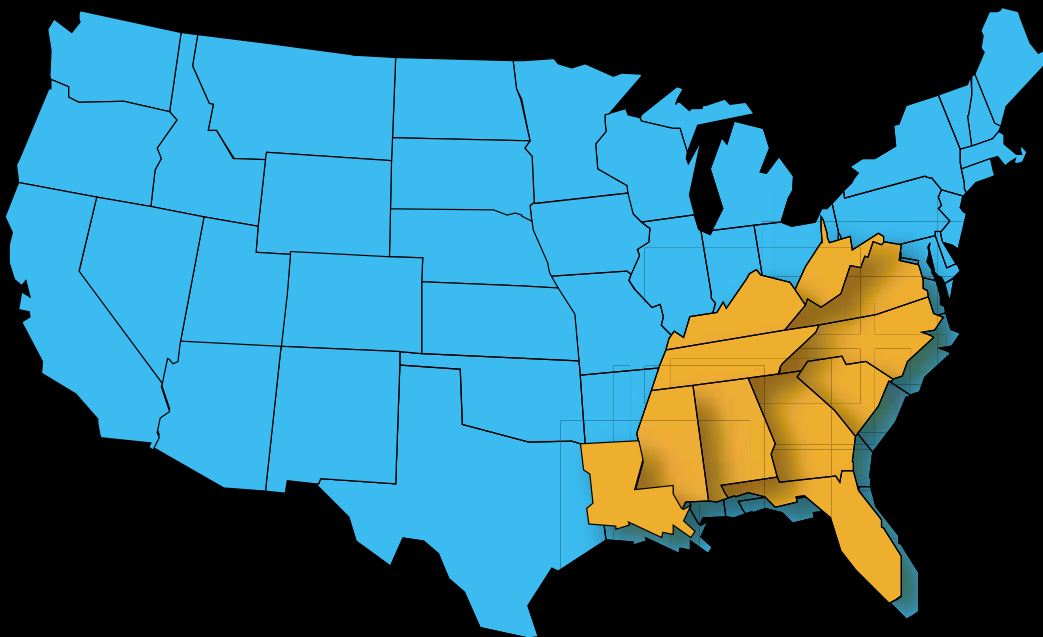




# The Health of Latino Communities in the South: Challenges and Opportunities



Report on the Findings of the  
National Council of La Raza Institute for Hispanic Health's  
Health in Emerging Latino Communities Project  
Funded by the Department of Health and Human Services – Office of Minority Health

# **THE HEALTH OF LATINO COMMUNITIES IN THE SOUTH: CHALLENGES AND OPPORTUNITIES**

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Funded by the Department of Health and Human Services – Office of Minority Health

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Permission to copy, disseminate, or otherwise use information from this report is granted, as long as appropriate credit is given to NCLR.

# TABLE OF CONTENTS

Acknowledgments ..... i

Executive Summary .....1

Background .....7

Study Design .....8

Descriptive Statistics .....9

Summary of Focus Group Responses .....14

Summary of Key Informant Responses .....16

Summary of Previous Assessment Findings .....18

Key Findings .....20

Recommendations .....21

Appendices .....24

## EXECUTIVE SUMMARY

### Overview

The significant increase in the U.S. Hispanic\* population, particularly in nontraditional regions of the country, such as the South, has not necessarily been accompanied by proportional increases in information about Latinos, their characteristics, and their needs. To address the knowledge gap about this diverse population and focus attention on the health care challenges that the Hispanic community in the South faces, the National Council of La Raza (NCLR) and the Department of Health and Human Services – Office of Minority Health (OMH) partnered to create the "Health in Emerging Latino Communities" (HELIC) project to assess, for the first time, the health care needs, wishes, and realities of newly emerging Latino communities in the South.\*\*

The following offers a brief snapshot of relevant demographic data, a summary of the project, key findings, and NCLR conclusions.

### A New Demographic Reality

Latino migration to the South in the 1990s went virtually unnoticed until the release of the 2000 Census data, which showed the tremendous growth of the Hispanic population in many states across the region. For example, from 1990 to 2000, the proportion of the population in Georgia that is Latino grew from 1.7% to 5.3%.<sup>1</sup> In North Carolina, the community grew to 4.7% of the population in 2000 from just 1.2% ten years earlier.<sup>2</sup> Specific city data show similar signs of expansion. Recent Census estimates found that the Latino community in the metropolitan Atlanta area has grown 30%,<sup>3</sup> and Nashville has experienced a 21% surge in its Latino population in just three years.<sup>4</sup> The 2000 Census and recent Census estimates serve as confirmation of what many

Latino activists and leaders in the South already know: new Latino communities are establishing roots in the Deep South and Latinos are no longer concentrated in "traditional" cities and states, like Los Angeles or Florida.

The growth of the Latino population in nontraditional immigrant areas of the U.S., while noted by some, took many others by surprise in the late 1990s and early 2000s, although evidence existed that Latinos had settled in the South prior to the release of the 2000 Census. The Latino presence was felt in area schools in the mid-1990s when some states nearly doubled the percentage of Latino students between 1990-1991 and 1996-1997. During that time, Georgia experienced an increase in its percentage of Latinos in public elementary and secondary schools, from 1.5% to 2.6% of total enrollment, while North Carolina's Latino student population expanded from 1.1% to 2.3% of total enrollment.<sup>5</sup> Likewise, the Latino presence was felt in the agro-industrial sector. In South Carolina, Latinos held 20% of the state's jobs in the meat industry despite only officially numbering 41,000 people out of a population of 3.7 million.<sup>6</sup>

The increased attention given to the growing Latino population in the South has brought with it a focus on the barriers Latinos face, particularly in the area of health care. These population increases also challenged an infrastructure that had not planned or was prepared to deal with a large number of newcomers who had specific needs. Uninsurance, immigration status, and language barriers long faced by more traditional Latino immigrant-receiving states like California, New York, and Texas became especially serious barriers for Latinos in states that were not accustomed to dealing with Latinos or immigrant populations. The combination of these factors prompted NCLR and OMH to develop the HELIC project.

\* The terms "Hispanic" and "Latino" are used interchangeably by the U.S. Census Bureau and throughout this report to identify persons of Mexican, Puerto Rican, Cuban, Central and South American, Dominican, and Spanish descent; they may be of any race.

\*\* According to the Census, the South includes the states of Alabama, Florida, Georgia, Kentucky, Louisiana, Mississippi, North Carolina, South Carolina, Tennessee, Virginia, and West Virginia.

## Project Summary

The HELC project consisted of:

- **Focus groups with community members.** These discussions were coordinated by four community-based organizations (CBOs) who were selected to partner with NCLR based on community reputation, reach of the organization in the community, its urban/rural location, prior work in the health care field, and a previous relationship with NCLR. The four sites selected were: Latino Memphis (Memphis, TN); El Pueblo, Inc. (Raleigh, NC); Latin American Association (Atlanta, GA); and Southeast Georgia Communities Project (Lyons, GA). Each focus group consisted of eight to ten adult clients (age 18 and over) who agreed to participate in the discussion; this was not a random sample and not necessarily representative of the Latino community of the South. A summary of focus group and participant characteristics shows that:
  - There were 50 focus group participants: 24 women and 26 men.
  - Four focus groups were mixed gender and two were single sex.
  - The average age of all participants who responded to the question was 35.3.
  - Close to 75% of the participants were married or living with a partner.
  - Spanish was the primary language of 98% of participants.
  - Nine in ten (92%) participants were foreign-born, and half of those were from Mexico.
  - Four of the participants were born in the United States or its territories, including Puerto Rico.
  - Three-quarters (73%) of participants had some education beyond the eighth grade, were attending, or had attended high

school. The rural group had the lowest educational level with no participants having completed beyond the sixth grade.

- Of the employed participants, 31.6% were employed in the service sector followed by 26.3% in manufacturing.
- More than two in five (42%) participants had either private or government-sponsored insurance. Of note is that more than two-thirds (68.2%) of North Carolina focus group participants had insurance, while the number of insured was relatively low for the other states.

