An Examination of Leading Health-Related Issues and Disparities Among Latinos in the South Sacramento Region

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ABSTRACT
The purpose of this study was to identify and examine leading health-related issues and disparities among urban Latinos residing in South Sacramento. Working through the CSUS Office of Community Collaboration, a service learning component allowed Dr. Wycoff and students enrolled in a graduate research course to link academic study and action research by assisting the Mexican American Alcoholism Program (MAAP) with two projects. Data analyses were multi-fold whereby Dr. Wycoff and students conducted a literature search and drew upon findings from previously published national survey data, studies by state-wide health indices, county survey & community-based monitoring projects in preparation for 1) administering and analyzing post-session evaluations at the Bi-National Latino Health Symposium; and 2) analyzing and reporting results from the Community Health Center Planning Questionnaire in preparation for federal funding.

INTRODUCTION
An article in the Washington Post (Stein, 2005) reported on a recent large-scale study that found Americans pay more when they get sick than those in five other Western nations do, and they also receive more confused, error-prone treatment. Published in the journal ‘Health Affairs,’ this study surveyed 6,957 adults who had recently been hospitalized, undergone surgery, or reported health problems between March and June of 2005. The survey was part of an annual series of cross-national surveys conducted for the Commonwealth Fund, a private, nonpartisan, nonprofit foundation based in New York to examine health care quality across several nations (Australia, Canada, New Zealand, Britain and Germany) during the same period of time.

Although the study found that Americans had the easiest access to various medical specialists, they experienced the most problems when trying to obtain after-hours care, and were the most likely to report problems seeing a doctor the same day they sought one. While the study found that patients in all six nations sometimes experiences obstacles in receiving care- including deficiencies in treatment, the United States had the highest error rates, most disorganized care and highest costs. For example, Americans were:

- Most likely to pay at least $1,000 in out-of-pocket expenses for their care, outpacing all other nations (as opposed to 14% of Canadians);
- More than half went without needed treatment because of cost, including not filling a prescription, seeing a doctor when they were sick or getting recommended follow-up tests (compared to 26% in Canada and 13% in Britain);
- Nearly one-third reported problems with the coordination of their care, such as test results not being available at the time of their doctor's appointment; and
- More than one-third reported the greatest number of medical errors which included getting the wrong medication or dose, incorrect test results, a mistake in their treatment or care, or being notified late about abnormal results.

During a debriefing in which the findings were released, Dr. Lucian Leape of the Harvard School of Public Health stated that the study "provides confirming evidence for what more and more health policy thinkers have been saying, which is, the American health care system is quietly imploding, and it's about time we did something about it." Similarly, Carolyn Clancy, of the federal Agency for Health Care Quality and Research, stated that “we have a lot to learn from our colleagues" in other countries, concluding that “the next frontier" must be about finding ways to improve the quality of care, particularly for the increasing number of Americans suffering from chronic illness, and findings ways to better coordinate care for all (cited in Stein, 2005).
Overview of Latino Demographics

Over the past 50 years, California’s population has grown at two to three times the rate of the nation as a whole, outpacing every other state in America – including Texas, New York, and Florida (California Budget Project, 2005; U.S. Census Bureau, 2005c). In terms of size at the start of the new millennium, California’s ‘White’ population alone was larger than the population of Illinois, and its Latino population was larger than the population of Michigan. According to the U.S. Census Bureau (2005a), it is estimated that by the year 2010, one in five Americans will identify as Latino; and in some areas of the United States, Latinos are projected to outnumber ‘Whites’ by the year 2035 (U.S. Census Bureau, 2005b). As the Latino population grows, professional health care providers can anticipate seeing increased numbers in their waiting rooms (Dingfelder, 2005). But for many Latinos who seek health care services, their first contact may also be their last, as many will never return after the first appointment. Several factors play into this, such as a significant number is disproportionately low-income and therefore access/service is limited or not available due to health care cost. For others, barriers include a lack of transportation or geographic isolation. Still others will prematurely terminate because they will not feel understood since they may not be entirely proficient or comfortable communicating in English, and/or the treatment practices being offered will be in opposition to their belief and/or value system (Aponte, Rivers, Wohl, 1999; Ashford, LeCroy & Lortie, 2005; Dumka, Roosa & Jackson, 1997).

