Quality Health Services for Hispanics:

The Cultural Competency Component

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Providing patients with quality health care, helping people to change risky behavior patterns, and understanding the benefits of healthy living are all hallmarks of the kind of good practices health care professionals in the United States strive to achieve. Unfortunately, practitioners in this country also face many unique obstacles to the level of care they would like to deliver. Some of these obstacles involve cultural misunderstandings and miscommunications with patient populations whose languages, experiences, and backgrounds differ from those of their providers.

This primer is a distillation of information health care providers may need to assure delivery of the best possible care to Hispanic clients in a variety of clinical, prevention, and social service settings.

This primer is designed to help health care professionals better understand, and more effectively respond to the growing needs of over 30 million Hispanics in the United States. It should facilitate greater access to, and utilization of, health and human services for this patient population, as well as provide useful suggestions on improving one-to-one provider-patient interactions. The primer is a distillation of information health care providers may need to assure delivery of the best possible care to Hispanic clients in a variety of clinical, prevention, and social service settings.

Perhaps nowhere are cultural differences more sharply drawn than in our approaches and definitions of health and healthy living. Culture is what we live every day and what we bring with us to our workplace, which is why Dr. Arthur Keinman, Harvard psychiatrist and anthropologist, believes every encounter between a health care provider and a patient is a cross-cultural experience.[1] By deepening our understanding of culture we can begin to strengthen the promise of high-quality primary health care that is accessible, effective, and cost efficient for all of our patient populations.

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Unlike certain animals, human beings are not hardwired with a complex set of behavior patterns and instincts that allow us to function successfully from birth, and so we have to learn how to survive our varied environments and pass these acquired lessons down through the generations by means of language, both verbal and symbolic. In the sociological sense this learned language is the culture, the way of life, of human society.

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Material culture includes the artifacts we create from stone tools to Mayan pyramids, from cave paintings to telecommunications satellites and the internet. Non-material culture is the common behaviors, thoughts, actions, customs, and beliefs that bind a racial, ethnic, religious or social group within society. In Mexican culture, for example, the celebration of the Feast of the Virgin of Guadalupe is rooted not only in Catholic religious tradition but in Pre-Columbian customs that transcend geographic borders in the American Southwest.

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Beyond unique examples like this one, anthropologist George Murdock has listed a number of cultural universals. These include: athletic sports, bodily adornment, cooking, cooperative labor, courtship, dancing, dream interpretation, family feasting, folklore, food taboos, funeral ceremonies,

I. The Basics
Chapter One: Culture – What it is, How it Works

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games, gift-giving, incest taboos, laws, music, myths, sexual restrictions, toilet-training, tool-making, religion, and of course medicine.[2] Every society recognizes its healers or health care providers as central to the functioning of human civilization, but few previous societies have been as culturally diverse as ours, offering both a challenge and opportunity to those who would, as their chosen vocation, cure and comfort the afflicted.

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One challenge to understanding culture is the simple recognition that, as certain as the existence of cultural universals, is the opposing tendency of every human society to develop ethnocentrism – to judge other cultures by the standards of one's own, and beyond that to see one's own standards as the true universal and the other culture in a negative way. The tendency towards ethnocentrism also may lead us to deny the reality that most cultures are in truth highly adaptive and likely to borrow from one another. This is certainly notable within the western hemisphere, where one can see the extent to which mainstream U.S. and Hispanic cultures have long benefited and been enriched by an ongoing exchange and intermingling of cultural standards, icons, symbols, and habits both within and outside of the United States' border.

While some aspects of culture remain steadfast, other parts evolve.

Another challenge to understanding culture is its permeability to critical events. While some aspects of culture remain steadfast, other parts evolve. They are influenced by social events such as technology, war, economic fluctuation, birth control, HIV/AIDS, etc. These events may or may not change values, practices, and beliefs. These influences complicate knowing which aspects of a culture are consistent and which are fluid. It is also the reason why many Hispanic subgroups differ in culture even though they all speak Spanish. Each country and often each region will experience various critical events. This is also the reason why each individual within a cultural

group may not be a sole reflection of cultural norms. Each person's experiences and susceptibility to social norming drives what aspects of culture change and what stays the same. This complicates the application of cultural competence.

"Mainstream" U.S. culture itself is going through a continuous renewal generated by Hispanic and other cultures that contribute to the mosaic of daily life in the United States. A typical American diet today consist of an array of foods from hamburgers to tacos, sushi to pupusas, middle eastern kabobs to paella, and curry to black beans and rice.

Of course if we were a more homogeneous society, medicine and social service work might be easier in that we could use a single all-inclusive model for health care delivery. Then again, in a simpler society our work wouldn't be as exciting or as challenging.

As a society based on laws and principles rather than religion, "blood," race, or ethnicity, the United States is rich in diversity and has one of the most fluid, complex, and democratic cultures in the world. It is, quite simply, a culture and society that recreates itself with each new wave of migration and immigration, technological change, and social progress. On the other hand, it is also a political culture that periodically generates fear of the "other," of the so-called stranger among us. Historically we've seen bias and backlash emerge with each new wave of ethnic immigration that has been added to the weave of our cultural tapestry. Today, 9% of the U.S. population was born in another country.[3]

Of course each new wave of immigration brings with it its own unique culture, questions, and problems. With the latest Hispanic immigrants comes the question of self-definition and

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issues of class structure, especially in light of a larger, more stable Hispanic population already living in the United States.

The term "Hispanic" did not come into wide usage until the 1970s and '80s. In the 50's and 60's, Hispanics tended to organize around their own national identities as Mexicans, Mexican Americans, Puerto Ricans, Cuban Americans, Central Americans, and South Americans. By the early 1970's, new organizations formed that brought together the numerous Hispanic subgroups to coalesce into a more unified voice around numerous social, civil, and political causes. Today, the term Hispanic has emerged as a cloaking term that refers to all Spanish speaking ethnic subgroups. Hispanics in the United States can be of any racial background — white, black, Asian, American Indian, etc.

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"We wanted all Spanish-speaking people involved. That was it. We weren't going to be isolated anymore," recalls one group's founder.[4] Today, most national Hispanic organizations, even those formed representing the interests of one Hispanic subgroup,work to strengthen the role of all Hispanics.

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To understand Hispanic culture, one first has to come to a more basic understanding of what constitutes a culture. What are the often ephemeral constructs of language, values, experiences and conditions that make for unique "peoples" and cultures, and how can an understanding of these assist health care providers to better meet the needs of Hispanic patients or clients, as well as, those of other emerging ethnic groups?

As health care providers we should appreciate the key role culture plays in our ability to influence behavior in a patient population or other group we seek to influence. We cannot afford to let cultural barriers limit our ability to meet the needs of our patients, or reduce their opportunity to benefit from the services we can provide.

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'So what exactly is "cultural competence?"' you might ask.

Cultural competence is, the set of behaviors, attitudes and policies that come together in an institution, agency, or among a group of individuals, that allows them to work effectively in cross-cultural situations.*

Key Concept

The need for cultural competence in health care at the individual patient-provider level can be justified by a number of specific factors that include:

- the perception of illness and disease and their causes varies by culture;
- the diverse belief systems that exist related to health, healing, and wellness;
- cultural influences that help seeking behaviors and attitudes toward health care providers;
- individual preferences and culture that affect traditional and non-traditional approaches to health care;
- patients having personal experiences of biases within health care systems;
- environmental conditions influencing cultural practices, beliefs, and perceptions; and,
- health care providers from culturally and linguistically diverse groups being under-represented in the current service delivery system.[5]

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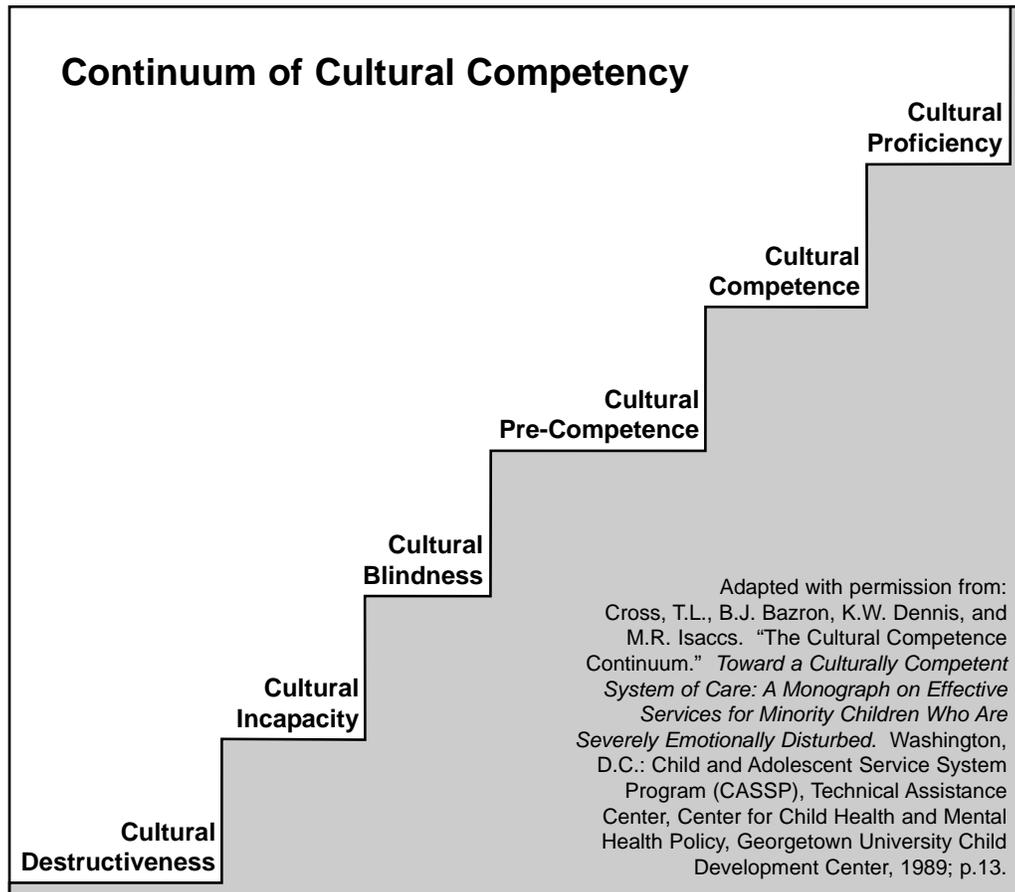* See endnote 6 for citation of source.

I. The Basics
Chapter Two: The Continuum of Working Across Cultures

... "culture," ... implies patterns of human behavior...that can bind a racial, ethnic, religious or social group within a society.

Key Concept

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The word "culture," as stated earlier, implies patterns of human behavior including thoughts, actions, customs, values, and beliefs that can bind a racial, ethnic, religious or social group within a society. Cultural behaviors are initiated at the moment of birth, learned in early infancy, and reinforced throughout a lifetime. This early learning and reinforcement become ingrained primary schemas/beliefs. They form our world view and perceptions about how the world should function.

Continuum of Cultural Competency

Cultural Proficiency

Cultural Competence

Cultural Pre-Competence

Cultural Blindness

Cultural Incapacity

Cultural Destructiveness

Adapted with permission from: Cross, T.L., B.J. Bazron, K.W. Dennis, and M.R. Isaccs. "The Cultural Competence Continuum." *Toward a Culturally Competent System of Care: A Monograph on Effective Services for Minority Children Who Are Severely Emotionally Disturbed.* Washington, D.C.: Child and Adolescent Service System Program (CASSP), Technical Assistance Center, Center for Child Health and Mental Health Policy, Georgetown University Child Development Center, 1989; p.13.

Often, it is difficult to alter the hold these beliefs have on attitudes, values, and behaviors. For instance, a Christian who believes in the concept of God may find it difficult to pray to Buddha, even when living in Japan and everyone else may be doing it. Unfortunately, while "culture" changes and is adaptive, it is challenging for individuals to recognize and change their own cultural practices.

The word "competence" implies having the capacity to function effectively. Cultural competence reinforces the need for understanding the core of one's beliefs. The client/patient may not be able to follow a recommended practice of care if it is contrary to their core cultural or individual beliefs. Since the provider is responsible for the quality of care, comprehending the patient's cultural beliefs and crafting them into the treatment or prevention plan becomes critical.

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However, having superficial knowledge of another's culture is often not enough. This knowledge must be integrated into the providers world view and must penetrate his/her ethnocentrism and professional training. The depth of the penetration into the provider's world view and the ability to see the world through another's world view is a precursory factor which influences one's ability to be culturally competent.

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A culturally competent system of care acknowledges and incorporates the importance of culture, the assessment of cross-cultural relations, vigilance towards dynamics that can result from cultural differences and ethnocentric approaches, the expansion of cultural knowledge, and the adaptation of services that meet culturally-unique needs.[6]*

Key Concept

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* The following 6 pages are derived from *Towards a Culturally Competent System of Care* (see endnote 6)."

I. The Basics
Chapter Two: The Continuum of Working Across Cultures

There is within our various institutions, including the health care system, **a continuum of cultural competency** that ranges from cultural destructiveness to cultural proficiency. This six-part continuum, as defined by researchers at Georgetown University's Child Development Center, is a progression from cultural destructiveness, to cultural incapacity, to blindness, to pre-competence, to competence, and finally, to cultural proficiency. Understanding this continuum may help the individual provider assess and improve their own workplace or institutional setting.

... cultural destructiveness,... attitudes, policies and practices that are destructive to cultures and the individuals within these cultures.

The most negative end of the continuum, **cultural destructiveness**, is represented by attitudes, policies and practices that are destructive to cultures and the individuals within these cultures. A system which adheres to a destructive extreme assumes that one race or culture is superior and should eradicate "lesser" cultures because of their perceived subhuman condition. Bigotry coupled with vast power allows the dominant group to disenfranchise, control, exploit, or systematically destroy the less powerful population.

The most extreme examples of cultural destructiveness involve programs, agencies, and institutions that actively participate in purposeful attacks on another culture, and dehumanize their clients from different racial and ethnic groups.

Historically, some health and social service agencies have been involved in services that have denied patients access to care. Among the most infamous example is the Tuskegee experiments in which poor black men with syphilis were observed but not treated for a number of years by white medical personnel interested in studying the progression of the disease. The consequences of this experiment left a legacy of distrust of government research programs among African Americans.

The term cultural destructiveness can also be applied to instances in which a peoples' trust has been betrayed by neglecting to fully inform them of medical risks and benefits, an approach that can also have grave legal consequences. One such example occurred in a 1989–1991 study conducted by the Centers for Disease Control and Prevention, Kaiser Permanente, and the Los Angeles County Department of Health Services during a measles outbreak. In this instance, Kaiser-members, mainly Hispanic and Non-Hispanic Black parents, were asked if they would allow their infants to take part in a study designed to compare the effectiveness of different measles vaccines. The parents, however, were never informed that one of the vaccines used was an experimental vaccine and not licensed for sale in the United States. Therefore, these parents made the decision to be included in the study without being fully aware of the risks involved.

Cultural Incapacity occurs when agencies do not intentionally seek to be culturally destructive but rather have no capacity to help clients from other cultures. The system remains extremely biased, believes in the superiority of the dominant group, and assumes a paternal posture towards "lesser" groups. A private hospital in which it may not have been unusual for a sick or injured Hispanic person to be turned away from an emergency room and directed to the nearest public hospital is an example of cultural incapacity.

Cultural Incapacity occurs when agencies do not intentionally seek to be culturally destructive but rather have no capacity to help clients from other cultures.

These agencies may apply resources disproportionately, discriminate against individuals, and believe in the supremacy of the dominant culture. Such agencies may act in a negative manner by enforcing policies which deny services to people and maintain stereotypes. Such agencies are often characterized by ignorance and an unrealistic fear of people who are different.

One example of cultural incapacity was described in a study published in the Journal of the American Medical Association.[7] This study found that Hispanics who were treated for certain bone fractures at the UCLA Emergency Medicine Center were twice as likely as non-Hispanic whites to receive no pain medication. The precise reason for this was not specified, but the investigators identified failure on the part of hospital staff to recognize pain in Hispanic patients as a possible reason for the discrepancy.

Cultural Blindness, the predominant system in place today, involves agencies and organizations providing services with the express philosophy of being unbiased. They function with the belief that color or culture makes no difference and that all people are the same. Culturally-blind agencies are characterized by the belief that all helping approaches traditionally used are universally applicable. If the system works as it should, all people — regardless of race or culture — will be served with equal effectiveness. This view reflects a well-intentioned philosophy. The consequences of such a belief, however, can often camouflage the reality of ethnocentrism, making services so ethnocentric as to render them useless to all but the most assimilated people from other cultures.

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A simple example of cultural blindness was the light tan bandage that for years was sold as "flesh colored." It was, but only if you were a fair-skinned white person.

Culturally-blind agencies suffer from a deficit of information and often lack the avenues through which they can obtain needed information. While these agencies often view themselves as unbiased and responsive to the needs of minority people, their ability to effectively serve these patient populations may in fact be severely limited.