All focus groups were completed by the same NCLR staff member and tape-recorded.

- **Key informant interviews with health care professionals who work with Latinos.** Each CBO also identified three to five individuals for key informant interviews. Eighteen key informant interviews were completed during the course of the needs assessment in all four areas in which the CBOs were located, as well as in Birmingham, Alabama. Key informants were from rural and urban areas. They worked as doctors, health educators, program coordinators, mental health counselors, and medical interpreters. Half of the interviews were conducted in English and the other half in Spanish. Two-thirds (66%) of the key informants were women. The average age of the key informants was 42.3 and the median age was 39. More than half (56%) cited Spanish as their primary language. Half of those interviewed were born in the United States. Eleven of the key informants provided direct services to Latino clients, while the remaining seven key informants were in management positions with their organizations or helped to design or manage programs for the CBOs. With the exception of two key informants, all worked at agencies that provided some social, educational, or direct service to Latino clients in their area. The

remaining two informants worked at organizations that conducted research and provided public information and advocacy.

In total, 16 different agencies were represented. Eight of the organizations represented provided services only to Latinos while the remaining eight provided services to everyone. However, while they provided services to everyone, five had a majority of Latino clients or offered some services only in Spanish.

- **A literature review of previous assessments<sup>\*\*\*</sup> on Latino health and Latino health statistics.** NCLR staff gathered and reviewed prior needs assessments and health reports from Alabama, Tennessee, North Carolina, and Georgia to supplement information obtained from the focus groups.
- **A meeting with key stakeholders from throughout the South was convened to gather additional perspectives and validate the assessment's findings.**

## Key Findings

The focus groups answered questions in three major areas: use of existing services by Latinos, barriers to obtaining health care services, and the gap between what is needed and what is currently available. A fourth area of questions concerning discrimination was added if the focus group brought up differential treatment as an issue. The following are the key themes that emerged from the focus groups and key informant interviews.

- **Latinos are reluctant to use available sources of health care and are treated differently from other patients when accessing care.** While focus group participants and key informants were not in complete agreement over whether the majority of Latinos used existing services, there is a perception by focus group participants – which is reinforced by some of the other assessments – that Latinos do not use available health care

services. Reasons ranged from lack of knowledge of available resources, lack of interpreters, lack of insurance, lack of trust in the medical system, and immigration status (i.e., not being legally present in the United States). Focus group participants and key informants cited use of over-the-counter medicines, home remedies, and the emergency room as methods of care used by Latinos who do not seek out or know of available sources of health care. Participants in the focus group and interviews mentioned that Latinos receive different treatment by health care staff. Specifically, they noted that Latinos experience longer waits and are denied services due to language barriers, lack of insurance, and lack of cultural understanding on the part of providers and their staff.

- **Spanish-language media is the best means to distribute information to the Latino community.** The majority of respondents stated that, while most Latinos get information about health services in their community by word of mouth, the Spanish-language media was the best method to reach the Latino community. Word of mouth was also mentioned as a means to share information in relation to door-to-door outreach efforts. Previous local assessments supported this finding.
- **The primary barrier to accessing health care is related to language and communication issues.** The barrier most often cited by Latinos when accessing health care is limited English proficiency and difficulty communicating with health care personnel. Focus group respondents were aware of a law requiring interpreters but felt that providers did not always follow the law. While other barriers such as lack of insurance, lack of transportation, and in some cases discriminatory behavior by health care staff were mentioned, all respondents and previous assessments felt that language challenges were the biggest barrier faced by Latinos.

<sup>\*\*\*</sup>For a complete listing of the previous assessments, please see the full report.

## Recommendations

Based on the findings of the HELC project, the National Council of La Raza Institute for Hispanic Health recommends the following:

### Government Agencies:

- *Federal and state governments should create a health awareness and education public service/information campaign specific to the South.*

The federal government should work in conjunction with state and local health departments, CBOs, and local media outlets to design and implement a comprehensive media-based campaign that provides information on local services available to listeners, viewers, and readers. The campaign should include information on diseases and illnesses that affect Latinos disproportionately, information on the rights of immigrants to access services, and information on local clinics.

- *Federal, state, and local governments and health insurers should establish and fund mechanisms through which appropriate language services are available when needed. In addition, recipients of federal funds must be accountable for providing language services as required under Executive Order 13166 and Title VI of the Civil Rights Act of 1964. The Office for Civil Rights (OCR) should increase its efforts to monitor and enforce Title VI violations related to language access and discrimination.*

A mechanism should be established between the Office for Civil Rights, state and local health departments, and local CBOs, which would allow for the reporting and investigation of suspected Title VI violations before a noncompliance order is issued. In North Carolina, El Pueblo, Inc. worked with the state health department proactively rather

than reactively to ensure that health providers had the resources and information needed to comply with the law. Its work can be used as a model for other southern states.

### Nonprofit Organizations:

- *Local nonprofits should create a regional Promotores de Salud Institute.*

The Institute would train local CBOs on how to develop *promotores* programs and on the latest community health education techniques. These programs provide a vehicle for using local community resources to educate the larger community about health issues.<sup>†</sup> The Institute would also conduct train-the-trainers sessions so CBOs could train their own *promotores* in their local area. In order to address the larger issue of access, the training would include information on the rights of citizens and noncitizens to access services as well as general information on the U.S. health care system.

### Professional Medical Associations:

- *Medical professionals should create a cultural competency curriculum for distribution to medical and allied health schools in the South. In addition, doctors' associations should offer continuing education courses dealing with cultural competency to ensure that all doctors have an opportunity to increase their knowledge of culturally and linguistically diverse populations.*

Although the number of Latinos in the South continues to climb, the number of Latino health care professionals is not keeping pace with this growth.<sup>7</sup> Therefore, it is important to ensure that young medical professionals and new graduates in the South are adequately prepared to deal with the changing demographics in this region. To help in this effort, the government and nonprofit sectors should collaborate to develop a curriculum that

<sup>†</sup> For a full description and models of *promotores* programs, see "Promotores Energizing Communities for Heart Health: Findings from the Salud Para Su Corazón Implementation Projects" by the National Heart, Lung, and Blood Institute, the National Council of La Raza, and the University of North Texas – School of Public Health, July 2002.



addresses Latino cultural beliefs but also the unique situation in the South. This curriculum should be adapted and offered as a course for continuing education credits so that current providers can increase their knowledge and improve their treatment of their diverse clients.

#### The Latino Community:

NCLR believes that the Latino community also has a role to play in improving service delivery and outreach and focusing policy-maker attention on health issues of importance to Latinos in the South. In particular, the Latino community should:

- **Increase education and public awareness efforts related to health issues.** Latinos should become as informed as possible about the health conditions affecting them and their families, and the community at large, and share this information with the broader community to begin to take steps to improve their well-being.
- **Participate in health forums and fairs** that may be sponsored by "mainstream" organizations in their community to represent the realities and needs of Latinos as a growing and important citizenry of the South, and increase the voice and presence of Latino families in this region.
- **Share information and research.** NCLR, other nonprofits, CBOs, and researchers should distribute and promote widely the findings of this report and other related research inside and outside the community to raise awareness and promote change.
- **Coordinate efforts between Latino and mainstream service providers and resources to enhance health advocacy.** Existing Latino or Latino-serving "gatekeeper" organizations should coordinate efforts and mobilize traditionally "mainstream" national health organizations to create the environment and dedicate resources within their own organizations to become part of the solution.

Similarly, Latino CBOs and individuals should network with existing services and community leaders to continue to express their needs, wishes, and demands, and to advocate for equal access to and fair treatment from health services.

- **Use existing resources to publicize information and services.** Spanish- and English-language media should play a role in highlighting the contributions, strengths, and needs of the growing Latino population in the South, as well as highlight and disseminate information that points to solutions and successes.