Sacramento is a high-growth metropolitan area with a population of nearly 2 million. It is a city and county with a very diverse population, identified by Time Magazine in 2002 as “America’s most integrated city.” Of the estimated 129,341 persons residing in the area serviced by MAAP in South Sacramento, 69% report as ‘ethnic minority,’ with Latinos accounting for 29% of this population (Pew Hispanic Center, 2005c). The average family size of Latino households was 4.06 persons. Although a significant percentage of the community was found to be employed (69.4%), very few reported having health insurance and related benefits. Low socioeconomic status is also a significant problem in MAAP’s service area, with 26.5% falling 100% below the federal poverty level, and 53.96% falling 200% below the federal poverty level. The educational standing of the Latino population was one of the most disquieting facts to emerge: only 16.6% graduated from high school and 4.7% had earned a GED. The largest number (40%) reported attending but not graduating from high school, and 31% of Latinos in South Sacramento report having less than an eighth grade education. These local findings are consistent with statewide statistics where over half of California’s Latino adults lack high school diplomas, versus 10% of non-Latino Whites and 20% of Blacks and Asians. Only 28% of Latinos attended college, and this includes a scant 8% who obtained a bachelor’s degree or higher. By contrast (statewide), 69% of non-Latino Whites, 56% of African Americans, and 66% of Asians/Pacific Islanders were college-educated (National Council of La Raza, 2003).

Although Latinos share a fairly common history, including similar values, and customs, tremendous cultural diversity exists. This diversity results from individual and group differences, generational differences, and dramatic socioeconomic levels within each Latino cultural group and subgroup. Moreover, the geographic proximity of the United States to Latin America as well as its historical and continuing political influence in the region distinguishes the Latino experience from other immigrant groups. For example, in his profile of American people, Axelson (1998) writes:

Like similar ethnic groups – the Irish, the Poles, the Italians, and others – the Latinos were expected to blend into the U.S. mainstream. However, acculturation and assimilation have not occurred in the same way as they did for preceding ethnic groups. One reason is the difference in the immigration pattern for some of the Latino ethnic groups as compared with that of the Europeans, who immigrated knowing that most likely they would never return: Mexicans have always had presence in the southwestern United States, but less so as a perceived immigrant group; Puerto Ricans have a quasi-dependent relationship as a result of commonwealth status; many Cubans, who came as political refugees, have always intended to return some day to Cuba; and many Central Americans fled North as refugees due to civil war (pp. 124-125).

Nationally, it is estimated that by 2025, Latinos will become the largest ethnic minority group in the United States (U.S. Bureau of Census, 2005c). As such, Latinos constitute a critical human resource for California. Indeed, the
state’s economic health is intricately tied to the health and productivity of its Latino population which rose from 33% in 2000, and is projected to increase to 43% by 2020; adding 7.8 million people in just two decades (California Budget Project, 2005). Also, while the Latino population is aging, it will continue to remain the youngest ethnic group with 34.2% projected to be under the age of 20 (California Budget Project, 2005). Paradoxically, in order to understand the future of Latinos, there is also a need to understand, prepare and care for its past. With older Californians expected to be healthier than at any other time in history, more than 6 million of the state’s current residents are projected to be age 65+ by 2020, thereby straining programs such as Medi-Cal, In-Home Supportive Services, and the Supplemental Security Income (Sacramento County Latino Cultural Competence Task Force, 2004). Since Latinos are expected to increase as a share of the state’s total population, these significant shifts in growth will have important implications to future local and statewide infrastructure and services.