As agencies move toward the positive end of the scale they reach a position called **Cultural Pre-Competence**. This term implies movement towards reaching out to other cultures. The pre-competent agency realizes its weaknesses in serving some communities and attempts to improve some aspect of its services to a specific population.

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Such agencies experiment with hiring staff who reflect a different culture, exploring how to reach underserved populations in their service areas, initiate training for their workers on cultural sensitivity, enter into needs assessments concerning minority communities, and recruit minority individuals for their boards of directors or advisory committees. Efforts at minority hiring and recruitment at the nation's medical schools in the 1970s are an example of this initial stage of cultural understanding. Pre-competent agencies are characterized by the desire to deliver high-quality, cost-effective services, and have a commitment to civil rights. They respond to the needs of racial/ethnic communities for improved services by asking, "What can we do?"

Pre-competent agencies are characterized by the desire to deliver high-quality, cost-effective services, and have a commitment to civil rights.

One danger at this level, however, is a false sense of either accomplishment or of failure that prevents the agency from moving forward along the continuum. An agency may believe that the accomplishment of one goal or activity fulfills its obligation, or conversely, it may undertake an activity that fails and become demoralized and reluctant to make another attempt at improving its health care delivery to the targeted community.

Culturally Competent agencies are characterized by acceptance of and respect for difference, continuing self-assessment regarding culture, careful attention to the dynamics of differences, continuous expansion of cultural knowledge and resources, and adaptations of service models in order to better

Culturally competent agencies are characterized by acceptance of and respect for difference...

meet the needs of different racial and/or ethnic groups. Such agencies recognize and value groups as distinctly different from one another and as having numerous subgroups, each with important cultural characteristics.

Culturally competent agencies work to hire unbiased employees and seek advice and consultation from their clients. These agencies seek staff who represent the racial and ethnic communities being served and whose self-analysis of their role has left them committed to their community and capable of negotiating a diverse and multicultural world. These agencies also provide support for staff to become comfortable working in cross-cultural situations. Further, culturally competent agencies understand the interplay between policy and practice, and are committed to policies that enhance services to a diverse clientele.

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The most positive end of the scale is **Cultural Proficiency**. This culmination point on the continuum is characterized by holding culture in high esteem. Culturally proficient agencies seek to add to the knowledge base of culturally-competent practices by conducting original research, developing new therapeutic approaches based on culture, and publishing and disseminating the results of their research and demonstration projects.

Culturally proficient agencies hire staff who are specialists in culturally competent practice. Such agencies are expansive, advocating for cultural competence throughout the health care system and for improved relations between cultures.

Chapter Three: On Language
¡Si puedes leer esto, ya vas por buen camino!
("If you can read this you're headed in the right direction!")

According to an article in the Journal of the American Medical Association (JAMA), "The physician-patient relationship is built through communication and the effective use of language. Along with clinical reasoning, observations, and nonverbal cues, skillful use of language endows the [physician-patient] history with its clinical power and establishes the medical interview as the clinician's most powerful tool."[8]

"The physician-patient relationship is built through communication and the effective use of language."

Growing numbers of Americans are proficient in two or more languages or at least have chosen to study a language other than English. In addition, there are some 32 million Americans who speak a language other than English at home. Spanish is the main "other language" spoken in the United States. A majority of Hispanics in the United States are bilingual and likely to retain their Spanish language skills as their communities are replenished with new Spanish speaking immigrants. Although only 24% of Hispanics were born outside the United States and the Commonwealth of Puerto Rico, 77% report Spanish as their primary language and the language they speak at home.

Interfacing with Hispanics, appreciation of the Spanish language, and the different accents, idioms, and meanings within different Spanish-speaking sub-groups, are crucial to becoming culturally competent.

Language is a communication tool by which cultural meaning is transferred and its complexity understood. When understanding language from this perspective, it is important to differentiate its layers. In it's simplest form, each word has a meaning. The combination of words within a particular context takes on a specific cultural meaning.

I. The Basics
Chapter Three: On Language

The initial stage of language develop-ment....may not be effective in communi-cating health beliefs, core values, or a description of symp-toms.

The initial stage of language development is direct translation of words with their literal meaning. However, this level of language may not be effective in communicating health beliefs, core values, or a description of symptoms. As a result, language differences and the width of the gap pose a challenge to both the patient and provider in health care communication. This is not to say that some form of quality care cannot be achieved even with the most extreme language differences.

Quality care has various components. Two important components that may be influenced by language are medical care and psychosocial care. In medical care, many health problems today are diagnosed with specialized tests such as blood analysis, Magnetic Resonance Imaging (MRI), CAT Scans, etc. Standardized treatments typically are associated with the diagnosis. Thus, language differences beyond the description of symptoms are less likely to present problems from the purely medical model. However, quality health care should involve psychosocial care as well. Beliefs, values, and behaviors are influential in determining the patient's assessment of satisfaction with care and compliance to treatment.

Beliefs, values, and behaviors are influ-ential in determining the patient's assess-ment of satisfaction with care and com-pliance to treatment.

To fully understand the complexities of language and culture one has to examine the layer of language development. Primary language development, the first learned language, provides relational meaning to words and phrases that reflect culture. Secondary language development, or learning a second language may not provide the speaker with the idiomatic expressions or cultural meanings specific to location and ethnicity. One can learn to speak a language without learning how to use the language to reflect culture.

One can learn to speak a language without learning how to use the language to reflect culture.

Cultural competence is not necessarily indicated by one's ability to speak the language. A provider or a patient may be able to literally speak the same language but the effectiveness of that communication is influenced by the cultural exposure that fosters command of the meaning of the words and phrases. A patient/provider that do not share any language knowledge will have more challenges to quality care than those who have learned the other's language (secondary language development). However, that relationship will be more facile in a patient/provider who share the same primary language development.

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Language differences can also interfere with aspects of the medical model. Subjective diagnosis or assessing which modality to test for a medical diagnosis is influenced by the patient's description of the symptoms.   What the patient says and how they say it, facilitates the appropriate diagnosis. Without the element of communication, quality care can be obtained, but it is challenged. The patient can become frustrated, does not return or is unable to comply with treatment. The physician/provider can misdiagnose and incorrectly treat the patient as well as expend additional costs to appropriately determine the problem.

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There is a growing number of health care professionals who care for America's multi-ethnic, multi-racial, and increasingly multilingual society. According to the Census Bureau, at least 14% of the nation's population now speaks a language other than English in their home. In major cities including New York, Los Angeles, Miami, Honolulu, Newark, and El Paso, Texas, the figure is over 40%. Some 7 million persons in the United States do not speak English well, or at all. Spanish, as stated earlier, is the second most common language in the United States, and the language of over half of the nation's non-English speakers.[9]

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In addition, direct translations of English into other languages without a cultural awareness of the meaning, idioms, slang usage, and various contexts in which those languages are used, can lead to confusion and miscommunication. A humorous example involved an insecticide ad that ran in the 1980s. Recognizing the value of the growing Hispanic market, the company promoted its product in Spanish-language ads as guaranteed to kill "bichos." What they didn't realize is that while bichos means bugs or insects in Mexico, in Puerto Rico it's understood to refer to the penis. Needless to say, they didn't have a lot of sales in San Juan. Similarly GM's Spanish language ads for the Chevy Nova were received with great hilarity by their target audience. The company hadn't considered that in Spanish "No va" means "It doesn't go."

...having a language-concordant physician resulted in better outcomes for well-being and functioning.

But in a health setting language differences can have some very deleterious effects. In one study "The Effects of Ethnicity and Language on Medical Outcomes of Patients with Hypertension or Diabetes," Dr. Perez-Stable et. al. found that for Spanish-speaking patients, having a language-concordant physician resulted in better outcomes for well-being and functioning. Monolingual Spanish-speaking patients were more likely to ask more questions and had a better understanding with physicians who also spoke Spanish.[10]

The communications difficulties associated with language differences have also made for some tricky legal arguments.

The communications difficulties associated with language differences have also made for some tricky legal arguments. Legal advocates for Hispanic and other limited English proficient (LEP) people seeking full and competent access to health care, education, and other resources have traditionally worked to advance their cause using Title VI of the Civil Rights Act of 1964. This act states, "No person in the United States shall, on ground of race, color, or national origin, be excluded from participation in, be denied the benefits of, or be subjected to

discrimination under any program or activity receiving Federal financial assistance." (such as Medicare, Medicaid, and Hill-Burton funds).[11]

The Civil Rights Act can be helpful on issues relating to protecting the rights of limited or non-English speakers. Title VI, according to the Department of Health and Human Services Office of Civil Rights, assures that language be taken into account in the provision of health and hyman services. This is particularly important with issues of informed consent.

The Joint Commission on Accreditation of Hospitals explains the doctrine of informed consent this way: "The patient has the right to reasonable informed participation in decisions involving his health care. To the degree possible, this should be based on a clear, concise explanation of his condition and of all proposed technical procedures, including the possibilities of any risk of mortality or serious side effects, problems related to recuperation, and probability of success. The patient should not be subjected to any procedure without his voluntary, competent, and understanding consent or the consent of his legally authorized representative."[12]

Informed consent must be obtained.

Unfortunately it is not possible to get a thorough patient history or give information to the patient required for informed consent when the patient and his or her health care provider do not speak the same language. But solutions can be found. Providers should also appreciate that in addition to being a medical necessity, serious efforts to accommodate Limited English Proficient (LEP) patients also makes good business sense as the following care study will illustrate.

Providers should also appreciate that in addition to being a medical necessity, serious efforts to accommodate Limited English Proficient (LEP) patients also makes good business sense.

A Kaiser Permanente Journal report found that, "communication failures between patient and physician are a

significant factor in a patient's decision to sue..."[13] and a more recent review of Harvard University-affiliated health care institutions, employees, and physicians found that, "12% of their total claims involved communication failure as the key risk management issue."[14]

...concept of linguistic accommodation in clinical and human service settings, even without the impetus of law, is easy to support as a common sense approach, smart business, and ethically responsible.

Of course, the concept of linguistic accommodation in clinical and human service settings, even without the impetus of law, is easy to support as a common sense approach, smart business, and ethically responsible. It's the development of practical means for realizing this accommodation that poses a great challenge to health care professionals.

In interviews conducted with experts in the field of addressing language barriers in health care settings, six approaches were identified to bridge the gap of cultural and linguistic barriers for effective health service delivery.[15]

Having identified these approaches, an in-depth assessment of health care facilities was conducted to determine to what extent they were using these existing approaches to address language barriers, and to gather advice from them on ways to improve their communication with non-English speaking clients.[16]

The assessment focused on 80 health care facilities serving 15 communities with significant Hispanic populations. Of the 80 health care facilities surveyed, 78 percent have a stated policy of hiring bilingual/bicultural professional staff; 43 percent use a language bank; 26 percent encourage language training; 23 percent hire trained interpreters; 16 percent use phone-based interpretation; and 13 percent use written translators.

Six Approaches for Bridging Language Barriers

Each method and key aspects are listed below in order from most effective to least effective.

1. Bilingual/Bicultural Professional Staff

- Recruit and retain bilingual/bicultural staff at all levels of the organization.
- Provide significant additional compensation for bilingual ability.

2. Interpreters

- Establish minimum standards for interpreter training, competency, and other continuing education efforts.
- Make a concerted effort to increase and foster medical interpreter training through national conferences, information clearinghouses, technical assistance, and start-up grants.
- Provide courses designed to train providers to work with interpreters.
- Use only trained medical interpreters.
- Reimburse for interpreter services.

3. Language Skills Training for Existing Staff

- Support the development of bilingual skills for all staff members.
- Establish clear goals and realistic expectations for Spanish language courses, including idioms.
- Offer classes in medical Spanish to all staff.
- Utilize training programs that have a demonstrated track record in increasing the bilingual level or the interpretation quality of services provided.

Six Approaches

1) Bilingual/Bicultural Professional Staff

2) Interpreters

3) Language Skills Training for Existing Staff

4) Internal Language Banks

5) Phone-Based Interpreter Services

6) Written Translators

4. Internal Language Banks (Only as a back-up measure)

- Hire supervisors to assess the language and interpretation capabilities of language bank members, to provide minimal interpreter training, and to regularly assess the quality of the language bank program.
- List interpretation as a secondary responsibility of language bank members so that supervisors of these staff members understand why they may spend time away from their regular duties.
- Compensate language bank members who do a significant amount of interpretation.

5. Phone-Based Interpreter Services (Emergency back-up measure for brief follow-up questions only.)

- Inform health care providers that phone-based interpreters may not be proficient in medical terminology.
- Use simple or common terms when using phone interpreters.

6. Written Translators (Emergency stop-gap measures, never as the sole means of communication)

- Develop mechanisms to promote the sharing of bilingual written materials, such as consent forms and patient education pamphlets.

Do not use patient's relatives, especially those younger.

Do not use support or janitorial staff who's primary job is not translation!

Two common approaches to resolving language differences are so detrimental that they warrant "Don't Statements."

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Do not use support or janitorial staff who's primary job is not translation!

Antonia M. Villarruel Ph.D., an assistant professor at the University of Pennsylvania School of Nursing recommends a seventh approach to overcoming language barriers through the use of "cultural mediators." "Cultural mediators form part of the health care team, working closely with medical and nursing staff," she writes. "In addition to medical interpreting, the cultural mediator interprets the cultural and social circumstances that may affect care. This enables providers to gain a more comprehensive understanding of patients needs, and to negotiate culturally appropriate plans of care."[17]

Use of "cultural mediators" is also recommended.

Cultural mediators often can bridge the gap created by language differences. They can also assist in getting to know the culture and to foster trust.

Providers who follow the programmatic approach outlined above can qualitatively improve their ability to interact effectively with patients/clients whose dominant language is one other than English. But language, of course, is only a first step to understanding culture and the positive role it can play in the delivery of effective health care.

..language of course, is only a first step to understanding culture and the positive role it can play in the delivery of effective health care.

In working with Hispanic patients language can be such an obvious barrier, challenge, and point of identity that it can sometimes obscure other more subtle aspects of cross-cultural understanding. These essential cultural aspects can involve interactions as simple as conversational gambits and spatial (physical space) relationships, along with larger institutional issues such as family visiting hours, patient education, and measuring individual responses to pain. Being aware and understanding the cultural context for these interactions can be a tremendous asset to you as a health care professional, and in your ability to deliver effective care, regardless of language.

... language can be such an obvious barrier, challenge, and point of identity that it can sometimes obscure other more subtle aspects of cross-cultural understanding.

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Closing the cultural gap to the width of a handshake

Both distal space and touching influence the interaction. "We're a touching people. If you're more than a handshake distance from your customer or patient you're too far," says a Mexican American pharmacist and state legislator who has conducted cultural competency trainings for her colleagues. "Touching, how you make eye contact, the subtle things all count," she explains.

Key Concept

←————

"Touching, how you make eye contact, the subtle things all count"...

Food preferences, often based on cultural and environmental exposure, affect the following of diet recommendations as preventive lifestyle practices or as an adjunct to treatment compliance. "Back in the early 1980s, I'd try and help my patients adjust their diet to their medications. But the American Diabetes Association at the time had nothing on the Latino diet. They had a mainstream diet plan, and a supplement on a Jewish diet, but nothing my Hispanic patients in their 60s and 70s could use. They weren't about to start eating Brussels sprouts and cod for the first time in their lives. One older woman I remember looked at the material and asked me — '¿Que son bagel?' (What's a bagel?)."[18]

There are certain cultural nuances or unwritten rules that govern social interactions...there will always be individual variation from any cultural norm.

There are certain cultural nuances or unwritten rules that govern social interactions. These unstated rules can impact the way in which individuals perceive, seek, and receive services. **In addition to language common cultural characteristics for Hispanics in the United States include: family, respeto or respect, personalismo, and confianza.** This chapter will give the provider a brief description of each these cultural concepts. It is important to note that there will always be individual variation from any cultural norm.

Key Concept:

←————

La Familia — A good starting place for any discussion of Hispanic culture is with la familia, the family.

A good starting place for any discussion of Hispanic culture is with la familia, the family. Traditionally, Hispanics include many people in their extended families, not only parents and

siblings, but grandparents, aunts, uncles, cousins and compadres, close friends and godparents (padrinos) of the family's children. When ill or injured, Hispanic people frequently consult with other family members and often ask them to come along to medical visits. Hispanic extended families and the support role they play for patients may run counter to certain institutional rules, such as hospital policies that limit patients to two visitors.

Hispanic families also traditionally emphasize interdependence over independence, and cooperation over competition....

Hispanic families also traditionally emphasize interdependence over independence, and cooperation over competition, and are therefore far more likely to be involved in the treatment and decision-making process for a patient. This level of involvement may not always be possible. Migration and separation from family may stress the values of young immigrant workers or couples newly arrived in the United States.

Similarly, teenagers who quickly acculturate to the United States and the manners of their peers may demand to be treated as individuals and show signs of typical adolescent conflict with their parents and other relatives who maintain traditional values and customs. Because such stresses to family functioning may have significant health implications, it's important for the health care provider to be aware of these issues. In the interest of effective care, such policies may need to be reexamined to allow for more direct involvement of the supportive family network.