Ensuring the integration of Latinos into the social fabric of the South United States will require a shared effort among service providers, government, and the Latino community. As demographic changes suggest, the health and status of Hispanics in the South will increasingly be tied to and influence the overall well-being of the region. NCLR believes that the recommendations outlined above to improve health care access and care are within reach and is hopeful that service providers, government, CBOs, and Latinos themselves will work in partnership to ensure fair treatment, quality services, and healthy outcomes for Latino children, families, and all residents in the South.

## ENDNOTES

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## BACKGROUND

Hispanic\* migration to the South in the 1990s went virtually unnoticed until the release of the 2000 Census data, which showed the tremendous growth of the Hispanic population in many states across the South.\*\* For example, from 1990 to 2000, the proportion of the population in Georgia that is Latino grew from 1.7% to 5.3%.<sup>1</sup> In North Carolina, the community grew to 4.7% of the population in 2000 from just 1.2% ten years earlier.<sup>2</sup> Specific city data show similar signs of expansion. Recent Census estimates found that the Latino community in the metropolitan Atlanta area has grown 30%,<sup>3</sup> and Nashville has experienced a 21% surge in its Latino population in just three years.<sup>4</sup> The 2000 Census and recent Census estimates serve as confirmation of what many Latino activists and leaders in the South already know: new Latino communities are establishing roots in the Deep South and Latinos are no longer concentrated in "traditional" cities and states, like Los Angeles or Florida.

Despite the surprise felt by many in the South concerning this growth, evidence existed that Latinos had settled in the South prior to the release of the 2000 Census. The Latino presence was felt in area schools in the mid-1990s when some states nearly doubled the percentage of Latino students between 1990-1991 and 1996-1997. During that time, Georgia experienced an increase in its percentage of Latinos in public elementary and secondary schools, from 1.5% to 2.6% of total enrollment, while North Carolina's Latino student population expanded from 1.1% to 2.3% of total enrollment.<sup>5</sup> Likewise, the Latino presence was felt in the agro-industrial sector. In South Carolina, Latinos held 20% of the state's jobs in the meat industry despite only officially numbering 41,000 people out of a population of 3.7 million.<sup>6</sup>

The increased attention given to the growing Latino population in the South has brought with it

a focus on the barriers Latinos face, particularly in the area of health care. The growth of the Latino population in nontraditional immigrant areas of the U.S., while noted by some, took many others by surprise in the late 1990s and early 2000s and challenged an infrastructure that had not planned or was prepared to deal with a large number of newcomers who had specific needs. Uninsurance, immigration status, and language barriers long faced by more traditional Latino immigrant-receiving states like California, New York, and Texas became especially serious barriers for Latinos in states that were not accustomed to dealing with Latinos or immigrant populations.

As the Latino community grew the challenges in serving this diverse population also grew, and greater information and insight was needed regarding the characteristics of the population and the challenges that the Hispanic community in the South faced. In 2001, the National Council of La Raza (NCLR) and the Department of Health and Human Services – Office of Minority Health (OMH) partnered to create the "Health in Emerging Latino Communities" (HELIC) project to assess, for the first time, the health care needs, wishes, and realities of newly emerging Latino communities in the South. Previous assessments were either state- or county-based and did not compare the challenges across state lines.

To accomplish this goal, the project worked with four Latino community-based organizations (CBOs) in the South to conduct focus groups with community members and key informant interviews with individuals currently working with Latinos in the health care arena. Prior needs assessment reports on Latino health and Latino health statistics were also collected in order to compare findings with data obtained from the focus groups and interviews.

\* The terms "Hispanic" and "Latino" are used interchangeably by the U.S. Census Bureau and throughout this report to identify persons of Mexican, Puerto Rican, Cuban, Central and South American, Dominican, and Spanish descent; they may be of any race.

\*\* According to the Census, the South includes the states of Alabama, Florida, Georgia, Kentucky, Louisiana, Mississippi, North Carolina, South Carolina, Tennessee, Virginia, and West Virginia.

Additionally, a meeting to convene key stakeholders – service providers, elected officials, and agency heads – from throughout the region was also held as part of the project. The meeting's purpose was to provide feedback, serve as an external mechanism to validate the report's findings, and seek input on strategies to address the concerns highlighted in the report. The meeting agenda, participants and their affiliations, as well as a summary of their comments and recommendations are included as Appendix A, B, and C, respectively.

The assessment was intended to be a snapshot of the needs of Latinos in the South. Although the final sample size was small, its findings were found to be representative of the concerns of the region as supported by the attendees of the meeting. The attendees represented 19 organizations with a client base of thousands of individuals from throughout the region.

## STUDY DESIGN

### Site Selection

Selection of CBOs that would collaborate on the project was based on community reputation, reach of the organization in the community, urban/rural location, prior work in the health care field, and previous relationship with NCLR. Based on these criteria, four CBOs were selected to participate in the needs assessment. The four sites selected were: Latino Memphis (Memphis, TN); El Pueblo, Inc. (Raleigh, NC); Latin American Association (Atlanta, GA); and Southeast Georgia Communities Project (Lyons, GA). The Southeast Georgia Communities Project allowed for collection of data from a rural community.

### Data Collection

Each site arranged one or two single-gender focus groups with eight to ten adult clients (age 18 and over) and assisted in identifying three to five individuals for key informant interviews. The

participants were selected by the CBOs from their pool of clients. The sample was a convenience sample and thus not necessarily representative of the Latino community of the South. The focus groups were originally planned as single-gender groups; however, several CBOs felt that having both genders participate in the same focus group would not inhibit participation from individuals. Only one site, Latino Memphis, held single gender focus groups. In addition, El Pueblo had one focus group with more than ten participants, and Southeast Georgia Communities Project's focus group had four participants.

The same NCLR staff person, using a focus group guide designed in conjunction with a consultant, conducted all focus groups. All focus groups were tape-recorded. For their participation in the HELC project, each site was given a grant to cover employee time, focus group participant stipends, and refreshments for the day of the focus group.

Key informant interviews took place in all four areas in which the CBOs were located in addition to Birmingham, Alabama. All key informants were over age 18, involved in the health field, and working with Latinos. Key informants were from rural and urban areas. They worked as doctors, health educators, program coordinators, mental health counselors, and medical interpreters.

Once all the focus groups and key informant interviews were completed, a contractor transcribed the data. However, the women's focus group in Memphis was not transcribed as the tape, upon review by the transcriber, was inaudible. The data from this group were obtained using the focus group moderator's notes.

Prior needs assessments and health reports were gathered from Alabama, Tennessee, North Carolina, and Georgia. Focus groups and interviews were conducted from April 2003 through August 2003 with report-gathering continuing through the end of the year. All individuals were asked to sign an informed consent form and a Participant Information sheet prior to the start of the focus group or interview.

## DESCRIPTIVE STATISTICS

### Focus Groups

Between April and June six focus groups in three states were completed. A total of 50 individuals participated in the focus groups. All six focus groups were conducted in Spanish.

#### North Carolina

Two mixed-gender focus groups of ten and 12 participants were conducted in April 2003. The first focus group had four women and six men. The second focus group had five women and seven men. Each focus group contained participants from throughout the state. The average age of the focus group participants was 34.6. The average age of the men was 35.3 and the average age of the women was 33.6. The majority of the participants were married (15). Two were living with a partner, three were divorced or separated, one was widowed, and one was single. Twenty-one (95.5%) cited Spanish as their primary language. One participant did not answer the language question.

The countries of birth varied in the focus groups. Seven participants were born in Mexico, while three were born in the United States, including one in Puerto Rico. Colombia and Argentina were the countries of birth for three participants each. Venezuela and the Dominican Republic were the countries of birth for two participants. Guatemala and Peru were the countries of birth for one participant each. The average length of time in the U.S. for all participants not born in the U.S. was 6.2 years (including the participant born in Puerto Rico). Length of time in the U.S. ranged from six months to 17 years not including those born on the United States mainland. All participants lived in the U.S. year-round.