Despite their long history and presence, Latino contributions and characteristics to the state remain misunderstood (Latino Issues Forum, 2003; Pew Hispanic Center, 2005a). One example is the ongoing national debate over immigration, with supporters and opponents from all sides offering media sound bites and online blogs either for- or against- an "earned path to citizenship" for an estimated 11 million illegal immigrants in the United States. This has been reinforced and fueled by televised news reports such as “Broken Borders,” hosted by CNN's Lou Dobbs (CNN.com, 2005). Similarly, it has been a year since the Minuteman Civil Defense Corps set up their volunteer watch-and-report operations along a snippet of Arizona's southeastern boundary with Mexico (CNN.com, 2006). Despite all this, the Latino population is firmly rooted in the United States. Contrary to the stereotype, California Latinos are geographically quite stable, and excluding the transitory nature of the migrant farmworker population, mobility is markedly low. In fact, most Latinos are native-born or naturalized citizens. Sacramento County (16%) and statewide census data demonstrates (County of Sacramento, 2005; U.S. Bureau of Census, 2005a) that Latinos are overwhelmingly long-term residents who rarely move outside their county with just over half being native-born (57% statewide), and approximately one-quarter being naturalized citizens. Even non-citizens are mainly long-term residents, and 7% who identified [statewide] as newcomers reported having arrived within the past five years (Office of Minority Health Resource Center, 2005; Sacramento County Latino Cultural Competence Task Force, 2004; U.S. Bureau of the Census, 2005c).

In Sacramento County, 25% reported Spanish as their preferred language, while 55% reported speaking English as their primary language, and 20% reported being bilingual (Sacramento County Latino Cultural Competence Task Force, 2004). These regional statistics are consistent with statewide demographics in which Latinos are almost entirely English proficient (67%), bilingualism (English/Spanish) is the norm among Latino adults (71%), and limited English proficiency is much smaller than the media or stereotypes portray (9%). Furthermore, English monolinguals outnumber Spanish-only speakers (though by a smaller margin than among youth). California would benefit by exploiting this widespread bilingualism, rather than treating it as a deficit (Office of Minority Health Resource Center, 2005; Sacramento County Latino Cultural Competence Task Force, 2004; U.S. Bureau of the Census, 2005c).

HEALTH RELATED DISPARITIES

The World Health Organization (WHO) defines ‘health’ as a state of physical, mental, and social well-being, and not merely the absence of disease. In contrast, WHO describes health ‘disparity’ as the disproportionate burden of illness, disease, disability and death among a particular population or group. Similarly, social-ecological models from the field of counseling-psychology (e.g., Brofenbrenner, 1986) contends that many social inequities associated with income and economic disadvantage have also been linked to health disparities at the individual and community levels. While the pathways linking these social and economic inequalities to health and disease are not yet well understood, there is growing evidence between socioeconomic status, economic development, and illness. In the United States, disparities in risks for chronic disease and injury exist among ethnic groups. For example, cardiovascular disease is the largest contributor to all-cause mortality in the United States, and the second leading (Department of Medicine, Baylor...
The next section provides a brief review of the literature related to the leading health problems among Latinos, including access to health care, health-status indicators, health-risk behaviors, and the use and non-use of preventive services.

**Alcohol Addiction**

Alcohol addiction is a strong mental and physical dependence and is considered a genetically influenced disorder that is often passed (inherited) from parents to their children. Frequently, it is accompanied by mental health problems, such as depression. Alcohol addiction touches all age groups and all socio-cultural, ethnic, and economic groups, and is one of the most serious health and social problems facing Americans in general, and Latinos in particular (Vega, et al., 2003). The National Institute on Alcohol Abuse and Alcoholism estimates that approximately 8.4% of the U.S. population, or 17.6 million people abuse alcohol; and among those with a diagnosable substance-related disorder, the majority (75%) are men, and a quarter (25%) are women. It is also estimated that only 22% of the people in need of intervention and treatment for any alcohol-related disorder will ever receive it (2004). The rates of alcohol addiction are increased among Latino men in the United States, and have reached epidemic proportions, ranking third among causes of admission to state and county mental health hospitals (Caetano, Mora, Marino, & Schafer, 1999). Mexican American men have been cited as the heaviest drinking among the Latino sub-groups. When compared with their Whites male counterparts, Latino men also have higher rates of secondary problems, including cirrhosis mortality, and intimate partner violence (Roberts, 1998). Within the Latino culture, alcohol plays a prominent role in rituals and events associated with both community and family life (McGoldrick, Giordano & Pearce, 2005).