Family involvement often is critical in the care of the patient. For many, several family members and extended family members as commadres, compadres, or padrinos will accompany patients to medical visits. Often family members include the very young and very old. They will want to hear what is being said and participate in the interactions.

Thus, the patient/provider conversation may take on a different dynamic. The collective nature of the interaction must be respected by the provider who may be challenged by time constraints and his/her professional training which only focused on one on one interactions. For example, the patient may not be the one responding to the provider's questions or even the one asking questions because he/she may defer to someone in the familial group. The person conversing with the provider may be a spouse, the eldest family member, son/daughter or commadre. Often, the spokesperson will be the person who has the respect and power in the family. Most often, the speaker is the matriarch/patriarch or in many cases in the U.S., it is the more acculturated children.

If it is the children, there is a disruption in the family dynamics. The provider must be respectful and inclusive of the elders even though the younger family members may be the key mediator. The provider must understand the collective nature of this interaction to realize the patient may not be the key decision maker for symptom descriptions, treatment options or compliance.

Key Concept

For Hispanics the intimate confines of extended families, close-knit Hispanic communities, and traditional patriarchal networks are mediated by respeto (respect). Respeto dictates appropriate deferential behavior towards others based on age, sex, social position, economic status, and authority. Older adults expect respect from those younger, men from women, adults from children, teachers from students, employers from employees, and so on.

Respeto *— Respeto dictates appropriate deferential behavior towards others based on age, sex, social position, economic status, and authority.*

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As a general rule, Hispanic patients tend to look forward to what the health care provider has to say and will value their direction and services.

Health providers, by virtue of their healing abilities, education, and training are afforded a high level of *respeto (respect)* as authority figures. As a general rule, Hispanic patients tend to look forward to what the health care provider has to say and will value their direction and services.

One way Hispanics show respect is to avoid eye contact with authority figures. This respectful behavior should not be misinterpreted as a sign of disinterest. At the same time the health care provider is expected to look directly at the patient, even when communicating through an interpreter. *Respeto* (respect) implies a mutual and reciprocal deference. The Hispanic adult patient expects the provider to treat him/her with returned respect and may terminate treatment if they perceive that respect is not being shown.

...cannot directly ask questions about... alcoholism, domestic violence, mental health problems, and sexual practices.

Another way to demonstrate respect, the provider and other outsiders cannot directly ask questions about problems in the patient's life such as alcoholism, domestic violence, mental health problems and sexual practices. Directly asking these kind of questions may be embarrassing and challenging to the cultural practice of keeping this information within the family. This kind of information needs to be obtained through indirect questioning such as "How often does your husband go out? Have you seen ads about the use of condoms? etc."

Along with good health care practices such as providing the patient with information about the examination, diagnosis, and treatment; listening to the patients concerns; and taking their individual needs into consideration while planning treatment, there are some additional steps you as a health care provider can take to assure the respect of your Hispanic patients.

Specific Points to Remember

- If you're a younger provider, even though you will be awarded respect as an authority figure, you should be more formal in your interactions with older Hispanic patients. Formality should not be taken to mean coldness or distance, but rather politeness. It is polite to address Hispanic adults as Señor (Mr.), Don (Sir), Señora (Mrs.), or Doña (Madam).

...you should be more formal in your interactions with older Hispanic patients.

- Even if you do not speak Spanish, greeting a patient with "Buenos dias" (good morning) or "Buenas tardes" (good afternoon) suggests that you have respect for the Spanish language. These few words become an important cue to people about your positive attitudes towards them as too often Hispanics sense hostility and disdain for their limited use or lack of English. If you speak some Spanish, it is important to remember to always use the formal usted (you) until such a time as the patient explicitly suggests the use of the informal tu.

A few words spoken in Spanish may become an important cue to people about your positive attitudes towards them.

- Encourage the asking of questions. Out of a sense of respeto many Hispanic patients tend to avoid disagreeing or expressing doubts to their health care provider in relation to the treatment they are receiving. They may even be reluctant to ask questions or admit they are confused about their medical instructions or treatment. Associated with this is a cultural taboo against expressing negative feelings directly. This taboo may manifest itself in a patient's withholding information, not following treatment orders, or terminating medical care. A good general principle: if you are not sure of the culture with which you are working — use formal language and avoid slang or idioms.

Health providers, as authority figures, need to take seriously the responsibility and *respeto* (respect) conferred on them by many Hispanic patients. They need to explain all medical procedures and treatments thoroughly, and to ascertain through careful questioning whether the patient has fully understood the explanations and instructions he/she has received.

Key Concept

Personalismo —
Personal rather than institutional relationships are important.

Hispanics tend to stress the importance of personalismo — personal rather than institutional relationships, which is why so many Hispanics continue to rely on community-based organizations and clinics for their primary care. Hispanics expect health providers to be warm, friendly, and personal, and to take an active interest in the patient's life. For example a health provider, even one with a limited time schedule for patient visits, might greet Señora Rivas with, "Buenos Días, Señora Rivas. How are you doing today? How did your daughter's graduation go?" Such a greeting implies personalismo, conveying to the patient that the provider is interested in her as a person and will help put the patient at ease before an exam or medical procedure.

The Hispanic loyalty to the individual provider also has significant implications for continuity of care.

When asked in focus groups where they received their medical care, the majority of Hispanics responded by naming their personal health care provider rather than their HMO or other health care institution. The Hispanic loyalty to the individual provider also has significant implications for continuity of care. If a health care professional leaves a health center for another in close proximity, their Hispanic patients are likely to follow him/her to the new setting. If the health professional leaves the area however, their Hispanic patients may frequently stop treatment, unless the provider has made introductions to the new health care provider and established a transitional relationship between them based on personalismo.

Unfortunately, personalismo tends to conflict with the health system's trend towards managed care, the eight minute visit, and physician rotations in public clinics.

- The Hispanic patient's desire for closeness to their health care provider is more than the content of their verbal exchanges; it also has to do with physical space. When interacting with others Hispanics typically prefer being closer to each other in space than non-Hispanic whites do.

- When non-Hispanic providers place themselves at their customary two feet or more distance away from their Hispanic patients, they may be perceived as not only physically distant but wrongly be thought of as uninterested and detached. Such perceptions can be overcome by sitting closer, leaning forward, giving a comforting pat on the shoulder, or other gestures that indicate an interest in the patient.

- Overall, Hispanics tend to be highly attuned to others' non-verbal messages. Non-Spanish speaking providers should be particularly sensitive to this tendency when establishing a relationship with patients who speak only Spanish. In an emergency situation the only way to immediately communicate may be nonverbal.

Over time, by respecting the patient's culture and showing personal interest, a health care provider can expect to win their confianza (trust). When there is confianza Hispanics will value the time they spend talking with their health care providers and believe what they say because confianza means that the provider will have their best interests at heart.

Unfortunately confianza is increasingly difficult to achieve these days due to the dramatic changes occurring in the health

Key Concept

Confianza — ...a health care provider can expect to win their confianza (trust).

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care system, i.e., long-term provider-patient relationships are less common, physicians may rotate in public health settings, and clinicians are limited in the amount of time they can spend with each patient, and HMOs and other institutions reduce their coverage and treatment of the poor. And yet despite these and other obstacles,

- The provider who is able to establish a bond of trust, or confianza, with his or her Hispanic patient will find a profound improvement in the quality of care-giving and willingness of the patient to take wellness and risk-reduction advice to heart.

- Having won confianza from your patients you may also find yourself coming to appreciate the Hispanic view of health. Remember that with confianza there is compliance.

- Health care brokers, community outreach workers or promotoras can play a key role in establishing trust with a new provider.

Key Concept

Integrated Body, Mind and Espiritu (Spirit)

While today's health care professionals work within the structures of mainstream medicine, providing separate physical and mental health care, Hispanic culture tends to view health from a more synergistic point of view. This view is expressed as the continuum of body, mind, and espiritu (spirit).

Health symptomatology often present from the mind/body/spirit connection. Mental health problems and life's stressors may appear as tight chest pain, shortness of breath, abdominal pain, sweats, and/or chronic illnesses, such as frequent colds or headaches.[19] These symptoms have traditional labels such as sustos, peña, attaques de nervios.[20] Culturally, each has a specific cause with a non-medication remedy.

Besides not having a separation of mind, body, and spirit, mental health problems are not necessarily validated, are often viewed as a sign of weakness, and may carry stigma. Consequently, physical symptoms are more of a conduit for support. The recovery process afforded physical illness may also afford respite from mental stressors.[21]

The physical symptoms presented in the U.S. medical system are often mislabeled as somaticizers and mistreated medically for depression.[22] Duran found that low acculturated Hispanic women who were labeled with somatic complaints did not present with depression as did the high acculturated U.S. born Hispanic women.

Within the last century, health and illness have been approached through a variety of treatments, each with its own philosophical base. Some have been based on empirical science (mainstream medicine), some believe disorders linked to the musculoskeletal system can be corrected by physical manipulations (osteopathy), some developed treatments based on the belief that minute doses of drugs that mimic diseases can be used to treat diseases (homeopathy). Still other approaches continue to base states of health on a purely spiritual belief system (Christian Science).

In addition there is an extensive practice of traditional medicine carried out by curanderas, espiritistas, or healers within the Hispanic community. In urbanized barrios this tradition has been carried on in part by Hispanic pharmacists, familiar with both traditional treatments like té de manzanilla (chamomile tea), as well as, placing a strong value on the use of modern prescription medicines such as antibiotics. In recent years, there has also been a dramatic increase of interest on the part of mainstream medicine in researching and identifying many

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In recent years there has also been a dramatic increase of interest on the part of mainstream medicine in researching and identifying many of the healing properties and pharmaceutical potentials of traditional medicines.

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Webster's New University Dictionary defines Synergy as, "1. The action of two or more organisms to achieve an effect of which each is individually incapable." and "2. The theological doctrine that regeneration is effected by a combination of human will and divine grace." The Hispanic view of the mind, body, spirit continuum is a very synergistic one, but also quite practical.

Hispanic patients may bring quite a broad definition of health to the clinical or diagnostic setting.

Combining respect for the benefits of mainstream medicine, tradition, and traditional healing, along with a strong religious component from their daily lives (over 77% of Hispanics in the United States are practicing Catholics), Hispanic patients may bring quite a broad definition of health to the clinical or diagnostic setting. Respecting and understanding this view can prove beneficial both in treating and communicating with the patient, as well as useful for the culturally competent health care professional.

Any good health provider can support the following recommendations.

Key Concept

Healthy Body, Mind, and Spirit[23]

Body

1. Do not smoke.
2. Limit alcohol.
3. Eat healthy meals.
4. Exercise regularly.
5. Listen to your body.

Mind

1. Set limits.
2. Learn to relax.

3. Worry less.
4. Give yourself time for pleasure.
5. Nurture healthy relationships.

Spirit

1. Do good acts.
2. Think good thoughts.
3. Have quiet time to yourself.
4. Pray.
5. Have lots of family and friends around to listen and talk with.

Key Concepts:

Familia, Respeto, Personalismo — Mind, Body, Spirit

Familia — **Family**

1. Allow for several family and friends.
2. Communicate with the group.
3. Determine the matriarch and patriarch.
4. Notice if the acculturated children or nonfamily members are the spokespeople.

Respeto — **Respect**

1. Always be respectful.
2. Explain without condescending.
3. Address elders in traditional ways (below eye level if you're younger).
4. Be mindful of the parents and elders in the room when the acculturated child or a health mediator is the spokesperson.

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5. Ask for questions or a description of what was first heard and experienced.
6. Indirectly ask personal/private questions such as alcohol use, mental problems, violence, stressors, sex, etc.
7. Ask permission to touch genitalia after explaining what you are doing and why.

Personalismo — Personal Familiarity

1. Respect distal space and touching based on familiarity.
2. Ask about their life (family, friends, work).
3. Share your own life stories.
4. Share pictures.
5. Converse with all of the family members.
6. Be respectful of gender, do not give an impression of being too familiar.
7. Make personal notes in medical records to cue provider of family names or special events to discuss on the next visit.

Mind, Body, Spirit

1. Physical symptoms of stressors, often labeled somatic complaints, may not have the same cultural meaning as the medical model and DSM IV pathology.
2. Foster psychosocial support and reduce stressors.
3. When appropriate, use traditional healers and remedies.

For Hispanics in the United States, history is a confluence of national and social narratives that have only recently merged into a powerful river of common understanding.

An historical perspective may be an important precursor to understanding the health status of Hispanics. Understanding the migration patterns and other environmental critical events provides perspective to genetic/biological/environmental interaction and helps to clarify potential health behaviors. Current theory states that major demographic events (population migration, bottlenecks, and expansions) leave imprints in the form of altered gene frequencies on the collective human genome.[24]

An historical perspective may be an important precursor to understanding the health status of Hispanics.

The majority of U.S. Hispanics have a shared pre-colonization American history that reflects a relatively healthy group even though there are high risk factors for some diseases and a low propensity for certain others.[25] To some extent, the heterogenous genetic characteristics of Hispanics have been shaped by a number of founder effects, such as migration and invasion by Europeans. Socially and culturally, the majority of Hispanics have a shared historical genetic family located in all of the Americas — North, Central, and South.[26]

The majority of Hispanics have a shared...historical genetic family located in all of the Americas...

History of migration patterns and critical events may differentiate one group from another in addressing health status, health behaviors, and health beliefs.[27]

II. About Hispanics
Chapter Five: History of Hispanics in the United States
Or why the City by the Bay is not called Saint Francis

Perhaps the health status of Hispanics needs to be further explored from it's own migration patterns, the Americas. As the history of Hispanics is examined in the rest of the chapter, contemplate the critical events before colonization.

In 1453, Constantinople fell to the Ottoman Turks, cutting off Europe's silk and spice trade with India and Asia. Thirty-nine years later an Italian named Christoforo Colombo (Cristobal Colón in Spanish), or Christopher Columbus, sailing west for the Queen of Spain, first reached the New World thinking he had found a new route to the orient.[28] His first landfalls included Juana (Cuba) and the island of Hispaniola (the Dominican Republic and Haiti) whose natural wonders so amazed him he declared his eyes, "would never tire of beholding so much beauty, and the songs of the birds large and small."[29]

Having recorded their first impressions of North America's natural wonders, the early discoverers quickly set about in search of gold and other objects of value. The Conquistadors were committed to expansion of the Spanish empire and recovery of treasure for the crown. Spanish Catholic missions soon followed with the goal of winning new religious converts. Colonial administrators began spreading Spanish culture from Mexico across Central and South America.

Spanish settlement of North America came early and included the first permanent European settlement of the New World at St. Augustine, Florida in 1565. In 1598, Don Juan de Oñate colonized New Mexico.

Yet almost all Hispanic immigration to the United States may be linked not only to the economic opportunities that would attract European and Asian immigrants, but also to U.S. military actions linked to policies of Manifest Destiny (that declared the United States' "God-given right" to all North American territory)

Spanish settlement of North America came early... St. Augustine, Florida in 1565. In 1598 Don Juan de Oñate colonized New Mexico.

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and the Monroe Doctrine (which declared United States hegemony over Mexico, Central, and South America and warned European powers not to intervene there). From the Spanish American War that brought Cuba and Puerto Rico under U.S. administration in 1898, to various invasions of the Dominican Republic, Nicaragua, Honduras and other parts of Central America, waves of immigration followed on war, rebellion, and occupation. This process has continued as recently as the 1980s, when large numbers of Guatemalans, Nicaraguans, and Salvadorans fled to the United States to escape civil wars.

Mexican Americans: "So far from God, so close to the United States," has been a proverb in Mexico for generations, reflecting the often turbulent relationship between the two nations. Continuing through the 1800's Spain extended its dominance across California and the Southwest. Eventually the goal of the church to convert the indigenous inhabitants would lead to conversions and intermarriage and the survival of large numbers of mestizo, or mixed blood people. Today the California mission system lives on in the names of its early settlements that evolved into towns and cities: San Diego, Los Angeles, Santa Barbara, San Luis Obispo, Monterey, San Jose, and San Francisco.

In 1821, Mexico fought to win its independence from Spain. Mexico lost half its northern territory to the United States following the Mexican American war through the Treaty of Guadalupe Hidalgo. For Mexicans living in the areas annexed by the Treaty, the border had crossed them adding new language and cultural obstacles that still exist today.

For Mexicans living in the areas annexed by the Treaty, the border had crossed them adding new language and cultural obstacles that still exist today.

With close family and community ties remaining on both sides of the frontier, Mexican migration to and from the United States has continued largely uninterrupted since the Treaty of

Chapter Five: History of Hispanics in the United States

Guadalupe Hidalgo. Today, Mexicans and Mexican Americans make up over 57% of the U.S. Hispanic population and include at least two million seasonal migratory workers who spend part of the year in the United States and part in their native Mexico.[30]

Puerto Ricans: The second largest Hispanic group (about 20%) in the United States with some 3 million people living on the U.S. mainland and 3.2 million more living on the island.[31] Borinquen (the indigenous name for Puerto Rico) was discovered by Columbus in 1492 and conquered by Juan Ponce de Leon in 1508. The Taino and Arawak Indians who lived there were quickly killed off through violence, starvation, and forced labor. Yoruba African slaves were then brought to the island to work the sugar cane fields. They eventually won their freedom, intermarried, and incorporated their culture and beliefs into the island life.