### Country of Birth – NC

COUNTRY	NUMBER OF PARTICIPANTS
Argentina	3
Colombia	3
Dominican Republic	2
Guatemala	1
Peru	1
Mexico	7
United States (including Puerto Rico)	3
Venezuela	2

Nineteen of the participants were employed at the time of the focus groups. Their occupations ranged from manufacturing to paraprofessional and professional work, such as vocational rehabilitation and teaching at a local community college and a Head Start program. The majority of the participants were occupied in paraprofessional roles followed by manufacturing work. Two men and one woman were not employed at the time of the focus groups.

### Employment Status – NC

EMPLOYMENT STATUS	NUMBER OF PARTICIPANTS
Employed	19
Unemployed	3

Eleven participants had completed, attended, or were currently attending college. One participant had a master's degree and another had a doctorate. Five had completed or attended high school or are currently completing a GED. Two had only an elementary school education and one did not answer the education question.

### Educational Attainment – NC

LEVEL OF EDUCATION	NUMBER OF PARTICIPANTS
Elementary school	2
Middle school/ junior high school	0
High school/GED	5
College	11
Master's or doctorate degree	2
No answer	1

One male and one female participant received Medicaid. Three participants, two men and one woman, received Medicaid for their children. Of the 20 who did not receive Medicaid for themselves, 13 participants had their own private health insurance while the remainder did not. Eighteen of the participants had had a physical in the year to two years prior to the focus group. Four participants did not answer the question.

### Insurance Status – NC

INSURANCE STATUS	NUMBER OF PARTICIPANTS
Insurance	13
No insurance	7
Medicaid	2

### Tennessee

Two single-gender focus groups of six men and eight women were conducted in May 2003 with participants from the Memphis area. The average age of focus group participants was 34.8. One male participant did not include his date of birth and thus was excluded from the calculation. The average age of the men was 43.2. The average age of the women was 29.5.

Ten focus group participants were born in Mexico, three in Argentina, and one in Peru. The average length of time in the U.S. was 4.7 years with a range of 6 months to 17 years. Three participants reported not living in the U.S. year-round but did not specify how much time they spend in the U.S. Eight of the participants were married, four were living with a partner, and two were single. All cited Spanish as their primary language.

### Country of Birth – TN

COUNTRY	NUMBER OF PARTICIPANTS
Argentina	3
Mexico	10
Peru	1

Nine of the 14 participants were employed in the service sector at the time of the focus groups. One participant was also a graphic designer in addition to working as a chauffeur. All of the men but only three of the women were employed.

### Employment Status – TN

EMPLOYMENT	NUMBER OF PARTICIPANTS
Employed	9
Unemployed	5

Three of the participants had completed or attended college while six had attended or completed high school or technical school. Three had completed sixth grade and one completed second grade. One male participant did not answer the question.

**Educational Attainment – TN**

LEVEL OF EDUCATION	NUMBER OF PARTICIPANTS
Elementary school	1
Middle school/ junior high school	3
High school/GED	6
College	3
No answer	1

One male participant received Medicaid. Two women participants received Medicaid for their children. Of those who did not receive Medicaid for themselves, none had private medical insurance. Eight participants had a physical in the two years prior to the focus group. Five participants did not remember the last time they had a physical, and one participant did not answer the question.

**Insurance Status – TN**

INSURANCE STATUS	NUMBER OF PARTICIPANTS
Insurance	0
No insurance	13
Medicaid	1

Georgia

Two mixed-gender focus groups were conducted in Georgia: one in rural Lyons in May 2003 and the other in Atlanta in June 2003. The participants in each group were from the city or town and surrounding areas. The Lyons focus group had four participants and the Atlanta focus group had ten participants. In total there were seven men and seven women focus group participants. The average age of the focus group participants was 37.0 excluding one man and one woman who did not include their date of birth. The average age of the men and women was 29.7 and 44.3,

respectively. Five participants were living with a partner, three participants were married, and three were single. One participant was widowed, another was divorced, and one participant did not answer the question. Thirteen of the 14 participants cited Spanish as their primary language.

Six participants were born in Mexico, five in Colombia, and one each in Uruguay, Guatemala, and Texas. The average length of time in the U.S., excluding the U.S.-born participant, was 4.5 years with a range of three months to 14 years. All lived in the U.S. year-round.

**Country of Birth – GA**

COUNTRY	NUMBER OF PARTICIPANTS
Colombia	5
Guatemala	1
Mexico	6
United States	1
Uruguay	1

Ten of the participants were employed at the time of the focus groups. Two men and two women participants were not employed at the time of the focus groups. Those employed were all employed in the service sector as housekeeping staff, retail workers, dishwashers, or field workers.

**Employment Status – GA**

EMPLOYMENT	NUMBER OF PARTICIPANTS
Employed	10
Unemployed	4

Four of the participants had completed or attended college. Five had attended or completed high school or technical school. Two had completed sixth grade and one had completed fifth grade.

Two participants reported no formal education. Of note is that the participants in Lyons had the lowest educational attainment level of all. The highest grade completed by the four participants in the Lyons focus group was sixth grade.

**Educational Attainment – GA**

LEVEL OF EDUCATION	NUMBER OF PARTICIPANTS
Elementary school	3
High school/GED	5
College	4
No formal education	2

One man and one woman participant received Medicaid. Two participants have children who received Medicaid. Of those who did not receive Medicaid for themselves, only three participants had private medical insurance. Thirteen of the 14 participants had received a medical examination in the three years prior to the focus group being conducted, with the overwhelming majority having had an exam in the two years prior. Only one participant could not remember when his last medical examination had taken place.

**Insurance Status – GA**

INSURANCE STATUS	NUMBER OF PARTICIPANTS
Insurance	3
No insurance	9
Medicaid	2

Summary Statistics

In total, there were 50 focus group participants: 24 women and 26 men. The average age of all participants who responded to the question was 35.3. The average age for women was 35.0. The average age for the men was 35.5. A total of three

participants, one woman and two men, did not respond to the question and were excluded from the calculations. The majority (26) of the participants were married while 11 lived with a partner. Out of the 49 participants who answered the language questions, 48 cited Spanish as their primary language.

Twenty-three of the participants were born in Mexico with eight participants born in Colombia and six in Argentina. The United States, including Puerto Rico, was the country of birth for four of the participants. The countries of Peru, the Dominican Republic, Venezuela, and Guatemala were the countries of birth for two participants each. Uruguay was the country of birth for one participant.

**Country of Birth – All Participants**

COUNTRY	NUMBER OF PARTICIPANTS
Argentina	6
Colombia	8
Dominican Republic	2
Guatemala	2
Uruguay	1
Peru	2
Mexico	23
United States (including 1 born in Puerto Rico)	4
Venezuela	2

Overall, the focus group participants had some education beyond the eighth grade. Eleven had attended or completed elementary and junior high school. Fifteen had completed, were attending, or had attended high school. Eighteen had some level of college education or had completed college, and two other participants had graduate degrees. Two participants had no formal schooling and two participants did not answer the question.



### Educational Attainment – All Participants

LEVEL OF EDUCATION	NUMBER OF PARTICIPANTS
Elementary/junior high school	11
High school/GED	15
College	18
Graduate school	2
No formal education	2
No answer	2

Out of the 38 participants who were employed, the majority of the participants (31.6%) were employed in the service sector followed by the manufacturing sector at 26.3%. A number of participants (18.4%) were employed as paraprofessionals/skilled workers in schools, health departments, or small newspapers, and 13.2% were employed as professionals in the health field or as teachers.

### Employment Status – All Participants

EMPLOYMENT	NUMBER OF PARTICIPANTS
Employed	38
Unemployed	12

Only five (10%) participants received Medicaid for themselves. Seven (14%) received it for their children. Out of the remaining 45 participants who did not receive Medicaid for themselves, only 16 had private medical insurance. Of note is that 68.2% of North Carolina focus group participants had insurance, while the number of insured was relatively low for the other states.

