dialysis center that she dreaded visiting three times a week. And for those battling terminal stages of illness, medical bills are a daily stressor (Navarro 2010). Irene couldn't believe how much was spent on health expenses after reviewing her monthly credit card bills. With the benefit of health insurance, her medical bills are at least manageable and she is able to maintain a roof over her head.

Limits of the ACA-healthcare benefits? Sal y limón

While the ACA requires companies to extend healthcare packages (for purchase) to those who have fallen through the cracks of full benefits, for many these packages are still steeply priced. Analis, working as a home aid, noted that if she purchased the home aid health insurance, it would cost the majority of her earnings. Analis had recently moved to the U.S. mainland, leaving Puerto Rico in the aftermath of the Wall Street-driven economic crisis. She rightfully critiqued the U.S. healthcare system, reflecting on the lack of healthcare options she had:

> Sal y limón. Porque si tu coges un seguro con esto de homemaker que yo trabajo, se te quedan con el cheque. ¿Como voy a mantener la hija mía? [*Salt and lemon. Because if you get insurance coverage with this home aide job that I work, they end up with (all) your check.*]

As a single mother navigating a new city, Analis needed all her earnings to maintain her family. Another stipulation with employer-based health packages, as Ingrid explained, are employees who are considered part-time vs full-time:

> … most of these jobs now they don't want to give health insurance. They tell you, no you're a part time even though you're working 35 hours. You're just 5 (hours) short, but they won't give you those 5 because that means they have to pay for (the insurance). So then you're forced to pay it (health insurance) yourself. The good thing is that they give you a credit. But now that Trump is the new (President), I don't know what is going to be for next year. Because like now we're insured through November of this year. But in November, we're gonna have to renew.

Ingrid's uncertainty about the future speaks to what Maribel critiqued about the precarious future of the ACA because, "el viejo lo va quitar," [*the old man is going to get rid of it*] referring to President Trump. Maribel's key insight about the temporality of legislation is a point of concern for many who have counted on this law to access their healthcare needs.

Another challenge has been the bureaucratic overhead. Public agencies are becoming fraught with caseloads of helping residents apply for the ACA. Responding to their inability to repeal or replace the ACA, the current administration has cut back the time period, funding and publicity for open enrollment. This burdens the public workers and one of the consequences may be that more people fall between the cracks and do not enroll in a health plan. Then come the fines in the annual income tax-- fines that even undocumented uninsured Latin@ who file taxes are forced to pay. These challenges became reality for Adriana. She explained that, after five different attempts of applying for the ACA and the medical card, she was told months later that she and her family did not qualify for one or the other. This delayed response left her and her family outside of the enrollment period and led to her to pay $600 in fines the first year and $2000 this past year. Another woman shared with me her concern that her eldest daughter, 19 at the time, had been told in July 2017 that she did not qualify for the medical card, although she had applied in December of 2016. Delayed responding periods, case overloads, temperamental lines of eligibility, mountains of paperwork and bureaucratic processes have kept such cases in limbo.

The growing premium costs, high deductibles and limited insurance plan options are examples of where the ACA can stand to improve, if it continues. Even though the ACA expanded coverage for many people, marginalized communities, including Chicago Latin@ communities, continue to endure challenges in seeking care, whether they be through private, public or informal channels. The ACA's uncertain future compounds these problems, and the lack of maintenance and attention to the issues that have surfaced may lead the ACA to collapse. As noted by Horton et al. (2014:3) in their ‘Take a Stand’ Statement:

> …in the current era of “corporate governance” (Sunder Rajan 2006:80). Advocates of privatization promise that the private sector can more efficiently and effectively spend states’ health care budgets. Yet, to date, the evidence on the efficacy of privatization in improving health outcomes while reducing costs remains unconvincing (Abadia-Barrero 2012; Almeida 2012; Mishtal 2012; Mulligan 2012; Ugalde and Homedes 2012).

Within community centers it appears as though the workloads increasingly pour down and the benefits are scare. I hope that these stories highlight areas that future healthcare policy can effectively address. I think it is important for public anthropologists (including myself) to continue engaging with communities and advocate for policies that are conscious of the intricacies our communities face.

Biomedical facilities

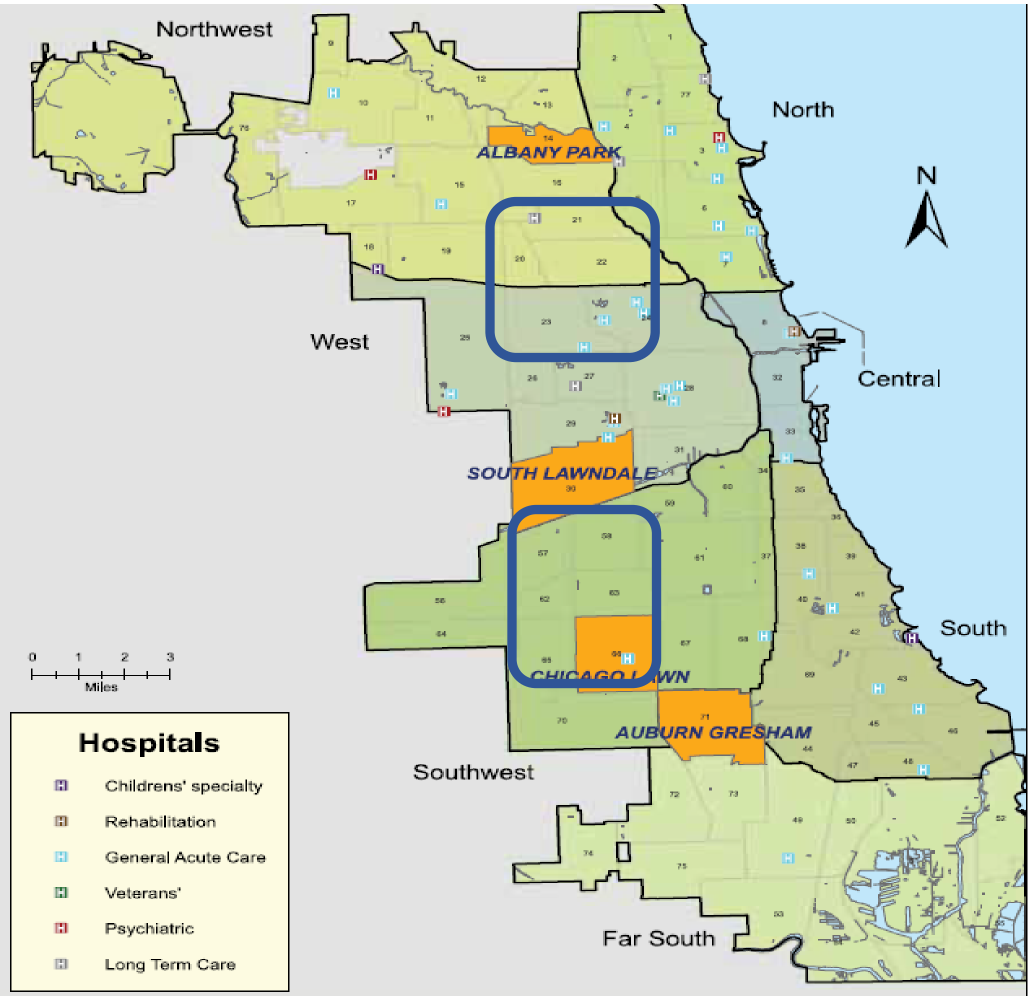
Emergency care

For the majority of the residents (both in the NW and SW) I spoke with, the Cook County hospital served as a resource in one form or another. For residents who were undocumented and without insurance, the Cook County Emergency Room was where they sought care when they felt that something was seriously wrong. Others were referred to Cook County to receive specialty care or conduct tests that were not accessible in smaller satellite clinics or private practices. Briana, one of the key informants that I interviewed, explained the impact of Cook County hospitals from the perspective of the patient population at Northwest Clinic, which she helped run. Briana explained how Northwest Clinic was working to establish a partnership with the Cook County hospital, especially since none of Northwest Clinic's patients had access to any form of health insurance, and it appeared that at some point or another almost each patient accessed care at Cook County. For patients whose care at an ER resulted in exorbitant bills like Analise's, necessary medical attention only served as an added stressor in their lives as they tried to figure out how they were going to pay or worried about the consequences of not paying.

While I was engaging in health outreach work in the NW side, there was one grocery store that tended to be frequented by undocumented residents. One man whose heart screening I was conducting asked if I knew of any help for paying for hospital bills. I admitted that I did not and inquired more about what kind of help he was seeking. He recounted that he had gone to an emergency room in one of the hospitals nearby because he had had a scare because he thought his blood pressure had gone up. It turned out to be nothing serious, yet he was still sent a monstrous bill totaling thousands of dollars. After receiving this bill, the man had not set foot in that hospital again, nor any other health care facility, out of fear that the worst could happen to him due to his negligent charges. He thought he could even be deported because of his inability to pay this hospital bill. The other outreach worker and I assured the man that neither the hospitals nor any other healthcare facility had that capacity, authority, or connection with Immigration and Customs Enforcement (ICE). We advised the man that in most hospitals they have a certain budget or fund to help patients who could not afford their care and that he should try and reach out to the hospital he had attended—even if it was by phone—to see if there was a payment plan or another way they could help reduce the cost of the bill he had been charged. The man was reassured and expressed how this situation had been stressing him out for a long time, sometimes not allowing him to sleep at night, worrying that these charges would catch up to him.

As in the case of the above man, many residents in the NW relied on many other health care facilities near them. For example, within the NW side community area there were three hospitals within one the community's boundaries. Figure 4.1 provides a more vivid example of the various hospitals available in the NW, in comparison to the SW. In the areas circled below, designated the NW and SW areas this project focused on, the NW area had a total of five different hospitals, whereas in the SW there was only one.

Figure 4.1: Hospitals throughout Chicago (Source: Yonek and Hasnain-Wynia 2011).



Almost all the residents had an emergency room experience that they spoke about. For some, a visit to an emergency room resulted in their being diagnosed with one (or more) of the conditions studied in this dissertation. In the case of one mother, Iris (originally from Jalisco, Mexico) had a scare with her husband in 2010 while they were still living in Mexico. Iris explained:

> Pero hace como siete años en México cuando se sentía bien mal. Y ya no podía respirar, ¿y 'que tienes?' Empezaba (gasping for air) 'no puedo' 'vámonos al doctor' y lo llevamos, y cuando le hicieron lo de la sangre, dijeron 'no podemos ni contar de tan alto que traía el colesterol.' Era 400 y tantos en México puntos y ya no lo pudieron contar porque era más. Entonces el doctor le dijo, 'sabes de que las venas se te pueden tapar de tan alto que están' dicen que así vas caminado. … y hasta hoy día está conformado. [*But it's been like seven years in Mexico when he felt really bad. And already he couldn't breathe, and 'what is it?' He would start (gasping) 'I can't' 'let's go to the doctor' and we took him and when they checked his blood, they told him that they couldn't even count his cholesterol from how high it was' It was 400 and something, in Mexican points and they weren't able to count it because he was way over. So the doctor told him, 'you know that your veins can become clogged from how high it was' they told him, that was the path he was on. …and until today he has been compliant.]*

Iris's husband had also been diagnosed with diabetes in 1999. When they had this scare, the whole family took matters into their own hands to make healthy lifestyle changes. Since then, even their young and adolescent children remind the father that he should or should not eat certain things because it was bad for his diabetes or his cholesterol. The wakeup call in the emergency room served as a reminder for Iris's husband and family that life was precious and they were committed to doing what they needed to do as a family to support their father to live a long, full, and healthy life.

Another woman, Carina, from Mexico had a scare while she was visiting her home country and also ended up in an emergency room in Mexico.

> Hace un año que me tome seis pastillas juntas. Eh, e iba yo a desayunar, y dice mi prima 'ándale vámonos' y digo yo, 'me siento sin fuerza.' Y me sirvieron y todo. Y ya cuando (acabamos), digo 'sabes que me voy a ir acostar, me siento mal. Ya llegando al cuarto, como que, (ella) dice 'que te pasa' le digo 'no se'. Y ya caí a la cama travesada. Llamaron unos de mis hijos y me llevaron a emergencia. Entonces ella me dijo que, porque yo me había tomado seis pastillas, juntas. Digo wow. Desde esa vez, ya no la tomo juntas. [*About a year ago I took six pills at the same time. Uh, I was on my way to have breakfast, and my cousin said 'come on let's go' and I said 'I feel without strength.' And then they served me and everything. And when we (finished), I said 'you know what I am going to lay down, I feel bad. Upon getting to the room, (she) said 'what's wrong with you' I told her 'I don't know.' And like that I fell across the bed. They called one of my sons and they took me to the emergency (room). She told me that it was because I had taken six pills all at once. I said wow. Since that time, I do not take them together*.]

Upon sharing this story with the group of mothers, Carina was immediately questioned on whether her doctor had told her to take her medication in that manner. Carina admitted that he had not, that her doctor had drawn out a schedule for her to take one at a certain time, another thirty minutes later and so on and so on. But Carina, being impatient and not seeing the difference between taking the medicines 30 minutes apart versus all at once, adapted her own medication schedule. After living with over five different conditions, and ten different medications for over thirty years, she was a pro at managing these various conditions.

Bringing the emergency room context back to the U.S., another young single mother, Analise, had many critiques of the U.S. healthcare system:

> El sistema abusivo que en una sala de emergencia no te hacen na', solo te revisan y te mandan pa' tu casa-no me dieron, no me dieron una aspirina

> no me dieron nada-y me llega un bill de dos mil pesos. Entonces en Guatemala, te atienden, te cobran menos de 300 dólares, el medico te chequea y te mandan a comprar tu receta; ¿cuál de los dos casos, tú lo encuentra mejor? [*The abusive system in which in an emergency room they don't do anything for you, they only check you and they send you to your house—they didn't give, they didn't give me one aspirin, they didn't give me anything—and I got a bill of two thousand dollars. In Guatemala, they attend to you and they charge you less than three hundred dollars. The doctor checks you and sends you to buy the prescriptions; which of the two do you find better?*]

Here, Analise compares the U.S. healthcare system to the healthcare system in Guatemala (with more state supported healthcare), where a visit to the emergency room would not result in the exorbitant healthcare charges (often seen in U.S.), which she personally went through. Analise (introduced in chapter three), was a single mother who had migrated to Chicago from Puerto Rico in 2016. She worked as a parent volunteer and a homecare aide in an elderly apartment building. Analise was outraged at her medical treatment (or lack thereof) at a hospital ER visit a few months earlier. She described her problematic visit to an ER in the NW side:

> …me subió la presión el otro día, bien alta y yo fui a ABC hospital… Y cuando me cheque en la sala de emergencia tenía una presión alta… Que queja yo tengo de eso, que yo fui al hospital, y se supone que yo no tengo ahora mismo seguro. Tengo seguro de assisted care que no es muy cálida, pero fui para la sala de emergencia, y me llego un bill de 2000 dólares. Si yo sé (eso), voy a un médico privado, voy $100, pago mi consulta y si el médico me ve muy mal muy grave pue la ambulancia o lo que sea. *[…my blood pressure went up the other day, very high and I went to ABC hospital…and when they checked me at the emergency room I had my blood pressure high…What complaint do I have about that? Well I went to the hospital, taking into account that I don't have health insurance now. I have (access) to insurance through my assisted care (employer) that is not very good, but I went to the emergency room, and I got a bill of two thousand dollars. If I had known, I would (have) go(ne) to a private doctor. I'd go (for) one hundred dollars, pay for my consultation, and if the doctor sees that I am really bad, really ill, well then to the ambulance or whatever*.]

She went on:

> Pues uno tiene algún miedo de que uno se deja, hasta sentir miedo con cosas así. Porque mira ahora ese dolor de cabeza, ¡mil-dos mil! Esa gente no me hicieron nada. Esa gente me dejaron, en la sala de emergencia por la presión y después de la hora me despacharon ‘no que el bill llega a su casa que usted viene por aquí que la podemos ayudar. Y ahora me salta que tengo que tener un seguro médico para que me pueden ayudar. Mi pregunta es, donde está la ayuda federal o de personas ricas-que ay un programa pa’ lo que no tenemos nada. Ay un programa de ayuda. Que hacen ellos con ese dinero. Porque se supone que si tu tiene un seguro tu no necesita ayuda porque el seguro cubre automático. [*Well one gets scared that something will happen to you, even feeling scared with things like that. Because look now I have this headache, thous—two thousand dollars! Those people did not do anything to me. Those people left me in the emergency room for high blood pressure and then after an hour they discharged me, ‘no your bill will come to your house and then you come back here to help you (with the bill).’ And now it turns out that I have to have medical insurance in order to get that help. My question is, where is the federal help or the help from rich people—that there is a program for those of us who don’t have anything. There is a program to help. That do they do with that money. Because you would think that if you have insurance you don’t need help because the insurance covers you automatically.*]

The last portion of this passage quoted from Analise points to the paradoxical way healthcare is managed. From Analise’s experience, if you did not have health insurance there was no aid to help you cover your medical or hospital bills. But if you had health insurance, presumably your insurance provider will cover at least some, if not most, of the costs of your hospital visit. After the insurance company deals directly with the hospital to lay out what exactly they will pay for, the remains of the bill will go to the patient. A bill that is seemingly less than the original cost of treatment. Additionally, in the beginning of this passage Analise pointed to the lack of care she received in this visit; they didn’t do any special tests on her, they confirmed that her blood pressure was high, they didn’t give her any medication, and after an hour or so she was sent home. Her phrasing of “no me hiceron nada” [*they didn’t do anything for me*] was a common viewpoint cited from other residents who were unhappy with the biomedical interactions or care they had received in the past. In closing, Analise made light of the situation:

> …entonces cuando ellos, tenerte en una emergencia y te llega un bill de 2000 y pico de dólares, tu dice coño pero estaré vendiendo droga pa' que me llegue un bill así?! ¿En la mente de qué ser humano, una homemaker puede pagar ese bill? *[… so when they have you in an emergency room and you get a bill of two thousand and something dollars, you say, damn, am I selling drugs to be getting a bill like this? In the mind of what human being, can a homemaker pay for that bill?]*

Experiences like Analise's, with her limited access to health insurance, are aspects where U.S. healthcare policy stands to improve (as explored in chapter three).

The clinician-patient relationship

Strategizing self-expertise

There were many residents who did active research to support their own health management and learned more about their respective conditions, with a thirst for knowledge of how their body functioned. Hermina (revisited in chapter five), for example, when her clinician suggested a path of care, did her best to follow the recommendations—even to the point of causing strife with her sister, who took her own care more lightly. An older, thin Cuban man, Mario, had his apartment full of books that he had read cover to cover repeatedly. He had been living with diabetes since 2008 and carried a roll of diabetic candies in his back pocket whenever he felt that his blood sugar levels were low. Mario adamantly expressed, "…la diabetes te cambia la vida completamente. Eso es mandatorio. Porque te mata." *[…diabetes changes your life completely. That is mandatory. Because it kills.*] Mario knew very well the risks that uncontrolled diabetes could bring and the steps necessary to keep his blood sugar levels controlled. Throughout the focus group of all diabetics, Mario listened keenly to each participant's story and concerns in their diabetes self-management and offered his advice and diagnoses as he saw them. For example, one Mexican woman felt down about her diabetes, and she explained to the group:

> V: Desde el '91, estoy (con diabetes). Eh estado…me da borracho, me quiero caer…mareos pues. Me daña. Y se me sube mucho. Me siento mal…no como mucho de noche. No puedo dormir. [*Since '91, I've had (diabetes). I have been…I get drunk feeling, I want to fall…in other words I get dizzy. It affects me. And it happens a lot. I feel bad…I don't eat much at night. I can't sleep*.]
>
> M*:* Señora. Es posible que los mareos son lo que vengan teniendo la azúcar baja. [*Ma'am. It's possible that your dizzy spells are due to having your blood sugar too low.]*

After further inquiry about this woman's average routine, Mario concluded that she was not eating enough and needed to "comer tres o cuatro veces al día" [*eat three or four times a day*]. Although the woman in this case had many more years of experience living with diabetes, she had trouble identifying the difference between the high and low blood sugar levels. Keeping Mario's original warning about diabetes in mind, it is the low blood sugar levels that cause more sudden diabetes deaths in comparison to high blood sugar levels. There is grave danger in a diabetic not having enough blood sugar in their system.

Carefully abiding by clinician recommendations

Another kind of strategy I encountered among the Latin@ Chicagoans I talked with, were residents who followed directions prescribed by their clinicians, to the 't', without question. One particularly fast-talking Puerto Rican elderly woman, Mirta, was a prime example of the loyal patient. Mirta explained:

> …los otros días que me pusieron un doctor allí—que me dio una medicina, esta pastilla que tenía que tomármela todo el tiempo (she got up to go get the pills). Esta (showing me, there were some inside), esa pastilla yo no se porque me la dieron pero que me la tenia que tomármela todo el tiempo! Entonces cuando el doctor me la miro, me dijo, no Doña Mirta, tu sabe hizo asi y… [*…the other day they put me, one of those doctors there—that gave me a medicine, this pill that I needed to take all the time (getting up to show us). This, this pill I don't know why they gave it to me but I know that I had to take it all the time! So when my doctor looked at it, he told me, no Ms. Mirta, you know he did like this and…]*

She went on, as Ms. Yaly and I tried to figure out what the medication was for that she had been prescribed:

> …no creo que sea vitamina. No creo. Y entonces pue' me dijo no, no se la tome más… (me tomaba) una por la mañana y una por la noche. Yo me estaba sintiendo cada día más mal y más mal. Sabrá Dios, tu sabe, pues entonces el doctor mío me dijo que para. Con todo y eso, ya vez, todo (lo que) eh rebajado. Eh rebajado muchísimo. *[…I don't think it is a vitamin. I don't think so. And he told me no, don't take it any more… (I would take) one in the morning and one at night. I was feeling each day worse and worse. God knows, you know, so then my doctor told me to stop taking it. With all that, you see, all (the weight) that I have lost. I have lost a lot.*]

After further googling on our phones we figured out that what Mirta had been prescribed was a blood thinner. She had been taking this medication for almost eight months, without really knowing what its function or purpose was. It later came out in the interview that she had had a mini heart attack and we all concluded that perhaps that was the reason why she had been put on these blood thinners. It was striking, however, that somehow information transfer about the purpose of the medication and what precautions need to be taken while a person is on blood thinners did not happen successfully.

Patient-clinician communication

Through the interactions I experienced, I came to believe that there is much room for improvement within the patient-clinician relationship. In chapter three, I brushed the surface of this discussion, but in the section below I discuss examples of interactions with clinicians, recommendations received by clinicians, and, in turn, patients' adapting of these recommendations to their liking. As noted below, sometimes patients are honest with their clinicians about not following the medication regimens; for the majority, however, the Latin@ Chicago residents I spoke with were not straightforward about their adapted treatment practices.

The same Latina physician cited earlier often empathized with her patients, noting:

> La otra cosa es que no están acostumbrados a tomar medicinas. Acá ay que tomar muchas medicinas. Entonces a veces se empiezan a tomar y después la dejan. Cada visita yo tengo que está segura de que están tomando la medicina. Y eso es algo que yo aprendí-porque eso es algo que uno aprende en la práctica. Tengo maneras de encontrar si es verdad o es mentira, de que están tomando. Porque si viene que la azúcar esta alta, o la presión esta alta, lo primero que hace el doctor, le aumenta la medicina. Pero si la causa es que no lo están tomando. Entonces, si le aumenta la medicina, no sirve y no la van a (tomar). Bueno y entonces ... Cuando yo veo que no la están tomando, algunas veces, porque yo chequeo cuando vino a sacar las medicinas, y quien no vino. Y ellos me dicen 'no no, la medicina, la farmacia me dieron más' cuando no es cierto no le dieron más. Entonces cuando sé que es eso, yo le confronto y le digo, te voy a dar las mismas medicinas, porque-y el paciente cuando le digas eso, acepta y es todo. Pero eso es un, un challenge que tenemos, en cuanto (¿) tomar la medicina. [*The other thing is that they are not used to taking medicines. Over here (in the U.S.) you have to take a lot of medicine. So sometimes they start to take them and then after a while they stop. Each visit I have to be sure that they are taking their medicine. And that is something I learned, because it is something you learn in practice. I have ways of knowing if it is true or a lie, that they are taking their medicines. Because if they come with high blood sugar, or high blood pressure, the first thing the doctor does is increase the medicine (dosage). But the cause is that they are not taking it. So, if they increase the medicine, it doesn't work, and they are not going to (take it). And so…sometimes I see that they are not taking it, because I check when they came to pick up their medicines*

> *and who didn't come. And they tell me 'no, no the medicine, the pharmacy gave me more' when it's not true, they did not give them more. When I know that is the case, I confront them and tell them, 'I am going to give you the same medicines', because –and the patient when you tell them that, they accept and that is all. But that is a challenge that we have, taking the medicine*.]

The example of patients not taking their prescribed medicine and then returning to their doctors to then find continuously high levels resulting in higher medication dosages can be seen in the case of Katrina's husband, as she explained:

> He went to the doctor before he went (for a work trip), and his cholesterol went up. So now they just prescribed him a stronger medication. Before it usually was 10 mg, and now it went up to 80. So, and …he didn't take them with him- his pills. He don't want to take it, he's like oh I don't want to do that. 'Uh uh you better,' I'm like 'you're going from a 10 to 80 that's a big difference.' And he don't wana take it.