Caetano (1990) reported that the majority of Latino subjects in his national sample viewed drinking as appropriate behavior when socializing with friends and family, relaxing and taking part in recreational activities, or when celebrating a happy or important life event (e.g. a wedding, baptism, or birthday). In many cases, alcohol is a primary social lubricant. At large social gatherings alcohol, like food, is offered in abundance. These social events are viewed as occasions to share food, drink, and good company rather than simply an occasion for heavy drinking. Often accompanying their parents, infants/toddlers, children, and adolescents learn at a very young age the “unwritten rules” about the importance of alcohol at social gatherings (Wycoff & Cameron, 2000). While alcohol consumption is shaped by the social and cultural context in which it occurs, the ongoing over-accessibility of alcohol in Latino neighborhoods and the ongoing efforts of media merchandising to tailor alcohol advertising to the Latino lifestyle are additional factors influencing drinking patterns (Alaniz & Wilkes, 1995). For example, drinking is regularly included in the frequent church-related activities in more traditional Latino communities; and for Latinos who participate in Catholic religious sacraments or who are secular members of a Catholic community, studies report that although the Church has no proscriptions related to alcohol use, it considers "alcoholism" as a moral weakness. As a result, this paradoxical message may inadvertently serve as a chief stumbling block in the way of outreach to alcohol-dependent Latinos and their families.

Gender-related patterns may also tend to exacerbate the problem. For example, traditional Latino families are hierarchical in form with special authority given to the elderly, the parents, and males. Within the family, the father assumes the role of the primary authority figure, and sex roles are clearly delineated. Family unity is seen as very important, as is placing one's family above oneself (Arredondo, 1999; McGoldrick, Giordano & Pearce, 2005). Other studies suggest that the tendency to avoid related health issues may vary according to the degree of assimilation to mainstream culture and access to services (Gropper, 1996). The literature on drinking and treatment practices between Latino males and females indicate that different members (i.e., male and female) of the family will receive different kinds of help from extended family, kin, and community members. For example, males are more likely to receive assistance from their families who tend to attribute their alcohol abuse or dependence on external problems such as bad luck, a bad employer, or an inattentive wife; whereas Latino females receive little to no support from their families and are directly blamed for their own alcohol dependence. Consequently, these factors are responsible for
the tendency of the Latino female to enter treatment at a more advanced or chronic stage of alcohol addiction. An important gender-related cultural characteristic to consider pertains to the concept of machismo. Used flatteringly, Latino children, both male and female, learn that machismo refers a strong sense of feminine pride (Caetano, 1998). Unfortunately, this term has been oversimplified to a unitary and stereotypic dimension within popular American mainstream culture. Understanding this concept along a continuum may provide better insight into proscribed gender-related patterns of behavior. In actuality, one end of the machismo continuum, refers to the courage to fight. More subtly, machismo also refers to dignity in personal conduct, respect for others, love for family, and affection for children (Padilla, Ruiz & Alvarez, 1995).

Latinos drinking practices as an expected masculine behavior is supported in the research (Arredondo, Orjuela & Moore, 1989; Caetano, 1998) and suggests that alcohol may present a contradiction in Latino male socialization patterns. In other words, heavy alcohol consumption in itself satisfies a positive behavioral expectation (i.e., the ability to drink large amounts with friends provided self-control is maintained), while culturally unacceptable or unsuccessful behavior (i.e., the loss of self-control and perceived social esteem or risking the loss of respect for one's manhood) may generate dysphoric feelings for which alcohol is a remedy. Among more traditional Latinos, if the male has a problem related to his drinking behavior, his family tends to blame the problems on fate (culpar en el destino), God's will (lo que Dios desea), or a bad wife. Consequently, because of the general portrayal of the Latino male as head of the household, there may be an effort by family members to protect the image even when his alcohol abuse or dependence negatively impacts the life of the family. Thus, there may be avoidance by the family to seek help outside the immediate family support network (McGoldrick, Giordano & Pearce, 2005; Wycoff & Cameron, 2000).

Typically, Latino women's drinking patterns have ranged between primarily abstainers to occasional drinkers. Among more traditional families, women do not engage in same sex drinking. If this is done however, it is done in the context of family, community, or home-based parties where men are present and where strict norms operate to control women's behavior (cited in Wycoff & Cameron, 2000). However, there has been a transformation toward heavier drinking among those Latino women of higher income, education and acculturation levels. This suggests that traditional cultural protectors are weakening. These data raise concerns as to why the acculturation level of Latino women is paralleled with heavier drinking practices. As has been true of all women in society, more Latino women are participating in the labor force. The assumption is that increased acculturation provides more opportunities for women to interact in social situations where frequent and heavier drinking among women is the norm, which results in increased drinking for later generations (cited in Wycoff & Cameron, 2000).