### Insurance Status – All Participants

INSURANCE STATUS PARTICIPANTS	NUMBER OF
Insurance	16
No insurance	29
Medicaid	5

### Key Informant Descriptive Statistics

Eighteen key informant interviews were completed during the course of the needs assessment. Half were conducted in English and half were conducted in Spanish or a mixture of both. Five interviews were conducted in the Atlanta area and five in Raleigh, three in South Georgia, four in Birmingham, Alabama, and one in Memphis. Twelve women and six men were interviewed. All worked in the health care field in some capacity. The average age of the key informants was 42.3 with a median age of 39. The average age for the women was 55.2 with a median age of 40.5. The average age for the men was 34.8 with a median age of 33.5. Twelve of the key informants were married, and ten cited Spanish as their primary language.

Half of the key informants were born in the United States. Of those not born in the U.S., four were born in Colombia, and one each was from Mexico, Brazil, Uruguay, Cuba, and the Dominican Republic. The average length of time in the United States for those born outside the United States was 21.9 years with a range from two years to 40 years.

Two held high school diplomas, five held college degrees, and one had attended college. Five held master's degrees and two had doctorate degrees. The remaining three held medical degrees although one medical degree was from a foreign country and the participant was not practicing in the U.S.

Eleven (61.1%) of the key informants provided direct services to Latino clients. Two provided mental health counseling and two provided medical services to Latinos, while the remaining five provided health education services. In addition, ten of the 11 also had management or program coordinating duties. The remaining seven key informants were in management positions with their organizations or helped to design or manage programs for the CBOs.

In total, 16 different agencies were represented. With the exception of two key informants, all worked at agencies that provided some social, educational, or direct service to Latino clients in their area. The remaining two informants worked at organizations that conducted research and provided public information and advocacy.

Eight of the organizations represented provided services only to Latinos while the remaining eight provided services to everyone. However, while they provided services to everyone, five had a majority of Latino clients or offered some services only in Spanish.

## SUMMARY OF FOCUS GROUP RESPONSES

The focus groups answered questions in three major areas: use of existing services by Latinos, barriers to obtaining health care services, and the gap between what is needed and what is currently available. A fourth area, discrimination, was added if the focus group brought up differential treatment as an issue. The following is a summary of the responses and the themes that emerged from their responses.

### Use of Existing Health Services:

When respondents or family members became ill in the U.S., all groups mentioned obtaining medical

services from doctors, clinics, the hospital, health department, or the emergency room. Respondents in one group mentioned using medications from their home country as the first alternative before seeking medical care due to cost concerns.

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*“The situation (in the U.S.) is difficult and you have to look for alternative home remedies...It is easier to have a house than to pay for health care here.”*  
 — Atlanta participant

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In their home countries, respondents mentioned that they sought services at the doctor or clinic because they had insurance in their countries or health services were provided free of charge. Two focus groups mentioned the use of home remedies as the first step before going to the doctor. The distinction was made by the groups

between an emergency and a minor illness that could first be treated by home remedies or with over-the-counter drugs.

All six focus groups were well aware of the health organizations, health programs, resources, and providers available in their communities. All groups mentioned local private clinics and the health department and their clinics as services. In addition, hospitals, urgent care clinics, and numerous health maintenance organizations were mentioned as service providers. Two groups mentioned local CBOs as providers of health information or resources. While participants mentioned using the emergency room when they or a family member became ill, none viewed it as a health resource.

Although respondents were aware of the health services, providers, resources, and programs available to them and the community, the overwhelming majority of participants in all focus groups did not feel that many Latinos used these services. The reasons for not using these services centered around lack of information or knowledge about services, fear of paperwork, no interpreters available, being undocumented, lack of insurance, and lack of trust in the U.S. medical system.

Instead, all groups, except for the Southeast Georgia focus group, mentioned self-medicating

with medicines from Mexico or their countries of origin or using other home remedies they knew or were mentioned to them by friends and family. Returning to their home country was also mentioned as an alternative due to lower cost of treatment. One group mentioned the use of *santeros* (traditional healers) as a means of treatment for some individuals, and another mentioned going to individuals who do not have a license to practice medicine in this country but have a license from their country of origin.

One participant from Atlanta stated, "...it is cheaper to go to Colombia. I went one time to a dentist (here in the United States) and they told me it would cost \$2,500, until I met a Colombian woman working with the (medical) license of someone else and I did the crown with her and it costs \$250."

Barriers to Health Care Access:

Participants were asked how they find out about services in their area. Word of mouth was the most mentioned means of obtaining information about health care. This was followed by use of the radio and other forms of media such as the newspapers and television. Mexican *tiendas* (stores) were mentioned as a means for finding out about health care. Lastly, pamphlets or flyers, the church, *promotores* (community health outreach workers), and local CBOs were also mentioned as methods for finding out about health care.

While churches were only mentioned by one focus group as a means of finding out about health care, the majority of the groups mentioned that churches assisted them with obtaining or accessing health care. Local CBOs and *promotores* were also mentioned, as well as employees at some of the clinics or hospitals they visited.

When asked about the best way for groups or agencies to let them and the community know about the health services they offer, the media was the response most often mentioned. Respondents

in all six groups mentioned radio, followed by newspapers and then television. Three groups mentioned outreach via pamphlets sent home or door-to-door as well as school as an opportunity to obtain information. Mexican *tiendas*, CBOs, and work were also mentioned.

Participants were asked about any groups or individuals that make it difficult to obtain care. Most mentioned system barriers, but the Atlanta group did mention that the government made it difficult to obtain care by the cuts they were making to health care funding. A North Carolina participant stated, "I know of a clinic in a rural area and if the person does not pay their interpreter they will not receive service in that clinic."

The overwhelming response to what barriers exist for Hispanics in accessing health care services was language. It was acknowledged that Latinos should make an effort to learn English, but one North

Carolina focus group mentioned possible violations of the law requiring interpreters and the lack of available interpreters. A majority of respondents also mentioned money and lack of insurance as barriers to accessing health care. Some individuals mentioned cultural barriers, legal status, and

transportation to facilities as additional barriers to accessing health care. Four groups mentioned discrimination or different treatment as barriers.

The Gap:

The majority of respondents, except for the North Carolina focus groups, did not have health insurance. Those whose employers provided health insurance felt that the cost was too high. Those whose employers did not provide insurance also felt that the cost was high but also mentioned their inability to obtain other insurance because of lack of legal status in this country. Participants who did not work cited the same reasons for lacking health insurance.

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*"We are in a different country and we should all learn English."*  
 — North Carolina participant

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Respondents felt that there were a large number of services that Latinos in their areas needed. Many of the responses across all three states were similar. All except one group mentioned the need for dental services. The same was true for the need for interpreters. In general, there was a lack of interpreters available, and a need for training of interpreters was also mentioned. Vision services were also mentioned as being needed by three groups. Two groups cited a need for better quality general health services as well. Family health services and a clinic for Latino adults were viewed as necessary, in addition to children's and women's services. In addition, the groups mentioned the need for prevention information, recreation sites, access to specialists, and more clinics.

Respondents were asked about their use of medicines prescribed by doctors. While many did fill prescriptions from the pharmacy when prescribed, many others did not. The reasons for not filling prescriptions varied from lack of money, not trusting that the medicines would work, lack of insurance, and preferring to obtain something cheaper even though it may not work. Some respondents preferred to get medicines from their home countries because of cost and having more confidence in those drugs. One participant mentioned not understanding the prescription when it is filled because the label is in English. Most groups mentioned that home remedies and over-the-counter medicines were used when they were unable to get prescriptions filled.

While only four groups mentioned discrimination or differential treatment by providers, not all were attributed to race. One woman mentioned having been the victim of inappropriate comments about her body by her doctor. Others mentioned that employees, such as front desk staff, mistreated clients by yelling at them, denying them services based on lack of interpreters, or asking for their legal status when accessing services. Others felt that they were treated well only if they spoke English. Only two respondents mentioned race or ethnicity as a reason for the differential treatment.