I witnessed many communication challenges about medications and dosages within the various clinical observations as a Spanish-language interpreter. Often times, because of my known role as a health researcher, residents shared such miscommunication stories with me. A comadre told me about an Ecuadorian friend who had fibromyalgia, a disorder characterized by widespread musculoskeletal pain, as well as fatigue, sleep, memory, and mood issues (Mayo Clinic 2018). When going over her medication with her, the clinician inquired about her medication use for this condition, which she utilized to helped her feel better when she would get pain around her face. Her clinician kept going back and forth trying to figure out exactly *how many* pills, *precisely*, the patient had been taking. The Ecuadorian friend responded in quantities or terms to her understanding, but there appeared to be a language lapse between the patient and Spanish-language interpreter, who was certainly not from Ecuador. After a more direct question, the patient was able to estimate that she took around three or four dosages in the entire month. Her clinician was floored and surprised after being initially worried that the patient was taking too many pills. The patient was soon corrected (by the clinician) about the importance of being consistent with her medication. This woman was surprised to learn that part of the reason why she continued to feel bad, was because she was not giving the medication time to work its chemistry on her body. Ultimately, she agreed and appeared to be satisfied with the new treatment plan, according to my comadre.

Open communication, con confianza [*with trust*]

One father, Andres (originally from Mexico) had been diagnosed with high cholesterol in the past and was also currently taking medication for a thyroid condition. About his cholesterol regimen he explained:

> Del colesterol me dieron pastillas, pero como a mí no me gusta estar tome y tome mucha pastilla, le dije, ‘Yo realmente no, sabes que no me las tome.’ Y yo, mi esposa me hizo otro tipo de remedies. [*For the cholesterol they gave me pills but since I don’t like to be taking and taking too many pills, I told the doctor ‘I really don’t, you know, I don’t take them.’ And my wife makes a type of remedy (instead).*]

I inquired more about his experience with his cholesterol diagnosis and treatment and Andres further explained:

> A veces yo creo como en tiempo de navidades, a veces lo sube uno un pocito porque me dice el doctor ‘hey bajale (motioning to belly) a los tacos, a los tamales,’ y eso es lo que mas lo entra uno. Si y dice, hace ejercio. [*Sometimes I think that during Christmas (the holidays) time, I go up (weight) because the doctor tells me ‘hey decrease the (belly) eating of tacos, tamales,’ and that is what we mostly eat. And he says, do exercise.*]

Not having ‘la confianza’ [*trust*]

Miguel (revisited in chapter five), was also keen on avoiding taking cholesterol medication, but instead of being open with his doctor, Miguel developed his own cholesterol remedies that depended less and less on the cholesterol medication prescribed to him. Miguel described his extreme efforts in attempting to avoid a life on medication: "...en 2012 me puse en una dieta que tan rigurosa que ya no estaba comiendo, que ya no quería usa medicina. Me estaba poniendo cadáver.*"* [*In 2012 I got on a diet that was so rigorous that I wasn't eating anymore, because I didn't want to use medicine. I was becoming a cadaver*.] Since 2015, Miguel has relied on his daily nopal smoothie as a more natural way to regulate his cholesterol levels (further discussed in chapter five). This strategy however was not something he shared with his physician, as he explained: "El doctor-no le he dicho nada al doctor-el doctor piensa que es la medicina que está funcionando bien. Si yo le dijera, ¡se la acaba la venta allí!*"* [*The doctor-actually I haven't said anything to the doctor—the doctor thinks it is the medicine that is working well. If I told him, his sale will end!*]

Biomedical treatment: 'La medicina le esta hacienda mal' [The medicine is making him ill]

Pills: '*¿es algo de raza?*' [is it something about our race?]

I conducted three different focus groups within one particular public school in the NW side. There were many parent volunteers and programs, and thus many interested in talking more about diabetes, hypertension and hyperlipidemia. Two of these three focus groups took on the format of venting sessions of young generations of parents expressing their frustrations about what they viewed as their own parents' reckless health management. There were many concurrences with “es muy difícil tratar de hacerles entender” [*it is very hard to try to make them understand*], and even equating elders to little children they had to watch and look out for because they didn’t want to follow the rules for what was or was not good for them. As one mother spoke of her mother: “La soda! Nada más llego y ya se tomó el vaso de soda. Le digo, ‘mami no’ y parece una niña chiquita porque la estoy reganando.*”* [*The soda! I had just arrived, and she had already drunk a cup of soda. I tell her ‘mommy no’ and she seems like a little girl because I am chastising her.*]

Two mothers of an extended Ecuadorian family expressed their concern:

> Con mi papa, por muchos años ya le hubieron dijeron que tiene los triglicéridos altos, también el colesterol, tanto como los triglicéridos...Mi papa siempre dice lo voy a controlar con dieta. Fue al doctor, el doctor le da un speech, le dice ‘no, no lo voy a cambiar con la dieta.’ Pero ya le ha dicho, es la última vez-te doy chance que lo cambias así. Tu cuerpo necesita medicamento para ayudarte junto con la dieta, pero no le gusta. Me abuelita, también es mama de mi tía [to her right], tiene diabetes, tiene la presión alta. No tome los medicamentos. Se los toma solamente cuando esta alta, o cuando la doctora dice que esta alto. Y eso es cuando dice ‘ya me la voy a tomar’. No sé si es, bueno no solamente eso, pero si es algo, hay mucho que no, no le gusta la medicina. Piensa que con la dieta o con hacer ejercicio y ya basta. [*They have told my dad for many years that he has high triglycerides, as well as high cholesterol. My dad has always said, ‘I will control it with my diet.’ He went to the doctor, the doctor had already given him a speech, but he says ‘no, no I will change with the diet.’ But they have already told him that this is the last time I will give you a chance to change it like that. Your body needs medicine to help you, together with the diet. But he doesn’t like it. My grandma also, she’s my aunt’s (sitting at her side) mother, she has diabetes and high blood pressure. She doesn’t take the medicine. She drinks them only when it’s (sugars/pressure) high, or when the doctor says it’s high. And that is when she says ‘I am going to take it.’ I don’t know if it’s good taking only that, but it is something. There are many that do not like (to take) the medicine. They think that diet or exercise is enough*.]

Furthering the case of her grandmother, she went on:

> En mi familia no les gusta tomar mucho medicamento. Tratan de comer todo supuestamente orgánicos, saludable, pero a veces si necesita medicina. Como mi abuela a veces dice si me lo tomo, se la toma solamente ese tiempito y después ya piensa que se curó y ya. [*In my family they don't like to take medicine. They try to eat everything supposedly organic and healthy, but sometimes you need medicine. My grandma sometimes says 'yes I will take it,' but she takes it only for a little while and then she thinks she's cured and it's done.]*

Not wanting to take pills for life

Ms. Yaly explained that the biggest challenge for her in dealing with a diabetes diagnosis was the fact that she had to take a pill for the rest of her life. She explained:

> You know I have to take a pill every day. For the rest of my life. You know and even though it gets controlled, it really never goes away. I'm looking forward that one day the doctor can tell me, you don't have to take this medicine. Which, you know, I know it has happened. And I'm doing pretty good with it, but I think that was the hardest for me. You know making sure that I do well and taking this medication. That was the hardest thing for me.

One mother, Jocelyn, who originated from Michoacán, Mexico explained her frustrations with her mother's conditions:

> Pues mi mama, no, mi mama antes nunca se cuidaba su medicamento, su enfermedad, así que hubo un año que de hecho ella dejo de tomarse complete la medicina. Mi mama se calló demasiado. Se le vinieron como los años encima. Se le, perdió su dentadura. Entonces ahorita nada más le queda como 4 dientes, y como se le sube mucho la presión. Le da pánico el dentista y pa' que le saquen sus dientes para ponerse una placa, tuve la presión y no le pueden hacer hasta que se anivele y no. Su pánico no le ha permitido que se pueda arreglar su dentadura. Entonces ya ella comenzó a tomarse su medicamento y todo entonces agarro conciencia de eso. [*Well my mom, my mom didn't used to take care of her medication, her illness, so there was one year in which she actually stopped taking her medicines completely. My mom fell out completely. The years accumulated all at once on her. She lost all her dentition. So now she only has four teeth and her blood pressure goes up a lot. She gets panic attacks going to the dentist in order for them to take out her teeth in order to put a crown, but she had (high) blood pressure and they weren't able to do it (the procedure) until it (blood pressure) was leveled, but no. Her panic has not*

> *allowed her to get her teeth fixed. So she has started taking her medicines and everything so she has developed consciousness about that.*]

Another Mexican mother recognized the downfall but also the positive in her husband's high blood pressure diagnosis:

> …recenetemente le degnositcaron a mi esposo, ah, presión alta. Y lo único mal que ya va tener depender todos los días de pastillas. El ha cambiado su estilo de vida, ah cambiado su alimentación, el se siente bien. So, sierve que el se cuide mucho. […*recently they diagnosed my husband with high blood pressure. The only bad thing is that he has to depend on a pill every day. He has changed his lifestyle, he has changed his nutrition, he feels good. So it is good in the sense that he takes care of himself a lot.*]

<u>Taking blood pressure pills does not translate to having high blood pressure</u>

In the time I spent as a health outreach volunteer conducting heart screenings for residents throughout the NW side of the city, there was a certain survey or script we asked participants as part of the blood pressure check. These heart screenings were part of a research grant through one of the several medical schools located within or near Chicago city limits. For this grant in particular, the medical school was collaborating with the Humboldt Park Health Center (HPHC) to provide this free service to residents throughout the city. With the HPHC being a community-based and driven site, this was an ideal partner and collaborator for this program. These blood pressure screenings were accompanied by a few survey multiple choice questions which participants were asked to complete on their own just before having their blood pressure checked. However, the method of having participants fill out the survey questions themselves proved inefficient for several reasons: participants would not respond clearly; participants often asked the outreach worker what was meant by the question; it overall made the entire process longer than when an outreach worker asked the patients the questions; and it even deterred some from getting their blood pressure checked—they didn't want to spend the time reading and responding to questions.

Various general health questions were part of the survey, and additional biometric data was collected such as height and weight, along with the two to three blood pressure readings. In the quick questioning of participants before taking their blood pressure, when the question would come up of whether they had been told they have high blood pressure before, sometimes participants would say no. But then a few questions later when asked if they took blood pressure medication, some would say yes. This led me to believe that for some patients, being diagnosed and treated for high blood pressure did not mean they had a problem with high blood pressure. Certainly, for people who have been treating their high blood pressure with medication resulting in successful lowering of blood pressure levels, they have reason to believe that high blood pressure is not an issue for them. Some of these same participants who took blood pressure medication, but did not believe high blood pressure to be an issue for them, were often surprised by a high blood pressure reading. During the time when I was conducting these blood pressure screenings (from 2014-2017) high blood pressure was considered to be a reading of 140/90 and higher. A reading over 130/80 was considered pre-hypertensive and participants were often advised to make dietary and physical activity changes, in addition to seeking formal clinical care (with a primary care provider).

One of the exchanges that I had with an elderly man from Guatemala is a prime example of how taking blood pressure medicine does not mean (in the resident's mind) that they have problems or “parecen de” [have] these different conditions. Below is a portion of the beginning of the interview with this man:

> LM: Si podemos empezar por introducir cada uno y contar un pocito con su experiencia que sea con la diabetes o presión alta o colesterol. [*If we can start by introducing ourselves and you can tell me a little about your experience with either diabetes, high blood pressure or cholesterol.*]
>
> E: Yo no he parecido de ninguna de las tres cosas. [*I don’t have problems with none of those three things*.]
>
> LM: ¿No? ¡Estas muy sano! [*No? You are very healthy!*]
>
> E: Bueno no estoy sano, pero estoy sano, sanito. [*Well I am not healthy, but I am in good health.*]
>
> LM: ¿Y no tomas nada de pastillas? [*And you don’t take any medications?*]
>
> E: Bien tomo pastillas. Tomo pastillas para presión alta- pero la presión alta—¿porque tú dices que me ahogo o que sea pero eso es la presión alta? [*Well I take medications. I take medicines for high blood pressure-but high blood pressure—because are you saying that if I am winded or whatever, is that the high blood pressure (you ask about)?*]

Narratives like these demonstrate the differences in perceptions of health and well-being from a clinical lens versus how residents view their health. For many people, having problems with blood pressure or cholesterol means the recurrence of secondary symptoms, like shortness of breath (described above), feeling dizzy, or overall not feeling like oneself. For many residents, being able to control elevated blood pressure or cholesterol levels through medication or other remedies meant they did not ‘have’ high blood pressure or cholesterol; these were no longer clinical issues they had to worry about battling in their daily lives.

<u>Residents evaluate biomedical information and take or leave the biomedical model for treatment</u>

In further discussions with the above-cited Latina physician who was very connected with her patient community at Northwest Clinic, she shared with me:

> El otro problema de no tomar las medicinas es otra cosa que ellos están convencido que la insulina trae ceguera. Eso, y entonces, ay que convérselos. La otra cosa, creen, que cuando esta…cuando está todo bien, todo bien, muy contenta, se van, y dejan todo. Porque estaba bien. Bueno entonces ya eso se lo tengo que decir ya de antes mano. Está bien porque—'como y no me voy a curar?' 'No, se va controlar.' [*The other problem with not taking medicines…that's another thing–that they are convinced that insulin causes blindness. And so you have to convince them. The other thing, they think that when everything is good, everything is good, they're very happy, they go, and they leave it all behind. Because they were doing good. So then I have to tell them in advance, you are doing good because (of the medicine/diet/exercise, etc.)—'What? And so I am not going to be cured?' 'No, it will be controlled.'*]

Teresa, another young Puerto Rican mother (in her forties), described herself as a "walking time bomb" because of all the conditions she had been diagnosed with. She had been dealing with high cholesterol, high blood pressure, diabetes and thyroid issues since 2003. In terms of her medication, she confessed:

> I do take medication, but I'm a bad patient. Sometimes I drink it, sometimes I don't because it's a lot of pills you know. For Metformin, for Atlantis for my diabetes-type 2, and then for my thyroids, blood pressure, the cholesterol at night. So it's so many pills you get to, like (making a puffed up face).

Another mother who served as a crossing guard for her children's school talked about her experience with her arthritis, which she had been diagnosed with in 2015. After a certain point she decided that she no longer wanted to take so much arthritis medicine, even though she was not honest with her providers. She described:

> Mi medicamento pues a mí me dieron, ay me cambiaron mucho este medicamento… Me dieron mucho medicamento… Dije ya no, ya no tanto medicamento, ya llené. Ya no (chuckling) tanta pastilla... Lo que si me preguntan, todavía, 'te estas tomando medicamento?' o me lo mandan,

> porque me llega a la casa. Y ya cuando se me terminaba, mas (laughing) (llegan). Y le digo que sí. Pero no, es muuuucha pastilla…cuando me recetaron el medicamento y después me daban uno, y me daban otro. Yo dije no, yo no quiero tanta pastilla. Porque había veces que ni me ayudaban y decía, ¿para que me la estoy tomando? [*My medication, oh they changed it so much, my medication…they gave me a lot of medication…I said enough, no more medication, I had my fill. No more (chuckling), so many pills…And yes they still ask me 'are you taking your medication' or they will send it, because it comes to my house. Already when it runs out more (comes) (laughing). And I tell them yes. But no, it's tooooo many pills…when they prescribed one medication and then they gave me another one, and then another one. I said no, I don't want so many pills. Because there were times that it wouldn't even help me and I would say, what am I taking this for?]*

Maria had type 2 diabetes but was more concerned with her chronic back pain. She explained her inconsistent diabetes medical treatment as follows:

> … tomo pastillas, me pongo la insulina. A veces me la pongo a veces no me la pongo porque eh podido de bajarme y a veces no me la pongo. Hoy todavía no eh tomado nada [it was almost 1:00pm at that point]. Porque cuando esta, cuando la llame por la manana ya estaba- para ayudarme, pero mira todo eso es medicina [a whole tray of pill bottles]. De bote de pastilla. [*…I take pills, I use insulin. Sometimes I use it, sometimes I don't use it (insulin) because I have been able to lower myself so sometimes I don't use it. Today I haven't yet taken anything (past 1pm at that point). Because when this girl, when I called her in the morning she was on her way to help me. But look all that is medicine (motioning towards tray of pill bottles). A container full of pills.*]

Many residents who had either of these conditions were often dealing with other conditions as well. Returning to the case of Carina, she explained:

> Mire, yo tengo, artritis, colesterol, alta presión, gastritis, este-perosi, todo tengo. Aquí tengo todas las recetas. Son 10 (pulling papers out of purse). Esta la traje porque últimamente me fui a Mexico y estuve bien estresada y, como 4 pastillas me están haciendo mal. El calcio, se me calienta mucho el estómago, la de la azúcar, también me marea. Y yo no sé, también lo traje para comentarle para usted porque yo tengo cita con mi doctora hasta el 20 de mayo, el 26. Y no sé si ya dejarlas o seguirlas tomando. [*Look, I have arthritis, cholesterol, high blood pressure, gastritis, osteoporosis, everything. Here I have the prescriptions. There*

> *are ten (pulling papers out). I brought this because recently I went to Mexico and I was really stressed and four of these pills are doing me harm. The calcium burns my stomach, the one for my sugar also makes me dizzy. And I don't know, I brought these to talk about because I have an appointment with my doctor until May 20th or the 26th. And I don't know if I should stop or keep taking these.*]

Insulin: '*la diabetes mas fuerte*' [the strongest diabetes]

One of the mothers, originally from Mexico, explained her experience with her husband's diabetes diagnosis:

> Hace 15 años le diagnosticaron a mi esposo con la diabetes. La diabetes, la más fuerte. El hace como 7 años, por una infección que empezó en su pie. Pero por la infección le dio, se puso muy mal, estuvo mucho tiempo en el hospital. Pero el todo salió bien, le dieron, y pues ahora el, él está usando insulina. Él tomaba medicina, pero el ahorita no está tomando medicina. [*It has been 15 years since they diagnosed my husband with diabetes. His diabetes, (is) the strongest kind. For him, about seven years ago, due to an infection that started in his foot. Because of the infection he got really bad (ill), and he spent a long time in the hospital. But everything turned out fine, they told him, and so now he is using insulin. He used to take medicines but now he is not taking medicine.*]

Jocelyn's mother, who was not taking her diabetes management seriously, now relies on insulin to regulate her blood sugar levels. Jocelyn explained:

> Y pero, de hecho, como no se cuida tanto, ya le recetaron insulina. So ahora se tiene que estar inyectando, y ahora si ya se quiere cuidar todavía un poco más porque ya le duele el estómago de que se pinche en un lado y en otro y otro. [*And so, actually, since she (her mother) didn't take care of herself as much, they prescribed insulin for her to use. So now she has to be injecting herself and now she does want to take care of herself a little more because now her stomach hurts from so many injections from one side to the other.*]

Another Mexicana, Marjorie, worried about her husband's lack of diabetes care. Marjorie noted the recent threat of insulin use in his last clinical visit:

> …esta vez parece que—ya esta vez le quería recetaron insulina. Pero le dio como un mes que estuviera chequeándose y ver si deberás necesitaba la insulina. Pero le dijeron que no. Y le digo, 'y tu bien miedoso que eras para las inyecciones. Na' más que le van a sacar sangre y empieza a sudar. *[…this time it looks like—now this time they wanted to prescribed him insulin. But they gave him only one month to be checking himself to see if he really needs the insulin. But they told him no. And I tell him, 'you who is so scared of injections.' Just to get blood work done he starts to sweat.*]

Samuel's (revisited in chapter five) history with diabetes brought him to the point of needing to rely on a combination of insulin and oral medication to control his blood sugar levels. In Samuel's case, he explained "no la respetaba (la diabetes) y ahora me tengo que inyectar" [*I didn't respect it (my diabetes) and now I have to inject myself.*] Samuel tried to use his personal experience as a warning for the other diabetes class participants to take care of their sugar levels while they were in the earlier stages of their diabetes experience. In this five-week long diabetes class, almost each week Samuel warned fellow classmates who seemed to be carefree about their dietary practices that he used to be just like them, that he would eat whatever he wanted with no restrictions on his quantity of servings either. But after so many years of elevated blood sugar levels, his body was no longer able to regulate the high sugar levels in his bloodstream and his medication regiment turned to relying on insulin injections twice a day, in addition to oral medication.

Another young Puerto Rican mother (in her thirties), Nadine, had been diagnosed with type 2 diabetes seven years ago. She had had gestational diabetes in her last pregnancy and it "never went away." She explained her treatment regimens but also the challenge to her being able to seek care since her medical card was taken away.

> I have to take the insulin and the Metformin … they took my medical card away since my husband makes too much. So I haven't been going to the

> doctor and I haven’t been-the Metformin I still take but like the insulin I already ran out. So Metformin, but like my sugar’s been skyrocket. I know the last time I had went—when I first started going my A1C overall was like 13.7.

The ideal, recommended Hemoglobin A1C level for a diabetic is closer to the level of seven. The A1C is the measure of the average blood sugar in one’s bloodstream over a two-to-three-month period. The A1C is often the ideal marker for clinicians to gauge how controlled a diabetic’s blood sugar levels have been, as opposed to the immediate blood sugar checks provided from a glucometer. Nadine’s A1C levels were almost double what the ideal levels were for a diabetic, especially for someone so young. At the time of the interview, in 2017, she had been almost two months without her prescription insulin because she and her family no longer qualified for healthcare aid.

However, just because insulin was made inaccessible due to exorbitant costs or limited healthcare coverage, residents often found ways of getting the treatment they needed when they needed it. One person I was told about had access to insulin through his work site, which served as a resource for him to attain discounted insulin vials for $15 when his insurance wanted to charge him $150 for this same product. This same insulin not only served as a resource for that individual’s daily injections, but also for his spouse. When his spouse was dealing with concerning high blood sugar levels, the man cared for her by giving her an insulin injection—a better alternative in their minds than having to go to the emergency room to wait hours on end, and most likely end up with an exorbitant bill. The underuse or misuse of prescription medications or treatment is a vital strategy when funds are limited to purchase these treatments. Mary Anglin and Jill Collins White emphasized the importance of recognizing these problems of poverty and limited healthcare access in such contexts and the implications these concerns bring. Additionally, Anglin and Collins White recommend training clinicians to:

> …take patient histories that included delicately worded questions about patients' ability to obtain medications and to take them at the recommended dosage (rather than consume smaller dosages of medicine to make them last longer, or not be able to afford the prescriptions in the first place) (Anglin and Collins White1999:2089)

'Natural' medicines

> El otro problema grande en la población Latina, es de acá en Chicago, no sé, creo que en otros lados también, es las medicinas naturales. Las medicinas naturales que son solo para ganar dinero, porque la venden. No están aprobada ni investigada por el FDA. Pueden ser tan toxicas. Ya se ha visto-trasplante de hígado necesitado por tomar medicinas naturales. O sea-pero ellos creo que como son naturales es bueno... La peor es Herbalife. Todos toman Herbalife. [*The other big problem in the Latin@ population, of those here in Chicago, I think that others in other parts also, are natural medicines. The natural medicines are only for making profit, because they sell them. They are not approved nor investigated by the FDA. They can be so toxic. It has already been seen—a liver transplant was needed caused by taking these natural medicines. In other words—but they think that because they're natural it's good. The worst is Herbalife. Everyone drinks Herbalife.*] (Dr. Paz)

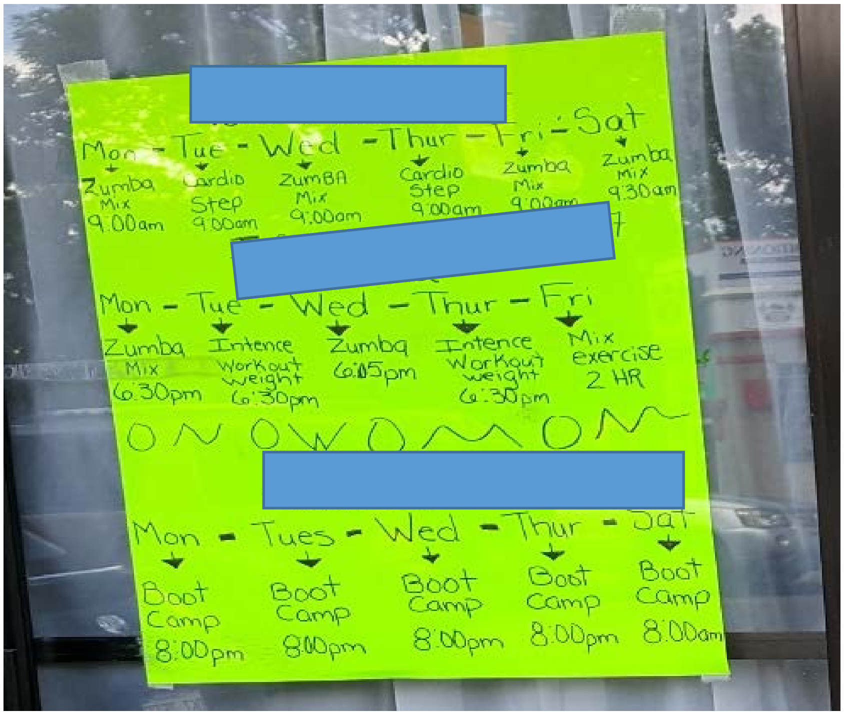
Herbalife was definitely one of the more popular dietary 'natural' supplements I witnessed, especially in the SW side of the city. Just half a block from my home in the SW was a house that appeared to be a kind of Herbalife recruitment spot. This house's windows were covered with two different shades of green in true Herbalife fashion. Their white car, always parked just outside the garage, was decorated with Herbalife advertisements for who to contact if interested in purchasing Herbalife, all in green stick-on lettering. The Herbalife recruiters of this home often stood on their corner during the morning school rush as parents walked by to take their children to the elementary school just across the street. These recruiters were always prepared with three-by-two-inch information cards for who to call, where and when to find out more about Herbalife. I was one of the guardians who, after dropping off my child at school, avoided that street corner like the plague to not get wrapped up in an information session I did not want anything to do with.