Alcohol use has also been identified as a probable factor related to unsafe sexual behaviors, and previous studies have examined ways in which individuals use alcohol to engage in sexual encounters (Chavez & Swaim, 1992; Holder, Janes, Mosher, Saltz, Spurs & Alexander, 1993). Although alcohol use may not be causally related to unsafe sex, drinking may play a role in sexual scripts. Sexual scripts are the narrative ways in which people organize their beliefs and expectations regarding sexual behaviors. One way in which a sexual script can be examined is from a cultural level, in which scripts are constructed by cultural and social groups for the purpose of contextualizing acceptable sexual activity (Chang & Geliga-Vargas, 1999; Diaz, 1998). A few studies have used sexual script theory to frame behavior involving the use of alcohol and drugs. These studies have helped in the understanding of the context of substance use for socializing and engaging in sexual behavior, since these scripts involve expectancies for alcohol or drugs within specific social contexts. Contexts may involve a bar with loud music, a club where people go to dance and meet potential partners, or a bathhouse where men have anonymous sex with other men. Therefore, alcohol may be involved in scripts for different occasions, including factors related to choice of partners, types of occasions, types of sexual acts, and decisions on whether or not to use condoms (DeBertolini, Scarso & Andreetto et. al., 1996; Diaz, Morales, Bein, Dilan & Rodriguez, 1999). Once ingested, alcohol mutes self-monitoring and therefore increases the impact of environmental stimuli. As a result, alcohol results in a person focusing their attention on the present context, thereby decreasing their awareness of the social norms or what is perceived as acceptable behavior. Studies of HIV-positive men have found this connection between alcohol use and unprotected sexual practices (Bird & Hopwood, 2003; Campbell, 1995). Others have found that other variables, such as outcome expectancies and
sensation seeking, may also play a role in predicting both unsafe sex and alcohol use (Dolezal, Carballo-Dieguez, Nieves-Rosas & Diaz, 2000).

One goal of recovery and sobriety is to bring about change through the modification of thoughts, feelings and behavior. Of cultural concern, when working with Latino families in the recovery process is the therapeutic expectation for self-disclosure. For the most part, this is the antithesis of the Latino family value not to discuss family matters in a public forum (Becerra, 1992; Castillo & Henderson, 2002; McGoldrick, Giordano & Pearce, 2005; Santiago-Rivera, 1995). Moreover, once in treatment for recovery, explanations about the reasons for psychological or functional impairment due to the addiction or the therapeutic use of direct confrontation may increase a family's sense of insecurity and may be perceived as disapproval rather than a stimulus for change. Therefore, when working with Latino families it is important to acknowledge the family's willingness to confront the problem of alcohol dependency. Searching for family strengths and the use of praise can also have a powerful impact (Ivey, Ivey, & Simek-Morgan, 2003). Being able to identify the family's assets will reinforce a sense of their own dignity and communicate a therapeutic appreciation of their personal resources. Above all, the cultural norms of the Latino family need to be understood and respected. Understanding Latino family norms and present social context within American culture is perhaps the single most important factor in defining the family's problem and in selecting the appropriate treatment process. It is important to address the issues of acculturation, language, socioeconomic class, and the influences of potential discrimination while making the distinction between normative cultural beliefs and impaired idiosyncratic transactions. This is especially true when establishing rapport, initiating an effective communication style, and taking a position of helping (Minuchin & Nichols, 1998; Santiago-Rivera, 1995).

Diet, Obesity, & Co-Morbidities

Today, 64.5% percent of all adult Americans are categorized as being overweight or obese. Each year, obesity causes at least 300,000 excess deaths in the U.S., and healthcare costs of American adults with obesity amount to approximately $100 billion. It is a serious medical disease that affects adults in the United States, and about 14% of children and adolescents. Statewide, more than one-third of California youth are at-risk or already overweight – greatly increasing their risk for conditions called co-morbidities. Co-morbidities are secondary illnesses that are caused by a person being obese. The most common co-morbidities include type-2 diabetes, cancer, and heart disease later in life. There is also an increased risk of early death due to obesity; not too mention the oppressive emotional and social effects as a consequence of obesity and these related health risks (American Obesity Association, 2005).