All groups had key points they wanted health professionals to know. Participants want to be treated better and not face discrimination or bad treatment when seeking services. Some stated that they simply want to be treated as humans. Many want doctors to have a better understanding of their circumstances and better education for both doctors and the community about prevention, health, and culture. Additionally, they want health professionals to understand that immigrants, despite not residing here legally, have rights. Better access to insurance as well as better-trained interpreters were also requested.

## SUMMARY OF KEY INFORMANT RESPONSES

The questions for the key informants mirrored the questions that were asked in the focus groups. All questions addressed the three main areas addressed by the focus groups. However, all key informants were asked about discrimination as well as background questions on their agencies.

### Use of Existing Health Services:

Overall the informants mentioned the same community health providers, resources, and programs as the focus group participants. Informants, presumably because of their work, were able to identify additional resources not mentioned by the focus groups. There was consistency between both groups with regard to hospitals, clinics, and the health department being mentioned as resources in the community. Key informants mentioned more often than the focus group participants the use of the emergency room as a source of care.

Key informants differed on the perception of whether many Latinos used the resources, providers, and programs mentioned. The majority of the informants felt that many Latinos used the programs because there were no other resources, particularly with regards to use of the emergency room. Only one informant felt that many Latinos did not use the available resources and providers in

their community because of the cost and the lack of trained interpreters.

Key informant answers more closely mirrored focus group participants when asked what Latinos who don't access the available services do when ill. The use of home remedies, self-medication, and healers was mentioned by informants in addition to the fact that some do nothing and suffer in silence. Most informants mentioned the use of the emergency room.

Barriers to Health Care Access:

The majority of key informants (12 out of the 18) stated that the manner in which most Latinos in the community find out about health care services is through word of mouth. This was the same response as the focus groups. CBOs, including the church, and community outreach were mentioned by many of the informants followed by media, the health department, and health fairs.

The informants' answers regarding how Latinos find out about health services in their community coincided with which organizations they believe assist Latinos in accessing health care. All informants mentioned some type of CBO or organization that assisted Latinos in accessing health care such as churches, universities, health departments, local CBOs, and individuals in the community.

The best way to reach the community, according to informants, was the use of the Spanish-language media. Nine informants mentioned the media in all forms (radio, print, and television) as one of the best ways to get information to the community. This echoes the responses from focus group participants. Word of mouth, the workplace, outreach and outreach workers, churches, CBOs, clinics, government services, and schools were also mentioned. Some of these were mentioned by the focus groups as well.

Overall, key informants felt that many groups made it difficult for Latinos to access health care services. This was in marked contrast to focus group participants'

views. Key informants mentioned the attitude of the general community, other minority groups, Latino practitioners, immigration reform groups, the state legislatures, and departments including the health department, employers, and the media. The reasons given were the policies of some of the government agencies and community not allowing time off to

obtain care, Latino practitioners "putting down" other Latino practitioners, and the use of the media to create anti-immigrant sentiment.

Similar to the focus groups, the most mentioned barrier that exists for Latinos is language. Every

informant mentioned language as a barrier. Informants mentioned transportation, lack of insurance, and cost of services as the next largest barriers. In addition, legal status, attitudes of providers and the public, cultural barriers, hours of operation, and lack of bilingual providers, interpreters, and information were listed as additional barriers. Many of the barriers were the same as those listed by the focus groups.

Lastly, 15 of the 18 informants believe that Latinos are treated differently than others when obtaining health care. Their sense was that because of language, lack of insurance, and cultural understanding, Latinos are made to wait longer, denied services, and treated as second-class citizens. Three informants felt that perception and bureaucratic red tape contribute to Latinos feeling as if they are treated differently.

The Gap:

Key informants felt that there was a need to expand services to Latinos in a number of areas. Basic access to services, insurance access, health education/promotion, prenatal care, migrant care, and substance abuse services were the most frequent answers with three to five informants mentioning them. Other areas in which informants felt services should be expanded was sexually transmitted disease information, mental health, and cultural sensitivity training. These answers differed somewhat from focus group participants. While there was some overlap,

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*"If you are blonde  
they treat you better."  
— North Carolina  
participant*

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focus group participants mentioned more concrete services such as dental and vision services which they felt were missing, while informants mentioned more preventative information and access issues.

Key informants were asked what type of health campaign they think the Latino community was ready for and what type of campaign they would like to see. The most cited answers were STD/HIV information, health awareness/prevention, and insurance access campaigns. Other responses included diabetes, substance abuse, domestic violence, nutrition, and sexual education, among numerous others. When asked for the campaigns they would like to see, there was more agreement. The most cited response was an STD/HIV campaign followed by domestic violence, substance abuse, and affordable primary care campaigns. The most common responses for what the campaigns should include were outreach by individuals (*promotores*) or via mobile units, prevention messages, and including government officials and the media.

In closing the interview, informants were asked if there was anything that they felt was the most important issue to address. While answers varied from person to person, some mutual concerns did emerge from the interviews, including the need for domestic violence and substance abuse education. Other concerns with multiple responses were the need for primary care, more bilingual staff, and community education and leadership training.

## SUMMARY OF PREVIOUS ASSESSMENT FINDINGS

A total of 16 state, county, or local Latino health-specific reports were obtained during the project year. Nine were from Georgia, with three from North Carolina, two from Alabama, and one each from Tennessee and South Carolina. The small number of Latino health-specific reports, their small sample size, and the fact that many reports

focus only on the barriers to access highlight the need for more state-based health data on Latinos.

Overall, the findings of the 16 reports were consistent with the findings of the HELC report and show agreement between the concerns and challenges facing the Latino community in the South U.S. However, there were some areas of divergence between some of the reports and the HELC assessment. What follows is an overview of the concerns and challenges raised by the HELC assessment compared to the previous reports.

### Utilization of Services:

While HELC focus group participants and key informant responses did not overlap on the question of whether many Latinos used the health resources and programs available in their areas, focus group participants raised concerns similar to the findings of

other reports. HELC focus group participants felt that many Latinos did not use the available resources because of lack of knowledge of existing services, fear of paperwork, no interpreters available, being undocumented, and lack of trust in the U.S. medical system. Some of these concerns were echoed in the collected reports.

For example, the Duke University *Access to Health Care by Durham's Low Income Latinos*<sup>7</sup> cited lack of knowledge about where to obtain services, and the Atlanta Regional Health Forum Town Hall<sup>8</sup> cited lack of interpreters and immigration status as well. In addition, a Whitfield County Health Department<sup>9</sup> focus group also found lack of knowledge and documentation to be a concern for Latinos not accessing health care, and the Latino Health Task Force of the North Carolina Institute of Medicine<sup>10</sup> (NC IOM Report) cited documentation as a barrier to seeking services.

The issue of lack of trust of the U.S. medical system can stem from the lack of knowledge of the system, which could potentially lead Latinos to turn away from seeking medical care or possibly

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*"If you speak English they treat you with quality attention."  
— North Carolina participant*

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seek medicines and remedies native to their home countries. The use of home remedies was acknowledged in the NC IOM Report and *The Needs of Georgia's New Latinos*<sup>11</sup> and documented in the HELC report.

#### Barriers to Health Care Access:

The barriers faced by Latinos when accessing health care are similar throughout the South. While language, cost of services, and lack of insurance were the most often cited barriers by HELC participants, other barriers such as transportation, legal status, and cultural barriers were mentioned as well. These same barriers were mentioned by the ten reports that addressed barriers to health care access. The final report was a survey on limited-English-proficient (LEP) services available in the North Georgia Health District<sup>12</sup> (North GA LEP Survey).

Language as a barrier to access was mentioned by 11 reports. As early as 1999, the North Carolina Office of Minority Health and State Center for Health Statistics<sup>13</sup> cited language as a barrier for Latinos. This was echoed by a study in Memphis, *Working for Culturally Sensitive Health Care for Latinos in Memphis*,<sup>14</sup> which found that out of 27% of their survey respondents needing interpreter services, 93% "did not find an interpreter to be readily available." Finally, *The Needs of Georgia's New Latinos* and the *Findings from the Hispanic/Latino Ad Hoc Committee*<sup>15</sup> of South Carolina also cited language as a barrier.