One of the key informants I interviewed, Guillermo, was a leader of one of the few SW side centers that provided services geared towards Latin@ and another 'Herbalifer'. The first time I met him he proudly proclaimed, "Yo soy unos de los 'Yerba-Lifes'" [*I am one of those Herbalifers.*] As I explained my research project to Guillermo and what I was doing, he also—almost at the end of our meeting—admitted to having been diagnosed with diabetes over a year before. I asked him more about his experience—if he was taking medication or going to seek medical treatment regularly, and he shook his head no. He did not believe this diabetes diagnosis he was given and refused to take the oral medication regimens the clinician had prescribed to him. Instead, he was devout to his Herbalife practices. In another meeting with Guillermo, I tried to press him more to explain these Herbalife practices but only got out of him that he would clock into the office, just past ten in the morning, after he did his Herbalife routine. He attributed his health success to Herbalife because with one Herbalife smoothie he would feel full and not have to worry about what he did or did not eat. The Herbalife smoothie was an easy, healthy (in his mind), dietary replacement for sitting down for a meal filled with meat and carbohydrates. Each day he would replace one meal, sometimes two, with an Herbalife smoothie, and he attributed his weight loss success and feeling overall healthier and better to incorporating these 'natural' smoothies into his daily routine.

When I asked Guillermo if there was anything in particular that the center where he worked offered to help people who were dealing with health, he was adamant in his response. He noted that if someone was looking to lose weight or improve their health, they really did not have to look far because there were many Herbalife or Zumba fitness centers throughout the city, in almost any corner where one looked. Figure 4.2 is an example of one of these fitness centers nearby the community center Guillermo helped run.

Figure 4.2: Makeshift fitness center in the SW side. Author personal photo.

Figure 4.3: Fitness center exercise schedule. A zoom-in of Figure 4.2. Author personal photo.



[redacted]

Mon	Tue	Wed	Thur	Fri	Sat
Zumba Mix 9:00am	Cardio Step 9:00am	ZumBA Mix 9:00am	Cardio Step 9:00am	Zumba Mix 9:00am	Zumba Mix 9:30am

[redacted]

Mon	Tue	Wed	Thur	Fri
Zumba Mix 6:30pm	Intence Workout weight 6:30pm	Zumba 6:05pm	Intence Workout weight 6:30pm	Mix exercise 2 HR

[redacted]

Mon	Tues	Wed	Thur	Sat
Boot Camp 8:00pm	Boot Camp 8:00pm	Boot Camp 8:00pm	Boot Camp 8:00pm	Boot Camp 8:00am

Areas throughout the SW side of the city, in particular, had many of these makeshift health or fitness facilities. Often times these facilities would not last very long, possibly three to six months at most, or if you were really lucky you could find one that had been around for almost two years. Although this was a very temporary resource, residents throughout the city, especially in areas like the SW, were creating health opportunities and resources for themselves. In the chapter that follows, I describe how residents have strategized outside of the clinical engagements described above.

CHAPTER FIVE:

Tactics and strategies of health—with or without the clinician's help

Tortillas and the healthcare settings: "You cannot tell a Mexican, don't eat tortillas"

While I was still in the pre-dissertation research phase of my work, I attended a local Lexington Spanish-Speaking diabetes support group. This was a group that met at least once a month and offered a space for diabetics to meet, learn and discuss various topics related to their diabetes management. During one of the sessions I joined, the discussion leader warned patients about the dangers of hidden and added sugars, mostly from preserved foods. The topic of discussion was to avoid using 'salsas' with food. The group leader—a white man—explained in Spanish that the group should be wary of using salsas. In this context the leader was talking about salad dressings, BBQ sauce, honey mustard, ketchup, and other condiments of the sort, which are often high in sugars, salt, and other preservatives that are not the best for one's health. The Mexican@s in the room seemed horrified at the idea that they could no longer use salsa on their food.

The shocked looks around the room demanded clarification. I spoke up and asked what the leader meant by 'salsa,' and he then clarified that he meant pre-packaged, high-sugar or high-sodium sauces. I had recently learned how certain Mexican salsas are typically made, and I noted to the instructor that for many, the hot sauce or 'salsa' that is typically used and eaten with most dishes is home made. I explained that the process of making this salsa requires combining different kinds of (boiled/grilled): tomatoes, peppers, onion, and/or garlic, cilantro, and salt to taste (although not as much as is found in pre-packaged salsas). These salsas are often a pillar of each meal; each meal is not complete without some type of *chile* (salsa). The instructor/leader agreed that these salsas were fine, and there was peace throughout the room again. Another group member, who spoke a little English, explained that these salsas were 'all natural' and made fresh each time. We were in a health education setting in which Latin@ cultural norms were disrupted by the generalized diabetes recommendation implemented from those at the top, in this case the American Diabetes Association, who define what is or is not considered to be a healthy diet. This is an example of generalized health education recommendations, based on assumptions about the average American diet. These recommendations often do not consider the vast contextual experiences shaping each person living in the U.S.

Since the late 1990s and early 2000s, there have been growing efforts to provide more culturally competent care, which involves teaching healthcare providers how to be more culturally sensitive towards their various patient populations. For example, in the case of Latin@s, when it comes to health education, this includes dietary recommendations for tortillas in addition to bread, rice, pasta or other typical ‘American’ carbohydrates. But the issues come when we assume that all Latin@s eat tortillas, or even that all Mexicans eat tortillas. Clinical ‘cultural competency’ training may dispel the myth that there is an average American diet or that it looks the same among the different ethnic groups represented throughout the U.S. However, cultural competency education for clinicians tends to reproduce stereotypes, and in the case of Latin@s, there are certain generalized assumptions. These assumptions, although more culturally sensitive than assuming that all patients eat bread or pasta, in turn provide food recommendations that put all Latin@s in one clinical category. Based on my observations, such assumptions in turn give misleading advice, and are not productive in improving Latin@s’ lived experience with these chronic conditions. I noted such slippery generalizations in discussions with a primary care physician whose majority patient population is Latin@.

In March of 2018 an article was published based on long term, “data-driven cluster analysis” speaking to the “heterogeneity” of the category of type 2 diabetes itself

(Ahlqvist et al. 2018: 1). This study, conducted with populations in Sweden and Finland, provides evidence of five different clustering, or kinds of diabetes, instead of the type 1 and 2 diabetes categories within which people are diagnosed. Table 5.1 provides a description of the five different clusters along with their corresponding characteristics. More specifically, this study was able to trace the increased risk of developing kidney disease within one specific clustering of patients (Ahlqvist et al. 2018: 8). The study found: "The increased incidence of diabetic kidney disease …was in spite of reasonably low HBA1C, suggesting that glucose-lowering therapy is not the optimum way of preventing this complication" (Ahlqvist et al. 2018: 8). Furthermore, the five clustered patterns identified in this study provide evidence that there are distinct forms of diabetes that operate differently, not merely that the same disease (diabetes) takes on different stages through out the life course (Ahlqvist et al. 2018: 8).

Table 5.1 The five 'types' of diabetes (Source: Ahlqvist et al. 2018: 4-5).

Cluster type	**Label given**	**Characteristics found among patients**	**Percentage of study sample**
Cluster 1	"severe autoimmune diabetes"	-relatively low BMI -early-onset -poor metabolic control -presence of GADA* -insulin deficiency	6.4%
Cluster 2	"Severe insulin-deficient diabetes"	-low BMI -low age onset -poor metabolic control -GADA* negative -relatively low insulin secretion	17.5%
Cluster 3	"Severe insulin-resistant diabetes"	-high BMI -high insulin resistance	15.3%
Cluster 4	"mild obesity-related diabetes"	-Obesity -not insulin resistant	21.6%
Cluster 5	"mild age-related diabetes"	-older patients -modest metabolic derangements	39.1%

*GADA stands for glutamic acid decarboxylase antibodies, which are found among adults with "latent autoimmune diabetes in adults" typically diagnosed as type 2 diabetes but with time, becomes more similar to type 1 diabetes.

Who is considered Latin@?

Who is included under the label Latin@? Who ‘counts’ as a Latin@? This question often came up, indirectly, especially among contextual interviewees. One of these contextual interviewees was Mara, another exceptional example of quality care catering towards the vast needs of Latin@s in Chicago. Mara was a dietitian who appreciated learning about different cultures and always tried to educate and better herself and her practice. During our interview, Mara commented on the lack of representation of Latin@s studying to become dietitians, stating:

> … we don’t know how many …Latinos (are lacking in dietetics programs). And there are some of my students, they’re Latinos but—and I like them, they’re so great—it’s just that some of them they grew up here, they were born here and they just grew up with this different mentality. There’s nothing wrong, it’s just a new, different culture.

In this referred to her ‘Latino’ students, she was in a way questioning, or challenging Latin@ identity. Perhaps her critique comes from a place of passion, and her constant drive to cater to Chicago Latin@ communities. In her work, Mara implemented grounded, well-informed and careful health education practices with Chicago Latin@s. Mara has been working throughout the Chicago community for many years now. At the institution where Mara is employed, she teaches future dietitians how to do their work in culturally sensitive ways to provide better dietary experiences for patients. In one of her classes, she even goes over for her students the history of the tortilla in order for them to “understand where this comes from and how it’s so horrible to tell a Mexican, don’t eat tortillas.” As a native from Mexico with 20 years of experience as a dietitian, she knew the response to prohibiting tortilla consumption for a Mexican could result in no dietary changes being made. She knew that when someone responded with ‘I finished one package (of tortillas)’ involved further interrogation because it often meant finishing a package of 12 tortillas in each sitting.

In turn, when consulting with patients, Mara presented tortillas in a different light by informing patients that one tortilla was equivalent to one teaspoon of sugar. With this comparison in mind, she would ask her patients, “how many less spoons of sugar do you want to eat?” Her overall philosophy was to simplify things for patients and to put things into understandable terms for the individual patient she was consulting with and based on the class topic they were covering. For example, she explained a one-on-one session for one patient:

> And I—a lot of people (clinicians) tell me, do carbohydrate counting for her because she has diabetes. But she’s 75 years old. She’s not gonna change what she’s been eating for all these years. So I just focus on two things…on her tortillas (and one other thing) …because if you say, ‘you know one tortilla is equal to eat one spoon of sugar, and now you’re eating 6 tortillas, you’re eating 6 spoons of sugar-then they are like ‘Oh!’ And I say, how many spoons of sugar-how many less-do you want to eat? And then it’s different. They gonna go home-she’s gonna go home, now she’s gonna make those changes, and you’re gonna see that changes in the A1C. Versus if I do a carbohydrate counting plan, as spending an hour and a half with so much information, they’re not gonna do anything.

Another example of the careful, personalized dietary recommendations Mara provided within individual consults with patients was to give handouts consisting mostly of images with little text. After our interview she took me aside to where her students were preparing for their health education class and showed me some of the handouts the students had prepared (with her guidance) to give the class participants. Mara told me another story of the evolution of their handout images and one-on-one consulting. She told me about a woman to whom she had given a handout with an image of a piece of torta (Figure 5.1). The image Mara had provided, was intended to depict the torta serving size and under the image she put “¼” to describe the serving size. Meaning that a recommending serving size was one-forth of this piece of torta, not the entire torta, which is usually served in its entirety as a sandwich. When the patient came back the next week and Mara asked the patient how they did in following the dietary plan, the patient was happy and gushed about her success of only eating four tortas in the whole day. Mara realized that she needed to explain what the fractions represented and she spent an hour explaining and teaching this patient fractions. After this experience Mara also found clearer and more efficient ways of illustrating serving sizes that did not involve fractions. But it has been through such reflective experiences that Mara has had so much success reaching patients and dispelling common dietary myths patients are often told by clinicians.

Figure 5.1: *The (Mexican) torta*. (Source: O'Donnell 2018).

Additionally, there were several people who (proudly) admitted to eating entire packets of tortillas. During one of these conversations conducted at a school, one of the mothers asked me for advice, related to her sister who was also in the room:

> Hermina: Usted que esta tratando estas enfermedades, digo que esta en platicas, que es bueno—o que no es bueno que uno coma? La que tiene colesterol y la que tiene diabetes? Porque a veces dicen que uno no debería comer mucha tortilla. Pero nosotros somos los que comemos con pura tortilla. [*You who are treating these conditions, I mean in these conversations, what is good—or what is not good for someone to eat? The*

> *person who has cholesterol or the person who has diabetes? Because sometimes they say that we shouldn't eat so much tortilla. But we are the ones that eat mostly tortilla*.]
>
> Sylvia: Yo me como un paquete! … En una sentada. En el almuerzo me como un paquete y una Coca (very firmly—like saying "y dime algo")! Con un monton de hielo. En la comida, que es a las tres de la tarde. En las tres de la tarde que me vuelvo a sentar, otra Coca, y otro paquete. [*I eat a whole package! ...In one sitting. At lunch I eat one package and a Coke (very firmly—like daring me to say something)! With a whole bunch of ice. At dinner, is at three in the afternoon. At three in the afternoon when I sit down again, another Coke, and another packet.*]

No matter how this woman, Hermina, tried to convince her sister Sylvia to take better care of her health, Sylvia was not having it. Hermina, on the other hand was one of the many patients who loyally followed clinical recommendations. In fact, Hermina noted that Sylvia would often get mad at her for trying to help Sylvia better her health and also for the extent to which Hermina took care of herself. Hermina explained:

> Y lo curioso es que ella (Sylvia) se enoja conmigo porque yo me cuido. **Yo trato de no comer** (her emphasis), si el doctor me dice no comas esto, no comas otro—yo trato. Y cuando vuelvan a sacar sangre, 'que raro, se te subió.' Y le dije, 'y yo me estoy cuidando, yo estoy haciendo esto' y me dice 'no pero usted lo tiene alto.' Lo único lo que a mi me preocupa es que en un analysis que me hicieron, me dijeron que el hígado tenia grasa. No se (pausing …like asking me to comment). Y yo digo que, parece mentira pero cuando uno se-le da una enfermedad, allí le van a ver bien muchas. Ya le van a venir. [*And the curious part about it is that she (Sylvia) gets mad at me because I take care of myself. I try not to eat (her emphasis), if the doctor tells me don't eat this, don't eat that—I try. And when they take my blood again, 'how odd, it went up.' And I say, 'and I am taking care, I am doing this' and he says 'no but you have it high.' The only thing that has me worried is that in one analysis they did, they told me that my liver was fatty. I don't know (pausing …as if asking me to comment). And I say, it seems unreal but when you get one illness, there you begin to see many others. You get others coming to you.*]

Here, Hermina was grappling with how to manage her different conditions and taking care of herself according to her physician's standards. Another exchange took place in a diabetes education class in which we set health goals for ourselves for the coming week. One woman, doña Himilda, had trouble narrowing down one focused goal for the week. She had mentioned earlier how she was worried about all the tortillas she ate and how “no lo puedo dejar” [*I can’t quit (eating) them*]. I reminded her of this and emphasized that she did not have to stop eating tortillas but could perhaps try cutting down the number she consumed each time she had them. She set the goal of limiting the amount of tortillas for each sitting from six to four. Another man, Samuel, was about 10-15 years younger than doña Himilda, and his goal was to limit his total consumption of tortillas to 4 in the entire week. Doña Himilda gasped when she heard this. Samuel nodded, stating that “tengo que hacerlo. Porque antes no le respetaba a la diabetes, y ahora lo estoy pagando” [*I have to do it. Because before I didn’t respect my diabetes, and now I am paying for it*]. This was the second diabetes education class Samuel took at the clinic. He had originally taken it soon after being diagnosed with diabetes, but he did not remember many of the recommendations he had received then. He was now re-taking the class because his blood sugar levels had become out of control and he was now forced to inject insulin in order to maintain balanced blood sugar levels. At the next class the following week Samuel was proud to report back his success, and doña Himilda was again shocked at him being able to achieve this goal.

Overall, for many residents, especially those with Mexican backgrounds, tortillas were still a basic component of each meal. I first encountered the importance of tortillas in the Mexican diet when I attended a baptism after-party. The Mexican family hosting the event had rented a hall filled with rounded tables filled with their distant relatives and friends. At the celebration after the baptism, along one side of the room, the food was set up buffet style with various square aluminum containers for food. On the menu were: carnitas (pork fried in lard), rice, beans, fried chicken, and nopal (cactus) pico de gallo. At the end of the serving table was a larger container of packets of ‘antojito’ brand tortillas being kept warm. As I served myself, I had skipped the tortillas since I already had a serving of rice. When I sat down I was immediately corrected and asked “y tus tortillas?” [and your tortillas]. I looked around at how the other party-goers were serving themselves and saw most people had each taken a packet of tortillas along with their plates. In more formal occasions such as these, most did not use the tortilla to hold together a taco of carnitas. Instead, I saw the delicacy as they rolled up the tortilla into a thin funnel and used it as a utensil, while simultaneously serving as a basis between bites of meat, rice and beans. The tortilla complimented everything. As my comadre told me “es que la comida no sabe a nada sin la tortilla” [it’s that food doesn’t taste like anything without tortilla].

This chapter, in addition to the previous chapter four, highlights ethnographic contexts surrounding residents’ strategies outside of the clinical area of care, especially related to diet and exercise. Clinicians emphasize diet and exercise as strategies for patients to control their blood sugar, blood pressure, and cholesterol levels. The idea of diet and exercise being important has been so ingrained among residents, as they are often instructed to self-surveil their caloric intake and their physical activity. However, some residents opt out of these strict, often unspecified and frankly unrealistic recommendations, and instead develop their own strategies for managing their conditions. I divide the strategies based on condition for what residents taught me were efficient in lowering blood sugar, blood pressure or cholesterol levels respectively. Such remedies ranged from incorporating nopal smoothies, to oatmeal, to increasing water consumption, to the fix all: exercise. Exercise carrying the misconception that the one hour of Zumba cancels out bad eating throughout the day.

Latin@s homogenizing Latin@s

To be clear, in the example I provide below, I believe this physician is a true model of someone who offers quality patient care and is one of the best physicians at this clinic, especially when it comes to treating Latin@s. For starters, she is one of the few native Spanish-speaking primary care physicians (if not the only physician) at this clinic and is thus able to communicate with patients directly without relying on a Spanish-language interpreter. There are a few other healthcare providers who did not rely on Spanish or Polish-language interpreters: both were Licensed Nurse Practitioners (LNP) and part of the full-time staff at the clinic. One white LPN spoke Spanish and was able to communicate fluently with patients, and another LNP, originally from Poland, spoke Polish and was able to directly communicate with her patients, most of whom were Polish. But as far as the volunteer clinical providers, Dr. Paz is the one of the few who can communicate with patients directly. It is widely said by the Northwest clinic staff and patients that Dr. Paz is the best. Many patients are referred to her when they appear to be struggling with their sugar levels. If after going through the diabetes education course patients are still struggling, many are assigned to Dr. Paz in order to improve their health. The quality of care she puts into her practice is an exceptional example of a physician going above and beyond to practice patient-centered care. Dr. Paz makes sure that patients are taking their medication, she takes the time to talk with patients and gets to know them, and she acts as a resource for patients. She always provides patients with information about where they can go to get free food (food pantries) or where they can go to do exercise for free. Throughout my time interpreting, I have not witnessed any other physician, resident, attending, medical student, or LPN provide such additional resources for their patients. In fact, even when it comes to advertising the other non-clinical services *within the clinic* walls, many providers did not refer patients to the health education courses, for example.

I suggested to some practitioners that the clinic also offered diabetes education, healthy cooking classes and exercise classes. One white LPN also seemed to go above and beyond in her patient care. She knew all her patients' back stories, life histories, who was taking care of whom at home, she made eye contact, she explained things on an understandable level, she took time with patients, and she always thanked interpreters for their service as well. I always loved interpreting for her. And she often recommended and referred patients to all the services available to them through the clinic from yoga for back pain, to physical therapy, to counseling services; this LPN was another model for quality care to follow.

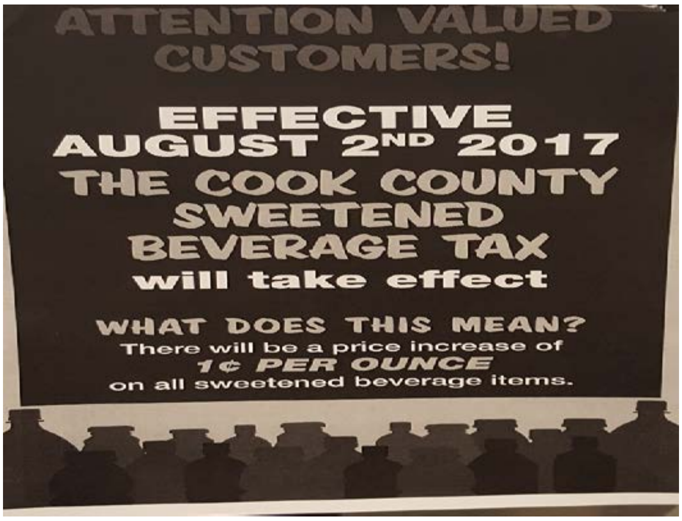
Although Dr. Paz noted in the beginning of the interview I conducted with her that the majority of the patients coming to that clinic were Mexican, throughout the rest of the interview she seemed to equate her experience with Mexican patients with 'Latinos.' In other words, her perception of 'Latino' patients was based on a presumed Mexican ethnicity. Granted, as a key informant, the purpose of my interviewing her was to ask about her experiences treating Latin@s generally in this clinical setting. But even as a self-identified Latina from Uruguay, there are certain assumptions she made about what were the problematic aspects of a 'Latino diet'. For example, she made certain comments such as: "los Latinos no comen postres," [*Latinos do not eat desserts*] and "la Coca-Cola. Numero uno problema de los Latinos. Son adictos, de una manera, a la Coca-Cola ...Pero la Coca-Cola lo toman todos" [*The Coca-Cola. Number one problem of Latinos. They are addicted, in some way, to the Coca-Cola…But Coca-Cola they all drink it.*]

At this point in the interview I commented on the recent sugary drink tax that was in the process of being implemented in Chicago. On July 1st, 2017, Cook County began charging an additional tax of $0.01 per ounce of soda. This was advertised in local news channels but also at the registers, as pictured below (Figure 5.2 and 5.3). By August 2nd, 2017 this tax included all sugar-containing beverages including sodas, juices, sports drinks, lemonade, and pre-packaged coffee; anything that contains pre-added sugar was taxed this one cent per ounce ratio. In response to this legislation, Dr. Paz provided intimate insight that "… ellos van a Indiana y compran allí la Coca-Cola." […*they go to Indiana and buy the Coca-Cola there.*] By the end of October this sugar tax was repealed and was no longer in effect as of December 1, 2017--one of the shortest-lived taxes in Illinois history (Chicago Tribune 2017).

Figure 5.2: *July 1st, 2017 'Chicago Sweetened Beverage Tax'*. The text reads "Loyal customers, effective 7/1/17 Cook County enacted the Sweetened Beverage Tax Ordinance which mandates a $0.01 tax on each ounce of sweetened beverage sold at retail. Please note this tax does not apply to LINK or SNAP recipients." Author personal photo.

Pete's
MARKET
Loyal customers, effective 7/1/17 Cook County enacted the Sweetened Beverage Tax Ordinance which mandates a $0.01 tax on each ounce of sweetened beverage sold at retail. Please note, this tax does not apply to LINK or SNAP recipients.

Figure 5.3: *August 2nd, 2017 'Chicago Sweetened Beverage Tax' change.* Author personal photo.



ATTENTION VALUED CUSTOMERS!

EFFECTIVE
AUGUST 2ND 2017
THE COOK COUNTY
SWEETENED
BEVERAGE TAX
will take effect

WHAT DOES THIS MEAN?
There will be a price increase of
1¢ PER OUNCE
on all sweetened beverage items.

On the note of generalizations, in my experience interpreting if there were awkwardly long pauses or silences while the physician took notes or looked through the patient's record, sometimes the patients asked me where I was from. They usually noted my different accent and way of phrasing things; they were often able to place my accent somewhere in the Caribbean. Sometimes I would ask patients as well, for their countries of origin. Yes, a majority of patients were from Mexico, but I also had translated for patients from Ecuador, Peru, Colombia, Venezuela, El Salvador, Guatemala, and Honduras. For a couple of patients, our cultural differences got in the way of my translating for them. During the typical four-hour shift of volunteering, I often consulted with fellow Spanish-speaking volunteer interpreters about the correct terminology for certain symptoms, diseases or conditions exposed to in between patient visits. Depending on the intra-ethnic diversity of the volunteers, we also came up with different names or translations. The intra-ethnic diversity among Latin@ Chicagoans is vast, and that translates into a diverse set of clinical experiences. Within clinical settings we must take such intra-ethnic diversities into account in terms of making treatment recommendations to improve patients' quality of care.