Within Latino culture, food plays a prominent role in rituals and events associated with both community and family life. While the relative good health of Latinos, especially immigrants, stems from healthy lifestyles, as Latinos adopt the U.S. mainstream lifestyle, they acquire habits that lower their health status (Balcazar & Cobas, 1993; Lin, Bermudez & Tucker, 2003). In California, 52% of all adults are overweight. When broken down by ethnic group, Latinos account for 71% of those who are overweight, with obesity being more prevalent among Latinos than their “White” counterpart, especially among Latina women. When it comes to diet, PROJECT LEAN, a longitudinal study conducted by the California Department of Health Services (2005) found that California Latinos, on average, consume slightly less than 4 servings of fruits and vegetables per day, while over one-third eat 2 or fewer (fruit and vegetable) servings. This is in contrast to one-quarter of all California adults, regardless of ethnic group who reported eating 2 or fewer servings of fruits and vegetables per day. When examined further, over 80% of Latinos (statewide) reported that fruits and vegetables were hard to buy in fast food restaurants, while 39% reported that fruits and vegetables were too expensive. Similarly, nearly 30% of Latinos reported that they do not eat more fruits and vegetables because they are not in the habit of doing so, while roughly 20% reported that fruits and vegetables took too much time to prepare. This situation becomes all the more arresting when considering Latino families that fall at- or below- poverty level who report not having sufficient food to eat ‘sometimes’ or ‘often,’ at rates much higher than White families. Consequently, hunger and malnourishment can make children irritable and make it difficult to concentrate, which can interfere with learning (Food Research and Action Center, 2005). While low energy and
malnourishment due to an inadequate diet can limit the physical activity of children, a study by Unger, Reynolds, Shakib, Spruijt-Metz, Sun & Johnson (2004) found that approximately 25% of fifth graders were overweight, and another 80% failed to meet minimum physical fitness standards.

In a study conducted by the Agriculture & Natural Resources Department at UC Davis, Kaiser, Martinez, Harwood, and Garcia (1999) found that some Latino parents resort to bribes and threats to get their children to eat, even though they may have allowed their children’s appetites to be spoiled by frequent between-meal snacking. Reported in the Journal of the American Dietetic Association (1999), the authors studied 61 low-income Mexican-American parents of pre-school children and observed eating habits during visits to 11 Latino households. While the results cannot be generalized to the larger population, they do reflect some clear patterns of feeding practices in Latino homes. For example, permitting frequent snacks and then forcing children to eat at meals may be disrupting the children’s natural ability to regulate food intake and may lead to a higher than average incidence of obesity. The researchers identified the most common strategies used to encourage children to eat were bribes, and/or parents forbid television viewing, playing at the park or outside, riding bikes, or having dessert unless they ate their meal first. At least five focus group participants said they used threats to get their children to eat. These threats consisted of telling the child: “You will need a shot;” “You will need a laxative;” “Your father will hit you;” “We will leave you at home alone;” or “I will love your sister (or brother) more” if the child did not eat.

The authors (Kaiser, Martinez, Harwood & Garcia, 1999) also found that children were losing their appetites by eating frequent snacks. Some participants said frequent child-initiated snacking was okay, as long as the foods were “nutritious,” referring to milk, fruit, vegetables, cheese, juice and peanut butter. However, their comments indicated that children also grabbed other foods, such as hot dogs, cookies and soda. The authors found that some of the participants’ ambivalence toward frequent snacking may have resulted from previous food insecurity. For example, many of the families reported enduring periods of low food supplies. If they had food in the home, they were more inclined to allow the children to eat simply because it was available. In their concluding discussion, the researchers provided professionals with suggestions to help them work with families to correct detrimental feeding strategies and finding culturally acceptable ways for families to get their children to the dinner table to eat more nutritious foods, helping parents set limits on snacking, offering healthy foods at meals and helping children get into a schedule so they will feel like eating healthy foods without being forced. Also included were collaborative ideas for developing radio campaigns to extend these messages to Latino families, including free educational workshops for professionals who work with Latino populations.