The North Georgia LEP Survey documented Spanish as the top language spoken by clients who receive LEP services. Indigenous Guatemalan languages were the second most cited, indicating that Latinos moving from Central and South America are a diverse group. Additionally, the interrelated barriers of cost and lack of insurance were mentioned by all reports. The *Obstacles to Medical Care for Latino Children in Gwinnett County, Georgia*<sup>16</sup> focus group report and the *Health Survey of Migrant Population in Appling County, Georgia*<sup>17</sup> mirrored these results in addition to addressing transportation.

Only four reports addressed the best way for health information to reach the community. HELC respondents cited the media, particularly the radio, in all of its forms as the best mechanism to reach the Latino community. The Gwinnett County Hispanic Focus Group, the *Health Needs and Resources of the Greater Birmingham Alabama Latino Community Survey*,<sup>18</sup> the Whitfield County Health Department Focus Group, and the North Carolina IOM Report addressed the use of the media as a means to disseminate health information.

In contrast to the HELC findings, the Birmingham report found that, among providers and the community, the best means to disseminate health information was the church. However, providers surveyed mentioned media such as newspapers, radio, and television as their next three answers. Radio was the last method indicated by the Birmingham community. Other mechanisms cited by HELC participants to get information to the community included *promotores de salud*, community workshops, schools, markets, and worksites. Many of these responses were cited in the previously mentioned reports as well.

#### The Gap:

Latino respondents in all reports, excluding the North Georgia LEP Survey, felt they needed more services or information on a variety of issues. The HELC report found that focus group participants wanted more dental services, interpreters, vision services, and better quality health care, as well as prevention information. While these responses differed from the key informants who felt that the expansion of services to Latinos should include basic access issues, health education/health promotion, prenatal care, migrant care, and substance abuse information and services, just about all responses from both groups were included in the reports that addressed the question. Although no report asked the question in the same format as the HELC report, reports that did address the need for information and services overlapped with some of the responses from HELC participants.

For example, in the *Floyd County Health Department Hispanic Survey*,<sup>19</sup> respondents wanted information on family planning and nutrition, prenatal care, domestic violence, sexually transmitted diseases (STDs), and immunizations. The lack of information on STDs was highlighted by a report on a syphilis outbreak in Decatur, Alabama in which Latino males accounted for half of the cases found.<sup>20</sup> Atlanta Regional Health Forum participants cited dental and vision services as well as access to primary care and preventive services as important health issues that challenge them or their families. The NC IOM Report and a report on Latino migrant farmworkers<sup>21</sup> also cited insufficient resources to address the health, behavioral, and dental health needs of Latinos.

Of note is the lack of Latino-specific mental health information. Only one report, *Treatment and Ethnographic Data in Latino Substance Abuse Services*,<sup>22</sup> contained data on Latino admissions into an outpatient substance abuse program. Although recognized by key informants as a service need for Latinos, there is a lack of southern state-specific data on the topic.

Overall, the findings of the HELC project echo those found in other reports, but also provide some new information on how Latinos view the health care system. Latinos want access to quality and affordable health care like all Americans. They do not view the emergency room as a health resource but rather as the last stop for obtaining needed care, and they have a need for culturally appropriate health care information. Many of the findings defy the conventional wisdom which suggests that Latinos do not care about their health or that health is not an important issue to them. Despite the nature of the challenges presented by the HELC project, the findings also indicate areas for opportunity.

## KEY FINDINGS

The following discussion highlights the key themes that emerged from the HELC focus groups and key informant interviews.

- *Latinos are reluctant to use available sources of health care and are treated differently from other patients when accessing care.*

While focus group participants and key informants were not in complete agreement over whether the majority of Latinos use existing services, there is a perception by focus group participants – which is reinforced by some of the other assessments – that Latinos do not use available health care services. Reasons ranged from lack of knowledge of available resources, lack of interpreters, lack of insurance, lack of trust in the medical system, and immigration status (i.e., not being legally present in the United States). Focus group participants and key informants cited use of over-the-counter medicines, home remedies, and the emergency room as methods of care used by Latinos who do not seek out or know of available sources of health care. Participants in the focus group and interviews mentioned that Latinos receive different treatment by health care staff. Specifically, they noted that Latinos experience longer waits and are denied services due to language barriers, lack of insurance, and lack of cultural understanding on the part of providers and their staff.

- *Spanish-language media is the best means to distribute information to the Latino community.*

The majority of respondents stated that, while most Latinos get information about health services in their community by word of mouth, the Spanish-language media was the best method to reach the Latino community. Word of mouth was also mentioned as a means to share information in relation to door-to-door outreach efforts. Previous local assessments supported this finding.



- *The primary barrier to accessing health care is related to language and communication issues.*

The barrier most often cited by Latinos when accessing health care is limited English proficiency and difficulty communicating with health care personnel. Focus group respondents were aware of a law requiring interpreters but felt that providers did not always follow the law. While other barriers such as lack of insurance, lack of transportation, and in some cases discriminatory behavior by health care staff were mentioned, all respondents and previous assessments felt that language challenges were the biggest barrier faced by Latinos.

## RECOMMENDATIONS

Based on the findings of the HELC project, the National Council of La Raza Institute for Hispanic Health recommends the following:

### Government Agencies:

- *Federal and state governments should create a health awareness and education public service/information campaign specific to the South.*

The federal government should work in conjunction with state and local health departments, CBOs, and local media outlets to design and implement a comprehensive media-based campaign that provides information on local services available to listeners, viewers, and readers. The campaign should include information on diseases and illnesses that affect Latinos disproportionately, information on the rights of immigrants to access services, and information on local clinics.

- *Federal, state, and local governments and health insurers should establish and fund mechanisms through which appropriate language services are available when needed. In addition, recipients of federal funds must be accountable for providing language services as required under Executive Order 13166 and Title VI of the Civil Rights Act of 1964. The Office for Civil Rights (OCR) should increase its efforts to monitor and enforce Title VI violations related to language access and discrimination.*

A mechanism should be established between the Office for Civil Rights, state and local health departments, and local CBOs which would allow for the reporting and investigation of suspected Title VI violations before a noncompliance order is issued. In North Carolina, El Pueblo, Inc. worked with the state health department proactively rather than reactively to ensure that health providers had the resources and information needed to comply with the law. Its work can be used as a model for other southern states.

### Nonprofit Organizations:

- *Local nonprofits should create a regional Promotores de Salud Institute.*

The Institute would train local CBOs on how to develop *promotores* programs and on the latest community health education techniques. These programs provide a vehicle for using local community resources to educate the larger community about health issues.\*\*\* The Institute would also conduct train-the-trainers sessions so CBOs could train their own *promotores* in their local area. In order to address the larger issue of access, the training would include information on the rights of citizens and noncitizens to access services as well as general information on the U.S. health care system.

\*\*\*For a full description and models of *promotores* programs, see "Promotores Energizing Communities for Heart Health: Findings from the Salud Para Su Corazón Implementation Projects" by the National Heart, Lung, and Blood Institute, the National Council of La Raza, and the University of North Texas – School of Public Health, July 2002.

Professional Medical Associations:

- *Medical professionals should create a cultural competency curriculum for distribution to medical and allied health schools in the South. In addition, doctors' associations should offer continuing education courses dealing with cultural competency to ensure that all doctors have an opportunity to increase their knowledge of culturally and linguistically diverse populations.*

Although the number of Latinos in the South continues to climb, the number of Latino health care professionals is not keeping pace.<sup>23</sup> Therefore, it is important to ensure that young medical professionals and new graduates in the South are adequately prepared to deal with the changing demographics in this region. To help in this effort, the government and nonprofit sectors should collaborate to develop a curriculum that addresses Latino cultural beliefs but also the unique situation in the South. This curriculum should be adapted and offered as a course for continuing education credits so that current providers can increase their knowledge and improve their treatment of their diverse clients.