Overall, Dr. Paz commented:

> La dieta es peor. Al paciente, por ejemplo, el Mexicano- el Latino, le cuesta cambiar el tamaño de la comida. Estan acostumbrados a platos-a comer una vez al dia porque trabajan tanto que comen una vez. Y esa comida es enorme. Y esa comida, en el platito, esta sobre todo, el base de carbohidratos. Ahora sabemos que es lo peor. Asi que una es la dieta. Y es muy difícil a una persona de 50 años, decirle lo que usted estaba haciendo estaba mal. Por otro lado, estos pacientes vienen a Estados Unidos para comer mas. Porque no tienen recursos. Lo primero que hacen es comer mas. Y se enferman. Entonces uno, es muy difícil hablarles, ay que hacer muy delicado con ellos porque no le va decir-usted se enfermo por venir aca, no. Entonces de a poco le tienes que explicar y decir-le cuesta. Para algunos, yo creo que la majoria aprenden y cambien. En mi-en la practica mia, aprenden y cambien. [*The diet is the worst. For the patient, for example, for Mexicans—for Latinos, it takes a lot to change the portion size of food. They are used to these plates—to eat once a day because they work so much that they only eat one time. And that meal is enormous. And*

> *that meal, on that plate is, overall a base of carbohydrates. Now we know that this is the worst. So one (difficulty) is the diet. And it is very hard for a person 50 years of age, to tell them that what they were doing was bad. Another aspect, is that the patients come to the U.S. to eat more. Because they don't have resources (in their home countries). The first thing they do is eat more. And they get sick. So one, it is very difficult to talk with them, you have to be very delicate with them because you aren't going to say—you got sick because you came here. So little by little you have to explain and tell them—it costs them (a lot). For some, I think the majority learn and change. In my—in my practice, they learn and change.*]

The stipulations of diet: "Es difícil …a veces poreque son comidas que no está acostumbrado comer" [It is hard … sometimes because (they suggest) food that you are not used to eating]

An article analyzing two research projects, based in southern California, compared anxieties and concerns related to obesity between foreign-born and United States-born Latinos (Greenhalgh and Carney 2014). These authors use the concept of biocitizenship, whereby "to be deemed a worthy responsible American, each of us must become a virtuous biocitizen" (Greenhalgh and Carney 2014:269). This is in line with Adriana Petryna's (2002) concept of biological citizenship, making biological claims to suffering to decide whether one deserves inclusion. This concept can be traced back further to Foucault's concept of bio-power and biopolitics. For Foucault, bio-power is imposed upon within two spheres: through 'scientific classification' and 'dividing practices', the latter being the "constituted subject …is a victim caught in the processes of objectification and constraint" and the former is a more hidden form of domination (Rabinow 1984:10-11)

In the study conducted in southern California, someone is considered a "good biocitizen" if they effectively use diet and exercise to maintain a "medically normal weight," and also ensure that others in their social environment abide by these same regulations (Greenhalgh and Carney 2014:269). Greenhalgh and Carney explain that the main mechanism for spreading biocitizenship culture is through “fat-talk”, at both the bio-pedagogical level (serving to inform) and the bio-abusive level (serving to induce change through shaming). A key passage is as follows:

> As a moral discourse, biocitizenship grants membership based on success in endeavors of personal health while excluding those who fail from the community of good Americans… Extensive research shows that in the U.S. today, the benefits to thin bodies and successful biocitizenship are economic, social, political, and cultural. This research suggests that virtually all institutions and actors actively manage and promote the terms of biocitizenship. (Greenhalgh and Carney 2014:269)

Their study confirms what I have also found: that many Latin@s are aware of what constitutes a healthy diet and what the recommended levels of physical activity are for them. In fact, most participants tried to integrate these practices into their lives, but the economic and social barriers proved too overwhelming, and in this case the authors argue that the ultimate “failure to become thin, fit biocitizens led them to internalize the identity of ‘bad citizen’” (Greenhalgh and Carney 2014:270). Clinicians and public health officials seem to not take into account the social, political and economic burdens and lived experiences of patients. By ignoring these contexts, those patients considered to be “obese” have imbedded into their minds of that fatness is their burden to deal with, their fault, and their societal responsibility to manage.

In many of the conversations I have had with Latin@ Chicagoans, from what they remember after being given a pre-diabetic/diabetic/hypertensive/high cholesterol diagnosis, they are told to watch what they eat, and that they need to eat healthier, eat less, have more vegetables and fruits, eat less red meat, and that they need to exercise. From the clinical interactions I have witnessed, doctors often make assumptions about the health strategies of patients without spending time asking patients what their eating and exercise habits include. I did witness several physicians ask about exercising or physical activity practices, but never did I see physicians asking patients about their diets. It is not to say that this does not happen, but based on what I have heard from Latin@s in Chicago, when it comes to nutrition, it is often a one-way exchange with not much discussion; mostly the professional is talking at the patient instead of engaging in a meaningful conversation about realistic and sustainable dietary changes that can be made to improve the patient's health.

Additionally, the standard guideline of what consists of a healthy diet is not inclusive of what Latin@s are accustomed to eating, and rarely includes typical Latin@ foods. As one woman mentioned:

> …es difícil a veces, hacerlas cosas que ellos (nutricionistas) quieren cuando coma. Porque a veces son comidas que no está acostumbrado comer, como los cereales (calientes). Yo digo, cereal no. No, no somos amigos del cereal. Este, si fruta y todo eso, pero, si empieza uno pero luego también se cansa. *[…it is difficult sometimes, to do the things they (nutritionists) want us to eat. Because sometimes they are foods that we're not used to eating, like (hot) cereals. I say, cereal no. No, we're not friends of cereal. Ah, yes fruit and everything, but, and yes you start and everything but then you also get tired.]*

This was a common concern for other residents and their family members as well. Many become tired of following rigid guidelines for what they should or should not eat, the carbohydrate counting, the medication regimens, the insulin injections, the pricking of the finger, it all becomes tiring. For example, when one woman was diagnosed with high blood pressure and told to eat fish instead of red meat, she proclaimed, "And I feel like everybody is like 'you want fish' ay no I do not-I feel like a mermaid!" Another resident spoke with concern about her father who lives in Mexico and how he was not consistent with his insulin injections. She described her father's predicament:

> Si porque (el) dice 'es que me harto'. Tengo que subir, porque tienen que ir hasta la clínica (por la insulina). Y me dice, 'la doctora me dijo que, si ya no quería ir, que mejor me la pongo (la insulina) yo solo, pero a mí me da miedo'. Todos los días tiene que ir. Y le digo que a veces dice, 'ya no voy a ir'. So a veces le hablo temprano y le digo 'ya fuiste' 'no,' me dice, 'no voy a ir hoy.' Y le digo porque no, y me dice 'pues yo estoy bien, yo no me siento mal, a mí no me duele nada. [*Yes because (he) says 'it's that*

> *I get fed up.' I have to go up, because he has to go all the way to the clinic (for his insulin). And he tells me, 'the doctor told me that if I didn't want to go, that it was better for me to inject my own insulin, but I am scared.' Every day he has to go. And I tell him that sometimes he says 'I am not going.' And I ask him why, and he tells me 'well I am fine, I don't feel bad, nothing in my body hurts.'*]

Although her father was based in a different clinical and national context, many residents voiced similar sentiments of being tired of their treatment or dietary regimens.

Self-policing of foods

In many of the focus groups, residents (especially the women's groups) could spend hours talking about the struggles they have with dieting and trying to avoid fast food and junk food and sharing tips they had learned that helped with their health or at least made them feel better. One woman, Maria, shared some of her practices of what she was doing to limit her carbohydrate consumption, touching on the key point that anything in excess is not good:

> Yo lo único que pienso es que todas las cosas en exceso hacen daño. Porque si yo misma eh sabido que no puedo comer arroz todos los días; entonces yo como arroz una vez al mes, cada dos semanas o cada tres semanas. Pues el pan como te digo, toda la vida-pues …El otro día fui con una muchacha a la tienda y me dice, 'no va llevar pan?' Y le dije no porque a mí me gusta calientito ese pan. Le dije no lo voy a llevar. Pero antier vino mi hermana, que vino almorzar algo conmigo y entonces ella me trajo pan y comí pan dos veces. Dos veces ese día. Entonces pues el pan y el arroz yo siento que es lo más que me sube la azúcar. [*For me, the only thing that I think is that anything in excess does harm. Because if I myself have known that I can't have rice every day; thus I have rice once a month, every two weeks or every three weeks. With bread, how do I say this, all my life-well…the other day I went with a girl to the store and she told me 'you're not going to take bread?' And I told her no because I like that bread freshly warm. I told her, I was not going to take it. But the day before yesterday my sister came and she had lunch with me and she brought me bread and so I ate bread twice. Two times that day. So with bread and rice, I feel that it is what raises my sugars (levels) the most.*]

Maria knew her body well enough to know which foods raised her blood sugar the most and did her best to avoid these foods on a regular basis. For another resident who was on dialysis, she had to be vigilant regarding the volume of liquids she consumed:

> …it takes a toll on you it's very depressing. Especially being on dialysis it's really, really hard because you gotta watch your fluids, you can't drink as much. Only a cup a day…. Like right now if I drank my coffee this morning, after that I can't drink no more until dinner time. You know we're only human we get thirsty but you gotta watch. Cause since our kidneys are not working, we don't go to the washroom as much. That's why we go to dialysis. So, it's really hard living with that. I think that's the worst thing I've ever been through.

This young woman, Irene (introduced in chapter four), was in her thirties and had had diabetes since she was 13. She was dealing with hypertension, depression, and at the time of our interview in 2017, was going on four years' remission from breast cancer, and was on dialysis three times a week. Out of all the things in her life she had already been through, dialysis was the worst according to Irene. In order to mitigate these difficulties, she strategized by using a measuring cup for everything she drank and ate, explaining that "Even foods got liquids in it. Oatmeal …I can't even eat that either. Because you've gotta add milk. That's why I got a measuring cup there and I measure everything."

In the early stages of the diagnosis period, some patients are referred to speak with dietitians or other support clinicians (such as diabetes educators or RNs) to help them in managing a new diagnosis. One young Puerto Rican man, Manny (in his late twenties), had been living with diabetes for almost five years and explained his frustrations with the dietary restrictions suggested to him:

> Yeah but the thing with the fruit, there's certain fruit that they told me I couldn't eat either because it had sugar in it. They said I couldn't eat grapes, strawberries, and I couldn't eat ah…apples! I was like they the main things I love!

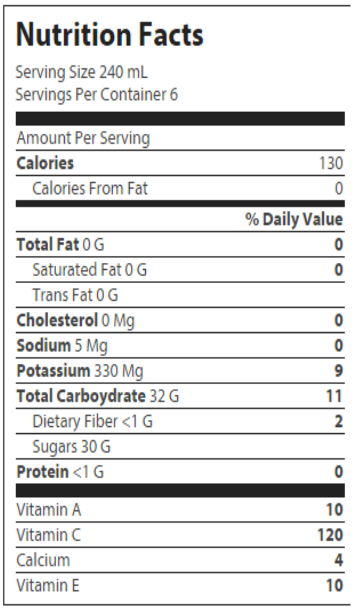
Another Puerto Rican man, Josue, responded in agreement to Manny's frustrations:

> That’s what they told me in the hospital. When I was in the hospital and I had my honey bring me some watermelon, and they told me that’s, ah, a lot of sugar. So I didn’t (eat it), so they told me what do you want to eat? They bring me a ham and cheese sandwich grilled that when you go like this (making a fist) it squeezed all the oil out, and you’re like okay is this healthier than the watermelon? Or, because-I mean I don’t know if they’re trying to kill you at the hospital but I mean…if you could squeeze the oil out of this, this grill cheese. And I’m like, I’d rather eat the watermelon and they’re fighting with me because that’s sugar, and the hamburger is not sugar. I mean that’s bread so bread turns into sugar. So, I don’t know. I mean I had a moment in there boy! I had to leave the hospital because I knew that I wouldn’t be better in there than I would outside.

It is moments like these in particular where I view residents I have spoken with and learned from as co-theorists. Here Josue was trying to recuperate from his high blood sugar levels, and the clinicians were castigating his food choice. Another resident who spent several days being hospitalized due to a virus that was going around had his wife bring him something (better tasting and in his mind healthier) than what he had been served at the hospital. She brought him something from Subway and a juice (thinking it was better than a soda). When the nurses checked his blood sugar, they were surprised at how high his blood sugar level was and immediately asked what he had eaten to make his blood sugar so high. When they found out the juice was the culprit, his wife felt guilty and thought that she had caused him further hardship in his road to recovery. But here was a man who had been living with diabetes for over five years and he had no idea that juice would make his blood sugar rise so quickly.

On the note of fruit juices, I want to provide a case example of actually how much sugar is in such beverages, by comparing canned Dole pineapple juice with different sodas. I used this specific type of juice as a basis of comparison because many residents refer to this juice as the one you are given with the WIC (Women, Infants, and Children) coupons. I learned the hard way that residents were right. In my several failed attempts at trying to get different kinds of ‘healthier’ food options with our monthly WIC coupons, I was often turned away at the register or told that such and such product did not qualify because it was organic, or because it was the most expensive, or because it was over the ounce or weight limit. Thus, when the WIC coupon reads ‘no more than 46 oz. of juice,’ you cannot get the typical juice that comes in the 64-ounce plastic bottle containers. Thus, you are left with canned pineapple juice, that in many cases has more sugar per 8-ounce serving than most sodas. In a 46-ounce can of Dole pineapple juice, there are about six serving sizes, with each serving size being 8 fluid ounces.

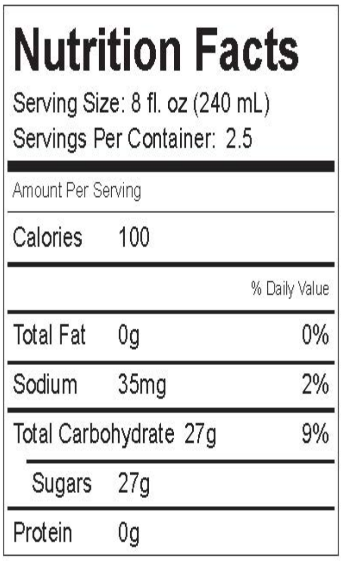
Figure 5.4: Comparing sugar content in beverages. Photos and nutrition facts were taken from each respective product’s website (Sources: https://dolesunshine.com/, www.coca-cola.com/global/, www.squirtsoda.com).



Nutrition Facts

Serving Size 240 mL
Servings Per Container 6

Amount Per Serving	
Calories	130
Calories From Fat	0
	% Daily Value
Total Fat 0 G	**0**
Saturated Fat 0 G	**0**
Trans Fat 0 G	
Cholesterol 0 Mg	**0**
Sodium 5 Mg	**0**
Potassium 330 Mg	**9**
Total Carboydrate 32 G	**11**
Dietary Fiber <1 G	**2**
Sugars 30 G	
Protein <1 G	**0**
Vitamin A	**10**
Vitamin C	**120**
Calcium	**4**
Vitamin E	**10**



Nutrition Facts

Serving Size: 8 fl. oz (240 mL)
Servings Per Container: 2.5

Amount Per Serving		
Calories	100	
		% Daily Value
Total Fat	0g	0%
Sodium	35mg	2%
Total Carbohydrate	27g	9%
Sugars	27g	
Protein	0g	

Nutrition Facts

Serving Size: 8.0 fl oz (240 mL)
Servings per Container 2

Amount Per Serving	
Calories 120	
	% Daily Value*
Total Fat 0g	**0%**
Sodium 10 mg	**1%**
Carbohydrates 30g	**10%**
Sugars 30g	
Proteins 0g	

Not a significant source of saturated fat, trans fat, cholesterol, dietary fibre, vitamin A, vitamin C, calcium or iron.

*Percent Daily Values are based on a 2,000 calorie diet.

In looking at the nutrition label above (Figure 5.4), each serving has 30 grams of sugar. Similarly, an eight-ounce serving of Squirt also has 30 grams of sugar, whereas an eight-ounce serving of Coca-Cola has 27 grams of sugar. In comparing the number of calories, total fat, cholesterol, sodium and carbohydrates, these three beverages appear to be roughly equal. The only real benefit of the pineapple juice, based only on the nutrition labels is that it provides much more vitamin C than the other drinks. Can we honestly say that such juice 'choices' promote a healthy life style especially for expecting, or nursing mothers or for our young children?

We must then ask ourselves, as in the case of Josue who wanted to make a 'healthy' food choice—who was told that a greasy (his words) ham and cheese sandwich was better for his health—would you opt for the same food selection? In turn, patients might misinterpret these messages. For example, Josue is now left believing that fruit, like watermelon, has too much sugar. Thus, if he must opt for a high sugar food, he might as well eat something more filling like a hamburger, instead of being left hungry and with high blood sugar when choosing to have fruit. For Manny, he was so discouraged by all the things he thought to be healthy, especially the fruits he most loved, such that now he chooses to eat whatever he wants with a kind of 'darned if you do, darned if you don't' mentality.

Furthermore, it seems as though biomedicine continues to ignore or hide the fact that stress greatly affects blood sugar levels and blood pressure levels (and most likely cholesterol levels) (Gravlee et al. 2005; Gravlee et al. 2009; Kitchen et al. 2015). As noted earlier in chapter three, I view the concept of embodiment to be especially useful to help understand how stressful circumstances become manifested within our bodies. When we think about how embodiment can be measured or implemented within clinical settings, it can be especially difficult to consider the effects of embodied illness because each body is unique, just as are each of our experiences. My point is to not add another factor or screening that we need to add to the list of primary care that we enact in clinical settings. My point is that blood sugar, pressure and cholesterol levels are not determined solely by the food that we consume nor the calories we burn. Yet, based on my observations and interviews, the way that most clinicians continue to treat these elevated levels is to write out more prescriptions, increase dosages, and almost always telling patients to watch their diet and exercise without explaining what this all really means.

Strategies and tactics: '¿Sabes lo que es bueno para eso?' [You know what is good for that?]

Navigating high and low blood sugar levels

Each resident had their own ways of navigating and striving for better overall well-being. Even those residents who did not themselves have any of the conditions addressed here still had certain tips or strategies to share that made them feel like they were actively working towards improving their health and well-being. Those who had diabetes had different strategies, especially when they were experiencing high or low blood sugar levels. For my friend Ms. Yaly, she often took to drinking a lot of water to flush out her system when she had high blood sugar. For her partner, he noticed that when he drank wine it helped to lower his blood sugar levels. He described:

> Yeah, I've checked myself before and …my sugar is always been over 300. And when I drink it (alcohol) comes down to 137-140. So, I'm like okay is this, is this a habit should I keep going at it or, or should I stop? But I notice that when I drink alcohol it comes down. So…maybe somebody should study that … I've literally noticed that when I check myself, you know wow. But I don't want it-anybody to become alcoholic!

For another Mexicana mother, whenever she noticed that her blood sugar levels were too high, she would cut slices of eggplant and put it in water and drink the eggplant water throughout the day. Many other residents opted for a more physically active approach to lowering their blood sugar levels by walking or exercising. For example, Ms. Yaly would also start up a work-out routine whenever she noticed her blood sugar levels getting concerningly high.

Navigating high and low blood pressure

In terms of dealing with hypertension there were various strategies, as well. Some residents went with more herbal or natural remedies such as consuming certain greens like parsley, which was said by many residents to be really good at reducing high blood pressure. One mother, Marina, explained that she put parsley in her daily smoothies several times a week to help manage her blood pressure. Passion fruit, also known as maracuya, and also as parcha (in Puerto Rico), pasiflorina or granada china, was said to help with her blood pressure as well. Additionally, for Marina's heart health she used a seed from a flower and drank it as a tea. Marina had been dealing with a heart murmur since she was a child and had developed various natural strategies—non-prescription medicines—to navigate her heart health and overall well-being. She explained:

> Ahorita estoy tomando—¿bueno para el corazón verdad? Ay una que se llama flor de manita. Esa estoy tomando cuando para que me ayude con lo del corazón. Y pues luego cuando me ayuda. Para la presión tomo una que se llama, como le dicen aquí passion fruit, maracuyá o pasiflorina… el alpiste también. [*Now I am drinking—well for the heart right? There is one that is called hand of flower. I am drinking that one to help me with my heart. And immediately it helps me. For the blood pressure I take one that is called, like they say here passion fruit, maracuyá or pasiflorina…and alpiste too.*]

When Marina was living in the NW side of the city, she relied on one particular produce place, Calle Produce, that offered a wide variety of produce, to provide the maracuya juice she needed whenever she felt her blood pressure rising. But since she has moved to the SW, she had not found a similarly versatile produce place. Instead she sought the help of a nearby Mexican grocery store owner to stock the juice she relied on, as she explained:

> …entonces cuando vine acá pues no sé dónde, entonces vine al señor de la tienda de El Bueno, y le dije, tengo un problema, de salud y necesito para controlarme, me ayuda este- el jugo verdad. Le digo, usted cree que me lo puede ordenar. Cuando lo necesito, voy con tiempo, paso y le digo al señor, me lo puedes ordenar los jugos (quietly). Y el señor me hace el favor. *[…so when I came here I didn't know where (to go), so I went with the owner of the store The Good One, and I told him, I have a health problem and I need-to better control myself, this juice helps me. I told him, do you think you could order this for me. When I need it, I go with time, I pass by and tell the man if he could order the juices for me. And he does me this favor*]

Some other residents took more non-conventional methods to treating themselves when they did not feel well. One woman explained the benefits of Coca-Cola:

> Yo desde que nací estoy tomando soda. … Le voy a decir una cosa muchacha. Yo la Coca, a mí la presión se me sube cada rato, y me siento media mareadita. Me tomo una Coca fría, adiós. Me siento bien tranquilla, dijera la señora, a ir a bailar y todo eso. [*Me, since I was born I have been drinking soda…I am going to tell you something girl. Coke for me, everyone once in a while my blood pressure goes up, and I feel a little dizzy. I drink one cold Coke, goodbye. I feel real calm, as the lady (other participant) would say, (ready) to dance and everything.*]

I had heard several residents speak to the benefits of Coca-Cola to *raise* one's blood pressure when they felt like their blood pressure was down. A few participants actually were dealing with too-low blood pressure and cited drinking a Coke or having a small piece of bitter chocolate to help bring their blood pressure and energy up.

Navigating high and low cholesterol

In terms of dealing with high cholesterol, several residents shared insightful strategies with me. One woman, Mirta, a very lively Puertorriqueña who enjoyed cooking for her bingo circle that met every weekend at her house, had a firm recipe to treat high cholesterol. She explained:

> …yo tenía, lo tenía (el colesterol) en 425 y el doctor me dijo '(Mirta) tienes el colesterol bien alto!!' yo 'no se apure yo me lo voy a arreglar pronto.' Y vine aquí ese mismo día, cogí y puse este, avena de la grande en agua y la batí, la puse en la nevera y cuando fui a la otra semana, que me dijo que fuera, que me pusieron de eso (un analysis) '¡Oiga la tienes a

> 107, ¿que hizo?! ¡¿Que tomo?!' [*I had, I had it (my cholesterol) at 425 and the doctor told me '(Mirta) your cholesterol is very high!' me, 'don't worry I am going to fix it quickly.' And I came that same day, I went and got the big kind of oatmeal in water and I mixed it, I put it in the refrigerator and when I went back the next week, that they told me to go, to do the (blood test) 'Hey you have it at 107 what did you do? What did you take?!*]

She went on to explain the recipe to my friend Yaly and I:

> M: Coge la avena, pero la avena gorda… De la Aldi. Que es una gorda…la dura, la grande… Tu la metes en agua, la dejas en agua y después la echan, con agua fría y la metan bastante [G*et the oatmeal, but the thick oatmeal…from Aldi. It is a fat one…the hard, big kind…you put it in wáter, you let it sit in wáter and then you add it, with cold water you put a lot (of oatmeal).]*
>
> Y: ¿Y la cuelas? [A*nd you strain it?*]
>
> M: No.
>
> Y: No la cuelas. [*You don't strain it*]
>
> M: …Y entonces fíjate con eso, la pongo en la nevera en agua, lo meto al agua y me tomo […A*nd so notice that with that, I put it in the refrigerator in wáter, I put it in wáter and I drink it.*]
>
> Y: ¿Sin azúcar? [W*ithout sugar?]*
>
> M : Sin azúcar sin nada. Una semana, te tomas eso. [W*ithout sugar or anything. One week, drink that.*]
>
> Y: Ok.
>
> M: Y después va para el doctor, tu vas a ver que te sale el colesterol bien. Porque a mí me paso. Tu va ver--te lo digo que lo mío es por experiencia tu sabe!... Eso es muy bueno. Pero tómatelo por una semana y a la avena-no le hechas la leche a la avena. Por que la hace-échale un toquecito de sal, un toquecito de canela, si tienes vainilla un chispito de vainilla y un chispito de azúcar…. Y te la tomes. Es lo que yo hago a veces tu sabe. Y eso me ayuda bastante. Eso es muy bueno. [*And then when you go to the doctor you will see that your cholesterol will come out good. Because it happened to me. You will see—I tell you based on my experience you know! That is very good. But drink it one whole week, the oatmeal-do not add milk to the oatmeal. Because it makes it—you can add a touch of salt, a touch of cinnamon, if you have vanilla extract a touch of vanilla and a touch of sugar…and you drink it. That is what I do sometimes, you know. And that helps me a lot. That is very good.*]

For another man, Miguel, attributed his good handle on his cholesterol to his smoothies (jugos) that he made at home every day. Miguel explained:

> …me estuvieron, me recetaron un medicamento para bajar el colesterol, pero lo eh ido reduciendo. Y lo que me ha funcionado más es –para controlar el colesterol-me tomo jugo de nopal con manzana y avena y eso me ha mantenido muy bien. De 7 días a la semana que me recetaron la medicina, ya na' más me lo tomo 3 días a la semana. [*…they were, they prescribed a medicine to lower my cholesterol but I have been reducing it. And what has worked better is—to control the cholesterol-I drink a smoothie of cactus with apple and oatmeal and that has maintained me well. Of the 7 days of the week that they prescribed the medicine, I only take it 3 days a week.*]

He went on:

> En el 2012 me puse en una dieta tan rigurosa que ya no estaba comiendo, que ya no quería usa medicina. Me estaba poniendo cadáver. Mucho ejercicio. Yo pienso que ni estaba comiendo los nutrientes necesarios. Me estaba poniendo bien, bien flaco-tan flaco que estaban empezando a preocupar. Y allí fue cuando el doctor fue que saco con las medicinas. Hace como, si como cinco años. Casi siempre yo le iba diciendo, 'no déjeme con la dieta, déjame'…De allí fue cuando empecé a recuperarme. Cuando me dio la medicina….Y no comía casi nada de carbohidratos, gasas. No, llevaba una alimentación bien estricta…. Yo sé que con el tiempo, tanta medicina para el colesterol va deteriorando los huesos. Eso lo vi en un compañero del trabajo. También otro compañero del trabajo, el señor ya es mayor, parecía de azúcar y colesterol alto. Y con ese jugo se le ha controlado hasta la azúcar. [*In 2012 I got on a diet that was so rigid that I wasn't eating anymore, because I didn't want to use medicine. I was becoming a skeleton. A lot of exercise. I think I wasn't even eating the necessary nutrients. I was becoming very, very skinny-so skinny that I was started to get worried. And that was when the doctor came out with the medicines. That was like five years ago. I always tried to avoid it, "no let me diet, let me"…From then was when I started to recuperate myself. When he gave me the medicine…I wouldn't eat almost any carbohydrates, no grease. No, I had a very strict diet…I (also) know that with time, so much cholesterol medicine begins to deteriorate your bones. That I saw in one of my co-workers…Another co-worker, that was an elderly man. He had diabetes and high cholesterol. And with this smoothie he has been able to control even his blood sugar.*]

Miguel's case demonstrates the extremities residents are willing to go through in order to avoid having to take medicines for the rest of their lives. Miguel followed all of the doctor's recommendations and even went above and beyond to do personal investigations of what foods had cholesterol. He was so desperate to not rely on medication that he put his body through starvation by his strict dieting and exercise practices. Despite being the perfect patient, or the ideal biocitizen, Miguel was unable to get his cholesterol levels under control.