When it comes to physical activity among adults, only 27% of California Latinos engage in 30 minutes of moderate physical activity 5 days a week, while less than one-fourth participate in 20 minutes of vigorous physical activity at least three times per week. Moreover, 60% of California Latino adults do not engage in any type of leisure-time physical activity at least once a month, as opposed to 24% of adults in all other ethnic groups in California. Numerous health studies have suggested that overweight adults are at an increased risk for developing certain cancers, coronary heart disease, high blood pressure, stroke (for men), type 2 diabetes, gallbladder disease and osteoarthritis (Flegal, Golden, & Carol, 2004; Matheson, Killen, Wang, Vandy & Robinson, 2004; Unger, Reynolds, Shakib, Spruijt-Metz, Sun & Johnson, 2004).

‘Cancer’ is a term representing many diseases with a variety of causes. Cancer in general is very common, and in the United States 1 in 3 people will develop some form of it during their lifetime (American Cancer Society, 2005). According to the American Cancer Society (2006), more than 570,000 Americans have died since January 1, 2005, and an estimated 1,372,910 new cancer cases are projected to be diagnosed during 2006-2007. However, because of its complex nature, cancer can be challenging to diagnose and treat. As a result, its causes are difficult and in some cases impossible to identify, particularly since the time between exposure to a cancer-causing agent, and the existence of other risk factors for developing cancer can be decades. It is estimated that ten or more years can often pass between an exposure or mutation and detectable cancer (2005). In general, medical researchers do know that the risk for cancer increases with age and has been linked to the following factors:
- External Factors (tobacco, chemicals, radiation, and infectious organisms)
- Internal Factors (inherited mutations, hormones, immune conditions)

In addition, behaviors such as nutrition, physical inactivity, obesity, and other lifestyle factors also play a role in cancer risk and outcomes; and these factors may act together—or-- in sequence, to initiate or promote cancer. Since cancer rates vary by age, race, gender, risk-factors, and type, this information is vital in helping to guide Latino cancer research, training, and awareness efforts at the national, regional, and local levels. For example, although cancer is the second leading cause of death among White Americans in the United States, it is the leading cause of death, including premature death among Latinos (Ramirez, Gallion, Suarez, Giachello, Marti, Medrano, Perez-Stable, Talavera, & Trapido, 2005). However, despite it being the leading cause of death among Latinos, there is limited knowledge of cancer-related issues specific to the Latino population, the largest minority group in the nation.

Using data from the 2000 National Health Interview Survey, Gorin (2005) examined Latino subgroups and their methods of screening for cancer. Results suggested that on a continuum, Latino women who had more years of education, a personal history of cancer in their family, were not current smokers, had health insurance, had visited a primary care provider over the past 12 months, and had taken at least one other health-screening test was more likely to request a mammography, CBE, or pap smear in an effort to screen for cancer. At the other end of the continuum were uninsured Latinos who were least likely to use a screening method and were 2 to 3 times more likely to have cancer diagnosed at a later stage, making it less treatable. Similar studies have found that among Latinos overall, lower socioeconomic status—and education levels negatively impacted health status. That is, economic status was directly related to availability of health insurance and therefore, offered access to care. As a result, uninsured Latinas with breast cancer are 2.3 times more likely to be diagnosed at a later stage; and uninsured Latino men with prostate cancer are 4 times more likely to be diagnosed at a later stage. Health risks experienced by the uninsured Latino population include reduced access to care and poorer medical outcomes. Because the uninsured are less likely to have a regular source of medical care, and less likely to have had a recent physician visit; they more likely to delay seeking medical care, more likely to report they have not received needed care, and less likely to use preventive service. Therefore, making cancer screening, information, and referral services available and accessible is essential for reducing the high rates of cancer and cancer deaths (American Cancer Society Facts & Figures, 2005). What medical experts agree on is that the risk for cancer, including the number of new cancer cases can be reduced substantially by adopting healthier lifestyles, which include:

- avoiding tobacco use
- increasing physical activity
- achieving optimal weight
- improving nutrition
- avoiding sun exposure