The Latino Community:

NCLR believes that the Latino community also has a role to play in improving service delivery and outreach and focusing policy-maker attention on health issues of importance to Latinos in the South. In particular, the Latino community should:

- **Increase education and public awareness efforts related to health issues.** Latinos should become as informed as possible about the health conditions affecting them and their families, and the community at large, and share this information with the broader community to begin to take steps to improve their well-being.
- **Participate in health forums and fairs** that may be sponsored by "mainstream" organizations in their community to represent the realities and needs of Latinos as a growing and important citizenry of the South, and increase the voice and presence of Latino families in this region.

- **Share information and research.** NCLR, other nonprofits, CBOs, and researchers should distribute and promote widely the findings of this report and other related research inside and outside the community to raise awareness and promote change.
- **Coordinate efforts between Latino and mainstream service providers and resources to enhance health advocacy.** Existing Latino or Latino-serving "gatekeeper" organizations should coordinate efforts and mobilize traditionally "mainstream" national health organizations to create the environment and dedicate resources within their own organizations to become part of the solution. Similarly, Latino CBOs and individuals should network with existing services and community leaders to continue to express their needs, wishes, and demands, and to advocate for equal access to and fair treatment from health services.
- **Use existing resources to publicize information and services.** Spanish- and English-language media should play a role in highlighting the contributions, strengths, and needs of the growing Latino population in the South, as well as highlight and disseminate information that points to solutions and successes.

Ensuring the integration of Latinos into the social fabric of the South will require a shared effort among service providers, government, and the Latino community. As demographic changes suggest, the health and status of Hispanics in the South will increasingly be tied to and influence the overall well-being of the region. NCLR believes that the recommendations outlined above to improve health care access and care are within reach and is hopeful that service providers, government, CBOs, and Latinos themselves will work in partnership to ensure fair treatment, quality services, and healthy outcomes for Latino children, families, and all residents in the South.

## ENDNOTES

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# APPENDIX A

## Meeting Agenda

**National Council of La Raza**  
Health in Emerging Latino Communities (HELC) Project Meeting  
March 11, 2004

### AGENDA

- I. **Welcome**  
(10:00-10:15 a.m.)  
Carlos Ugarte, Deputy Vice President, National Council of La Raza – Washington, DC
- II. **Introductions**  
(10:15-10:30 a.m.)
- III. **Overview of Findings**  
(10:30-11:15 a.m.)  
Liany Elba Arroyo, Project Coordinator, National Council of La Raza – Atlanta, GA
- IV. **Latino Health in NC: Status and Policy Efforts from an Advocacy Perspective**  
(11:15 a.m.-12:00 noon)  
Andrea Bazán-Manson, Executive Director, El Pueblo – Raleigh, NC
- V. **Lunch and Networking**  
(12:00 noon-1:00 p.m.)
- VI. **Participant Discussion on Findings**  
(1:00-1:45 p.m.)  
Facilitated by Liany Elba Arroyo
- VII. **Participant Recommendations**  
(1:45-2:30 p.m.)  
Facilitated by Liany Elba Arroyo
- VIII. **Next Steps**  
(2:30-3:00 p.m.)  
Carlos Ugarte

## APPENDIX B

### Meeting Participants

#### Health in Emerging Latino Communities Project

1. Edgar Angulo – Georgia Department of Community Health – Office of Minority Health, Atlanta, GA
2. Andrea Bazán-Manson – El Pueblo, Inc., Raleigh, NC
3. Carolina Caseres – National Center for Primary Care, Morehouse School of Medicine, Atlanta, GA
4. Andres Crowley – El Pueblo, Inc., Raleigh, North Carolina
5. Andrea Cruz – South Georgia Communities Project, Lyons, GA
6. Delma de la Fuente – Georgians for Healthcare, Atlanta, GA
7. Alina Flores – Centers for Disease Control and Prevention
8. Corina Florez – South Georgia Communities Project, Lyons, GA
9. Jerry Gonzalez – Georgia Association of Latino Elected Officials
10. Chris Griffin – Department of Health and Human Services, Office for Civil Rights, Atlanta, GA
11. Julia Hayes – Alabama Department of Health – Office of Minority Health, Huntsville, AL
12. Dr. Pierluigi Mancini – Clinic for the Education, Prevention and Treatment of Addiction, Atlanta, GA
13. Yolanda Martínez – Children’s Health Insurance Program, State of Alabama
14. Lisa Reddington – St. Vincent’s Hospital, Birmingham, AL
15. Michael Rhein – National AIDS Fund, Washington, DC
16. Angel Roca – Centers for Disease Control and Prevention
17. Dr. Isabel Scarinci – University of Alabama-Birmingham
18. Blanca Torres – Centers for Disease Control and Prevention
19. Dr. Henrie Treadwell – National Center for Primary Care, Morehouse School of Medicine, Atlanta, GA
20. Rogelio Valencia – North Carolina Department of Health and Human Services
21. Dr. José Velazquez – Latino Memphis, Memphis, TN
22. Charles Walker – United Way of Metropolitan Atlanta – Cobb County, Marietta, GA
23. Kirsten Witt – Coca-Cola Company, Atlanta, GA
24. Melissa Wolowicz – Community Foundation of Greater Memphis

#### NCLR Staff

Carlos Ugarte, MSPH – Deputy Vice President, Institute for Hispanic Health

Lynda Barros – Director, Emerging Latino Communities Initiative

Liany Elba Arroyo, MPH – Project Coordinator, Southeast Health Program Office – Institute for Hispanic Health

Natalie Hernandez – Consultant

## APPENDIX C

### Summary of Participant Comments and Recommendations

#### Meeting Background:

The Health in Emerging Latino Communities meeting was held March 11, 2004 in Atlanta, Georgia. The Latin American Association, the largest provider of services to Latinos in metropolitan Atlanta, hosted the meeting in its facilities. A total of 24 individuals attended from the four states represented in the assessment. In all, 65 individuals from Alabama, Georgia, Mississippi, North Carolina, South Carolina, and Tennessee were invited. Participants did not receive the draft of the report in advance.

Two presentations were made during the meeting. The first was an overview of the Health in Emerging Latino Communities project. The overview was followed by a presentation on North Carolina's approach to Latino health from the perspective of a state-based Latino advocacy organization and a National Council of La Raza affiliate.

Participants were invited to give input and discuss the report findings as well as give their recommendations to improve Latino health in the South United States. What follows is a summary of the discussion and their recommendations.

#### Summary of Participant Comments:

1. Do the findings mirror what you encounter in your work? How so?

Overall, meeting participants felt that the findings of the HELC project mirrored what they found in their own work. Participants felt that it reflected the situation in the South.

2. If not, how do they differ?

While the report reflected the challenges and barriers encountered by Latinos in the South, meeting participants stated that they did see some differences in their own work not reflected in the assessment. First, participants felt that the sample population was not truly reflective of the overall Latino community. Examples of this included the level of insurance and education. In the assessment, the education level and insured rate were higher than what most providers found in their work.

3. General Comments

Participants had many insights to share regarding Latino health in the South. Some felt that more funding was necessary to conduct adequate research on a representative sample. Likewise, that funding should also make its way down to the community level. Participants recognized that, while funds that are being expended are targeted for the Latino community, these funds were not making it to the community level.

Participants felt that the community needed to be more engaged in the programs targeting their communities as well. One participant stated, "Who better knows the community than the community itself? The community needs to define needs...how can you solve problems? You solve them by empowering the community." *Promotores* were mentioned as a means to work with the community as they come from and share the same values as the community. However, it was stated that agencies needed to find bicultural and bilingual staff as well.

**Participant Recommendations:****Research:**

1. Examine differences between Latinos living in rural and urban areas.
2. Identify social and political determinants of health for Latinos in the South.
3. Examine the intensity of the needs of Latinos.
4. Define core elements of a multicultural health system.

**Policy:**

1. Promote the development of Latino human resources in the South.
2. Create a system of continuing education for medical interpreters.
3. Extend Title VI by incorporating cultural competency standards.
4. Require that existing providers receive continuing education in cultural competency.