For another Mexicana mother, she cited ginger and roasted garlic as keys to her success, explaining:

> M9: Y ahorita lo que me ayuda mucho el jengibre. El jengibre es lo que me ayude. El jengibre es muy bueno para el colesterol, te baja la azúcar. Siento que más me ayudo fue el jengibre y el ajo asado. Eso me lo tomo diario para el colesterol. [*And now what has helped me a lot is ginger. Ginger is what helps me. Ginger is very good for the cholesterol, it lowers your blood sugar. I feel that what helped me the most has been ginger and roasted garlic. I have them daily for the cholesterol*]
>
> M2: ¿Y el ajo asado como se lo come? [*And the garlic how do you eat it?*]
>
> M9: …cuando calientas tus tortillas, allí pongo hacer mis tres a cuatro dientitos de ajo y ya me lo como así (making motions of eating with hand) con la comida. Y el jengibre también este, en rebanaditas con tantita sal y poquito limón. Con la comida, como si fuera chile. Y este, yo, yo sabía que se me salía el colesterol a 205, 210 y ya la vez pasado que fui, me salió 117. Entonces este, por eso yo siente que desde que eh estado comiendo jengibre, me ha ayudado bastante. [*…while you heat up your tortillas, right there I put my three to four cloves of garlic and just like that I eat it (motioning) with my food. And the ginger too, in slices with a pinch of salt and a little bit of lime. With your food, as if it were hot pepper. And so, I knew that my cholesterol would come as 205, 210 and now the last time that I went it came out as 117. And so with that I feel that since I have been eating ginger it has helped me a lot.*]

Such vivid examples from residents who knew their numbers beforehand and knew the changes they were making to improve those numbers spoke to the ways residents took their health into their own hands and felt good about that changes they were making. Additionally, many residents were also aware of certain things they needed to avoid in order to better manage their health, as discussed below.

‘Eso es malísimo’ [*That is really bad*]—things to avoid when managing diabetes, high blood pressure or high cholesterol

Overall, many residents knew what a healthy or balanced diet consisted of and what foods they needed to avoid. In fact, it was often easier for them to cite which foods they could not eat instead of explaining the foods they could. But most also knew of general recommendations that one should eat ‘salads’, not drink soda, not eat sweets or too many greasy foods, and not eat fast foods or junk foods (*comida chatarra*). Below are particular tactics from residents who navigated each of their conditions.

In one focus group, a man explained how he thought the smoothies he made daily helped him manage his blood sugar. When he explained some of the ingredients he put in his smoothies, one of which was beets, another man explained the history of how beets were originally used to produce sugar and how he was making a big mistake by consuming this:

> B: Amigo, usted está tomando medicamento que va contra la diabetes. En el año mil ocho cientos se describió, que la remolacha era pura azúcar. Y se hizo la azúcar de remolacha…por lo cual Napoleón declaro la guerra por su prensa por control de la remolacha y la azúcar. De allí viene la azúcar. Usted está tomando pura azúcar. [*Friend, you are taking a medicine that goes against diabetes. In the year 1800 it was discovered that beets were pure sugar. And beets sugar was produced…for which Napoleon declared war in order to control the production of beets and the sugar. It is from there that sugar comes from. You are drinking pure sugar.*]

One of the mothers who had recently been diagnosed with high blood pressure was surprised by their diagnosis since she had never had any issues with blood pressure before. The hospital gave her a pamphlet with recommendations of the dietary changes she needed to make. From this literature provided to her, she knew she needed to be careful of her salt consumption. She switched out her high sodium seasoning for Mrs. Dash (a salt-free seasoning alternative), or used pink sea salt for her cooking. At the grocery store she was vigilant of the products’ sodium content, taking the time to read nutrition labels before she opted for certain purchases. She explained, “I look at the sodium que está bajo—porque algunos tienen veintisiete, veinticuatro. I look for four, three and I buy that stuff. Que no tenga sal." [*I look at the sodium that is less-because some have twenty-seven, twenty-four. I look for four, three and I buy that stuff. That does not have salt.*]

Many residents who were navigating a high cholesterol diagnosis tried to avoid consuming too much fatty or greasy, oily foods. In particular, some cited missing pork-based meals, such as chuletas, carnitas, chicharron, often attributing their cholesterol levels to frequent consumption of these dishes. In one focus group they attributed a cholesterol diagnosis to the consumption of carnitas:

> D: Pues mi papa, mi papa lo que hacía, iba cada fin de semana, se compraba sus carnitas sus chicarrones ... Y se los comía todo. Y yo le decía, ay le va dar colesterol. Y no, y ay como lo juzgo. Y este, y sí. Ahora, y ahora ya le corté. [*Well my dad, my dad what he would do, he would go each weekend, and buy his carnitas, his chicharron. And he would eat it all. And I would say, oh you're going to get high cholesterol. And no, wow did I criticize him. And um, yes. Now, now he cut this out.*]

Commenting on this experience another participant shared:

> K: Bueno en mi caso, yo parezco, o—todavía parezco, pero no igual. Anteriormente estaba, como dice la señora, yo era-y soy-de muy buen comer. De eso no le tengo que mentir. Yo le entraba muchas veces a las carnitas, arrachera. Y sin embargo cuando veo unas de esas, a veces come uno de más. Yo principalmente, yo comía de eso, y me la comía puro, cuando esta uno que lo estaban asado y come y come. [*Well, well in my case, I have—I still have but not the same. Before I was, like the lady was saying, I was-I am-a good eater. That I am not going to lie to you. I would oftentimes dig into the carnitas, to the skirt steak. And actually when I see one of those, sometimes I eat one too many. Me primarily, I would eat that, and I would eat them fresh, when you are there around where they are grilling, and eating and eating.*]
>
> E: Mi esposo es de que cada ocho días quiere carnitas. Y yo le decía, ya cada ocho días, cada ocho días (es malo) …(ahora) Si las compra, pero ya no cada ocho días. Ya na' más cuando es de antojo. [*My husband is the type that every eight days wants carnitas. And I would tell him every eight days, every eight days (is bad). He still buys them, but not every eight days. Now it's only when he's craving them.*]

> O: Mi esposo tenia, que le habían diagnosticaron con diabetes, que estaba comiendo la misma comida que el (esposo de E). Pero este, así como E, las carnitas y menudo, y lo que se guisa (en casa). [*My husband had, because they had diagnosed him with diabetes, since he was eating the same as (E's husband). But um, just like E, carnitas and tripe and what is cooked (at home).*]

These parents struggled with their love of comfort food but knew that it was not good for their overall health, striving for balance and limiting the number of times these greasy foods were consumed throughout the weeks or months.

The struggle with food/diet/weaknesses/cravings

Each resident knew their weakness when it came to giving into food cravings. For one woman from Peru, she could not eliminate rice from her diet, and she loved ice cream. For many it was the Mexican pan dulce in the mornings with their warm coffee or tea that they were not willing to do without. For others it was the chicharron (what seems like a Latin@ universal—who does not like chicharron?), carnitas or chuletas. As another resident stated, "…of course all the things I love is what I'm not supposed to eat" as instructed to her by a nutritionist she went to when she began having blood pressure issues. For another woman it was the Puerto Rican bread (el pan sobao) that she indulged in while in Puerto Rico. She explained her dilemma:

> Si como fruta me sube la azúcar y si como arroz me sube la azúcar. ¡Entonces uno pues no sabe que comer! Y yo no soy amante a los vegetales ni a la fruta. A mí me dan un pedazo de carne o un pedazo de pan, un plato de arroz o lo que sea. Pues yo no soy amante a la ensalada o a la fruta y que-yo no soy amante a eso. Y pues eso es el problema. Ahora mismo me fui a Puerto Rico (chuckling)- me comía una libra de pan todos los días.. ¡Aumente! Aumente 16 libras allá… Pero ya eh bajado. Ya eh bajado…Ese pan esta rico. ¡Un pan con aguacate! ¡Ha! [*If I eat fruit my sugar rises and if I eat rice my sugar rises. So one then doesn't know what to eat! And I am not a fan of vegetables or fruit. Give me a piece of meat or a piece of bread, a plate of rice or whatever. So I am not a fan of salads or fruit and-I am not a fan. So that is the problem. Now I just went to Puerto Rico (laughing)-I would eat one pound of bread every day. I gained! I gained 16 pounds…but I've already lost some…That bread is so good. A piece of bread with avocado. Ah!]*

In the same vein as what the dietitian discussed at the beginning of this chapter noted, that a Mexican cannot be told not to eat tortillas. Another way to emphasize or make sustainable more healthful food choices is by working with residents to find ways of making the foods they are used to eating healthier. For example, with beans, adding more vegetables mixed into the beans to add more nutrients into these traditional dishes is an option. Or in addition to exchanging white rice for brown rice, also demonstrating how to make these healthier options ‘taste better’. For example, in a healthy cooking class I observed how adding chicken stock (preferably homemade) to cook the brown rice in (instead of water) helps to make the rice taste better, altering the ‘carboard’ like taste many people did not like. Another key philosophy I learned from the Humboldt Park Health Center (HPHC) was “everything in moderation.” The HPHC workers and volunteers were all fellow Latin@s who were from the community or lived nearby, so they knew that telling residents they could not eat rice, tortillas, or bread was an unrealistic recommendation. Instead they encouraged residents to watch their portions, that if they wanted to indulge in a piece of cake or a cookie, to make sure that it was a small piece or only one cookie, and to not make it a habit. Additionally, having health outreach workers who are from the communities themselves, familiar with the histories and backgrounds of residents, helps to foster more holistic and sustainable changes in community health.

Physical activity: ‘Al altritis yo le doy una patada asi (¡fum!)’ [To arthritis I give it a kick like this (pow!)]

Physical activity—as those in the HPHC find more appealing to phrase—or exercise, is one of the strategies that most residents had no problems engaging in. Being active was often seen as the best way to be ‘healthy,’ and one of the ways to make up for all the ‘bad food’ that was eaten. When someone wanted to lose weight, they often focused on exercising and sometimes dieting, although most residents acknowledged that physical activity was much easier to accomplish. However, when it comes to losing weight or inches of body mass, exercise is only the tip of the iceberg. As one participant also pointed out:

> …a lot of people, like you could be fat, and you could lose weight, but if you don’t, the most thing about it, like if you stick to you’re diet. What you intake is what, makes you lose weight and what makes you gain weight. … You could work out every day, and work out and run, but you still don’t lose weight cause your food, the way you’re dieting the way you take care of yourself.

This is something I have tried to convey to residents who have asked me to give health education presentations. Below is an image (Figure 5.5) of what I have used in the past to express the relationship between exercise and nutrition for overall health.

Figure 5.5: Balancing diet and exercise for health (Source: marciashealthyslice.com).

With this image I hoped to express that one could not expect to sweat out a bad diet. That it mattered more what we consumed than the hour or so we put in each day to be physically active. Additionally, I always emphasized that when it came to achieving optimal health, it was not a matter of going a fad diet or taking certain natural vitamins to lose weight. It was more important to make healthier eating (which I also further defined) a part of daily life, and to focus on eating more fresh fruits and vegetables as one of the most important aspects through which they can improve. This was easier said than done, but, as discussed above, residents found their own ways of taking care of their health and well-being based on what they had found to have worked for them. In the section below, I focus on the various ways residents engaged in physical activity and the nuances surrounding this component of health.

The misguided idea that exercise outweighs diet

As mentioned earlier in this chapter, my dear friend Ms. Yaly had been dealing with high blood sugar for almost a month. She had been going through a lot in regards to her health, and was also not sleeping well. Every once in a while, she would check her blood sugar levels when she felt something was ‘off’ with her body. When she saw how high her levels were, she decided to take matters into her own hands. She started attending a Zumba studio where the fee included a one-hour instructor-led fitness class, a cup of tea, and a post-workout shake. She felt good about attending these classes a few times per week. Ms. Yaly noted that she also had been trying to drink a lot of water to ‘flush out’ the excess sugar from her system. One day I picked her up just after she had got home from her Zumba class. Fresh out the shower, she was sipping the post-Zumba shake they had provided her. We went to run an errand and when we came back to her apartment a couple hours later her partner, Josue, was up after having some rest from his night shift. When we arrived Josue was using a deep fryer to make pizza bites (the ones stuffed with pepperoni and sausage). I had never seen pizza bites being fried before. He said as he served us that he didn’t like how they came out; he said those pizza bites were supposed to be cooked in the oven but I guess he wanted to try out his newly acquired deep fryer that the elderly ladies at his work had gifted him. He explained that they were supposed to be crispy and that when you fry them the sauce dried up, or at least that was his theory. Ms. Yaly got to working in the kitchen to make lunch. Ms. Yaly had the supplies to make egg sandwiches so that was what was on the menu. The sandwich consisted of white-bread, covered with ‘I can’t believe it’s not butter,’ a lot of mayo, a fried egg (made the right way—with the yoke ready to burst once you bite into it), ham, and a slice of individually wrapped American cheese. It was so good! But I don’t know how much my cholesterol was raised between that one sandwich and the fried pizza bites—it seemed to me like a heart attack on a plate. But at least this meal was easier on our wallets than eating out, and a fast fix for our hunger. Often, residents eat what is available to them with factors such as affordability, accessibility and convenience (less labor intensive) determining their food choices.

Schools offering free exercise classes

Of the CPS (Chicago Public Schools) I interacted with, most offered some sort of free or reduced price physical activity class at their facility for parents of students. Often, the exercise class was offered in the school gym and each week there was the same schedule. For example, they might offer Zumba three days a week and yoga twice a week. Other classes included boxing, kickboxing, HIIT (High Intensity Interval Training), and Tai Chi. The Zumba instructors often came decked out in their official Zumba gear, affirming they were the real deal, branding and all. In the summer when classes were on break, one group of mothers gathered in the park adjacent to the school for their morning Zumba. As I rushed to my shift at Catholic Charities, this group of women was having a great impromptu work-out session. The teenager and adolescent children of these mothers sat in the shaded grass while their moms worked out. A couple of mothers had small babies, one danced with her infant in her arms, another had her baby in a covered stroller next to her as she danced to the beat. The music played from a large stereo connected through the metal fence to a running SUV with a man waiting inside, looking through his phone.

Once I went to a Zumba class when Leo was just past two months old. I had not felt comfortable being physically active until much further past the recommended six weeks of recovery after my cesarean. The music started just past 8:15am, just after it was time for the elementary school students to begin their classes. Some mothers got their children ready earlier than usual to make sure they had a good spot and with plenty of room to move around in Zumba class. The instructor had her tight-fitting Zumba gear on: gray leggings and a bright pink fashionably cut-up Zumba t-shirt. Her thick, curly hair was pulled back in a low-ponytail and held in place with a bright pink Zumba ball-cap. I admired her confidence in wearing what she had on, wishing I had the same mindset to be proud of my similar curves. Leo was entertained, listening to the loud (although probably too loud) music and watched all of us move around from one side of the room to the other. A little over half-way through the class, he started to protest at being confined to the same position in the stroller—he wanted to get up and see what else was going on. The rest of the class I tried to keep moving to the beat with Leo in my arms, although with not as much bouncing, of course. Leo has always loved music and dancing in my arms. Our friend, Heidi, was one of the regulars who got her kids out of the house early enough to make sure she was present at the class with enough time before the music started. Lorena, another friend and comadre of Heidi, usually arrived just after the class started; she always struggled to get her kids up and ready for school in time. She found a spot close to the front and loved moving to the cumbias often played during the session. You always knew when Lorena was cleaning by the familiar Zumba tunes blasting and vibrating the upper and lower floors—apartments of her two con-cuñas-comadres (their husbands are all brothers so they are each other's sister-in-laws, but are also each other's children's godparents). Antonia, Heidi, and Lorena's other con-cuña-comadre, had had a busy year helping her daughter's teacher and hardly ever got to partake in the exercise classes.

When the Zumba class was over, Lorena and Heidi invited Leo and me over to 'almorzar[1]' [have breakfast]. The morning sweat session had Lorena salivating for something she could fix at home. She had sliced bread and some sliced ham so she got to putting together a sandwich assembly line. Lorena brought out the white sliced bread and the wheat, asking which I preferred. I said whichever she wanted to serve, then noticed her struggle to decide, so I said wheat was good for me. She agreed, "si verdad, para que sea mas saludable" [*right, so that it (the sandwich) can be healthier*]. She started rummaging through her refrigerator to see what else she could offer me, but I assured her that the sandwich would be more than enough. Soon Heidi joined us from her part of the house downstairs. Lorena asked her how she wanted her sandwich and Heidi graciously declined, and instead pulled out an opened package of pre-made salad from Lorena's refrigerator. She filled her Styrofoam plate with the iceberg lettuce leaves and took Lorena up on some slices of ham and cheese to put on her salad. Shortly after sitting down Antonia joined us from her shift at the school, she was famished and took Lorena up on her healthy whole wheat sandwich.

Heidi chomped away happily on her makeshift salad and asked Lorena why she had so much salad left over. Heidi knew Lorena's struggle to convince her husband and three sons to eat more vegetables. Lorena confessed that she had attempted to serve salad

---

[1] This was a cultural difference I learned as I became more integrated with my Mexican in-laws. Growing up in a Cuban-American household, to almorzar meant to have lunch. But apparently for Mexican families, to almorzar was the heavier late breakfast meal.

the night before but that nobody touched it besides her. On another occasion, Lorena disclosed to me, “es que no se como hacer para que los vegetales saben buenos” [*it’s just that I don’t know how to make them (vegetables) taste good*]. Eating healthy within her immediate family was not supported by her spouse or children, a fight that she often gave into by cooking what her family liked and was accustomed to eating—usually consisting of a meat and tortilla or other carbohydrate basis.

Community center offerings

The HPHC had a vast range of physical activity options for residents. This center’s program, *Activate*, was founded by a Humboldt Park native when her physician told her that she might spend a lifetime on medication if she did not turn her health around. Noemi started walking laps around Humboldt Park even in the cold weather, and she did not falter. Soon, local residents started noticing and joined her, establishing a walking group at the park. Then the staff of the Humboldt Park Field House took notice, and made a proposition to Noemi. They offered one of their gymnasium spaces free of charge for her to use, if she could recruit at least 10 other residents to use the space with her. Surely enough she recruited the numbers, and to this day Noemi is one of the longest-serving volunteers within the Humboldt Park Chicago Park District, seeing many staff members cycle in and out of this site in her 12 years of involvement. Now with her *Activate* program fully underway, her program holds physical activity classes primarily in the HPHC, and a few at the NW Field House. They also offer classes at the Logan Square Field House, as well. The classes offered by her program include Zumba and Bail-erobics (the two most popular), yoga, tai chi, Pilates, and in the beginning of 2017 they held a six-month long boot camp class offered once a week. Most classes were offered in the late afternoon and early evening. These services were all free; residents just needed to fill out some paperwork ensuring that they have consulted a physician before engaging in any physical activity, and asking the goals for engaging in physical activity. No official ID was required for residents to complete the paperwork, nor payments, nor insurance coverage either.

In the various health outreach exchanges with local residents, countless times many did not even know the HPHC existed, much less that they had a free gym within reach. Although, during the later phases of my research, I have found that more residents are aware of the HPHC services. Some residents take advantage of the free offerings of the HPHC, while others might have been very active with the HPHC during a certain time but their involvement has since fizzled out, as they have found other methods for remaining physically active. For example, for many residents, since the 2015 construction of the 606 trail (introduced in chapter two), they preferred walking at times that fit in their own schedules.

Northwest Clinic also offered free exercise classes for the general public, although most participants tended to be clinic patients, and even then, not many patients knew about the various health education classes offered at this site. They offered Zumba, yoga (including one specific for lower-back pain), and Pilates. All health education classes at Northwest Clinic were taught by clinic volunteers and thus did not entail specific certification (whether it be the official Zumba certificate or the diabetes education training). This allowed for funds to be used for other means, and increased the number of volunteers able to offer a range of classes at different times. Although Northwest Clinic had over 1,000 volunteers, meanwhile the HPHC less than 20, the Northwest Clinic exercise schedule was not as full for health education class offerings. Part of this may be because most of the HPHC's exercise instructors are volunteers who are paid a small stipend and asked to work at least two hours a week, whereas in

Northwest Clinic, most volunteers are involved in the foreign-language interpreting portion of the clinical services.

Gyms

Other residents mentioned gyms they have frequented, the most popular being Blast Fitness and Planet Fitness, and LA Fitness was mentioned a few times. These two gyms (Blast and Planet Fitness) were known for their affordability and convenience. The aspect residents preferred about Blast Fitness was the fact that they offered group exercise classes, from cycling to Zumba, among others. In regards to Planet Fitness, members basically did things at their own pace, which many liked, but it did not offer fitness instructor-led sessions. One of the drawbacks about this gym—and other community centers—was the fact that children were often not permitted at these gyms. This was an issue for the HPHC's *Activate* program, as Noemi explained to me:

> Another thing also is child care. That's another thing we struggle with because we're not equip to have children here…-we're not child-friendly in the sense that we don't have resources for children. So then we've lost a lot of women …because a lot of children were coming in and there was no supervision and moms were doing other kind of stuff and it was becoming dangerous for the children and for the parent. Then for that reason we made strict rules about how many kids, and at what age and that kind of stuff. And we lost a lot of women because of that. So we also struggle with that part.

Parks

Many local parks were a resource for residents to at least be able to walk laps around. Some residents did not trust in the parks nearest to them and opted to go to parks in better areas of the neighborhood, sometimes even traveling to the further north more 'rich,' 'white' neighborhoods. When I arrived to one of the SW CPS to give an overview of my research and to see if I could interest the mothers in the parent meeting room to participate in my study, the parent coordinator, Wendy, was reporting on end-of-the-year events and the plans that she was supposed to pass on information to the parents. Wendy read from her detailed hand-written notes in her notebook: the kindergarten graduation was set to take place in the library and parents were welcome to come. The end of the year field day was scheduled for two Fridays from then at a park nearby. Some of the mothers spoke up in protest inquiring how the kids would be getting to the park, who was going to take them, and why the field day could not take place within the school boundaries. Wendy and the mothers discussed this topic for a while, negotiating and prioritizing the safety of their children because they did not trust the atmosphere of the nearest park to the school, where they were proposing to host the field day. They settled on Wendy going back to the school organizers to change the location within the school grounds, even if it meant changing the date.

Although most neighborhoods had parks nearby, not all parks were created equally. One of the parks in the SW had a nice soccer field that was almost always occupied. The nearest water fountain at the corner of the park was dried out for the entire summer, and the bathrooms were always locked. How were kids supposed to replenish themselves? Through the cart-pushing vendors who were always in sight. One vendor pushed a cart full of paletas, another had a cart just for snow cones, and another vendor had a shopping cart of everything from churros (chips), supplies for snow cones, bottled beverages and sodas, and typical Mexican candies. Such vendors sold their bottled beverages at a cheaper price than the surrounding corner stores, especially the water because it was the least popular commodity. The remains of the most popular products were sprinkled along the corners of the park: candy and chip wrappings and sports drink bottles.

Walking as the simplest, easiest and most accessible form of exercise

Walking was a form of physical activity that seemed most accessible for most residents, especially for the elderly generations. In one focus group of elderly diabetics, they explained:

> L: Bueno yo lo (diabetes) tengo perfecto. Yo tomo medicina, camino media hora a veces 45 minutos…eh bajado y me eh sentido mejor haciendo los ejercicios. [*Well I have it (diabetes) perfect. I take my medicine, I walk half an hour sometimes 45 minutes…I have lost weight and I have felt better doing these exercises.*]
>
> F: Cuando me dijeron que tengo diabetes, caminaba todas las tardes, todas las tardes…no eh caminado. Pa' que te voy a mentir. [*When they told me I have diabetes, I would walk each afternoon, each afternoon…I haven't walked (recently). Why am I going to lie.*]
>
> A: En mi caso, como vuelvo y le repito, hago ejercicio de cardiovascular. Caminar mucho, de veces en cuando un brinquito, tengo que cambiarle porque a veces uno se adapte de camine, camine y trabajo, entonces meto un brinquito. Buen. Ya eh caminado, meto un brinquito, pero lo que quiero decir, mi condición, bajo escalera, subo escalera, a veces no cojo el elevador en casa. [*In my case, like I said before, I do cardiovascular exercise. Walking a lot, sometimes a jump here and there, I have to change it up because sometimes you become adapted to walk, walk and work, so I put a jump in there. Good. When I've walked I put a jump in, but I want to say, my conditioning; I go down stairs, upstairs, sometimes I don't take the elevator in my house.*]
>
> M: Yo tengo cinco años con la diabetes. Y siempre he tratado de caminar para controlarme la diabetes y tener una vida saludable. [*I have been 5 years with diabetes. And I have always tried to walk to control my diabetes and have a healthy life.*]
>
> W: I walk, because when I first got diagnosed they told me that I had to use needles. I'm terrified of needles. I do not test my blood sugar, I don't do—I'm afraid of needles.
>
> S: I enrolled in tai chi, but then I wasn't able to come last Thursday…it's only every Thursdays but I wasn't able to come...nobody came to take the kid on time. So, what I'm doing now is to have a five to ten minute walk every day. I try to manage that.