In 1815, a second wave of Spanish settlers known as the 'Real Cedula de Gracias' were encouraged to emigrate to Puerto Rico in order to "whiten" its population. Instead, by defining themselves as a new elite, they exacerbated tensions between islanders and their colonial administrators. In 1897 Puerto Rican nationalists declared themselves independent from Spain. A year later, United States forces landed in Puerto Rico, Cuba, and the Philippines during the Spanish-American War. But unlike in Cuba and the Philippines, the United States never gave up its claim on Puerto Rico. In 1917, Puerto Ricans were made United States Citizens under the Jones Act and eligible males were required to enlist in the military. In 1952, Puerto Rico was declared a Commonwealth of the United States, although from within the island there continues to be movements for statehood and independence.

Economic underdevelopment on the island, along with the

Today, Mexicans and Mexican Americans make up over 57% of the U.S. Hispanic population....

In 1917, Puerto Ricans were made United States Citizens under the Jones Act and eligible males were required to enlist in the military.

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United States' expanding post-war industrial base, and job opportunities led to the migration of close to a million Puerto Ricans to the mainland between 1945 and 1965. Large Puerto Rican communities were established in New York, other parts of the Northeast, and Chicago.

Half a century later people on the mainland continue to maintain close links with their families at home through the Puerto Rican "air bridge," of regular flights between the mainland and Puerto Rico. At the same time the cultural, political, medical, and social needs of Puerto Ricans on the mainland and on the island have tended to diverge over time, although key social agencies like New York's Puerto Rican Family Institute try to bridge that gap by maintaining service centers in both locales.

Cuban Americans comprise about 4% of the Hispanic population in the United States.

Cuban Americans: Cuban Americans comprise about 4% of the Hispanic population in the United States.[32] Even though they have the highest level of education and income of any Hispanic group, the median income of Cuban Americans is nevertheless 25% less than that of non-Hispanic whites. Cuba, only 90 miles from Key West, Florida was visited by Columbus in 1492 and colonized by Spain in 1511, during which all the native people were killed.

The largest island in the West Indies, Cuba, and its capitol port Havana, became a major shipping and transportation hub, as well as a key to the trade in rum, sugar, cod, and slaves. It's population was also a mix of European settlers and African slave laborers. Even before the Spanish-American War of 1898, Cubans began emigrating to the U.S..

In 1902, four years after annexing Cuba in the Spanish-American War, the U.S. granted it independence. However, the U.S. maintained a major influence in Cuba over the next fifty

years as it became a popular resort destination.

The Cuban Revolution of 1959 that overthrew the regime of Fulgencio Batista and brought Fidel Castro to power drove close to half a million upper and middle-class refugees to south Florida. Later, waves of immigrants from the communist island, such as the "Marielitos" of 1980, included less-skilled people along with some criminals and mentally ill people, released from Castro's jails and asylums.

The Cuban Revolution of 1959 that...brought Fidel Castro to power drove some half million upper and middle-class refugees to south Florida.

Central Americans: Since its early settlement, Central America has had a history of turmoil. The economies of Central American countries tend to be unstable because of their dependence on a few agricultural export crops such as coffee, sugar, bananas, and cotton owned by a very small segment of society. Because of the political and economic struggles that the nations of this region have endured, many Central Americans have immigrated to the United States, often in search of refuge from violence and economic instability created by civil wars and other conflicts.

Central Americans have settled in different parts of the country. Salvadorans have settled mainly in Los Angeles and Washington D.C.; Guatemalans in Los Angeles, San Francisco, and Houston; and Nicaraguans in San Francisco and Miami. Many suffer from post traumatic stress problems, relating to their countries' civil wars.

Dominicans: Discovered by Columbus in 1492, the island of Hispaniola later divided following a slave rebellion and the establishment of the independent nation of Haiti. The remaining eastern two-thirds of the island would eventually become the Dominican Republic, a predominantly agricultural Spanish-speaking nation with thick rain forests and spectacular mountain

II. About Hispanics

Chapter Five: History of Hispanics in the United States

... over half a million Dominicans and their descendants have settled in the United States, with 70% of them located in New York City and adjacent parts of New Jersey.

Although there are various reasons for South American immigration to the United States, two key causes include political instability in certain instances and the search for economic opportunity or prosperity in others.

ranges. Since the U.S. invasion of the Dominican Republic in 1965, during a period of civil unrest, over half a million Dominicans and their descendants have settled in the United States, with 70% of them located in New York City and adjacent parts of New Jersey.

South Americans: Several hundred thousand Colombians have also settled in the U.S., mainly in Florida and New York. Smaller numbers of Hispanics have come to the United States from Venezuela, Ecuador, and other Latin American nations. Although there are various reasons for South American immigration to the United States, two key causes include political instability in certain instances and the search for economic opportunity or prosperity in others.

From a psychosocial perspective the history of Hispanics in the United States clearly indicates that in dealing with Hispanic populations in a medical or social service context, one must recognize the tremendous range of historical experiences that exists among the various sub-groups. Each nationality has its own historical perspective that affect how they view themselves within the context of living in the United States and how the U.S. has treated them. In fact, differences among subgroups may be related to how they entered the U.S., i.e., as legal immigrants, legal refugees, undocumented workers, or as a result of war.

To date, the health profile of Hispanics has not been fully available. The lack of information is primarily due to the historical lack of Hispanic and Hispanic subgroup identifiers in major data sets, including the census, mortality, medical records, the National Health Interview Survey, and many others. Many national data sets added Hispanic identifiers by 1995. By 1996, all States has added Hispanic identifiers to mortality data. Still today, Hispanic identifiers are absent from medical records and many state disease/disorder registries. Without this information, it is difficult to know the complete profile of Hispanic health.

To date, the health profile of Hispanics has not been fully available....primarily due to the historical lack of Hispanic and Hispanic subgroup identifiers in major data sets...

Prior to 1995, the historical racial/ethnic classifications often appeared as white and nonwhite which masked relevant information. The transition to the categories of "white", "black", and "others" continued to camouflage pertinent health information about Hispanics. This labeling also contributed to the notion that minority meant black because the populations clustered into "others" were fairly invisible due to the fact that the information was meaningless. Recognition marks a struggle for Hispanics to achieve official Government recognition. This recognition uniquely identifies Hispanic health issues, clearly depicts an Hispanic health profile and mandates a visible presence in minority populations.

Another issue which seems to confound the collection of Hispanic information is the misclassification of race/ethnicity. When race/ethnicity is not self-identified, up to one-third of data misclassification has occurred mostly due to the heterogenous phenotypes of the Hispanic population. All Hispanics do not look alike. Some misclassification occurs when those who are asked to self-identify are presented with "white," "African American," and "Hispanic" options. Many Hispanic ethnic groups identify with their heritage or country of origin, such as Mexican, Cuban, Salvadoran, Chilean, etc.

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II. About Hispanics
Chapter Six: Hispanic Health Status

Today in the U.S., Hispanic is considered an ethnicity with any racial background.

Today in the U.S., Hispanic is considered an ethnicity with any racial background. Each racial category can be associated with a specific migration pattern and representative of clusters of the population with a higher prevalence of a particular disease. White is associated with European descent and migration patterns. Black is associated with African descent and migration patterns. Asians have Asian descent and migration patterns – likewise for American Indians, Alaska Natives, Pacific Islanders and Native Hawaiians.

...Hispanic is a U.S. government created term....this labeling has to be both learned and accepted as an identity for those it is attempting to identify.

As noted in Chapter 1, Hispanic is a U.S. government created term; thus, this labeling has to be both learned and accepted as an identity for those who it is attempting to identify. Recognition of the misclassifications has facilitated the Government to partner with Hispanics to reduce mistakes by adding the word "Latino" and asking "Are you Hispanic/Latino?" before asking the race question. However, errors continue because many Hispanics see themselves as a race, not just an ethnicity. In this country, Hispanics are not white nor black in their psychosocial and cultural presentation and treatment.

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As science tries to unravel the answer as to whether precursors of disease within kinships are due to some genetic/biological factors or some nonrandom force, the current social labeling of race may confound the answer. As mobilization and diversity of the U.S. population increase, understanding cluster variants and changes in mixed migration patterns will provide insight to engineering and improving the health status of Hispanics and all humans. This understanding will enhance culturally competent services.

An examination of the classification/misclassification is based on the hypothesis that each sequence variant that confers disease susceptibility must have arisen in a particular

individual at some time in the past and must have been inherited by his or her descendants to create a disease — associated polymorphism prevalent in a population.[33] The cluster could then be examined for the genetic/biological mutations that result from invasion, expansion, and filtration of different migration patterns such as the Spaniards (Europeans) conquering of Mexico's indigenous (Americas).

If this avenue of culturally competent research is pursued, science may be better able to determine whether the pattern and magnitude of phenotypic variation are consistent with random evolutionary forces or whether a more complex explanation is required.

To fully present an Hispanic health profile, specific or targeted research is needed to augment the national depiction. Yet, there is little to no information which details Hispanic health information and treatment outcomes. For example, there is no information on cancer treatment outcomes for Hispanic women with breast cancer; on theoretical models for health behavior changes; on effective community-based alcohol interventions; on pharmacological treatments; etc. The list of inadequate information is exhaustive and can be experienced by each literature search in any area or field.

...there is little to no information which details Hispanic health information and treatment outcomes.

As a result of inadequate national data and specific information, it is difficult to fully determine Hispanic health status and profile. The most recent changes indicate potential shifts in current knowledge. For example, SEER (the National Cancer Institute's Surveillance Epidemiology and End Results project) expansion in 1995 repositioned Hispanic children with brain cancer from third to first. It is likely that similar shifts will be presented as other data are analyzed and reported.

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Due to the lack of information, cultural competence should be practiced by not identifying any one group as having a lesser or greater health status than another.

This incomplete determination of health status makes it difficult to assess the burden of disease and disorders on Hispanics or in comparison to other groups. Due to the lack of information, cultural competence should be practiced by not identifying any one group as having a lesser or greater health status than another. Cultural competence should also be practiced in interpreting data given the fact that Hispanics are often classified as white or black; yet, neither the white or black body of information is fully applicable to Hispanics. There are language, psychosocial, cultural, and biological/genetic differences that confound the application of white and black prevention, intervention, and treatment models and may not have the same internal and external validity. For instance, in genetic research, the Genome project has identified a marker for diabetes in Mexicans. This marker does not appear in non-Mexican whites or Japanese. As more information unravels, Hispanic health status will be clarified.

The Genome project, a major Federal initiative to map genetic components, has declared that genetic factors contribute to virtually every human disease, conferring susceptibility or resistance, or influencing interaction with the environment.[34] The Genome project also has determined that racial/ethnic groups are more alike than different.[35] However, clusters of the population, often proxied by race/ethnicity, may have a greater prevalence of a particular genetic marker or set of markers (codes for disease).[36] Examples include diabetes in Mexicans and Pima Indians, sickle cell anemia in blacks, and Tay Sachs in Jews.

While one cannot be expected to memorize all the data that is provided in this chapter, there are three key points worth remembering in dealing with the issue of Hispanic health status:

Key Facts

- Hispanics have lower mortality rates than the overall population but are at greater risk for number of chronic illnesses and diseases. Mortality is not a good measure for this population.

- Hispanic populations exhibit a number of positive health indicators in terms of diet; low levels of smoking and illicit drug use; and a strong family structure. However the longer each generation has been in this county these positive indicators tend to deteriorate. Positive aspects of traditional cultures need to be reinforced.

- There is similarity, as well as, variability among Hispanic subgroups.

Hispanics, as outlined earlier, share a range of sociocultural characteristics, as well as national, experiential, and in some instances genetic make-up, that can impact their health status within the United States. Certain cultural factors, such as a more traditional diet and lower rates of smoking among women impact favorably on their health status, while others, such as low-immunization rates linked to low-economic status and fear of authority among new immigrants, have negative consequences. Unfortunately acculturation among new immigrants and their children seems to weaken the positive health factors and lead to the adoption of negative ones from U.S. culture (such as smoking, alcohol use, and early sexual activity).

When politicians and policy-makers address topics such as "black and minority health," they're usually referring only to issues and statistics dealing with African-American health profiles and then extrapolating from these, even though

Mortality is not a good measure for the population.

Positive aspects of traditional cultures need to be reinforced.

Unfortunately acculturation among new immigrants and their children seems to weaken the positive health factors and lead to the adoption of negative ones from U.S. culture.

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Hispanics, with their unique health needs, made up 12% of the population in 1998.[37]

...until 1989, the National Model Death Certificate did not have an Hispanic identifier. As data became more available an Hispanic health profile emerged which ran counter to....the "Minority" health model....

The major reason for this distortion, is that until 1989 the National Model Death Certificate did not have an Hispanic identifier. This prevented the emergence of an authentic Hispanic health profile. As data became more available, an Hispanic health profile emerged which ran counter to the prevailing models of health. The "Minority" health model did not explain the state of Hispanic Health.

Mortality and Morbidity

In 1985, the Report of the Task Force on Black and Minority Health of the U.S. Department of Health and Human Services, attempted to outline the disparities in health status existing between the non-Hispanic white population and the rest of the population. However, it remained difficult to ascertain the actual differences in health status among "minority" populations due to the fact that although mortality data were available for blacks, Asian/Pacific Islanders, Native Americans, and whites, it was still not available for Hispanics.

Even today the organization of reliable and accessible data on Hispanic mortality and morbidity lags behind that for other racial and ethnic groups. Nonetheless certain trends and statistical health profiles have become clear, with the mortality rates for Hispanics proving counter-intuitive to the traditional view that the lower economic status and educational attainment of "minorities" dooms them to a higher rate of mortality.

Despite having a lower income than white Americans, Hispanics live longer than whites.

Despite having a lower income than white Americans, Hispanics live longer than whites. Hispanics have an average life-expectancy of 75.1 years for men and 82.6 years for women.[38] As a result, for the Hispanic community the issues of

morbidity rather than mortality are of greatest concern. These issues include lifestyle and behaviors affecting health; environmental factors such as exposure to pesticides, unclean air and polluted water; and the ongoing need for more effective use of existing health services. Of course many of these morbidity factors also play a significant role in Hispanic mortality rates.

The top ten leading causes of death for Hispanics of all age groups are:

1. Heart disease
2. Malignant neoplasms,
3. Accidents and adverse effects,
4. Human immunodeficiency virus infection (HIV),
5. Homicide and legal intervention,
6. Cerebrovascular diseases,
7. Diabetes mellitus,
8. Chronic liver disease and cirrhosis,
9. Pneumonia and influenza,
10. Certain conditions originating in the prenatal period.[39]

The top two leading causes of death are the same for the Hispanic and for the non-Hispanic white population: heart disease and cancer. However, for Hispanics these two causes account for 43% of deaths, whereas they accounted for 59% of all deaths among non-Hispanic whites in 1992.[40]

Of the ten leading causes of death for the Hispanic population, two, "Homicide and legal intervention," and "Certain conditions originating in the prenatal period," also reflect differences in age composition between Hispanics and other groups. The Hispanic community is marked by its youthfulness. Its median age is 26.3 years, compared to 36.6 years for the non-Hispanic white population.[41] Because the Hispanic population has a greater proportion of young persons, it also has

Key Concept

←

Top Ten leading causes of death for Hispanics of all age groups.

The top two leading causes of death are the same for the Hispanic and for the non-Hispanic white population: heart disease and cancer.

a larger proportion of deaths due to causes that are more prevalent at younger ages, such as male violence and female child birth.

Within broad age categories the leading causes of mortality are similar. However, some differences still exist.

- Homicide and legal intervention consistently ranks higher for Hispanics than for non-Hispanic whites for all age groups between 15–24 years and 45–64 years.

- HIV infection for Hispanics aged 1–64 years ranks consistently higher than for non-Hispanic whites.

- Diabetes mellitus and chronic liver disease and cirrhosis also rank higher for Hispanic populations aged 45–64 and 65 years and over than for non-Hispanic whites of the same age groups.[42]

The following sections provide some current known and unknown information about incidence and risk factors for disease. Much more information is needed to fully determine the health status of Hispanics.

Smoking

While Hispanic adults have the lowest rates of smoking, Hispanic eighth graders now have the highest rates of smoking among all their peers.

The relationship between smoking and various cancers, heart disease, and respiratory disorders has been well and clearly established. Lung cancer remains the number one cause of death due to carcinomas in both men and women. For the past twenty years there has also been a steady decline in the number of Hispanics who smoke tobacco. By 1998, only 18.9% of Hispanics smoked tobacco compared to 26.5% of Non-Hispanic blacks and 25.9% of Non-Hispanic whites.[43]

While Hispanic adults have the lowest rates of smoking, Hispanic eighth graders now have the highest rates of smoking among all their peers. A recent survey found that 51.1% of Hispanic eighth graders had smoked within the previous 30 days compared to 42.1% of non-Hispanic blacks and 49.7% of non-Hispanic whites.[44]

In addition, a recent survey in San Francisco found that while only 15% of first-generation immigrant Hispanic women reported smoking, 23% of second-generation Hispanic women smoked. This was consistent with other findings showing that as Hispanic women acculturate to the United States they tend to give up a number of their healthier habits such as good nutrition.[45]

Diet

Diet has been shown to affect several cancers, diabetes, and heart disease. The Hispanic diet is high in fiber, relies on vegetable rather than animal proteins, and includes few dairy products and leafy green vegetables. In cattle producing countries however, diets tend to include a greater amount of animal protein.