This last woman, Sonia, had been living in Chicago for just a few months. She came from the Philippines and had been diagnosed with diabetes in 2008. However, what concerned her more recently was her blood pressure. She had just weeks before ran out of her blood pressure medication and was waiting for her son to send her the medication she needed from the Philippines sometime soon. She took care of her grandchild during the day while her son and daughter-in law worked. Being a recent immigrant, she did not have access to medical insurance nor did she have an ID acceptable for the state nor proof of residence, which are some of the basic requirements asked of residents to be able to attain city, state, or federal aid. Sonia was in a liminal state of waiting to be able to qualify for aid and counting on her transnational network to supply her with her healthcare needs.

Each resident, especially those who had been were managing their condition(s) for many years had at this point developed strategies to feel good and healthy in their body. For some, clinical tactics were part of their daily practices, for others, they counted on more natural remedies through smoothies, oatmeal derivatives, or incorporating ‘superfoods’ into their routines in order to attain wellness on their own terms.

CHAPTER SIX:

Agency and concluding thoughts: "Tengo esas enfermedades pero enferma no soy" [I have these diseases but I am not sick]

This final chapter summarizes the agentive ways that residents navigate and strategize resources throughout the city for their own and their families' well-being. Based on my research, I suggest ways to improve clinical experiences with residents, from individual well-care visits to reaching out to Latin@s left outside of clinical reach. I also discuss policy recommendations for local and national officials, organizations, and programs. Lastly, I discuss hopes and plans for future research as I continue learning from these communities.

Agentive ways Latin@s navigate the city for their well-being

During an impromptu get-together with comadres, cuñadas, cousins or close friends in 2017, the mothers all gathered together in Lorena's kitchen, which was filled with all the tables she could draw together to fit all twenty of us. Lorena's mother, Doña Fe, was also visiting. We finished off our meal of tostadas con picadillo [ground beef] with all the fixings (lettuce, tomato, onion, cream, white crumble cheese and of course chile [salsa]), and ensalada [macaroni salad]. The conversation turned to health and fitness. The mothers commented on how good Antonia's sister was looking. Antonia's sister, Vero, shared her home secret of having a stepping machine which she used often rather than worrying about going to the gym. Inevitably, the conversation turned to dieting and how 'los tacos están demasiado ricos para evitar' [*the tacos were too good to avoid*]. Just like el pan dulce. One of Lorena's comadre-cuñadas, Itzel, shared her tactic to deal with a bag of pan dulce at home. Itzel would wait for each member of the family to have their fix over the first day or so, but if any bread remained—especially during the school week—she would throw away whatever remained in the bag. She knew that if that bag of sweet bread remained in the house, especially when she was home alone, she would be the one to end up eating it and so would just throw it away before even getting to that point.

Doña Fe and her husband were granted a tourist visa and spent half the year in Chicago and the other half in Mexico. When in the U.S. they visited their seven (out of eleven) children and their respective families, who had been living in Chicago for decades. Doña Fe often noted how healthy and great she felt at her age. In most ways, Doña Fe had better health than five of her seven U.S.-based children who often shared concerns about their aches and pains. Doña Fe would proudly proclaim, "¡A mí no me duele nada!" [*I don't feel any aches!*].

Lorena, on the other hand, had many aches and pains, especially in her feet and ankles. She was not sure what condition she had but when she showed me the paperwork one day it appeared that she had been diagnosed with Lupus at some point—a diagnosis for which she never received treatment. The recurrent feet and ankle pain resulted in her not being able to walk sometimes, even prohibiting her from taking the Zumba classes she always enjoyed going to. Instead, her pain led her to seek treatment from a 'sobedor' often. Her comadre-cuñadas, however, were convinced that Lorena's lower extremity pain was due to her over-consumption of 'la Coca,' something she could never seem to give up. After years of being told she was pre-diabetic, Lorena had been diagnosed with diabetes near the end of 2017. The diabetes diagnosis was not something that stopped her or made her feel bad. She just kept moving forward because “pues ya lo tengo” [*well I already have it*] and there was nothing else that could be done but to keep on living life.

Several mothers shared their strategies for controlling the consumption of soda in their household. Yuri was very health conscious regarding the foods she prepared for her family. She explained:

> … en mi casa trato de comer muy balanceado. Uso mucho las aves, ensaladas, las verduras. Casi no compro sodas, o si lo compro, compro jugos o una soda para toda la semana. Y nunca la acabamos, siempre tiro la mitad. Este, toma mucha agua, y pues si lidiar también de no comer tanta grasa, tratar de no comer carne todos los días, nada más tres veces a la semana. Y ya nada más tratar de usar menos sal, azúcar, grasa. […*in my house I try to eat very balanced. I use a lot of poultry, salads, vegetables. I hardly ever buy sodas, or if I buy, I buy juice or one (liter of) soda for the whole week. And we never finish it, I always throw half away. Drink lots of water, and deal with avoid eating so much grease, try to not eat (red) meat every day, only three times a week. And then also try to use less salt, sugar, grease.*]

Juana, a mother who was extremely involved in her children’s (and grandchildren’s) school noted the impact of introducing all the things she learned from school programs into their daily practices at home. She explained:

> Los refrescos no lo abrimos, papitas tampoco, muy en ocasión cuando me piden es porque llegamos por ella. No ay en casa nada de golosinas así, en cantidades. Pero sí. Lo que si tengo que hacer es cocinar más seguido porque dependo mucho de, como se llama, de comida rápida que voy a muchas casas (chuckling). Voy y le toco a los vecinos y si, y si cocinan muy bien. [*The sodas we don’t open them, chips either, very occasionally when they ask is when we get these things. At our home we don’t have any candies in large quantities. But yes. What I do need to do is cook more consistently because I depend a lot on, what is it called? Fast food, from going to many houses (chuckling). I go and knock on my neighbor’s homes and yes, they cook very good.*]

Not only did Juana limit the amount of soda accessible within the home, but also chips and candies. She also pointed out another strategy—the resource her neighbors presented as a place to get a good, home-cooked, fast meal. As one of the lead parent volunteers at her school, Juana rarely had time to stop at home and think about cooking, much less attend to her own health according to clinical recommendations.

Additionally, many residents theorized and problematized the high costs of ‘health’ food. For example, one Spanglish exchange between a group of four mothers revealed:

> AN: Yo pienso que también tiene que ver con el alimento porque toda la comida que es like no bueno para ti es barata. Y eso lo que uno puede…comprar. [*I think it also has to do with the nutrition because all the food that is not good for you is cheap. And that is what one can …buy.*]
>
> AN (continued in the same breath): And it’s like vegetales, frutas y todo eso, y a veces, [*vegetables, fruits and all that, and sometimes*], you just can’t. so you’d rather get a bag of rice that is gonna like—para casi—[*for almost*—]
>
> Z: Toda la semana. [A*ll week long.*]
>
> AN: La semana, mes, [*the week, month*] or whatever. Some hot dogs, you know stuff like that. And it’s like fruits and vegetables, they’re good for you but a lot of times they’re expensive you know. So maybe like something like that too, kinda look for a place that could kinda like work with the people that don’t have that income to buy you know all those stuff.
>
> E: To me too. It’s a lot about what you buy in the store. There’s a lot of families here that have 6 or 5 kids. They gotta buy bread, bologna and cheese and…
>
> AN: Exactly!
>
> E: For the whole week! To make it. And buy like maybe a little thing of bananas or something like that, a bag of grapes. And grapes now a days cost like $4!

These mothers were very much in-tune with the fluctuation of market prices for household produce and what was or was not feasible to purchase for the entire household to enjoy. Another group of mothers commented on how they strategized shopping for healthy food and opted for ‘unhealthy’ food.

> N: I love zucchini. But if I go and its $2.99 a pound of zucchini and I need meat to go with that zucchini side and I don’t have that kind of money, what do you think I’m gonna buy. I’m gonna buy the sides? The cheaper, and the meat that all my kids are gonna eat. Rather than the zucchini that I would prefer. So I look at it in the aspect of what are my kids gonna eat. What is my husband gonna eat, plus I have extra people who live with me, what are they gonna eat. And then, it’s like you always put your, I always put myself to the back burner. Even when I need something and then my kids need it. I’m gonna do for my kids before I do for myself. Which is probably part of my problem.
>
> K: It’s expensive.
>
> N: It is. I love vegetables.

In another focus group however, one of the mothers refuted the claim that healthy food was expensive. The majority of the parents in this focus group were talking about their experiences with these conditions based on observations from caring for their parents or extended family members. One of the mothers noted that it was actually more expensive to buy the junk foods in the grocery store (the processed foods, chips, candy, and soda) than if you were to only focus on buying the produce, grains, and meat. This mother often found that when grocery shopping with her younger children, her cart would get filled with packaged foods that tended to rake up the bill at the end of their shopping excursion. The above group of mothers having a problem with a $2.99 pound of zucchini also had an issue with excess spending on fast food (noted in chapter three). Latin@ Chicagoans are well aware of their surrounding and their families’ needs as well as what does or does not constitute ‘healthy’ food, especially from a clinical/public health point of view. Their decisions are often based on a combination of convenience, price, time, and labor required to get food on the table.

Another key resource for many Latin@s was the internet, usually by searching directly on one's phone or a computer accessible in the home or workplace. Many of the secret recipes to lower cholesterol, blood pressure, or blood sugar levels were found by searching for health tips online. Other times these recipes were shared amongst co-workers, making the workplace a key site of the exchange of information and tactics. One man, Raul, who was diagnosed with epilepsy as a young man living in Puerto Rico, had one kidney and soon after moving to Chicago in 2010 was diagnosed with high blood pressure. Raul explained some of the tactics he had developed to take care of his body:

> R: Cuando como carne roja. O como antes que (making sound) ah-me jartaba. (Now) Just to taste it. You know [*When I eat red meat. Or like before, when I would gorge.*]
>
> R (continued): …casi siempre la mayoría (como), pollo. Hay veces que I'll Google you know, que es lo que puedo o no puedo comer y me muero. Porque más…mas…(es) menos de lo que puedes comer que lo que más (puedes comer). So es duro. No te cree, que no es nada fácil. Y eso que me voy a un dietista que me va poner peor. So por eso yo—unh-uh (no). [*…almost always the majority of the time (I eat), chicken. Sometimes that I'll Google you know what it is that I can and cannot eat, and I'd die. Because more…more… (it's) less of what I can eat than what I can. It's hard. Don't be fooled, it is not easy. And to then go to a dietitian who is going to make it worse. So for that me—unh-uh (no).]*
>
> LM (trying to encourage meeting with a dietitian): Bueno uno nunca sabe, a veces le dan muchas opciones. [*Well you never know, sometimes they give you many options.*]
>
> R (going on): No yo miro a la computadora y más o menos, cosas tú sabes, vamos a decir mucho vegetales, tú sabes. [*No I look at the computer and more or less, things you know, let's say lots of vegetables, you know.*]

Raul was not letting his health and well-being take a backseat. He often actively searched for healthier food options and noted differences in his body in what foods he could or could not eat. Raul was also very knowledgeable about his own body, the effects consuming certain foods had on him and was constantly balancing and measuring the moments of indulgent.

How stigmatization might be addressed

Many Latin@ Chicagoans were especially knowledgeable about their bodies and how their bodies reacted to certain things. Examples of this include residents like Maria (chapter five) who knew exactly which foods (mostly carbohydrates) caused her blood sugar levels to rise and made a conscious effort to avoid the bread she enjoyed having so much. Raul (from the above section) knew that his body weight never changed. He could be working out, on a diet, or not necessarily watching what he was eating, and he would always weigh the same. His son, who was also participating in the focus group, attested to Raul's point. Raul noted:

> R: I'm supposed to (lose weight) too but I'm always, I'm always in, you know 230. I don't go down, I don't go up. No matter what I eat I always stay there.
>
> JR: And we all hang together so (we know).
>
> R: But I'm almost, I'm almost there (at the same weight). Don't go up, don't go down. It don't matter what I eat.

In another focus group of close Puerto Rican friends, two of whom were siblings, Carmen, the sister, explained:

> C: Everybody's got different-um-their metabolisms are different. Like us, we get, us two we get like a little bit thick like Mami, but my other brother

> and my other sister they'll look like tanks. Like my father's side of the family. So I think it really depends on el cuerpo de uno [*your own body*] … Like me, I can't do iron pills because I get constipated, excuse me. But also other people pueden comer ciertas cosas, y no pueden comer ciertas cosas [*can eat certain things, and can't eat certain things*] … Like me, me I could burn carbs. But I can't burn fat. It's hard for me to burn fat. So all my fat goes right to my stomach. So tú me vez a mi como la vieja, patas flacas, [*you see me like the old woman with skinny legs*] … Me como una ensalada al día. [*I eat a salad a day*] Or when I notice that I don't eat a lot of fat, my stomach fat decreases and I'm like okay wow. So I don't have that tire around my waist. So it depends what the body consumes.

Although Carmen had described herself as a ticking time bomb from all the conditions she had, she knew her body well enough to know what was or was not good for her. Since her oldest son was diagnosed with type 1 diabetes, she came to know exactly how to care for her family and herself. The other focus group members continued discussing their observations about the kinds of food they ate in relation to the effects on their bodies:

> B: Empieza con McDonalds que eso, obviamente nos ponemos (a comer) fast food porque no hay cocina en la casa pero… [*Starting with McDonalds that is, obviously we get to (eating) fast food because there is no kitchen at home but…]*
>
> W: That's the part too, cause you eating out all the time, that's bad calories. There's good calories and bad calories. I'm proud of the good calories. You know olive oil is good.
>
> B: Like a quarter pounder, quarter pounder with cheese y se me pone la cara toda roja [*my face gets all red*].
>
> W: I'm telling you cook at home. Then you don't have to watch what you eat. And it's all good and more natural than what they're giving you at the restaurant. That's a big part too.
>
> B: Yo pienso una dieta, la dieta fue parte de esa cosa. [*I think a diet, the diet was part of the cause of that thing*].

Bobby, who was dealing with high blood pressure since he was a young boy living in Puerto Rico, noticed that whenever he had that quarter-pounder with cheese his face would show his body's discontent in the brighter hues of color expressed. Wilmer, in his early 30s at the time (in 2017), had been diagnosed with diabetes just months before. He was proud of everything he knew and had learned to improve his health and easily shared his knowledge with the group.

The stories shared with me by the Latin@ Chicagoans that I spoke with demonstrated a resounding wealth of knowledge about their bodies, healthy food, and practices. The stigmatization that Latin@s have cultural practices that produce ill -health is one that needs to be disrupted. I aim to educate biomedical providers about culturally appropriate questions and care, and ultimately about how to provide personalized care for individuals based on listening and communicating effectively.

Within the healthcare setting, we are not paying enough attention to the impact of stress and embodied illness, or risk of embodied illness (as described in chapter three). Peoples' lived realities have the capacity to drastically affect their bodies, in both positive and negative ways. People's general health and well-being are impacted when they are living with enormous pressures from various forms of discrimination and structural limitations. For Latin@s who are undocumented or living in mixed status families, the growing everyday violence and symbolic violence reproduced by the structural violence of the U.S. immigration system have disproportionate impacts on health and well-being.

When families are worried about going to the grocery store because of threats of ICE raids, their health is impacted. When residents cannot engage in five minutes of walking because their back or foot or leg pain is so drastic that they become immobile, their health is impacted. When residents worry about their children's safety in neighborhoods dealing with gun violence, their health is impacted. When there is only one hospital meant to serve an entire area of the city, their health is impacted. When people cannot communicate with their providers, or do not feel heard by their clinicians, their health is impacted. Especially for people who have been living with chronic conditions such as diabetes, high blood pressure, or high cholesterol, their illnesses cannot be written off as cultural, or pre-disposed genetic history. In finding best practices to improve the health of Latin@s throughout the U.S. we must pay attention to each person's local contexts and narratives.

Another key aspect I learned about the Latin@ Chicagoans was their strategizing of various health settings (beyond specifically clinic or hospital sites). For example, in the health education classes I gave and observed throughout the city, residents often used these opportunities to ask the health experts about questions that were left in the back of their minds. At one of the weekly health education classes at the HPHC, the topic was about foot health. Lupe, one of the elderly ladies I came to know very well, was the leader of the elderly ladies' crew and arrived to the class right at the tail-end of the session. Lupe had the HPHC's front desk number as part of her contacts on her phone to be able to find out what was going on at the HPHC ahead of time. When she learned that the topic was podiatry, she rushed to the center. Lupe had a callus that had formed along the side of her foot that had been bothering her and she wanted to see if the resident who was giving the class could take a look at it. As she asked her question at the end of the class she began untying her sneaker and taking off her sock. The resident agreed to examine Lupe's concern. Once the class had concluded, Lupe unabashedly held up her foot to the Latina resident. Lupe had health insurance and a primary care physician as well as access to specialty care, like a podiatrist. But the opportunity that presented itself at the HPHC was one she could not miss. Often times waiting to see one's primary care physician to make a referral, to then make an appointment with the referred specialist—given approval by the insurance company—was more of a hassle than a benefit.

The time I spent as a health outreach worker taught me many aspects of how residents strategize and utilize health experts. While conducting heart screenings, a typical spot that we (the outreach workers) would set up to advertise free blood pressure checks was in front of the HPHC. We would set up a table almost every day during the late spring and summer season in which the weather was hospitable to sit outside for long periods of time. The HPHC was on a busy street corner where we often convinced people to stop by our table before or after running errands at the Cash Checks place or the Metro PCS nearby. Most passers-by agreed to sit down for a bit and talk with us while getting their blood pressure checked. I recall a couple of times when, at the conclusion of the heart screening, residents asked me to take a look at a bill that they had received which they could not decipher. Sometimes paperwork that appeared important would arrive in English, and therefore was not connected with the needs of customers. Paperwork from the gas or electric company was particularly difficult to understand even in one's native language. Residents wanted to be sure they were not missing anything or were not being charged something in excess, and made efforts to consult us on any ambiguous mail received.

Within the focus groups or individual interviews, many residents viewed me as a clinical expert and consulted with me about certain medications, symptoms, or other health concerns or questions that had been bothering them. I want to re-iterate here (as described in chapter one), we as health outreach workers made it very clear that we were not clinical professionals and always directed residents towards the community resources and clinics that were within reach. Community Health Worker (CHW), or *promotora* models in public health programing, have been growing since the 1960s and 1980s in the U.S. in efforts to address growing health needs and inequities among more 'ethnic minority,' 'hard to reach' inner-city, or immigrant populations (Swider 2002:11). The specific roles of promotoras vary from project to project, region to region, and community being worked with. Additionally, within the public health literature "there does not appear to be a consensus" either (Deitrick et al. 2010: 396). Raisa, for example, who was a contextual interviewee in this dissertation research told me about her similar experiences as a health outreach worker:

> R: That's when I really started to feel like I was fulfilling a need … because not only was I going to the places where the people were that needed the help, but you're also giving them a service—which is basic, basic blood pressure, but it was still something that they didn't know and we were giving it to them for a free cost and it was just like…it was so nice to see these people like 'Oh you know, it's free? Okay let me do it.' And it just, I don't know I just thought it was really cool. But then as I was also doing the heart screenings I also noticed the limitations, like a person who'd be asking advice like "Oh this hurts or this hurts" or what's pain on this or that (mean), and to me it was frustrating because I wanted to be able to answer those questions, I wanted to be more than just, let me take your blood pressure, but let me give you some advice. Which also made me realize that I wanted to get into the medical field because I feel like once I get that proper training I'll be able to do more for my community.

Raisa was living in the Logan Square community at the time (in 2015) and had lived in the greater Humboldt Park area for all her life. Her family was from Ecuador and she recruited one of her cousins to work at the front desk of the HPHC when she got a—

better paid—public health position. That summer Raisa was studying to take the GRE to get into physical therapy school. In the years after this initial interview, Raisa's passion for the community remained unaltered. She carried her commitment to the community with her throughout each of the public health programs she helped run and coordinate.

As a fellow outreach worker, she was familiar with the common exchanges that residents often had with us expecting us to be health experts, even though we had no such training. Of the less than 15 health outreach workers, three were nursing students studying to complete their degree at the time, four were middle-aged Latinas from the community who had various experiences working and volunteering for the public, and then there were the handful of college students who came to fulfill service hours, practicum, or class requirements for that point in time. The fact that the HPHC health outreach workers were not medically trained did not limit the impact and benefit of providing residents this free basic health service. A service that many in the SW would have been grateful for as well. At the end of 2016 the HPHC's carrying out of the Heart Program concluded. Doña Nancy had been offered a job at a different public health office, and the grant money to provide the health outreach workers with their volunteer stipends ran out. If any resident walked into the HPHC and asked for a blood pressure check, the receptionist was able to provide them with this service. But the receptionist, Olivia, lamented that Doña Nancy's leaving meant that many of the HPHC services for diabetics became limited. In the year following, 2017, the center continued to go through structural changes and challenges to their sustainability. The main program housed out of the center, *Activate*, became the spotlight resource advertised. In addition to a new grant the HPHC had received for domestic violence awareness and support for domestic violence survivors, the HPHC remained afloat because of the receptionist's passion for the community and the center.

In the early months of 2017 I stopped by the center to catch up. A conference table, ordered by the non-profit managers who oversaw the center, had arrived the day before. This new addition to the center was thought to be an improvement in the other community leader's eyes because it had the capability to turn into a ping-pong table. But for the director and jack-of-all-trades, Mara, it was an impediment to her *Activate* fitness schedule because the table was not collapsible. The previous conference tables would be folded upright and rolled into the hallway to make room for the always-filled Zumba classes in the evening hours.

Even within grassroots organizations, completely run by members of 'the community', there are different ideas about what the optimum uses of these spaces would be. For the leadership of the BC, it appeared that the priority was not to be the original initiative the HPHC was founded on: to promote health and wellness among diabetics, to prevent complications from diabetes, preventing diabetes, or other related conditions. At the close of 2017, Olivia, the one who held the last threads of the center together, went to a different position. She was tired of doing all the work and feeling undervalued. The future of the center remains more precarious with this loss.

Solutions and policy recommendations

In this final section I offer solutions for moving forward, based on the Latin@ Chicagoans' own suggestions. Overall I offer three solutions: improving the clinician-patient relationship; improving local health food geographies; and expanding resources throughout areas of the city that remain underserved. Each of these solutions is detailed below.

On the clinician-patient relationship

One of the most important findings of this dissertation is the significance of the clinician-patient relationship. Assuming that residents have a primary care physician, their working relationship with this clinician is key to managing these conditions. To begin, there needs to be improved communication between patients and their healthcare provider. In this sense, I return to the example of Dr. Paz, who went above and beyond to make sure her patients were following her treatment recommendations. She would go to the pharmacy to check if her patients had recently come to pick up their prescriptions and when they did not, she would confront them. Dr. Paz also noted the time it often took patients to disclose concerns or practices having to do with their care, often taking two or three visits to be upfront and honest with her. Translating from English to Spanish and vice versa is a continued issue in seeking healthcare in Chicago, and communicating from clinical discourse to more understandable, ‘layman’ language is another aspect of that problem. Even when patients speak the same language as their healthcare provider, a certain level of trust needs to be built before patients feel able to share their health concerns. Although for some, trust can only go so far.

In efforts to improve the clinician-patient relationship and communication, the concept of empathy has gained increasing clinical medical attention. For clinicians, empathy can be defined as “the ability to understand the patient’s situation, perspective, and feelings and to communicate that understanding to the patient” (Coulehan et al. 2001:221). The physicians who wrote this commentary explain ‘empathy in practice’ to involve: “active listening, framing or sign posting, reflecting the content, identifying and calibrating the emotion, and requesting and accepting correction” (Coulehan et al. 2001:223). The authors of this commentary also provide key phrases for other clinicians to use in their own practice of empathy and cross-cultural phrasings to better understand patients. The administratively imposed time constraints upon clinical settings remain a challenge to address. This is a challenge that should be responded to in the language of cost-benefit analysis to emphasize the financial benefit of such quality care.

Additionally, residents highlighted the importance of taking into account people’s community of origin and the increased potential of environmental contaminants. The evidence to support residents accounts can be seen within the research on endocrine disruptors, defined as foreign chemicals that “modify or interact with vertebrate and invertebrate endocrine systems” (Barrios-Estrada et al. 2018:1517). A majority of endocrine disruptors are found in agricultural products such as pesticides, fungicides, rodenticides, in addition to a variety of products used in plastics, and building materials (Barrios-Estrada et al. 2018:1518). Furthermore, these endocrine disruptors have been linked to various diseases including reproductive, cardiovascular, neurological, and metabolic disorders (Barrios-Estrada et al. 2018: 1519-1520). Based on the narratives in my surroundings, cancer was taking a toll on people at earlier ages—below official U.S. standards for cancer prevention screening (as described in chapter three). Young people were taken from this earth with no cause or reason besides malignant masses appearing and consuming their bodies, residents said.

In the post-ACA landscape that has left out a foundational part of the U.S. population, undocumented immigrants, access to health insurance remains a prominent issue among Chicago Latin@s. For those left out of the ACA, we must further explore where care is being received, if it is being accessed, and what the complexities of these clinical settings include. Those who are within reach of the ACA but have deemed it financially better to pay the fee instead of the cost of insurance, or others who fall between the gaps of their employer's health plan because of not working enough hours, or making too much to qualify for state or federal benefits, leave residents' with precarious access to healthcare. Should their health fail them, they are faced with exorbitant hospital bills and added stressors.

Additionally, clinicians need to be open to educating themselves on how to provide better quality care, instead of reproducing stereotypes from cultural competency training. There is a case here for personalized medicine for all patients, not just Latin@s. In this respect, a turn towards personalized medicine means understanding that not all Latin@s are the same, nor do all Latin@s eat tortillas or tostones for that matter. Epidemiologists have begun identifying the intra-ethnic diversity among U.S. Latin@ dietary patterns (Mattei et al. 2016) and productive steps can be seen in the longitudinal Hispanic Community Health Study / Study of Latinos (HCHS/SOL) that began in 2008 (HCHS/SOL 2018). On the topic of dietary changes, it would be more productive to emphasize what patients can consume instead of limiting everything they have grown up consuming for over 30 years. In many ways, I interpret the way people have adapted their diets as forms of resistance to the strict, often unrealistic, dietary regiments imposed on them by health care providers.

Improving local health food geographies

It is not that people are ignorant, or that they eat badly because it is in our culture—us as Latin@s, and I include myself here. There are a lot of factors involved, from looking at the food geographies and the food options we have (availability of fast food vs. fresh produce) and other resources available to us in our local geographies (from healthcare facilities to formal and informal community centers), as well as all other factors such as our socioeconomic and citizenship status.

Many parents cited temptations on every corner to eat poorly, the hiked-up expenses of purchasing fresh produce (especially if attempting to buy organic), and the cheap and convenient price of fast foods. Such landscapes promote over-consumption of dietary poor foods and many residents hoped to see their communities with an abundance of more healthful food options instead of the poison constantly promoted to us, Latin@s and countless other marginalized communities, in every direction.

In hopes of improving their healthful food landscapes, residents wanted to see more community gardens in their localities. Many schools had their own community gardens. One in particular invited parents to get some of the products of their harvest for free, although not many came. One of the teachers of this school took it upon herself to make a salad with the products of their harvest for her kindergarten class. The students loved it and the whole scenario was deemed successful by the parents, teachers, and students alike. One caveat with community gardens is the various forms a community garden can take. In the NW, one community garden was filled with a plentiful harvest ripe for picking. One day I finally came across someone working in the garden, a—I assume—young white woman, and I asked her about the garden. She did not say much, busily pulling weeds from the raised bed she was working on. I asked who ran the garden and she said each person had their own plot that they rented each year and were able to plant and manage as they saw fit. This is a common model of community gardens I had seen in other states. This model of community gardening appeared to be one of the many by-products of the growing entrenchment of gentrification in the Humboldt Park community. From the people I had met, few were willing to pay a ‘rent’ to do the work of growing one’s own produce.

Another growing trend was that of farmers’ markets. The city of Chicago dedicates a portion of their webpage to advertise the many farmers’ markets found throughout the various neighborhoods of the city. In one of the focus groups in the NW, one of the mothers noted the disparity in the quality of goods provided within the farmers’ markets of the north, versus those she had seen in the SW. She had been to a school in the north where every week or so the farmers’ market came to the outskirts of the school, providing beautifully colored vegetables and fruits to the families and neighbors of the school. This mother wanted to see something similar offered at their school. She critiqued the one table ‘farmer’s’ market seen at the corner of the nearby park on Saturdays, whereby the options for fresh produce were on a ‘while supplies last’ basis.

Other parents noted the temptations on each corner, especially the fellow Latin@s pushing carts of churros [chips], paletas [ice cream bars], raspados [snow cones], elotes [corn], and other snacks. Fresh fruit and vegetables, if available, were not in the public eye, and certainly not what they craved on a hot summer day, with three different kinds of ice creams being offered everywhere one turned. Parents wanted to see more work being done to make healthy foods desirable, for their children and themselves. Especially in the SW, for every five different push-chart offerings per park, you were lucky to find one that sold elotes or fresh cut produce (often served with chamoy [a hot, sour fruit-based sauce], powdered chile and lemon).

Expanding resources to include areas of the city that have been underserved

An overall finding of this research has been the limitation of resources to certain parts of the city, leaving others out. In this comparison, the SW side has been one of the areas left to fend for themselves in terms of community or state resources. Of particular concern is the exceeding growth of the Latin@ community in this area and the potential to provide for these communities' needs, yet the lack of interest by researchers, programs, or funding to support these community areas.

Parents in the southwest side of the city often saw the limited resources and scarce opportunities provided to their local communities, such as the lack of guitar lessons or other extracurricular activities for their children, or the skimpy parks in the south in comparison to the northern, richer, whiter neighborhoods. Additionally, in the SW, certain communities are still dealing with gun violence to the extent that families cannot even go to their local parks or count on having an hour of peace during recess without gun shots threatening them blocks away—a devastating reality. Such threats are often not taken into account when health recommendations call for residents to 'take a walk' in order to get them to spend some time outside, stay active, and lose weight.

Health needs to be considered in terms of space, infrastructure, the economy, and social justice. In future work with Latin@s in Chicago, more scholars, programs, organizations and funding need to gain interest in these communities that have been left out. There are spaces to listen and learn from residents all around the city. It is imperative that for health inequities to be combated, residents' needs and concerns be met in order to make any progress on improving the health of those living with chronic conditions. The collaborative community–engaged research potential is immense throughout the city. It is just a matter of beginning these conversations with residents, listening to each area’s local narratives, and establishing true partnerships with residents as collaborators and not research objects.

APPENDIX:
Interview Guides

Individual Interview Guiding Questions

The following questions were used to guide each of the semi-structured individual interviews. Within these semi-structured interviews, the order of these questions changed depending on the topics brought up by the interviewee.

1. *Introduction:* After the project was explained to them, interviewees introduced themselves (if they wanted to) and talked a little about their experience with either diabetes, high blood pressure or high cholesterol, defining those illnesses and giving an overview of how they have been addressing them. Whether these accounts were based on experiences with their own personal health or with a relative's, was up to each person.

2. *How long have you lived in Chicago? Where have you lived in Chicago*?)
   ¿Por cuanto tiempo haz vivido en Chicago? ¿Por donde haz vivido en esta ciudad? ¿Por cuanto tiempo en cada lugar?

3. *Which are some of the resources* (places and people) *you draw on for your own and your family's well-being*? (Invitation to map them)
   ¿Cuales son los recursos/sitios que usted ha utilizado para manejar su salud/bien estar (por ejemplo, oficinas del doctor, farmacias?) Haz un mapa de los recursos que hayas usado para su salud/bienestar y la salud de su familia.

4. *How would you map what you see as resources you and others you know use in Chicago in meeting your needs for well-being?*
   Si hacemos un mapa de recursos que ustedes y otros han utilizado para la necesidades de su salud y bien estar, ¿cómo luciría?

5. *What are examples of long-term illnesses people are living with?* H*ow did they find out they have those illnesses?*
   ¿Me pudieran dar ejemplos de algunas enfermedades crónicas con que la gente vive? ¿Como supieron que tenía esta enfermedad?

6. *How do you navigate everyday life working toward yours and your family's well-being*?
   ¿Como usted(es) maneja su vida diaria trabajando para su bien estar y el de su familia?

7. *Do you see differences in how people are able to access resources? How might these differences affect well-being*?[1]
   ¿Usted ve diferencias en cómo o cuales son las gentes que tienen acceso a ciertos recursos? ¿Como estas diferencias afectan su bien estar?

8. *What do you see as the biggest challenges facing Latinx residents of Chicago living with the long-term illnesses we are discussing?*
   ¿Que son las cosas más difíciles que enfrenta la comunidad latina aquí en Chicago viviendo con las enfermedades crónicas de las que estamos hablando?

9. *What are some of the practices/sites/resources that lead to well-being in ways you think others could benefit from*?
   ¿Qué so algunas prácticas/sitios/recursos que guíen nuestro bien estar en formas que usted cree que a otros les beneficie saber?

10. *Have you experienced any changes made with the passing of the Affordable Care Act (ACA or Obamacare)? From your point of view, was the ACA a positive or a negative change?*
    ¿Usted ha visto cambios con la implementación del Affordable Care Act (ACA o Obamacare)? ¿De su punto de vista, el ACA ha sido algo positivo o negativo?

11. *What kind of health insurance do you have? For how long? What other health insurance companies have you had in the past? For how long?*
    ¿Qué tipo de seguro médico (cuál es la compañía de seguro médico) usted tiene? ¿Por cuánto tiempo? ¿Cuáles otras compañías de seguro médico usted a tenido en el pasado? ¿Por cuánto tiempo?

12. *What would you like to see happen in Chicago to help with well-being among Latinx residents?*
    ¿Qué le gustaría ver pasar en Chicago para ayudar con la salud y bien estar entre los Latino/as de Chicago?

---

[1] This question was difficult to grasp by most residents. After various attempts at re-wording/explaining this question, I stopped asking this question within the focus groups and individual interviews.

Focus Group Guiding Questions

The following questions were used to guide each of the focus group discussions. Within each of the focus groups, the first question asked to start the discussions was an introduction. The remaining questions (2-5) were asked within the focus groups, the order of these questions changed depending on the topics brought up by the focus group participants. When time permitted or the topics came up, questions 6-12 were asked within the focus groups as well.

1. *Introduction:* After the project was explained to them, each participant introduced themselves (if they wanted to) and talked a little about their experience with either diabetes, high blood pressure or high cholesterol, defining those illnesses and giving an overview of how they have been addressing them. Whether these accounts were based on experiences with their own personal health or with a relative's, was up to each person.

2. *How long have you lived in Chicago? Where have you lived in Chicago*?
   ¿Por cuánto tiempo has vivido en Chicago? ¿Por dónde has vivido en esta ciudad? ¿Por cuánto tiempo en cada lugar?

3. *Which are some of the resources* (places and people) *you draw on for your own and your family's well-being*? (Invitation to map them.)
   ¿Cuáles son los recursos/sitios que usted ha utilizado para manejar su salud/bien estar (por ejemplo, oficinas del doctor, farmacias, etc.)? ¿Haz un mapa de los recursos que hayas usado para su salud/bienestar y la salud de su familia.

4. *How do you navigate everyday life working toward yours and your family's well-being*?
   ¿Como usted(es) maneja su vida diaria trabajando para su bien estar y el de su familia?

5. *What would you like to see happen in Chicago to help with well-being among Latinx residents?*[2]
   ¿Qué le gustaría ver pasar en Chicago para ayudar con la salud y bien estar entre los Latino/as de Chicago?

Depending on time, the following questions were asked within the focus groups:

---

[2] This question was used as a way to wrap up the focus group discussions and try to end the conversations on a positive note, in hopes for future activism and action.

6. *How would you map what you see as resources you and others you know use in Chicago in meeting your needs for well-being?*
   Si hacemos un mapa de recursos que ustedes y otros han utilizado para las necesidades de su salud y bien estar, ¿cómo luciría?

7. *What are examples of long-term illnesses people are living with?* H*ow did they find out they have those illnesses?*
   ¿Me pudieran dar ejemplos de algunas enfermedades crónicas con que la gente vive? ¿Como supieron que tenía esta enfermedad?

8. *Do you see differences in how people are able to access resources? How might these differences affect well-being*?
   ¿Usted ve diferencias en cómo o cuales son las gentes que tienen acceso a ciertos recursos? ¿Como estas diferencias afectan su bien estar?

9. *What do you see as the biggest challenges facing Latinx residents of Chicago living with the long-term illnesses we are discussing?*
   ¿Que son las cosas más difíciles que enfrenta la comunidad latina aquí en Chicago viviendo con las enfermedades crónicas de las que estamos hablando?

10. *What are some of the practices/sites/resources that lead to well-being in ways you think others could benefit from*?
    ¿Qué so algunas prácticas/sitios/recursos que guíen nuestro bien estar en formas que usted cree que a otros les beneficie saber?

11. *Have you experienced any changes made with the passing of the Affordable Care Act (ACA or Obamacare)? From your point of view, was the ACA a positive or a negative change?*
    ¿Usted ha visto cambios con la implementación del Affordable Care Act (ACA o Obamacare)? ¿De su punto de vista, el ACA ha sido algo positivo o negativo?

12. *What kind of health insurance do you have? For how long? What other health insurance companies have you had in the past? For how long?*
    ¿Qué tipo de seguro médico (cuál es la compañía de seguro médico) usted tiene? ¿Por cuánto tiempo? ¿Cuáles otras compañías de seguro médico usted ha tenido en el pasado? ¿Por cuánto tiempo?

REFERENCES

Abraído-Lanza, Ana F. 2015. "Latino Health: A Snapshot of Key Issues." *Health Education and Behavior* 42 (5):565-568. doi: 10.1177/1090198115606906.

Acosta, Luis M., Dolores Acevedo-García, Matthew S. Perzanowski, Robert Mellins, Lindsay Rosenfeld, Dharma Cortés, Andrew Gelman, Joanne K. Fagan, Luis A. Bracero, Juan C. Correa, Ann Marie Reardon, and Ginger L. Chew. 2008. "The New York City Puerto Rican Asthma Project: Study Design, Methods, and Baseline Results." *Journal of Asthma* 45 (1):51-57. doi: 10.1080/02770900701815784.

Acosta-Córdova, José Miguel. 2017. The Latino Neighborhoods Report: Issues and Prospects for Chicago. Chicago, Illinois: Institute for Research on Race and Public Policy & Great Cities Institute.

Adams, Vincanne. 2012. "The Other Road to Serfdom: Recovery by the Markey and the Affect Economy in New Orleans." *Public Culture* 24 (1):185-216.

Adeigbe, Rebecca T, Shannon Baldwin, Kip Gallion, Sonya Grier, and Amelie G Ramirez. 2015. "Food and Beverage Marketing to Latinos: A Systematic Literature Review." *Health Education and Behavior* 42 (5):569-582. doi: 10.1177/1090198114557122.

Ahlqvist, Emma, Petter Storm, Annemari Käräjämäki, Mats Martinell, Mozhgan Dorkhan, Annelie Carlsson, Petter Vikman, Rashmi B. Prasad, Dina Mansour Aly, Peter Almgren, Ylva Wessman, Nael Shaat, Peter Spégel, Hindrik Mulder, Eero Lindholm, Olle Melander, Ola Hansson, Ulf Malmqvist, Åke Lernmark, Kaj Lahti, Tom Forsén, Tiinamaija Tuomi, Anders H. Rosengren, and Leif Groop.

2018. "Novel subgroups of adult-onset diabetes and their association with outcomes: a data-driven cluster analysis of six variables." *The Lancet Diabetes & Endocrinology*. doi: 10.1016/s2213-8587(18)30051-2.

Alivio Medical Center. 2018. "History." accessed December 12, 2017. http://www.aliviomedicalcenter.org/about/history.

American Cancer Society. 2012. “Cancer Facts & Figures for Hispanics/Latinos 2012-2014.” Atlanta: American Cancer Society. accessed November 18, 2018. http://www.cancer.org/statistics

Anglin, Mary K. 2006. "Whose Health? Whose Justice? Examining Quality of Care and Forms of Advocacy for Women Diagnosed with Breast Cancer." In *Gender, Race, Class & Health: Intersectional Approaches*, edited by Amy Schulz and Leith Mullings, 313-344. San Francisco, CA: Jossey-Bass.

Anglin, Mary K., and Jill Collins White. 1999. "Poverty, Health Care, and Problems of Prescription Medication: A Case Study." *Substance Use & Misuse* 34 (14):2073-2093. doi: 10.3109/10826089909039439.

Año Nuevo Kerr, Louise. 1976. "The Chicano experience in Chicago, 1920-1970." Ph.D., History, University of Illinois.

Anthias, Floya. 2012a. "Transnational Mobilities, Migration Research and Intersectionality." *Nordic Journal of Migration Research* 2 (2):102-110. doi: 10.2478/v10202-011-0032-y.

Anthias, Floya. 2012b. "Hierarchies of social location, class and intersectionality: Towards a translocational frame." *International Sociology* 28 (1):1-18. doi: 10.1177/0268580912463155.

Arredondo, Gabriela F. 2008. *Mexican Chicago: Race, Identity, and Nation, 1916-1939*. Chicago, Illinois: University of Illinois Press.

Associated Press. 2007. "Chicago Mayor Richard Daley Wins 6th Term; May Become City's Longest-Serving Mayor." *Fox News*, February 27. http://www.foxnews.com/story/2007/02/27/chicago-mayor-richard-daley-wins-6th-term-may-become-city-longest-serving-mayor.html.

Association House. 2018. "Our History." accessed December 12, 2017. https://www.associationhouse.org/home/about-us/our-history/.

Barnett, Jessica C, and Edward R Berchick. 2017. Health Insurance Coverage in the United States: 2016. In *Current Populations Reports*. Washington, D.C.: United States Census Bureau.

Barrios-Estrada, C., M. de Jesus Rostro-Alanis, B. D. Munoz-Gutierrez, H. M. N. Iqbal, S. Kannan, and R. Parra-Saldivar. 2018. "Emergent contaminants: Endocrine disruptors and their laccase-assisted degradation - A review." *Sci Total Environ* 612:1516-1531. doi: 10.1016/j.scitotenv.2017.09.013.

Basch, Linda, Nina Glick-Schiller, and Cristina Szanton Blanc. 1994. "Theoretical Premises." In *Nations Unbound: Transnational Projects, Postcolonial Predicaments and Deterritorialized Nation-States*, edited by Linda Basch, Nina Glick-Schiller and Cristina Szanton Blanc, 21-48. Langhome: Gordon and Breach.

Becker, Gay. 2004. "Deadly Inequality in the Health Care “Safety Net”: Uninsured Ethnic Minorities' Struggle to Live with Life-Threatening Illnesses." *Medical Anthropology Quarterly* 18 (2):258-275. doi: 10.1525/maq.2004.18.2.258.

Bennett, Megan. 2016. "Domestic violence shelter opens, provides South Side refuge." *Columbia Chronicle*, February 22.

Biasco, Paul. 2016. "Logan Square Hispanics Vanishing As Neighborhood Becomes More White." *DNA info*, May 16.

Biehl, João, and Adriana Petryna, eds. 2013. *When People Come First: Critical Studies in Global Health.* Princeton, New Jersey: Princeton University Press.

Biles, Roger. 2005. Machine Politics. In *Encyclopedia of Chicago*. Chicago, Illinois: Chicago Historical Society.

Borovoy, Amy, and Janet Hine. 2008. "Managing the Unmanageable: Elderly Russian Jewish Émigrés and the Biomedical Culture of Diabetes Care." *Medical Anthropology Quarterly* 22 (1):1-26. doi: 10.1111/j.1548-1387.2008.00001.x.

Bourdieu, Pierre. 1997. Pascalian Meditations. Stanford, CA: Stanford University Press.

Bourgois, Philippe. 2001. “The power of violence in war and peace: Post-Cold War lessons from El Salvador.” *Ethnography* 2(1):5-34.

Braveman, Paula. 2012. "Health Inequalities by Class and Race in the U.S.: What Can we Learn from the Patterns?" *Social Science and Medicine* 74:665-667.

Briggs, Laura, Gladys McCormick, and J.T. Way. 2008. "Transnationalism: A Category of Analysis." *American Quarterly* 60 (3):625-648.

Burnam, M. Audrey, Richard L Hough, Marvin Karno, Javier I Escobar, and Cynthia A Telles. 1987. "Acculturation and Lifetime Prevalence of Psychiatric Disorders Among Mexican Americans in Los Angeles." *Journal of Health and Social Behavior* 28 (1):89-102.

Casa Central. 2018. "Our Story." accessed December 12, 2017. http://www.casacentral.org/our-story/about-casa-central/.

(CDC), Centers for Disease Control and Prevention. 2017. National Diabetes Statistics Report, 2017: Estimates of Diabetes and Its Burden in the United States. edited by Division of Diabetes Translation National Center for Chronic Disease Prevention and Health Promotion.

(CDC), Centers for Disease Control and Prevention. 2018. Diabetes Atlas United States Diabetes Surveillance System, Division of Diabetes Translation website. Accessed March 21, 2018. https://gis.cdc.gov/grasp/diabetes/DiabetesAtlas.html.

(CDPH), Chicago Department of Public Health. Chicago Health Atlas. Smart Chicago Collaborative website. Accessed March 21, 2018. https://www.chicagohealthatlas.org/

Charles, Sam. 2018. "More minority cops in Chicago? Not many. Yet." *Chicago Sun-Times*, January 16. https://chicago.suntimes.com/news/minority-cops-chicago-police-department-watchdogs/.

Chavez, Leo R. 2008. *The Latino Threat: Constructing Immigrants, Citizens, and the Nation*. Stanford, CA: Stanford University Press.

Chicago City Clerk. 2018. "Office of the City Clerk Anna M. Valencia." City of Chicago, accessed March 1, 2018. http://chicityclerk.com/city-council-news-central/council-agenda#about.

Chicago Tribune. 2017. "Editorial: Good riddance to the Cook County soda tax." *Chicago Tribune*, November 29. Accessed February 20, 2018.

http://www.chicagotribune.com/news/opinion/editorials/ct-edit-soda-tax-cook-county-20171129-story.html

Cho, Sumi, Kimberlé Williams Crenshaw, and Leslie McCall. 2013. "Toward a Field of Intersectionality Studies: Theory, Applications, and Praxis." *Signs* 38 (4):785-810.

Cintron, Ralph, Maura Toro-Morn, Ivis Garcia Zambrana, and Elizabeth Scott. 2012. 60 Years of Migration: Puerto Ricans in Chicagoland. Chicago: The Puerto Rican Agenda.

City of Chicago. 2015. Aldermanic Wards for the City of Chicago Map.

City of Chicago. 2016. City of Chicago Community Areas Map.

City of Chicago. 2018. "Government." accessed March 1, 2018. https://www.cityofchicago.org/city/en/chicagogovt.html.

Coates, Ta-Nehisi. 2014. “The Case for Reparations” *The Atlantic*, June: 1-65.

Coca-Cola. 2018. Product Facts. Accessed January 20, 2018. https://www.coca-colaproductfacts.com/en/products/coca-cola/original/12-oz/

Coe, Cati. 2011. "What's the Impact of Transnationalism on Family Life?" *American Ethnologist* 38 (1):148-163. doi: 10.1111/j.1548-1425.2010.01298.x.

Coen, Jeff, and Bill Ruthhart. 2017. "Weighing third term, Emanuel relies on campaign dors who get City Hall benefits." *Chicago Tribune*, September 8. http://www.chicagotribune.com/news/local/politics/ct-rahm-emanuel-campaign-fundraising-met-0908-20170908-story.html.

Cook County. 2018. "Cook County Government." Accessed March 1, 2018. cookcountyil.gov

Coulehan, John L, Fredric W Platt, Barry Egener, Richard Frankel, Chen-Tan Lin, Beth Lown, and William H Salazar. 2001. ""Let me See if I Have This Right...": Words The Help Build Empathy." *Annals of Internal Medicine* 135 (3):221-227.

(CPD), Chicago Police Department. 2018. "History." accessed March 1, 2018. https://home.chicagopolice.org/inside-the-cpd/history/.

(CPL), Chicago Public Library. 2018. Harold Washington Archives & Collections.

Craven, Christa, and Dana-Ain Davis, eds. 2013. *Feminist Activist Ethnography: Counterpoints to Neoliberalism in North America.* Lanham, MA: Lexington Books.

Crenshaw, Kimberlé. 1989. "Demarginalizing the Intersection of Race and Sex: A Black Feminist Critique of Antidiscrimination Doctorine, Feminist Theory and Antiracist Politics." *University of Chicago Legal Forum* 140:139-167.

Cruz, Wilfredo. 2009. *Images of America: Chicago Latinos at Work*. Chicago, Illinois: Arcadia Publishing.

Deitrick, Lynn M., Hannah D. Paxton, Alicia Rivera, Eric J. Gertner, Nyann Biery, Abby S. Letcher, Lissette M. Lahoz, Edgardo Maldonado, and Debbie Salas-Lopez. 2010. "Understanding the Role of the Promotora in a Latino Diabetes Education Program." *Qualitative Health Research* 20 (3):386-399. doi: 10.1177/1049732309354281.

Delgado, Jane L, and F. M. Trevino, eds. 1985. The State of Hispanic Health in the United States. Oakland, CA: National Hispanic Center for Advanced Studies and Policy Analysis.

Dole. 2018. Products. Accessed January 20, 2018. https://dolesunshine.com/products/juice/canned-juice/canned-pineapple-juice

Donnan, Hastings, and Thomas M Wilson. 1999. *Borders: Frontiers of Identity, Nation and State*. Oxford, United Kingdom: Berg Publishers.

Dressler, William W. 1990. "Lifestyle, stress, and blood pressure in a Southern black community." *Psychosomatic Medicine* 52:182-198.

Dressler, William W. 1991a. "Social class, skin color, and arterial blood pressure in two societies." *Ethnicity & Disease* 1:60-77.

Dressler, William W. 1991b. "Social support, lifestyle incongruity, and arterial blood pressure in a Southern black community." *Psychosomatic Medicine* 53:608-620.

Duany, Jorge. 2011. *Blurred Borders: Transnational Migration Between the Hispanic Caribbean and the United States*. Chapel Hill, NC: The University of North Carolina Press.

Dubowitz, Tamara, Lisa M Bates, and Dolores Acevedo-Garcia. 2010. "The Latino Health Paradox: Looking at the Intersection of Sociology and Health." In *Handbook of Medical Sociology*, edited by Chloe E Bird, Peter Conrad, Allen M Fremont and Stefan Timmermans, 106-123. Nashville, TN: Vanderbilt University Press.

Dumit, Joseph. 2012. *Drugs for Life: How Pharmaceutical Companies Define Our Health*. Durham: Duke University Press.

Ennis, Sharon R, Merarys Rios-Vargas, and Nora G Albert. 2011. The Hispanic Population: 2010. In *2010 Census Briefs*: U.S. Census Bureau: U.S. Department of Commerce Economics and Statistics Administration.