The Hispanic diet is high in fiber, relies on vegetable rather than animal proteins, and includes few dairy products and leafy green vegetables.

Recent studies also indicate that Mexican American women report a higher intake of vitamins A, C, folic acid, and calcium than do non-Hispanic white women. Again, however, these positive indicators tend to decline with U.S. acculturated second generation Mexican American women whose dietary intake is the same as that for non-Hispanic white women.[46]

Reflecting differences among Hispanic sub-groups, there are findings of both positive and negative nutritional indicators for Hispanic children. While mean iron intakes of Cuban American

and Puerto Rican children meet the recommended level for iron, Mexican American infants are below the recommended level. While Hispanics consume less than five fruits and vegetables per day, the intake of chili peppers and tomatoes provide much needed antioxidants. The majority of Mexican American children also consume less than the recommended servings of fruits and vegetables, including fruits and vegetables with high vitamin A and C content. Also, after age 5, the majority of Mexican American children consume less than the recommended daily servings of milk.[47]

Although Hispanic women are regarded as coming from a breast-feeding culture, their nursing rates begin to decline as they acculturate to the United States.

In terms of mother's milk, according to 1990 statistics, 52% of Hispanic women breast-fed their infants compared to 59% of non-Hispanic white women and 26% of non-Hispanic black women. Although Hispanic women are regarded as coming from a breast-feeding culture, their nursing rates begin to decline as they acculturate to the United States. In addition, bottle-feeding ad campaigns conducted in Puerto Rico and throughout Latin America by corporations that produce baby formula, has also led to a steady decline in breast-feeding in these areas.[48]

Cholesterol

... cholesterol levels are lower for Hispanics than those reported for non-Hispanic whites and non-Hispanic blacks.

Linked to diet and nutrition, cholesterol levels are lower for Hispanics than those reported for non-Hispanic whites and non-Hispanic blacks. For all Hispanics, cholesterol levels gradually increase with age. Hispanics with high cholesterol levels tend to be less aware of their situation than their non-Hispanic white counterparts.

Mexican American men are more likely than non-Hispanic white adults to have high serum cholesterol levels. However, Mexican American women are somewhat less likely than non-

Hispanic black women and slightly more likely than non-Hispanic white women to have high serum cholesterol levels.[49]

The traditional Hispanic diet includes a carbohydrate staple (such as rice or corn tortillas) with beans, which together provide a balanced source of protein without cholesterol. However, as Hispanic immigrants and other groups adapt to the dominant culture's diet their serum cholesterol levels begin to rise.

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Weight and Exercise

It is estimated that approximately one-third of all adults in the United States are overweight with a greater prevalence among Hispanics. Overweight percentages (based on white standards of body composition) for Mexican American males (39.5%) are higher than for non-Hispanic whites (32.1%) and non-Hispanic blacks (31.5%). A greater percentage of Mexican American females (47.9%) are overweight than non-Hispanic white females (32.4%) but less than non-Hispanic black females (49.5%).[50]

Despite evidence linking regular physical activity to a range of health benefits, millions of United States adults remain essentially sedentary, a fact which has generated the descriptive title of "TV couch potatoes" (or with the advent of the internet, "mouse potatoes"). While there is a woeful lack of data on Hispanic populations and exercise, researchers report that men are more likely than women to participate in physical activity and non-Hispanic whites more likely than other ethnic groups. A CDC study of high school students found that adolescent males are about twice as likely as adolescent females to report engaging in vigorous physical activity.[51]

While many Hispanics work in occupations requiring heavy manual labor, many of these activities do not contribute to aerobic fitness.

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While many Hispanics work in occupations requiring heavy manual labor, many of these activities do not contribute to aerobic fitness. A heart study conducted in San Antonio, Texas, found that Mexican Americans engaged in aerobic exercise less often than any other group.

Alcohol and Substance Abuse

Another lifestyle issue facing the Hispanic community is excessive alcohol use that can, over time, cause serious medical problems, as well as, increase the more immediate risk of accidents and violence.

According to SAMHSA's Prevalence of Substance Use Among Racial and Ethnic Subgroups, Hispanics vary markedly in their prevalence of substance abuse, alcohol dependence, and need for illicit drug abuse treatment. Relative to the total population, Mexicans and Puerto Ricans have high prevalence of illicit drug use, heavy alcohol use, alcohol dependence and need for illicit drug abuse treatment. In contrast, Caribbeans, Central Americans, and Cubans have low prevalence and South Americans and other Hispanics have prevalence similar to the total U.S. population.

A 1992 survey found Hispanic males are far more likely to have used alcohol (85.5%) than Hispanic females (67.4%). Hispanic males also report a higher percentage of heavy alcohol use in the past month (5.6%) than non-Hispanic whites (5.1%) or non-Hispanic blacks (4.5%).[52] This is especially true for Mexican American males.

Alcohol appears to be the major drug of abuse among Hispanics.

Alcohol appears to be the major drug of abuse among Hispanics. Among high-school students, 55% of Hispanic males report current alcohol use compared to 51.1% of non-Hispanic

whites and 48.2% of non-Hispanic black males. Additionally, 39.4% of Hispanic high-school males report episodic heavy drinking, the highest rate among any group. Hispanic females in high school are less likely than non-Hispanic whites but more likely than non-Hispanic blacks to report any alcohol use.[53]

Most recent research, has demonstrated that drinking patterns and rates of alcohol-related problems often differ among Hispanic subgroups. According to the Hispanic Health and Nutrition Examination Survey, Mexican-Americans and Puerto Rican men have higher rates of heavy drinking than do Cuban-American men.[54] In the same survey, Mexican American women have higher rates of both abstinence and frequent heavy drinking than do Cuban-American and Puerto Rican women.

It has also been demonstrated in several studies that a higher level of acculturation is related to greater alcohol consumption, especially in relatively young Hispanic women.[55] The prevalence of alcohol dependence is higher among U.S. born Mexican-American women than among Puerto Rican and immigrant women.[56] Recent Cuban immigrants appear to have patterns of alcohol consumption and alcohol problems that resemble those of Mexican Americans and Puerto Ricans.[57] Acculturation also was positively associated with the total number of drinks that Cuban-American and Mexican-American women consumed and with the volume of alcohol that Mexican-American women consume per occasion.[58]

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Overall, only 29.2% of Hispanics report ever having used an illicit drug including marijuana in their lifetime, compared to 33.6% of non-Hispanic blacks and 37.7% of non-Hispanic whites. Hispanics are also less likely to report using illicit drugs during the past year (10.8%), compared to 11.3% of non-Hispanic whites and 11.5% of non-Hispanic blacks. However,

the percentage of Hispanics reporting cocaine use within the past month (1.2%) is higher than that of non-Hispanic blacks (1%) and over twice as high as that of non-Hispanic whites (0.5%). Hispanics are less likely to have used crack cocaine in the past year (0.5%), than blacks (1.1%) but more likely than whites (0.3%). Inhalants represent a particular threat for Hispanic adolescents: 6.5% of Hispanics age 12–17 report they've used inhalants, compared to 6.2% of white youth and 3.1% of black youth.[59]

Violence and Unintentional Injuries

Self-inflicted and unintentional injuries and death, as well as, violent homicides also have a disproportionate impact on youthful Hispanic groups and individuals.

...Hispanic high-school students are more likely to have made at least one suicide attempt (13.4%), compared to their non-Hispanic black (8.9%) and non-Hispanic white (7.8%) peers.

Studies find that Hispanic high-school students are more likely to have made at least one suicide attempt (13.4%), compared to their non-Hispanic black (8.9%) and non-Hispanic white (7.8%) peers. Even more disturbing, Hispanic female high-school students are significantly more likely to have made at least one suicide attempt in the previous year (21%), than their non-Hispanic black (10.8%) or non-Hispanic white (10.4%) peers. Rates for female students are higher than for male students across all racial and ethnic categories.[60]

Violence is another increasing challenge to the health and well-being of Hispanic youth. The percentage of deaths from homicide and legal intervention is almost five times greater for Hispanic adolescents and young adults (36.8%) than that of their non-Hispanic white peers (7.4%). Twenty-two percent of Hispanic high-school students now report they fear physical and violent attacks when going to and from school.[61]

Accidents are the third leading cause of death among Hispanics, accounting for 9% of all Hispanic deaths, but only the fifth leading cause among non-Hispanic whites at 4%. For children, accidents and adverse effects are the leading cause of death for all groups. For Hispanic children, the rate of accidental deaths (15.4 per 100,000 persons under the age of 14) is similar to that for non-Hispanic white children (15.1) and lower than that for non-Hispanic black children (23.6). When examining accidental death rates due to motor vehicle accidents, the death rate for Mexican American children (9.4) is higher than that for either white or black children.[62] Two contributing factors that have been noted: Hispanic children are less likely to use seat belts or to be placed in child safety seats than their white counterparts, and Hispanic adults are greatly over-represented in the number of arrests for drunk driving.

When examining accidental death rates due to motor vehicle accidents, the death rate for Mexican American children (9.4) is higher than that for either white or black children.

Environment

In addition to lifestyle and behaviors, health status is significantly impacted by our surrounding environment. Most of the major environmental laws in place today, the Clean-Air Act, Clean-Water Act, Community Right to Know law, etc. have as their objective the protection of our public health and yet very few Hispanics are aware of them. This is unfortunate as Hispanics in the United States, face the highest rates of exposure to pollution and toxic substances. Hispanics are the group most likely to live in areas failing to meet air quality standards according to the EPA, with 80% living in areas that fail to meet at least one National Ambient Air Quality Standard (as compared to 65% of blacks and 57% of whites). Additionally, 18.5% of Hispanics are exposed to the nation's worst air pollution (as opposed to 9.2% of blacks and 6% of whites).[63] Studies indicate that Puerto Rican children are also more than three times as likely as non-Hispanic white children to suffer from active asthma.[64]

...Hispanics in the United States, face the highest rates of exposure to pollution and toxic substances.

Hispanic children in Los Angeles have the highest rates of brain cancer and rising rates of leukemia. In addition, Hispanics are more than two times as likely as blacks or whites to live in areas with either elevated levels of particulate matter or in areas with high levels of lead in the outdoor air. Another source of lead exposure for children is derived from swallowing nonfood items such as chips of paint containing lead, inhaling of lead dust, and hand to mouth contamination. House renovations, folk medicines, and cosmetics are others sources of environmental lead exposure.

Mercury...is highly toxic to humans. Unfortunately it is sometimes used by Hispanics as a folk medicine or spiritual agent.

Mercury, commonly known as "quicksilver" or Azogue (in Spanish) is highly toxic to humans. Unfortunately it is sometimes used by Hispanics as a folk medicine or spiritual agent. Azogue is frequently sold in botanicas — small stores that carry religious and cultural products. Azogue is sold in 3–5 ounce capsules. Believed to possess spiritual power it is sometimes burned as an incense, or in a candle, or sprinkled about the home.

Hispanics are also more likely than other groups to live in EPA non-attainment areas for ozone and carbon monoxide in the air.

Hispanics are also more likely than other groups to live in EPA non-attainment areas for ozone and carbon monoxide in the air. Indoor air pollution agents include asbestos, carbon monoxide and second-hand or environmental tobacco smoke (ETS). According to the National Health Interview Survey, 44.3% of Hispanic pre-school children have been exposed to tobacco smoke.

The importance of safe drinking water to health can hardly be emphasized enough. Eighty-two percent of public health officials polled rated it the most important or a very important factor in increasing life-expectancy and quality of life. Water quality issues are impacted not only by water sources, but also delivery systems including municipal pipes and household plumbing.

In urban areas, low-income Hispanics are more likely to rent older homes and apartments which may contain antiquated lead plumbing (and wall paint). Additionally, biological contamination of urban water systems is getting more notice since outbreaks of cryptosporidum were reported in Milwaukee, Washington D.C., and other cities. Both industrial and biological contamination of water is also a persistent problem along the United States-Mexico border particularly in colonias. In six Texas counties there are about 842 colonias (low-income subdivisions outside municipal boundaries) with some 200,000 Mexican and Mexican American residents. Only three colonias (less than 1%) have public sewage disposal systems. As a result, water supplies often become contaminated with bacteria and viruses. The EPA reports that "outbreaks of dysentery and hepatitis A are commonplace in the colonias."

In urban areas, low-income Hispanics are more likely to rent older homes and apartments which may contain antiquated lead plumbing (and wall paint).

Farmworkers

Of the billion pounds of pesticides used annually in the United States 80% is used in agriculture. Hispanics comprise 71% of all seasonal agricultural workers and 95% of all migrant farmworkers. This is cause for great concern among public health professionals serving Hispanic patients and clients. Exposure to agrochemicals has been associated with a variety of cancers, particularly hemopoietic cancers; acute and chronic neurotoxicity; lung damage; chemical burns; infant methemoglobinemia; immunologic abnormalities; and, adverse reproductive and developmental effects.

Hispanics comprise 71% of all seasonal agricultural workers and 95% of all migrant farmworkers.

It's been reported that prolonged exposure to pesticides is responsible for an estimated 1,000 deaths and 313,000 illnesses annually among agricultural workers in the United States. Among young Mexican American farmworkers interviewed in New York State, 48% reported working in fields with pesticides, and 36%

..health professionals working with Hispanic patients in rural communities should be familiar with the signs, symptoms and long term impacts of various pesticide and other agro-chemical exposures.

Hispanics...are over-represented in the electronics sector as laborers and assemblers, and in the oil and petrochemical industry.

reported being sprayed with pesticides while working in fields and orchards.[65] Thus, health professionals working with Hispanic patients in rural communities should be familiar with the signs, symptoms and long term impacts of various pesticide and other agro-chemical exposures.

Biological and chemical contamination of water supplies in migrant labor camps is another widely reported, although not well documented problem. One study found that 43% of water supplies at state-licensed migrant camps in nine Michigan counties contained nitrates. Migrant labor camps in California have also been cited by the EPA for having excessive levels of nitrates and coliform bacteria in their drinking water.

Occupational exposure to chemicals is also widespread in the Hispanic community. Many Hispanics work in settings in which the risk of exposure to a variety of chemicals, gases, and other toxic substances is very high. Hispanics predominate in the migrant and seasonal agricultural workforce, and are also over-represented in the electronics sector as laborers and assemblers, and in the oil and petrochemical industry.

Key Areas of Concern

Community-based Hispanic health and human services groups throughout the United States and Puerto Rico have come to identify certain key health issues that are having major impacts on Hispanic health such as AIDS and HIV; cancer; coronary heart disease; stroke; hypertension; diabetes; environmental health; stress and mental health; and, tuberculosis. These are areas that could be of particular interest if you are a health care provider working with Hispanic patients.

AIDS and HIV

The Centers for Disease Control and Prevention (CDC) reported a cumulative total of 711,344 cases of AIDS in the United States by June 1999. Hispanics accounted for 18% (129,555) of the cumulative AIDS cases. In 1982, Hispanics represented 7% of the U.S. population; yet, accounted for 13% of all AIDS cases in that year. By December 1997, Latinos represented 12% of the total U.S. population; yet, accounted for 21% of the new AIDS cases.[66] HIV diagnoses increased 10% among Hispanics as observed in the most recent data available. At the same time, it decreased slightly among African Americans and among Whites.

As of June 1999, there have been 22,936 AIDS cases among Latinas. Of that number, 41% of those cases are directly related to injecting drugs (9,399). Heterosexual contacts account for 47% of the cases (10,753). Within this heterosexual category, 5,031 Latinas became infected due to sexual contact with an injecting drug user. Disparities in health outcomes by race/ethnicity and gender show that AIDS incidence and deaths declined most dramatically for whites and least among women and people of color.

AIDS strikes Puerto Ricans the hardest, followed by Cubans, probably in part because Puerto Ricans and Cubans are concentrated in East Coast cities where AIDS has taken a high toll. Mexican Americans seem less affected by the epidemic. Overall, Hispanic men are nearly twice as likely as white non-Hispanic men to die from AIDS, and Hispanic women are nearly five times as likely to die from the disease as white non-Hispanic women. Factors that contribute to disparities in AIDS incidence and mortality among Hispanics, when compared to whites, include late identification of HIV infection, less access to

The annual incidence rate of AIDS for Hispanic adults is 4 times that of non Hispanic white adults.

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experienced HIV/AIDS physicians, less access to HIV therapy that meets federal guidelines and lack of health care insurance to pay for drug therapies.

Cancer

Malignant neoplasms are the second leading cause of death in the United States among both Hispanics and non-Hispanic whites, although Hispanics have a slightly lower rate.

Malignant neoplasms are the second leading cause of death in the United States among both Hispanics and non-Hispanic whites, although Hispanics have a slightly lower rate. In terms of total numbers, of 520,578 deaths classified as due to malignant neoplasms: non-Hispanic whites accounted for 81.8%, non-Hispanic blacks for 11.2%, and Hispanics 2%.[67]

Hispanics have a higher incidence of colorectal cancer, as well as cancer of the pancreas, cervix, prostate, and stomach, with twice the rate of cervical and stomach cancers than that found among non-Hispanic whites. Among Hispanic women rates of cervical cancer for Mexican American women and Puerto Rican women are more than twice as high as the incidence rates for non-Hispanic white women. However, the incidence rate for breast cancer among Mexican American women and Puerto Rican women is lower than that for white non-Hispanic women or non-Hispanic black women.[68]

Prostate cancer in Hispanic males is the only group increasing in incidence.[69] Brain cancer of Hispanic children in Los Angeles moved from third to first in incidence.[70] Lung cancer is the leading cause of death of all cancers for both men and women. Despite lower incidence of breast cancer, Hispanic women have high mortality rates.

Coronary Heart Disease, Stroke, and Hypertension

Diseases of the heart were the leading cause of death among Hispanics in 1998.

Diseases of the heart were the leading cause of death among Hispanics in 1998. Still, according to the National Center for Health Statistics the death rate for diseases of the heart is lower for Hispanics (83.3 deaths per 100,000), than for whites

(297.6) or blacks (237.3). This lower rate of heart disease is surprising since Hispanics have a higher prevalence of conditions that increase their risk for coronary heart disease, including obesity and diabetes.[71]

Cerebrovascular disease (stroke) is the sixth leading cause of death among Hispanics, accounting for 5% of all Hispanic deaths. It is the third leading cause of death among non-Hispanic whites, accounting for 6.7% of all deaths.[72] Since hypertension, diabetes, and obesity are all associated risk factors for stroke and related diseases, Hispanics might be expected to face a higher stroke rate than non-Hispanic whites. In fact the opposite is true. If there is some sort of genetic "protective effect" prevalent in Hispanics, future research may be able to isolate and identify this mechanism, and use it to lower rates of cerebrovascular disease.

...Hispanics have a higher prevalence of conditions that increase their risk for coronary heart disease, including obesity and diabetes.

Hypertension affects 24.4% of Mexican American males and 22.9% of Mexican American females.[73] Hispanic men are more likely to have undiagnosed, untreated, or uncontrolled hypertension than the national average. Hispanic females are more likely than Hispanic men to be aware of their condition, although fewer receive treatment for it, and very few have it controlled. In a report out of New York City, it was found that 10% of Dominicans and 12% of Puerto Ricans sampled were hypertensive. The study suggested that race is a significant factor in hypertension: 9% of non-Black Hispanics were found to be hypertensive, compared to 12% of Black Hispanics.[74]

Hispanic men are more likely to have undiagnosed, untreated, or uncontrolled hypertension than the national average.

Diabetes

Non-insulin dependent diabetes is a major health problem among Hispanics, especially Puerto Ricans and Mexican Americans, who are about twice as likely to be afflicted by it as

...Puerto Ricans and Mexican Americans, who are about twice as likely to be afflicted by it [diabetes] as non-Hispanic whites.

non-Hispanic whites. Data shows that incidence of diabetes to be 26.1% for Puerto Ricans, 23.9% for Mexican Americans, and 15.8% for Cuban Americans, compared to 12% for non-Hispanic whites and 19.3% for non-Hispanic blacks for individuals aged 45–74.[75]

This higher rate of diabetes is correlated with the higher prevalence of obesity among Mexican American women, but overweight Hispanic women are still more likely to have diabetes than overweight non-Hispanic women. Another risk factor was assumed to be genetic as the incidence of non-insulin diabetes appears to be highest in Mexican Americans with substantial Pima Indian heritage.

Environmental Health

Both the Agency for Toxic Substances and Disease Registry (ATSDR) and the EPA produce toxicological profiles that can assist you in diagnosing illnesses related to an environmental risk or toxic exposure.

The environmental health status of Hispanic communities is poor, and is a major source of health problems. Among their high risk exposures: ambient air pollution; worker exposure to chemicals in industry; pollution indoors; pollutants in drinking water. In terms of exposure. Hispanics consistently face the worst exposure levels, or levels that represent significant threats to health. Health practitioners should consider environmental sources in diagnosing and treating a variety of conditions affecting Hispanic patients and clients. Both the Agency for Toxic Substances and Disease Registry (ATSDR) and the EPA produce toxicological profiles that can assist you in diagnosing illnesses related to an environmental risk or toxic exposure.

Mental Health

Although rates of mental illness may be similar to whites, the prevalence of particular mental health problems, the manifestation of symptoms, and help-seeking behaviors within Hispanic subgroups need attention and further research. The prevalence of depressive symptomatology is higher in Hispanic women (46%) than men (19.6%); yet, the known risk factors do

not totally explain the gender difference.[76] Acculturation appears to be a factor in depression as well. Duran found differences in depression in Hispanic women dependent on acculturation.[77]

A recent report from the National Alliance for Hispanic Health focuses our concern on "The State of Hispanic Girls." The statistics are unsettling. One in three Hispanic girls has seriously considered suicide, the highest rate of any racial or ethnic group. The Commonwealth Fund survey shows a strong connection between depression among girls and participation in risky behaviors. Girls subject to depression or lacking in self confidence are twice as likely to report use of cigarettes, alcohol, and illicit drugs than their non-depressed peers. In addition, Cubans are less likely to die from treatable illnesses than other Hispanics, but they have the highest suicide rates, surpassing those of white non-Hispanics. The trauma of exile and family separation may explain the differences.

One in three Hispanic girls has seriously considered suicide, the highest rate of any racial or ethnic group.

There are several stressors related to social adjustment to the dominant culture which affect several generations of Hispanics. Al-Issa has defined three:

1. Acculturative Stress, which is most typically felt by immigrants who are faced with the turmoil of leaving their homeland and adapting to a new society.

2. Socioeconomic stress, which is often experienced by ethnic minorities who feel disempowered because of inadequate financial resources and limited social class standing.

3. Minority stress, which refers to the tensions that minorities encounter resulting from racism.[78]

Although some overlap exists among these stressors, they are conceptually distinct forces and often require specific coping strategies. Each stressor influences the quality of life and mental health of non-whites regardless of immigration status.

The concept of social adjustment stressors has historical roots in two theories: Durkheim's (1933) theory of anomie and Leighton's (1968) theory of mental illness and social disintegration.

...rapid cultural change causes a condition called anomie — the absence within a society of common social norms and controls...people lack clear behavioral guidelines, possibly resulting in destructive tendencies.

According to Durkheim's theory, rapid cultural change causes a condition called anomie — the absence within a society of common social norms and controls. Under those conditions, people lack clear behavioral guidelines, possibly resulting in destructive tendencies (e.g. depression and alcohol abuse). Leighton proposed that social disintegration and lack of social cohesion precipitate psychological distress and mental illness. He argued that rapid social change and disruptions (e.g. low and unstable income, conflict cultural values, and fragmented communication networks) cause high stress levels that can result in deviant behaviors and psychological disorders. Although most Hispanics in this country are born in the U.S., even prior to the border moving, the current minority status supports the existence of these social adjustment stressors.

Hispanics are identified as a high-risk group for mental health problems, particularly for depression, anxiety, and substance abuse. Of course people in transition often experience feelings of irritability, anxiety, helplessness, and despair. They may mourn the loss of family, friends, language, and culturally determined values and attitudes. These reactions are not signs of individual pathology, but rather normal responses to the often disruptive process of change. Sources of stress include: life in a society that does not support their culture and way of life; having to cope with low-incomes and poor

housing; experiencing suspicion and distrust regarding their legal status; experiencing exploitation and mistreatment from both individuals and institutions in the workplace and other settings.

Such stress had been assumed to increase the risk for somatic and functional illness, depression, organic disease, and interpersonal problems. In September of 1998, the Archives of General Psychiatry published an article, which provided compelling data that Mexican born United States residents had less mental illness than Mexican Americans.[79] This was contrary to the years of myth that Hispanic immigrants would suffer more mental illness than Hispanics born in the United States as a result of post-traumatic stress disorders resulting from wars and other violent events in their countries of origin, and hostile attitudes towards Hispanic immigrants.

The evidence indicates that higher levels of acculturation and birth in the United States are associated with higher incidence of phobia, alcohol abuse, drug dependence, and anti-social behavior such as gang membership. Sociologist Herbert Gans argues that immigrant children who hold fast to their parents' ethnic communities may do better than those who assimilate rapidly and adopt the American culture that they see all around them, including cynical attitudes towards school and rejection of low-wage employment opportunities.[80]

John Hopkins professor Alejandro Pertes finds that the chances for downward mobility and anti-social behavior are greatest for second generation immigrant youth living in close proximity to other American minorities who are poor to start with, and who are themselves victims of racial and ethnic discrimination.[81]

...Mexican born U.S. residents had less mental illness than Mexican Americans.

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II. About Hispanics
Chapter Six: Hispanic Health Status

Severe psychiatric disorders among Hispanics are sometimes diagnosed incorrectly, when practitioners are unaware of prevalent cultural beliefs and practices, and when they use psychological tests that have not been standardized for bilingual populations.

Tuberculosis

Among Hispanics TB is most prevalent in young adults, ages 25–44.

Approximately 10 to 15 million Americans are infected with mycobacterial tuberculosis (TB). In the United States, the number of cases of active TB increased over 20% between 1985 and 1992 with a disproportionate rise among racial and ethnic minorities. During this period, the number of cases of TB increased 26.8% among non-Hispanic blacks, 46.2% among Asian/Pacific Islanders, and 74.5% among Hispanics. The risk of contracting TB among Hispanics is more than four times the risk among non-Hispanic whites. Among Hispanics TB is most prevalent in young adults, ages 25–44. Evidence suggests that the HIV epidemic is in part responsible for the recent increases in tuberculosis among Hispanics in this age group. TB may also be a particularly significant problem for migrant workers. Screening of 214 Hispanic migrant workers in Virginia in the 1980s found that over a quarter had tuberculosis infection, and were at significant risk of developing the clinically active disease.[82]

Conclusion:

It is crucial to assess the specific needs of each Hispanic population you are serving before developing educational or clinical approaches to treatment. It is also very important to re-evaluate approaches at regular intervals to assure quality of care provided, as well as, to assure proper compliance with protocols by patients.

Outreach and prevention programs can promote healthy behaviors and facilitate early detection of disease and disorders. However, not all diseases and disorders can be prevented; therefore, culturally appropriate and cost effective treatment must also be available for physical, mental health, and substance abuse problems. Treatment of Hispanic patients/clients must move beyond the medical model of care and examine the quality of that care to practice healing. To respond to the need for culturally competent treatment for Hispanic patients/clients, new service models are being developed.

Treatment of Hispanic patients/clients must move beyond the medical models of care...

Even beyond the barriers of language and culture, attempts at effective outreach to the Hispanic community may profoundly challenge health providers in varied and unexpected ways. Strategies for developing and bringing new health models, education and access to individuals within their own community settings are an essential but largely overlooked component of the health care system in the United States. Community-based organizations within Hispanics neighborhoods, barrios, colonias, and other ethnic enclaves provide a significant point of entry and opportunity to expand on any outreach effort you may be involved in.

Strategies for bringing new health models, education and access to individuals within their own community settings are an essential but largely overlooked component of the health care system in the United States.

While the health care system has established some links to historically black universities, colleges, and medical schools, and through health-education programs and African-American churches; limited relationships exist with the Hispanic community. In fact, the Hispanic community has a completely different institutional structure when it comes to issues of health and health services, a structure with little organic or historical connection to mainstream providers. In America's barrios and colonias there are no "Historically Hispanic" colleges and universities or medical schools and the Catholic Church, with over three-quarters of all Hispanics, sees its focus on the spiritual aspects of life.

As a result, a network of hundreds of local community-based organizations have emerged in almost every Hispanic community in America. For the past 30 years, these organizations have acted as frontline advocates for and providers of Hispanic health care and social services, yet continue to struggle for existence because of limited funding.

...a network of hundreds of local community-based organizations have emerged in almost every Hispanic community in America.

Many of these organizations, and hundreds of others like them, trace their origins to the political upheavals of the late

III. Implementation

Chapter Seven: Outreach

1960s and early '70s, when Hispanics began to assert themselves in bold, confrontational demonstrations linked to anti-Vietnam war protests, civil rights, and demands for economic justice. Among the highlights of the period were the emergence of Cesar Chavez and the United Farm Workers Union that organized in the West with a focus on work-related issues. In the East, there was the emergence of the Puerto Rican Young Lords in New York with a focus on meeting community-based needs.[83] Interestingly, one of their first actions was the seizure of Lincoln Hospital in Harlem to demand that it become more responsive to the health needs of the Hispanic community. Equally interesting was the fact that, even in the context of highly polarized times, the New York public hospital system's response was not to call in the police, but to agree to some early, tentative steps towards becoming culturally competent and more responsive to the Hispanic population that it served.

...community-based health and social service organizations have established histories of providing linguistically and culturally credible services within their own communities.

Still, to a large extent the community-based health and social service organizations that grew out of this period of upheaval were and still are a product of community frustration at being denied access to mainstream health services or resources. Born out of community struggles, they remain governed by community boards and have established histories of providing linguistically and culturally credible services within their own communities. It is this national infrastructure and network that is the most appropriate and sensible entry point for designing and implementing health outreach programs for Hispanic communities. The following case studies and key concepts are relevant to other situations.

Case Study

The Latin American Research and Service Agency (LARASA), in Denver, Colorado established Project CORE — Cancer Control Through Outreach, Research, and Education. In 1995, CORE has aimed at increasing the number of Latinas in Colorado who are screened for breast and cervical cancer.[84]

CORE grew out of a needs assessment survey and focus groups conducted within the Hispanic community by LARASA. Among the survey's findings: Latina women are traditionally the care takers of the family, but few health studies focus on women, particularly Latinas. While Latinas in Colorado were diagnosed with lower rates of invasive breast cancer and higher rates of invasive cervical cancer than white women, their five-year survival rates were found to be lower in both cases. The key program components included:

CORE grew out of a needs assessment survey and focus groups conducted within the Hispanic community by LARASA.

- Holding educational forums in both English and Spanish on the importance of early screening and detection of cancer for Latinas in local neighborhoods and at a northwest Denver elementary school.
- Distributing written educational materials to 1200 homes, through 400 mailings, and at a statewide conference attended by 200 Latinas.
- Providing 93 women with a clinical breast exam or breast exam and mammogram through use of a mobile van operating in targeted neighborhoods within Denver's Hispanic community.
- Initiating a meeting of Latina women who have survived breast and/or cervical cancer.
- Helping to bring the issue "out of the closet" by organizing and participating in an interview with a Latina breast cancer survivor broadcast on local Spanish-language television.

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Case Study

...Texas health educators surveyed Mexican Americans asking them what was their primary source for health information.

In pre-planning a community outreach and awareness program on cardiovascular disease in Houston, Texas health educators surveyed Mexican Americans asking them what was their primary source for health information. Thirty-five percent identified their physician. Nearly 50% identified some form of mass media (TV, newspapers, magazines, radio). The planners then used the survey findings to design a Spanish-language media program, *El asesino silencioso* (The Silent Killer) that linked television programming and other mass media with credible medical authority.[85]

Case Study

The effectiveness of the program was confirmed when a number of the kids' parents began asking for and receiving instruction on how to prepare these healthy Hispanic recipes.

In 1996, in New Mexico, Youth Development, Inc. (YDI) was able to move a youth outreach program from a gym-based after-school setting to its own community training center, a converted 2,000 square foot residential house in the south valley section of Albuquerque. Since many of the twenty-five 9 to12 year-old students YDI worked with each year were "latch-key" kids (children who returned home from school while their parents were still at work), the organization was able to utilize this house as a training facility for home safety and nutrition. Along with basic instruction on safety hazards such as exposed electrical plugs, they also instructed the children, many of whom already cooked for themselves and their younger brothers and sisters, on how to safely prepare healthy and nutritious Hispanic meals. Along with showing them videos on nutrition and health, and providing recipes, YDI staff and a volunteer chef also gave them hands-on cooking instructions in the center's kitchen. The effectiveness of the program was confirmed when a number of the kids' parents began asking for and receiving instructions on how to prepare these healthy Hispanic recipes.[86]

Case Study

An example of positive role-modeling took place in Chicago where, beginning in 1992, the Pilsen-Little Village Community Mental Health Center provided an after school and summer school program for children whose families were in treatment for substance abuse. The range of activities included drama, poetry, and art therapy workshops. Mother's Day poems that the children composed were read to their mothers at a special family event. Thirty 9 to12 year-old children also participated in the Great Chicago River Rescue Day Clean Up of the I&M canal in 1996 along with older Hispanic teens from other parts of the city. At a subsequent picnic these children heard a steel band and were taken on canoe rides by a Hispanic river guide who became a favorite adventure career role-model for many of the children. Other nature-oriented field trips included bus and van visits to the Indiana Dunes and Illinois forest reserves.