Everett, Margaret, and Josef N. Wieland. 2012. "Diabetes Among Oaxaca's Transnational Population: An Emerging Syndemic." *Annals of Anthropological Practice* 36 (2):295-311. doi: 10.1111/napa.12005.

Farahani, Fataneh. 2013. "Racializing Masculinities Different Diasporic Spaces." In *Rethinking Transnational Men: Beyond, Between, and Within Nations,* edited by Hearn, Blagijevic and Harison, 147-162. New York: Routledge.

Farmer, Paul. 2004. "An Anthropology of Structural Violence." *Current Anthropology* 45 (3):305-325.

Farmer, Paul. 2005. *Pathologies of Power: Health, Human Rights and the New War on the Poor*. Berkeley: University of California Press.

Farmer, Paul. 2006. *AIDS and Accusation: Haiti and the Geography of Blame*. Berkeley, California: University of California Press. Original edition, 1993.

Fernandes, Leela. 2013. *Transnational Feminism in the United States: Knowledge, Ethics and Power*. New York: New York University Press.

Fernandez, Lilia. 2012. *Brown in the Windy City: Mexicans and Puerto Ricans in Postwar Chicago*. Chicago: University of Chicago Press.

Fikkan, Janna L, and Esther D Rothblum. 2012. "Is Fat a Feminist Issue? Exploring the Gendered Nature of Weight Bias." *Feminist Forum* 66:575-592. doi: 10.1007/s11199-011-0022-5.

Flores, Antonio. 2017. Facts on U.S. Latinos, 2015: Statistical portrait of Hispanics in the United States. Pew Research Center.

Foster, Shelagh. 2013. Cancer Health Disparities in the United States: Facts & Figures. American Society of Clinical Oncology.

Foucault, Michel. 1979. *Discipline and Punish: The Birth of the Prison*. New York: Vintage Books.

Freire, Paulo. 2000 (1970). *Pedagogy of the Oppressed*. New York, NY: Bloomsbury Press.

Galtung, Johan. 1969. "Violence, Peace, and Peace Research." *Journal of Peach Research* 6:167-191.

Glick Schiller, Nina, Tsypylma Darieva, and Sandra Gruner-Domic. 2011. "Defining cosmopolitan sociability in a transnational age. An introduction." *Ethnic and Racial Studies* 34 (3):399-418. doi: 10.1080/01419870.2011.533781.

Glick-Schiller, Nina, and Andrew Irving, eds. 2015. *Whose Cosmopolitanism? Critical Perspectives, Relationalities and Discontents*. New York: Berghahn Press.

Gomberg-Muñoz, Ruth. 2017. *Becoming Legal: Immigration Law and Mixed-Status Families*. New York, NY: Oxford University Press.

Governing the States and Localities. 2018. Police Department Race and Ethnicity Demographic Data. e.Republic.

Gravlee, Clarence C, Amy L Non, and Connie J Mulligan. 2009. "Genetic Ancestry, Social Classification, and Racial Inequalities in Blood Pressure in Southeastern Puerto Rico." *PLoS One* 4 (9):e6821. doi: 10.1371/journal.pone.0006821.t001.

Gravlee, Clarence C, and William W Dressler. 2005. "Skin pigmentation, self-perceived color, and arterial blood pressure in Puerto Rico." *American Journal of Human Biology* 17:195–206.

Gravlee, Clarence C. 2005. "Skin pigmentation, self-perceived color, and arterial blood pressure in Puerto Rico." *American Journal of Human Biology* (17):195-206.

Gravlee, Clarence C. 2009. “How race becomes biology: embodiment of social inequality.” *American Journal of Physical Anthropology* 139(1):47-57.

Green, Paul. 1988. SON/SOC: organizing in white ethnic neighborhoods. In *Illinois Periodicals Online*. Dekalb, Illinois: Illinois Issues.

Greenhalgh, Susan, and Megan Carney. 2014. "Bad Biocitizens?: Latinos and the US "Obesity Epidemic"." *Human Organization* 73 (3):267-276.

Grewal, Inderpal. 1999. "Traveling Barbie: Indian Transnationality and New Consumer Subjects." *Positions* 7 (3):799-826.

Gruner-Domic, Sandra. 2011. "Transnational lifestyles as a new form of cosmopolitan social identification? Latin American women in German urban spaces*."* *Ethnic and Racial Studies* 34 (3):471-489. doi: 10.1080/01419870.2011.533782.

(GSDC), Greater Southwest Development Corporation. 2018. "Neighborhood History." accessed December 12, 2017. http://greatersouthwest.org/who-we-are/neighborhood-history/.

Guell, Cornelia. 2011. "Candi(e)d Action: Biosocialities of Turkish Berliners Living with Diabetes." *Medical Anthropology Quarterly* 25 (3):377-394. doi: 10.1111/j.1548-1387.2011.01167.x.

Gunewardena, Nandini and Ann Kingsolver. 2008. "Introduction." In *The Gender of Globalization: Women Navigating Cultural and Economic Marginalities*, edited by Nandini Gunewardena and Ann Kingsolver, 3-22. Santa Fe: SAR Press.

Han, Clara. 2012. *Life in Debt: Times of Care and Violence in Neoliberal Chile*. Berkeley: University of California Press.

Harrison, Faye V. 2008. "Feminist Methodology as a Tool for Ethnographic Inquiry on Globalization." In *The Gender of Globalization: Women Navigating Cultural and Economic Marginalities*, edited by Nandini Gunewardena and Ann Kingsolver, 23-34. Santa Fe: SAR Press.

(HCHS/SOL), Hispanic Community Health Study / Study of Latinos. 2008. National Heart, Lung, and Blood Institute (NHLBI), accessed May 9, 2018. https://sites.cscc.unc.edu/hchs/.

Headley, Kathleen J, and Racy J Krol. 2015. *Legendary Locals of Chicago Lawn and West Lawn Illinois.* Charleston, South Carolina: Arcadia Publishing.

Hill Collins, Patricia. 1990. *Black Feminist Thought: Knowledge, Consciousness, and the Politics of Empowerment*. New York, NY: Routledge.

Hirsch, Arnold. 2005. Blockbusting. In *Encyclopedia of Chicago*. Chicago Illinois: Chicago Historical Society.

Holli, Melvin G. 2005. Mayors. In *Encyclopedia of Chicago*. Chicago Illinois: Chicago Historical Society.

Holmes, Seth M. 2013. *Fresh Fruit, Broken Bodies: Migrant Farmworkers in the United States*. Berkeley: University of California Press.

Horton, Sarah, Cesar Abadía, Jessica Mulligan, and Jennifer Jo Thompson. 2014. "Critical Anthropology of Global Health "takes a stand" statement: a critical medical anthropological approach to the U.S.'s Affordable Care Act." *Medical Anthropology Quarterly* 28 (1):1-22. doi: 10.1111/maq.12065.

Hyatt, Susan B. 2001. "From Citizen to Volunteer: Neoliberal Governance and the Erasure of Poverty." In *The Ethnography of Power, Politics, and Impoverished*

People in the United States, edited by Judith Goode and Jeff Maskovsky, 201-235. New York, NY: New York University Press.

Igoe, Jim. 2010. "The spectacle of nature in the global economy of appearances: Anthropological engagements with the spectacular mediations of transnational conservation." *Critique of Anthropology* 30 (4):375-397. doi: 10.1177/0308275x10372468.

Jovanovic, M. 2014. "Creating the 'dis-ease' of high cholesterol: a sociology of diagnosis reception analysis." *Social Science & Medicine* 101:120-8. doi: 10.1016/j.socscimed.2013.11.008.

Kingsolver, Ann. 2016. "When the smoke clears: Seeing beyond tobacco and other extractive industries in rural Appalachian Kentucky." In *The Anthropology of Postindustrialism: Ethnographies of Disconnection*, edited by Ismael Vicarro, Krista Harper and Seth Murray, 38-55. London, United Kingdom: Routledge.

Kitchen, Andrew, Amy L Non, Clarence C Gravlee, Connie J Mulligan, Christina Warinner, Ceil M Lewis Jr., Richard J Bankoff, Heritiana D. D. Randrianatoandro, George H Perry, Ripan S Malhi, Alyssa C Bader, and Jennifer Raff. 2015. "Vital Topics Forum: Anthropological Genetics." *American Anthropologist* 117 (4):736-749. doi: 10.1111/aman.12364.

(KFF), Kiaser Family Foundation. 2012. How Is the Affordable Care Act Leading to Changes in Medicaid Today? State Adoption of Five Options. In *Policy Brief: Kaiser Commission on Medicaid and the Uninsured*. Washington, D.C.: Henry J. Kaiser Family Foundation website. Accessed November 2, 2017. http://www.kff.org/medicaid/8312.cfm

Knox, Douglas. 2005a. Ward System. In *Encyclopedia of Chicago*. Chicago Illinois: Chicago Historical Society.

Knox, Douglas. 2005b. West Lawn. In *Encyclopedia of Chicago*. Chicago Illinois: Chicago Historical Society.

Krieger, Nancy. 2005. "Embodiment: a conceptual glossary for epidemiology." *Journal of Epidemiology & Community Health* 59:350-355.

Krogstad, Jens Manuel, Jeffrey S Passel, and D'Vera Cohn. 2017. 5 facts about illegal immigration in the U.S.: Pew Research Center.

Kromidas, Maria. 2011. "Elementary Forms of Cosmopolitanism: Blood, Birth, and Bodies in Immigrant New York City." *Harvard Educational Review* 81 (3):581-618.

Lamphere, Louise, Helena Ragoné, and Patricia Zavella, eds. 1997. *Situated Lives: Gender and Culture in Everyday Life*. New York, NY: Routledge.

Leatherman, Tom, and Alan H Goodman. 2015. "Critical Biocultural Approaches in Medical Anthropology." In *A Companion to Medical Anthropology*, edited by Merill Singer and Pamela Erickson, 29-48. West Sussex, United Kingdom: John Wiley & Sons Ltd. Original edition, 2011.

Ledogar, Robert J, Analia Penchaszadeh, C. Cecilia Iglesias Garden, and Luis Garden Acosta. 2000. "Asthma and Latino Cultures: Different Prevalence Reported Among Groups Sharing the Same Environment." *American Journal of Public Health* 90 (6):929-935.

Lim, Song Hwee. 2007. "Is the trans- in transnational the trans- in transgender?" *New Cinemas: Journal of Contemporary Film* 5 (1):39-52.

Lopez, Iris. 2013. "Negotiating Different Worlds: An Integral Ethnography of Reproductive Freedom and Social Justice." In *Feminist Activist Ethnography: Counterpoints to Neoliberalism in North America*, edited by Christa Craven and Dana-Ain Davis, 145-164. Lanham, MA: Lexington Books.

Marcia's Healthy Slice Blog. 2015. "Truths About Running For Weightloss." *Marcia's Healthy Slice*. http://www.marciashealthyslice.com/2015/03/truths-about-running-for-weightloss.html.

Mattei, Josiemer, Daniela Sotres-Alvarez, Martha L Daviglus, Linda C Gallo, Marc Gellman, Frank B. Hu, Katherine L. Tucker, Walter C. Willett, Anna Maria Siega-Riz, Linda Van Horn, and Robert C Kaplan. 2016. "Diet Quality and Its Association with Cardiometabolic Risk Factors Vary by Hispanic and Latino Ethnic Background in the Hispanic Community Health Study/Study of Latinos." *The Journal of Nutrition* 146 (10):2035-2044.

Mayo Clinic. 2018. Fibromyalgia. In *Diseases & Conditions* website. Accessed February 10, 2017. https://www.mayoclinic.org/diseases-conditions/fibromyalgia/symptoms-causes/syc-20354780

McCarthy, Anne Marie, Tamara Dumanovsky, Kala Visvanathan, Amy R. Kahn, and Maria J. Schymura. 2010. "Racial/ethnic and socioeconomic disparities in mortality among women diagnosed with cervical cancer in New York City, 1995–2006." *Cancer Causes & Control* 21 (10):1645-1655. doi: 10.1007/s10552-010-9593-7.

McMahon, Eileen M. 2005. Chicago Lawn. In *Encyclopedia of Chicago*. Chicago, Illinois: Chicago Historical Society.

Mendenhall, Emily, Rebecca A. Seligman, Alicia Fernandez, and Elizabeth A. Jacobs. 2010. "Speaking through Diabetes." *Medical Anthropology Quarterly* 24 (2):220-239. doi: 10.1111/j.1548-1387.2010.01098.x.

Metropolitan Family Services. 2018. "History." Accessed December 12, 2017. https://www.metrofamily.org/about-us/history/.

Mock, Brentin. 2015 “Remember Redlining? It’s Alive and Evolving.” *The Atlantic*, October 8: 1-6.

Montoya, Michael J. 2011. *Making the Mexican Diabetic: Race, Science and the Genetics of Inequality*. Berkeley, CA: University of California Press.

Moore, Justin Xavier, Ninad Chaudhary, and Tomi Akinyemiju. 2017. "Metabolic Syndrome Prevalence by Race/Ethnicity and Sex in the United States, National Health and Nutrition Examination Survey, 1988-2012." *Preventing Chronic Disease* 14 (E24):1-16. doi: https://doi.org/10.5888/pcd14.160287.

Mumm, Jesse. 2014. "When the White People Come: Gentrification and Race in Puerto Rican Chicago." Ph.D., Anthropology, Northwestern University.

(NAHH), National Alliance for Hispanic Health. 2000. *The State of Hispanic Girls.* Washington, D.C.: Estrella Press.

(NAHH), National Alliance for Hispanic Health. 2001. *A Primer for Cultural Proficiency: Towards Quality Health Services for Hispanics.* Washington, D.C.: Estrella Press.

Navarro, Vincent. 2010. "Consequences of the Privatized Funding of Medical Care and of the Privatized Electoral Process." *American Journal of Public Health* 100:399-401.

Nusbaum, Martha. 1997. "Kant and Stoic Cosmopolitanism." *Journal of Political Philosophy* 5 (1):1-25.

O'Donnell, Sara. 2018. "Grilled Chicken Torta Recipe." *www.averagebetty.com*.

Orr, David. 2018. Townships and Municipalities Cook County - 2016.

Pacyga, Dominica A, and Ellen Skerrett. 1986. *City of Neighborhoods: Histories and Tours*. Chicago, Illinois: Loyola University Press.

Padilla, Felix M. 1987. *Puerto Rican Chicago*. Notre Dame, Indiana: University of Notre Dame Press.

Pallares, Amalia, and Nilda Flores-Gonzalez, eds. 2010. *Marcha: Latino Chicago and the Immigrants Rights Movement.* Chicago: University of Illinois Press.

Patterson, Elizabeth A. 2005. Logan Square. In *Encyclopedia of Chicago*. Chicago, Illinois: Chicago Historical Society.

Pear, Robert. 2012. "Uncertainty Over States and Medicaid Expansion." *New York Times,* June 28. Accessed November 6, 2017. https://www.nytimes.com/2012/06/29/us/uncertainty-over-whether-states-will-choose-to-expand-medicaid.html.

Perez, Gina. 2004. *The Near Northwest Side Story: Migration, Displacement, and Puerto Rican Families*. Berkeley: University of California Press.

Petryna, Adriana. 2002. *Life Exposed: Biological Citizens After Chernobyl*. Princeton, New Jersey: Princeton University Press.

Prachand, Nikhil G. 2015. Community Health Status Assessment: Mini-Compendium. Chicago, IL: Chicago Department of Public Health.

Purkayastha, Bandana. 2012. "Patricia Hill Collins Symposium: Intersectionality in a Transnational World." *Gender and Society* 26 (1):55-66. doi: 10.1177/0891243211426725.

Rabinow, Paul. 1984. "Introduction." In *The Foucault Reader*, 3-29. New York: Pantheon Books.

Ramos-Zayas, Ana Y. 2003. *National Performances: The Politics of Class, Race and Space in Puerto Rican Chicago*. Chicago: The University of Chicago Press.

Ready, Timothy, and Allert Brown-Gort. 2005. The State of Latino Chicago: This is Home Now. Institute for Latino Studies, University of Notre Dame.

Rock, Melanie. 2003. "Death, Taxes, Public Opinion and the Midas Touch of Mary Tyler Moore: Accounting for Promises by Politicians to Help Avert and Control Diabetes." *Medical Anthropology Quarterly* 17 (2):200-232.

Rouse, Carolyn. 2010. "Patient and practitioner noncompliance: rationing, therapeutic uncertainty, and the missing conversation." *Anthropology & Medicine* 17 (2):187-200.

Saldaña-Portillo, Maria Josefina. 2007. "From the Borderlands to the Transnational? Critiquing Empire in the Twenty-First Century." In *A Companion to Latina/o Studies*, edited by Juan Flores and Renato Rosaldo, 502-512. Oxford, UK: Blackwell.

Sargent, Carolyn and Stephanie Larchanche. 2011. "Transnational Migration and Global Health: The Production and Management of Risk, Illness and Access to Care." *Annual Review of Anthropology* 40:345-361. doi: 10.1146/annurev-anthro-081309-145811

Schencker, Lisa. 2016. "Uninsured rate drops again in Illinois after Obamacare takes effect." *Chicago Tribune*, September 13. Accessed November 6, 2017. http://www.chicagotribune.com/business/ct-census-uninsured-obamacare-0914-biz-20160913-story.html

Scheper-Hughes, Nancy. 1992. *Death without Weeping: The Violence of Everyday Life in Brazil*. Berkeley: University of California Press.

Scheper-Hughes, Nancy. 1996. “Small Wars and Invisible Genocides.” *Social Science and Medicine* 43 (5):889-900.

Schoen, Cathy, Sara R Collins, Jennifer L Kriss, and Michelle M Doty. 2008. "How Many Are Underinsured? Trends Among U.S. Adults, 2003 and 2007." *Health Affairs* 27 (4):w298-w309. doi: 10.1377/hlthaff.27.4.w298.

Schoenberg, Nancy E., Elaine M. Drew, Eleanor Palo Stoller, and Cary S. Kart. 2005. "Situating Stress: Lessons from Lay Discourses on Diabetes." *Medical Anthropology Quarterly* 19 (2):171-193. doi: 10.1525/maq.2005.19.2.171.

Schulz, Amy, Shannon Zenk, Barbara Israel, Graciela Mentz, Carmen Stokes, and Sandro Galea. 2008. "Do Neighborhood Economic Characteristics, Racial Composition, and Residential Stability Predict Perceptions of Stress Associated with the Physical and Social Environment? Findings from a Multilevel Analysis in Detroit." *Journal of Urban Health* 85 (5):642-661.

Schwartz, Norah Anita, and David Pepper. 2009. "Childhood Asthma, Air Quality, and Social Suffering Among Mexican Americans in California's San Joaquin Valley: "Nobody Talks to Us Here"." *Medical Anthropology* 28 (4):336-367. doi: 10.1080/01459740903303944.

Seligman, Amanda. 2005. Community Areas. In *Encyclopedia of Chicago*. Chicago, Illinois: Chicago Historical Society.

Sheinfeld Gorin, Sherri, and Julia E. Heck. 2005. "Cancer screening among Latino subgroups in the United States." *Preventive Medicine* 40 (5):515-526. doi: https://doi.org/10.1016/j.ypmed.2004.09.031.

SINAI Health System. 2006. The Community Survey in Humboldt Park: Preventing Obesity and Improving Our Health.

Squirt. 2009. Products. Accessed January 20, 2018. http://www.squirtsoda.com/

Stockwell, Clinton E. 2005. Brighton Park. In *Encyclopedia of Chicago*. Chicago, Illinois: Chicago Historical Society.

(SUHI), SINAI Urban Health Institute. 2005. Improving Community Health Survey.

Swedlund, Alan. 1997. "Diabetes As a Disease of Civilization: The Impact of Culture Change on Indigenous Peoples by Joe and Young, eds." *Medical Anthropology Quarterly* 11 (1):118-120.

Swider, Susan M. 2002. "Outcome Effectiveness of Community Health Workers: An Integrative Literature Review." *Public Health Nursing* 19 (1):11-20.

(SWOP), Southwest Organizing Project. 2018. "History." accessed December 12, 2017. http://swopchicago.org/about/history/.

Thomas-Houston, Marilyn M. 2005. *"Stony the Road" to Change: Black Mississippians and the Culture of Social Relations*. Cambridge, United Kingdom: Cambridge University Press.

U.S. Department of Health and Human Services. 1999. Mental Health: A Report of the Surgeon General. Rockville, MD: National Institute of Mental Health.

United States Census Bureau. 2010. American FactFinder website. Accessed December 12, 2017. http://factfinder2.census.gov

United States Census Bureau. 2012. 2012 American Community Survey 1-Year Estimate. American Community Survey Office.

United States Census Bureau. 2015. 2011-2015 American Community Survey 5-Year Estimates. American Community Survey Office.

United States Census Bureau. 2016. 2016 American Community Survey 1-Year Estimate. American Community Survey Office.

Vasquez del Aguila, Ernesto. 2014. "Imagined Romances: Searching for Love Transnationally." In *Being a Man in a Transnational World: The Masculinity and Sexuality of Migration*, 169-188. New York: Routledge.

Vertovec, Steven. 2004. "Migrant Transnationalism and Modes of Transformation." *International Migration Review* 38 (3):970-1001.

Vivanco, Leonor. 2016. "Marchers take to the 606 trail to protest gentrification." *Chicago Tribune*, May 17.

Weaver, Lesley Jo. 2015. "Reconstructing Obesity: The Meaning of Measures and the Measure of Meanings Book Review." *Medical Anthropology Quarterly* 29 (1):245-247. doi: DOI: 10.1111/maq.12133.

Wells, Jonathan C. K. 2012. "Obesity as malnutrition: the role of capitalism in the obesity global epidemic." *American Journal of Human Biology* 24 (3):261-76. doi: 10.1002/ajhb.22253.

Whitman, Steve, Abigail Silva, and Ami M. Shah. 2006. "Disproportionate Impact of Diabetes in a Puerto Rican Community of Chicago." *Journal of Community Health* 31 (6):521-531. doi: 10.1007/s10900-006-9023-7.

Wiedman, Dennis. 2012. "Native American embodiment of the chronicities of modernity: reservation food, diabetes, and the metabolic syndrome among the Kiowa, Comanche, and Apache." *Medical Anthropology Quarterly* 26 (4):595-612. doi: 10.1111/maq.12009.

Yonek, Juliet, and Romana Hasnain-Wynia. 2011. A Profile of Health and Health Resources within Chicago's 77 Community Areas. Evanston, Illinois: Northwestern University Feinberg School of Medicine, Center for Healthcare Equity/Institute of Healthcare Studies.

Zambrana, Ruth E, and Bonnie Thorton Dill. 2006. "Disparities in Latina Health: An Intersectional Analysis." In *Gender, Race, Class & Health: Intersectional Approaches*, edited by Amy J Schulz and Leith Mullings, 192-227. San Francisco, CA: Jossey-Bass.

Zambrana, Ruth, Nancy Breen, Sarah Fox, and Gutierrez-Mohamed. 1999. "Use of Cancer Screening Practices by Hispanic Women: Analyses by Subgroup." *Preventive Medicine* 29:466-477.

Zangs, Mary. 2014. *The Chicago 77: A Community Area Handbook.* Charleston, SC: The History Press.

VITA

Lilian Luisa Milanés

Educational institutions:

University of Central Florida, Bachelor of Science (2012)

Professional positions:

- University of Kentucky, Department of Anthropology: Teaching Assistant (August 2014-December 2014)
- University of Kentucky, Department of Anthropology: Primary Instructor (January 2018-May 2018)

Scholastic and professional honors:

- National Science Foundation Fellow Graduate Research Fellowship Program (GRFP) (2012-2014 & 2015-2016)
- University of Kentucky Graduate Student Incentive Program (2012, 2013 & 2015)
- University of Kentucky Graduate Student Travel Grant (2014, 2016 & 2017)
- University of Kentucky Latin American, Caribbean, Latino Studies Program Summer Research Grant (Summer 2015)
- University of Kentucky Lyman T. Johnson Fellowship (2015 & 2017)
- Association of Latina and Latino Anthropologists 2017 Graduate Student Paper Award, Honorable Mention

Professional publications:

Milanés, Lilian. 2018. “Navigating Healthcare Dilemmas in Chicago.” *Anthropology News* website (http://www.anthropology-news.org/index.php/2018/05/09/navigating-healthcare-dilemmas-in-chicago/), May 9, 2018. DOI: 10.1111/AN.853

Milanés, Lilian and Joanna Mishtal. 2018. "Too Little, Too Late? The Challenges of Providing Sexual and Reproductive Healthcare to Men on College Campuses." *Anthropology in Action*, Volume 25: Issue 2.

Conference Papers Presented

- 2018 "Azúcar, Presión y Colesterol: 'Yo no tengo problema ninguna'/Sugar, (Blood) Pressure and Cholesterol: 'I don't have any problem'" *Panel Chair and Presenter* (Society for Applied Anthropology 78th Annual Meeting, Philadelphia PA)
- 2017 "Shifting Health Policy Landscapes: ACA or no ACA and what it means for Chicago Latinx" *Panel Chair and Presenter* (American Anthropological Association 116th Annual Meeting, Washington, D.C.)
- 2016 "Contesting and Reconfiguring Health Inequities through Community Centers" *Panel Co-Organizer and Presenter* (American Anthropological Association 115th Annual Meeting, Minneapolis, MN)
- 2016 "Community Based Programming and Narratives of Resistance: strategies for managing type two diabetes in a Latino community" *Panel Chair and Presenter* (6th Annual Dimensions of Political Ecology Conference, Lexington, KY)
- 2015 "U.S. Latina/o Community Engagement and Health" *Presenter* (5th Annual Dimensions of Political Ecology Conference, Lexington, KY)

- 2014 “Too Little, Too Late: The Challenges in Expanding Sexual and Reproductive Healthcare to Men” *Panel Chair and Presenter (*Society for Applied Anthropology 74th Annual Meeting, Albuquerque, NM)