...in Chicago . . . Pilsen-Little Village Community Mental Health Center provided an after school and summer school program for children whose families are in treatment for substance abuse.

Case Study

In Los Angeles, youths were taken on a field trip to Kaiser Permanente's Sunset Hospital in Hollywood. There they learned about health care issues, saw how a hospital works, and met with physicians, nurses, a physical therapist, and other health care professionals. After the tour they all expressed their desire to work in health care. After a similar tour of the UCLA campus, all the youngsters announced they wanted to be college students and health care providers. They were told they could do both.

In Los Angeles, youths...learned about health care issues, saw how a hospital works, and met with physicians, nurses, a physical therapist, and other health care professionals.

As a result of Kaiser Permanente's participation in this project, the East Los Angeles Multicultural Area Health Education Center (MAHEC) was granted funds to provide childhood immunization services, and began to consider other ways in which it, as a health care institution, could participate in preventative and outreach role-modeling opportunities for Hispanic and other youths from underserved communities.[87]

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Case Study

Hotline promotion is conducted primarily through Spanish-language media, including radio, television, newspapers and magazines, and by public service announcements and interviews highlighting the services provided by the hotline.

The National Hispanic Prenatal Hotline (NHPH) (1-800-504-7081) provides outreach to over 3,000 Hispanic consumers a year interested in information about pregnancy and prenatal care and offers referrals to local prenatal care services. Hotline promotion is conducted primarily through Spanish-language media, including radio, television, newspapers and magazines, and by public service announcements and interviews highlighting the services provided by the hotline. NHPH is staffed by bicultural, bilingual information specialists who use the language the caller feels most comfortable speaking. The information provided, both verbal and written was free to consumers and individualized to the callers' needs.[88]

Key Concept

To earn confianza in a targeted community find out who is respected in the community.

Don't assert your agenda, instead listen for the community's agenda — what people are asking for — and assign your priorities based on their needs.

Important Points for Developing Outreach Programs

1. To earn *confianza* (trust) in a targeted community find out who is respected in the community. Ask your patients, your staff, business owners, clergy, members of the media, and teachers who are the respected leaders and agencies that serve the community's needs.

2. Remember the value of *personalismo (familiarity)*. Go to local leaders and ask for their opinions about what people in the community most need. Ask them who is already helping with that, and what outreach resources are available. Ask for advice about who you should work with. Don't assert your agenda, instead listen for the community's agenda — what people are asking for — and assign your priorities based on their needs.

3. To work effectively with community-based organizations, outreach programs must demonstrate a capacity and willingness to allow community priorities to guide them. They must earn the community's trust or *confianza*; reach into the community through existing, respected groups; select culturally relevant media and/or materials to convey their messages; and, target whole families with understanding and respect.

    ...outreach programs must demonstrate a capacity and willingness to allow community priorities to guide them.

4. To effectively meet the needs of Hispanic communities, health outreach and promotion programs should also target the specific community or Hispanic subgroup they seek to serve. Spanish-language signs, educational materials, and videotapes do not work as well when they're simply translated directly from English. They have to be developed specifically for the target population. The person(s) developing the materials should be familiar with the language, literacy level, and culture of a specific target group and should have the materials reviewed by members of the target audience. Providers must be open receivers and listeners of "culture" and its dynamics in the delivery of health care.

    Spanish-language signs, educational materials, and videotapes do not work as well when they're simply translated directly from English.

5. *Respeto* (respect) dictates appropriate deferential behavior toward others on the basis of age, sex, social position, economic status, and authority. The provider enters into a reciprocal interaction when treating an Hispanic patient. If a patient feels that the provider has violated the rules of respeto, the patient may terminate treatment. Younger providers, even though they will be awarded respeto as authority figures, are expected to be especially formal in their interactions with older patients. Formality is a sign of respect, but should not be confused with emotional distance.

    If a patient feels that the provider has violated the rules of respeto, the patient may terminate treatment.

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The great risk is in not making the effort

What is Prevention?

Prevention is important in lifestyle choices for health behaviors that may reduce chronic health disorders, eliminate some infectious disease, and deter mental health and substance abuse problems. The purpose of prevention is ultimately to change behavior, the social and environmental norms that support unhealthy behaviors, and to foster use of systems of care that can detect health conditions before problems arise. Prevention is most effective when the activities are culturally relevant and address social norms, attitudes, and values which may contribute to the targeted behavior change.

The purpose of prevention is ultimately to change the cultural and environmental norms that support unhealthy behaviors.

To date, many prevention models have been developed and widely distributed for the mainstream culture which are egocentric or individual-oriented in focus. Few prevention models that are sociocentric or group-oriented in focus have been developed and validated. It is essential to understand the differences in the focus of the orientation because it helps to understand what is generally important and how importance is manifested. Although many of the factors appear to be similar, the differences are often found in the emphasis and related behaviors. For instance, most cultures may value family; however, the behaviors expected may be very different.

Egocentric values tend to place emphasis on autonomy, success of the individual and independence. Thus, an eighteen year old daughter from an egocentric culture may value her family and go to college across the U.S. with little familial contact even though she wants to work in the neighborhood library. Reflective of the individual-oriented focus, she may believe her good grades and a high income job will mark her success and fulfillment of her family values.

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Alternatively, sociocentric values tend to place emphasis on the good of the group. An eighteen year old daughter from a sociocentric culture may value her family and go to work in the neighborhood with daily familial contact even though she wants to go away to college. The happiness of her family (because she is close to home) marks her success and fulfillment of her family values given that the group is better because she stayed home. Both daughters are fulfilling their family values and neither is better or worse than the other. Knowledge, as well as, experiences in the other perspective will enable the discernment of the complex differences and foster the value of each culture. This understanding will enable the development of prevention models tailored to specific groups and minimize the ethnocentricism of mainstream general application of egocentric models.

As stated earlier, few sociocentric models have been validated in the U.S. and egocentric models may not be applicable. In the absence of science-based group-oriented models, a public health model which addresses the individual and the environment is recommended. The public health model supports the notion that behavior patterns are developed, maintained, and supported within a social context.

The public health model supports the notion that behavior patterns are developed, maintained, and supported within a social context.

The socialization of behaviors falls on a continuum by which new and old behaviors are either supported or chastised. Therefore, it is important to differentiate between the process for adopting new behaviors (known as social norming) and the sustaining of old behaviors referred to as culture. Culture is the total lifestyle of people from a particular social group, including all the ideas, symbols, preferences, and material objects they share. Culture evidences stability over time as beliefs, traditions, and values are passed from one generation to the next. However, social conditions and environmental changes

may impact and change aspects of culture for any group. The Culture-Value Theory suggests some cultures are more likely to bring about risky shifts, while others are more likely to result in cautious shifts. In other words, some aspects of culture shift with external influences. What causes these shifts is best understood through the process of social norming which is the implicit or explicit rules a group has for the acceptable behavior, values, and beliefs of its members. Social norms can be influenced by critical events such as AIDS, war, economic depression, migration, etc. They are also impacted by purposeful acts such as media, social marketing, discrimination, acculturation, basic science findings, laws, and technological advances. In order to prevent unhealthy behaviors and promote healthy ones, prevention approaches must focus on both culturally motivated behaviors, as well as, social norming influences.

...Culture-Value Theory suggests some cultures are more likely to evince risky shifts, while others are more likely to evince cautious shifts.

Understanding the rules of the culture, how it functions, and how it is influenced foreshadows effective prevention strategies. The prevention strategies employed must be tailored to the targeted individual and his/her environment, including culture and social norms. Individual change may be difficult without communal support or guides. Some of the components which are more resistive to change may be assisted with public and organizational policy changes.

The prevention strategies employed must be tailored to the targeted individual and his/her environment, including culture and social norms.

To date, there is little to no validated information to delineate prevention strategies specifically for Hispanics. However, it is known that Hispanics are not an individual-oriented culture; therefore, the mainstream prevention approaches focusing on the individual may not be appropriate because they do not address the importance of culture, nor do they provide a social context. The prevention strategy which may be more appropriate, until cultural specific models are developed, is the

...Hispanics are not an individual-oriented culture; therefore, the mainstream prevention approaches focusing on the individual may not be appropriate...

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A public health model that utilizes a comprehensive community approach to include family, school, college, church, work, community, and health care-based activities would probably be the most effective prevention plan for health promotion and dissipating high risk social norms with Hispanics.

public health model. A public health model that utilizes a comprehensive community approach to include family, school, college, church, work, community, and health care-based activities would probably be the most effective prevention plan for health promotion and dissipating high risk social norms with Hispanics. Although there is little scientific base to date, prevention models which factor in the influences and impact of social environment are probably the most culturally appropriate for Hispanics.

Hispanics, in all areas of prevention, including prenatal and pediatric check-ups, inoculations, adult physicals, HIV/AIDS, abuse of alcohol and illicit drugs, and smoking tend to receive fewer benefits and have significantly limited participation in behavior-based prevention programs. Given the low rates of Hispanic use, the application of current prevention models seemingly lack cultural competence which consequently discourages utilization and misunderstanding of the relevance of prevention programs.

Culturally appropriate prevention activities must promote healthy behaviors and reduce risk behaviors. Each presents a different challenge, but must be integrated successfully and efficiently into merging models of health care delivery, such as managed care or care of the uninsured.

The remainder of this chapter examines key concepts for promoting healthy behaviors and reducing risk behaviors.

Promoting Healthy Behaviors   **Key Concept**

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   The purpose of promoting healthy behaviors is to foster decisions that will maintain good health and have early detection of health problems.

1. Lifestyle Choices

   Diet, exercise, and weight control appear to be factors that contribute to good health. The current standards for appropriate diet, weight, and exercise levels are based on mainstream whites. Based on these standards, Hispanics report as overweight, lacking exercise, and falling short of the recommended daily allowances of fruits and vegetables. Standards must be determined specifically for Hispanics with programs established that promote good lifestyle choices and have support systems instituted to sustain change.

The current standards for appropriate diet, weight, and exercise levels are based on mainstream whites...standards must be determined specifically for Hispanics...

2. Mental Health

   To promote good mental health, social stress and cultural conflict must be addressed as many Hispanics are first, second, and third generation immigrants. Research has shown it takes approximately three generations to acculturate. For many others for which the border moved, social stress and cultural conflict must also be dealt with, as the invasion of the dominant culture forced unwanted changes in their behaviors. Validation of cultural strengths and ethnic heritage are needed in conjunction with the coping skills to manage social stress and conflict.

Research has shown it takes approximately three generation to acculturate.

   The daunting statistics of substance abuse, violence and suicide reflect coping behaviors that need new strategies and skills. To foster good mental health, behaviors must be

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promoted that build upon the respectful values of the Hispanic culture and provide appropriate strategies for managing the ill feelings and anger that have resulted from troubled environments and perceptions of discrimination.

The social, economic, familial, and personal costs of mental illness are too great to have ill persons go without treatment.

Mental health problems are a burden to the ill person, their family, and society. The social, economic, familial, and personal costs of mental illness are too great to have ill persons go without treatment.[89] Hispanics with diagnosable mental disorders receive insufficient mental health care, especially from specialists. More Hispanics use a medical care provider for their mental health and substance abuse problem.[90] It was also found that rates of use were lower for Mexican born in Mexico and those who are low acculturated. Much less information is known about Hispanic children. Leaf et. al. found fewer children receive services in the specialty mental health sector than are in need of these services.[91] To ensure good mental health, culturally appropriate mental health services must be made available to Hispanics with mental health problems and mental health illnesses.

3. Disease and Disorder Screening and Other Preventive Practices

Many Hispanics, due to geographic location. lack of resources, and no insurance, have limited access to screening and preventive practices.

To promote health, culturally appropriate screening services and preventive practices, such as immunizations, must be available, accessible, affordable and practical. Many Hispanics, due to geographic location, lack of resources, and no insurance, have limited access to screening and preventive practices. Consequently, care is sought for critical conditions and later stages of disease and disorders which often result in unnecessary death or mutilation. Early detection and treatment of disease increases the probability of recovery.[92]

Some Hispanics, like most other Americans, may need to be educated about the value of screening and other preventive practices. The most effective education appraisal for prevention and early diagnosis is often improved outcomes. Due to the frequent lack of trust in bureaucratic systems and limited access to preventive care, cognitive information may not be enough to persuade the perception of value or to counter the negative social norms that have resulted from inadequate preventive care. As services are made more available and the health status improves, conditions that created a social norm such as "fatalism" when diagnosed with cancer may change. If those diagnosed with cancer typically live, the social norming process transforms the fatalist belief that a diagnosis of cancer equates to death. Combine this experience with the knowledge that cancer is mostly curable if detected early through screening. Ultimately, the benefits of early detection and improved recovery could motivate screening and preventive practices which are reflective of an improved health status.

Due to the frequent lack of trust in bureaucratic systems and limited access to preventive care, cognitive information may not be enough to persuade the perception of value or to counter the negative social norms that have resulted from inadequate preventive care.

In the advocacy for screening and prevention practices, the social environment must also be assessed. The negative consequences of screening and support for healthy behaviors must also be addressed. Screening and prevention should be accompanied by additional resources and services. For instance, it is not enough to screen for alcohol without services for the problem drinker. It is not enough to screen for cancer or mental illness without follow-up treatment. Prevention is best when there is support and feasible alternative behaviors. Screening and prevention are not stand alone practices and may have negative impacts on communities where additional resources are unavailable.

Screening and prevention should be accompanied by additional resources and services...it is not enough to screen for alcohol without services for the problem drinker.

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Reducing Risk Behaviors

Accurately assessing the array of mental processes that influence behavior is inherently difficult, primarily because it relies on that person's subjective report of how he or she feels, justification for a particular behavior, and the often lack of awareness of cues. Consequently, it is difficult to determine what prevention or intervention strategy will actually reduce risk behaviors. Initial model development supports the notion of reducing risk factors and increasing protective factors across many areas of a person's life. The motivation foreshadowing risk behaviors may be individually driven; however, there appears to be strong social influences, especially for sociocentric groups, such as Hispanics. Consequently, the models developed and validated for Hispanics must include the many domains or social influences surrounding the person.

The motivation foreshadowing risk behaviors may be individually driven; however, there appears to be strong social influences, especially for sociocentric groups, such as Hispanics.

In order to consistently prevent or reduce risk behaviors, refusal skill training and life-skill training programs that are specifically targeted to Hispanics should be used. As a sociocentric group with additional life stressors, such as discrimination and poverty, the expected models are more complex than just saying "no."

1. Alcohol and Illicit Drug Abuse

Data from the past 20 years show that prevention has succeeded in substantially reducing the incidence and prevalence of illicit drug use. Successful substance abuse prevention also leads to reductions in traffic fatalities, violence, unwanted pregnancy, child abuse, sexually transmitted diseases, HIV/AIDS, injuries, cancer, heart disease and lost productivity.

Although few models have been validated specifically for Hispanics, the current mainstream models being tested include a comprehensive approach which reduces risk factors, increases protective factors, and addresses use/abuse in all domains or environments.

Risk Factors vary considerably according to an individual's age, psychosocial development, ethnic/cultural identity, and environment. However, the impact of any single risk factor may change over time with the development of changes in his or her environment. Some of the risk factors to consider include social acceptance, parents or peer usage, stressors, availability, accessibility, etc.

Protective Factors can increase a child's resilience to substance abuse, since they act as buffers to initiating or continuing substance use. The literature on protective factors and resilience is more diffuse than that for risk factors, and there is less clarity about which factors are most important in the prevention of substance abuse, especially for Hispanics. Some protective factors include group support, knowledge, laws, etc.

Domains interact, with the individual at the core of the framework, primarily through an individual's risk and protective factors. The precise nature of the links between substance use and each of the risk factors identified under the six domains (individual, family, peer, school, community, and society) are not yet fully understood. Research must be directed to understanding the decision and influence paths to use/abuse for members of sociocentric groups, such as Hispanics.[93]

...the current mainstream models being tested include a comprehensive approach which reduces risk factors, increases protective factors, and addresses use/abuse in all domains or environments.

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2. Tobacco Use

An estimated 48 million adults in the United States smoke cigarettes, even though this single behavior will result in death or disability for half of all regular users. Tobacco use is responsible for more than 430,000 deaths each year, or 1 in every 5 deaths. Paralleling this enormous health toll is the economic burden of tobacco use: more than $50 billion in medical expenditures and another $50 billion in indirect costs. Each year, smoking kills more people than AIDS, alcohol, drug abuse, car crashes, murders, suicides, and fires — combined! Current smokers were more likely to be heavy drinkers and illicit drug users. Among smokers, the rate of heavy alcohol use (five or more drinks on five or more days in the past month) was 12.8 percent and the rate of current illicit drug use was 14.7 percent. Among nonsmokers, only 2.5 percent were heavy drinkers and 2.6 percent were illicit drug users. In 1996, current smoking rates were higher among whites (29.8 percent) and blacks (30.4 percent) than among Hispanics (24.7 percent) and those of other race/ethnic groups (17.2 percent). Both white and black females in the total population were significantly more likely than Hispanic females to be current smokers.

Each year, smoking kills more people than AIDS, alcohol, drug abuse, car crashes, murders, suicides, and fires — combined!

However, there is an increase in Hispanic smokers, which may be an indicator of potential problems. Among Hispanic high school seniors, cigarette smoking declined from 1977 (35.7%) to 1989 (20.6%); however, smoking prevalence was 25.9% in1997. Among Hispanic 10th-grade students, smoking prevalence was 18.3% in 1992 and 23.0% in 1997. For Hispanic eighth-grade students, prevalence was 16.7% in 1992 and 19.1% in 1997. Current cigarette smoking prevalence was lower among Hispanic high school students than white students. There was a 34% increase in smoking prevalence among Hispanic students from 1991 (25.3%) to 1997 (34.0%).[94]

...there is an increase in Hispanic smokers, which may be an indicator of potential problems.

Smoking is responsible for 87% of the lung cancer deaths in the United States. Overall, lung cancer is the leading cause of cancer deaths among Hispanics. Lung cancer deaths are about three times higher for Hispanic men (23.1 per 100,000) than for Hispanic women (7.7 per 100,000).

Overall, lung cancer is the leading cause of cancer deaths among Hispanics.

Studies have documented that tobacco products are advertised and promoted disproportionately to ethnic communities. Examples of target promotions include the introduction of a cigarette product with the brand name "Rio" and an earlier cigarette product "Dorado," which was advertised and marketed to the Hispanic community. Thus, targeted comprehensive Hispanic community approach is needed to prevent smoking, including economic interventions, counter advertising, retailer-directed interventions, environmental policies, etc.

Studies have documented that tobacco products are advertised and promoted disproportionately to ethnic communities.

In the past, helping people quit smoking was the primary focus of efforts to reduce tobacco use at all ages in order to reduce the risk of premature death. In recent years, the focus of tobacco control has expanded to include strategies to prevent individuals from ever starting to smoke — particularly young people, since the decision to use tobacco is nearly always made in the teenage years, and about one-half of young people who take up smoking continue to use tobacco products as adults. Yet, there are no validated models specifically for Hispanic youths.[95]

...the decision to use tobacco is nearly always made in the teenage years...

3. Crime Prevention

In 1996, U.S. residents age 12 or older experienced approximately 36.8 million crimes, according to the National Crime Victimization Survey. Three out of four were property crimes; 25 percent were crimes of violence.

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Chapter Eight: Prevention

The nation's law enforcement agencies reported a four percent decrease in serious crime during the first six months of 1997. Violent crime decreased five percent and property crime fell four percent during the first half of 1997.[96] The juvenile arrest rate for violent crime in 1996 dropped nine percent from 1995 and 12 percent from 1994.[97]

Issues such as domestic violence, violence in the workplace, emergency room visits, homicide, suicide, and assaults are all public health issues.

Issues such as domestic violence, violence in the workplace, emergency room visits, homicide, suicide, and assaults are all public health issues. Crime tends to occur in neighborhoods with high poverty. People who are victims of crime often experience both physical and mental health problems. There is no data available to specifically depict Hispanic health issues and crime; however, crime prevention and the injuries and loss due to crime should be considered in health models.

Case Study

In 1995, the Puerto Rican Family Institute (PRFI) of New York applied to a foundation for a grant to establish a pediatric health clinic in the Bushwick section of Brooklyn. This program provided preventative health care services to children ages 9 to 12 year-olds. Working with a pediatrician from Brooklyn's Wycoff hospital and a part-time outreach worker, the project provided physicals and immunizations for hundreds of children, along with referrals, progress reports, and escort services for children needing blood work and other medical follow-up. While the clinic's mission was to provide preventative care to children, because of its bilingual/bicultural benefits and easy access within the community, many parents and other family members also began to use it as their "one-stop shop," health care provider.

PRFI's response was to try and develop an effective referral system to help reconnect families with the health care system and educate them on the importance of long-term preventative health care action.

The clinic also provided crucial lifesaving interventions for the children of undocumented workers and others who might have fallen through the cracks in the health care system had the clinic not been there. One example involved a 12 year-old girl who had recently arrived from Mexico who was diagnosed with acute lupus, and referred to treatment. Another instance was a 10 year-old boy, suffering possible brain damage from a traffic accident that took place while he was being illegally transported from Mexico to New York. He was also provided long-term medical treatment as a result of a clinic diagnosis.

By providing a people-friendly environment with offerings from coffee and snacks for parents, to lollipops and stickers for their young patients, to children's books, art supplies and health educational videos in the waiting room, PRFI created a model of an informal community based bilingual/bicultural health care facility.

With the end of its foundation funding in 1998, PRFI was able to negotiate with Wycoff Hospital for the establishment of a five-day a week pediatric satellite clinic to be based within PRFI. This reflected a recognition by this mainstream health care provider that working on prevention programs with a culturally competent community-based organization could provide benefits for the patient population, while at the same time providing economic benefit to the hospital in the form of reduced costs.[98]

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III. Implementation

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As with community outreach, at-risk behavior prevention programs are most successful when they emphasize the connection between the individual, their family and the community. The importance of establishing a relationship of trust with community leaders and institutions in order to assess and create effective prevention strategies can not be overemphasized. Important questions to ask yourself are: do you do your outreach through existing Hispanic groups, select influential media, develop culturally relevant materials, and target the whole family with your prevention messages?

Culturally relevant materials, as stated earlier, must be relevant to the specific Hispanic subgroup targeted with a prevention message or program.

Culturally relevant materials, as stated earlier, must be relevant to the specific Hispanic subgroup targeted with a prevention message or program. Simply assuring that something is in Spanish will not ensure that the message will be delivered. Taking it one step further would be to develop specific messages for each family member. A preventative health video, for example, that was produced for a government agency by a non-Hispanic production company used a Mexican cast in a border setting and was found to be useless as an educational tool for Puerto Ricans, Dominicans, and Central Americans in other parts of the country. By contrast, videos produced by Hispanic organizations, have used a range of actors who speak a non-idiomatic Spanish, and cannot be easily identified with any single Hispanic sub-group.

Spanish language print and broadcast media by contrast have proven far more willing to run and even help produce prevention-oriented public service announcements than has the mainstream English language media. These free ads have ranged in content from smoking reduction, cancer, radon, and prenatal information messages, to instructions on how to receive free check-ups, child-car seats, and home fire detectors. Still, available resources such as these, within low-income and

underserved Hispanic communities, remain limited so that getting out the prevention message will require imagination, cooperation and creativity.

Conclusion

    To date, there are few prevention models to promote healthy behaviors or to reduce risks that are tailored specifically to Hispanics. Additional research is needed. In the interim, public health models may be the most effective. However, at a minimum, it is critical to understand that even though there may be relevant factors in mainstream/egocentric-based prevention models, they cannot be generally applied to Hispanics as a sociocentric group and expect successful outcomes. The challenge is for providers to move beyond their belief systems and values and expand their world views to validate how others function.

...it is critical to understand that even though there may be relevant factors in mainstream/ egocentric-based models, they cannot be generally applied to Hispanics as a sociocentric group and expect successful outcomes.

"You have to establish a relationship of trust with patients, if you want to practice healing."

Access to health services is a major barrier for Hispanics. Despite the benefits many Hispanics have gained from risk-reduction, outreach, and prevention efforts; reinforcement of positive cultural traits, and clinical treatment; Hispanics remain the United States population least likely to have access to a regular source of health care services and most likely to underutilized available health care services. Currently, health care benefits are primarily linked to type of employment. Although Hispanics are the group most likely to be employed, they are not working in jobs which offer health care benefits. Approximately, one-third of full-time employed Hispanics do not have health care benefits. Access to treatment must be addressed and corrected, along with the availability of culturally competent care.

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Access to health services, particularly those relating to chronic and disabling conditions is of prime importance to Hispanic adults. However, Hispanic adults are the group least likely to see a physician. According to the National Ambulatory Medical Care Survey, the number of physician visits per year for persons 45 to 64 years old was 4.8 for Mexican Americans, Cuban Americans, and Puerto Ricans, compared to 5.6 for non-Hispanic blacks and 6.5 for non-Hispanic whites.[99]

For many Hispanics, health insurance is another major barrier to service, if not the major barrier to health care utilization. As noted earlier Hispanics are the racial/ethnic group least likely to be insured.

The lack of insurance in the Hispanic community is tied in part to a lack of health insurance in the workplace, where the rate of uninsured Hispanics is a disturbing 37.9%. Over one-third of working adult Hispanics are uninsured, compared to about a quarter of working adult blacks and an eighth of working adult whites.[100]

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...a study of UCLA Emergency Medicine Center went on to find that ethnicity — not language, gender, or insurance status, was the main predicator for inadequate pain relief.

Unfortunately even when Hispanic patients have medical insurance and do seek medical services, they often must contend with a health care system that is not responsive to their needs. For example, a study of UCLA Emergency Medicine Center patients with long-bone fractures found that Hispanics were twice as likely as non-Hispanic white patients to be denied adequate pain medication (analgesia) in the emergency room. The study went on to find that ethnicity — not language, gender, or insurance status, was the main predicator for inadequate pain relief. The importance of cultural competency in improving Hispanic access to and service in health care settings seems to be key to making progress in this area.[101]

...Hispanics today comprise 12% of the U.S. population, only 4.3% of physicians, and less than 3% of registered nurses are Hispanic.

The growth in numbers of Hispanic health professionals has also not kept pace with the recent growth of the Hispanic population as a whole. While Hispanics today comprise 12% of the U.S. population, only 4.3% of physicians, and less than 3% of registered nurses are Hispanic.[102] By 2050, Hispanics could make up 25% of the population according to the Census Bureau.

Will Hispanics be equally well represented in the health and social service professions? While this is an important question in terms of social equity, an equally important question is, will Hispanics be able to receive culturally competent care and service from their health-care providers regardless of who those providers are?

On a cultural level you may encounter a definitional problem about who is a health care provider and what that person does. In traditional Hispanic culture physicians, nurses, and other health care professionals are seen as authority figures to be visited when one is sick. The idea of going to a doctor when one is feeling well may strike some Hispanics as odd (or if uninsured, an unaffordable luxury). Consequently, for many Hispanics, care such as physical exams or screenings for

diabetes, cholesterol, heart disease, cancer, etc. may be unfathomable. One result is that Hispanics with high cholesterol levels have been found to be less aware of their situation than their non-Hispanic white counterparts. That is also why one-third of Hispanic, adolescent women who make their first gynecological visit do so for a pregnancy test compared with one-tenth of non-Hispanic women.

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Since Hispanic women tend to look forward to pregnancy as a natural part of life, they do not see it as an illness or a medical condition. Therefore, they are less likely to visit a health care provider once they have confirmed they are pregnant. Consequently, Hispanic mothers are more than three times as likely as non-Hispanic white mothers to have late or no prenatal care, (approximately 30% receive no prenatal care). Although the infant mortality rate for Hispanic mothers (6.8 per 1,000 live births) is similar to that of non-Hispanic white mothers (6.9 per 1,000 live births), there is no question that the benefits Hispanic mothers derive from traditional Hispanic diets, family-support, etc. could be greatly supplemented and improved upon by regular prenatal check-ups with a health care professional.[103]

Through outreach and prevention programs many Hispanics are now being exposed to healthy living models that no longer see hospitals as a place where you go to die. At the same time, new service models are being developed that respond to the need for culturally competent treatment for Hispanic patients and clients.

Case Study

One example is taking place at the Women's and Children's Hospital of the University of Southern California School of Medicine. In their paper, "Evaluation of a Culturally Competent Outpatient Management Program of Insulin-requiring Diabetes in Pregnancy in a Latina population," doctors Carolina Reyes,

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Martin Montoro, and Siri Kjos, and R.N.s Maria Victor and Norma Chavez report that under that hospital's Outpatient Diabetes Education Program (ODEP), between 1987 and 1993, 508 women, "All underwent intensive one-day (12 hour) instruction in diet and insulin therapy taught by bilingual certified diabetes educators...Ninety-five percent of patients were Spanish-speaking with 29% completing less than 6 years of education (and yet)...The program successfully avoided hospitalization in 97% of patients."[104]

The article reports that, "Protocols for initiating insulin therapy with gestational and non-insulin dependent diabetic pregnant patients historically included routine hospitalization...Such management is labor intensive and has serious social and financial implications for the patients and the institutions rendering their care. Pregnant patients are often the central caretaker of other small children and hospitalization creates major hardship. Many who work cannot afford lost revenue or the expense of hospitalization. Hospitalization is very disruptive, at many levels, for the pregnant patient and those dependent on her.

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"Fundamental to the success of this program is a requirement of bilingual certified diabetes educators with the ability to communicate fluently in Spanish and a cultural understanding of the factors influencing their diet and exercise behavior," the authors point out.

"This type of program may be hospital-based or office-based. It requires a coordinated team (physician, diabetic educator, nutritionist) to offer education, management, and prenatal follow-up for those requiring initiation of insulin therapy during the pregnancy. Outpatient education for people with diabetes is an effective way to reduce health care costs and improve efficacy."[105]

Case Study

 A similar project has been initiated in Oklahoma City, Oklahoma by the Latino Community Development Agency. A project summary report states that, "To decrease service access barriers, enhance service efficiency and reduce costs, our agency decided to develop a multi-service community center." Located in a 27,000 square foot converted school house in a low-income Hispanic community, it has been dubbed "Clinica Amistad" or Friendship Clinic. Among the culturally competent services it offers is pediatric care for children up to the age of 16, an immunization center, a well-baby clinic, a daycare program, drop-in child care, community college classes, after-school programs (including health education) for school-age children, and a recreational youth facility for teens.[106]

Of course, only when mainstream institutions including major managed care programs, public and private hospitals, clinics, and nursing facilities fully integrate into their systems culturally competent approaches to patient care, will Hispanic and other populations in the United States feel confident they can receive the best care possible. A proxy indicator to access culturally competent care is client satisfaction and patient perceptions of quality. To determine the effectiveness of developing models for Hispanics, client satisfaction must be assessed for both critical care and long term care. These assessments are necessary as more institutions are transitioning to the new service models.

A number of major institutions have already transitioned to this new service model, including Harbor View Medical Center in Seattle, Washington and Thomason Hospital in El Paso, Texas. Often providing these kinds of culturally competent services proves to be both low-cost and high-benefit from a care-delivery, as well as, from a financial point of view.

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Harbor View provides transportation (including ambulance ride-alongs when advisable) for family care givers of patients, particularly migrant workers from the eastern part of the state, where the injury or illness of one family member can be highly disruptive to the lives of others. Harbor View has also provided expanded in-hospital visitation and living opportunities, including translation and social service help in locating housing, clothing, laundry and other needed services for the dislocated care-giver as well as the patient. Along with a family approach in case management, all in-patient staff are given cultural competency training for their Hispanic, Southeast Asian, and other patient populations. In addition, there are cross-cultural rounds conducted at the hospital every month, involving speakers and presentations from different community-based groups. Those rounds are open to staff, faculty, and community members to attend. Recently, Harbor View, working with St. James Catholic Church, also initiated an on-site English as a Second Language, program for interested patients and their family members.[107]

Case Study

Thomason, a public hospital with 335 beds and 1400 employees in El Paso, Texas has an 80% bilingual, bicultural staff serving a patient population that is 94% Hispanic. The main focus for patient care, as well as, collegiate work is *respeto* (respect) according to hospital C.E.O. Pete Duarte. "You have to establish a relationship of trust with patients if you want to practice healing," he explains.[108]

This translates to a range of culturally-adjusted service relationships, from allowing families to spend the night with

their in-patient relatives and providing them access to clergy, staff psychiatrists or other comforts they might seek, to on-going contractual agreements between the hospital and community-based health care and social service agencies that help patients resolve problems that go beyond their immediate medical condition but may contribute to it. These problems may include risk-taking behaviors, lack of employment, poor housing, or nutritional shortfalls.

To promote its holistic approach to service, the hospital has developed a motivational CARE program. The "C" stands for community and recognizes the hospital's role in helping to make the surrounding community a better place for families to live in and prosper, the "A" stands for accountability not only for the health care dollars they administer but also to the shared values of the community they are a part of, the "R" stands for respect and dignity, "the most important research and development program we have in terms of healing," according to Duarte, and the "E" is for excellence of service and care-delivery, a standard expected of every staff member regardless of their position.[109]

"It goes back to the basics of what we are as human beings," hospital C.E.O. Duarte explains. "We have to get beyond the cultural stereotypes of the media and recognize that all our patients are human beings. We all come from the same place and have the same dreams for our families and our future, and we have to base our actions, as health care professionals, on trying to provide the best possible vision of healing in the very sacred places where we do our work."

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Conclusion

Health professionals must continue to adjust to a more multi-ethnic, multi-racial society in order to meet the needs of their patients and clients. A provider must always be aware and respect the uniqueness of the patient. The desire of health care professionals like yourself to reach out to community-based organizations and develop more effective ways of serving your Hispanic and other patients' needs, will create the kind of American health care system we can all be proud of.

The desire of health care professionals to...develop more effective ways of serving Hispanic and other patients' needs, will create the kind of American health care system we can be proud of.

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