To help identify cancer issues of greatest relevance to Latinos, The National Latino Cancer Network (2005), a major collaborative among the National Cancer Institute's Special Populations Networks, recently conducted a survey of 624 key opinion leaders from around the country, including scientists, health care professionals, leaders of government agencies, professional and community-based organizations, and other stakeholders in Latino health. Respondents were asked to rank the three cancer sites most important to Latinos in their region of the United States, and the five issues of greatest significance for this population's cancer prevention and control. Recommendations were prioritized for three specific areas: 1) research; 2) training/professional education; and 3) awareness/public education. The issues of greatest significance to Latinos were determined to be: 1) access to cancer screening and care; 2) tobacco use; 3) patient-doctor communication; 4) nutrition; and 5) risk communication. The results from this large-scale study have laid the foundation for a national Latino cancer agenda, with the long-term goal of providing a useful tool for individuals and organizations engaged in cancer prevention and control efforts specific to the Latino population.
**HIV / AIDS**

Latinos in the United States are disproportionately affected by HIV, accounting for 18% of the total AIDS cases while comprising only 12% of the population (Carballo-Dieguez, 1998; Diaz, 2001; National Commission on AIDS, 1999). Similarly, Latino children under the age of 13, make up 24% of U.S. pediatric AIDS cases (Centers for Disease Control and Prevention, 1999). At present, married “heterosexual” men who have sex with men and gay men now account for the majority of existing cases of HIV/AIDS infections in the United States with 25% of new infections annually (Centers for Disease Control and Prevention, 2000; Miller, Guarnaccia & Fasina, 2002). As a result, this life threatening illness has become a major threat in Latino communities, many of which were already disadvantaged even prior to the HIV epidemic due to ethnic minority status, economic disparities, and language barriers (Diaz, 2001; Herek, 2000; Jiminez, 2003; Vidrine, Amick, Gritz & Arduino, 2003).

Not surprisingly, HIV prevalence among Latinos in the United States varies strongly by region. For example, a high rate of HIV exists among Latinos in the Northeast (53%) where many U.S. Latinos from Puerto Rico and the Dominican Republic live, reflecting the geography of injection drug use (Des Jarlais, et al., 1995; Roldan, 2003). In terms of secondary transmission, the majority of cases among Puerto Rican adult women occur because of heterosexual contact with an injection drug user (Roldan, 2003). Interestingly, much lower rates are reported for Latinos in the West and Southwest regions, where many Latinos are of Mexican and Central/South American origin (Koblin, Chesney & Husnick, 2003). In 1997, 34% of all AIDS cases among Latino men occurred in men who have sex with men, and 30% among injection drug users (Centers for Disease Control and Prevention, 1999). In the same region that year, 46% of AIDS cases among Latino women were due to heterosexual contact (i.e., being infected by their male partners), while 29% were due to injection drug use. Among Latino gay/bisexual men, rates of HIV infection are increasing faster than among White gay/bisexual men (National Commission on AIDS, 1999). However, these rates are likely underestimates because many Latino men who have sex with men do not self identify as gay/bisexual.

Cultural influences such as *machismo* and *familismo*, coupled with homophobia may be internalized by Latino gay men and make safer sex practices difficult (Miller, Guanaccia & Fasina, 2002). Culturally, *machismo* dictates that sexual intercourse is a way to prove masculinity. For MSM Latinos, *machismo* and *familismo* can create conflict because families perceive homosexuality as sinful. As a result, familial support is virtually non-existent because of the silence about one’s sexual preference or shame about one’s secretive behavior -which in turn- reinforces shame, self-loathing and low self-esteem among these Latino men. Not surprisingly, many of those subsequently infected with HIV/AIDS face challenges of living with a chronic terminal disease, feeling alone, rejected, and ostracized by both family and community (Crawford, 2001; Roldan, 2003). Traditional interpretations of cultural values and gender roles may also serve as barriers to maintaining safer sex practices for many Latino women. For example, in a survey by Needle, Trotter, Singer, Bates, Page, Metzger and Marcelin (2003), 67% of Latino women reported never using condoms with their steady male partner. Culturally, in a traditionally *machista* society, women often do not talk to men about sex because it suggests promiscuity; and within a traditional framework, frequency and type of sex is most often determined by men. Current findings on harm reduction and prevention identify the need to raise public awareness about sexual coercion and help women and men develop the skills needed to prevent it. For women to protect themselves from HIV infection, they must rely on their own skills, attitudes, and behaviors regarding condom use as well as their ability to convince their partner to use a condom. Gender, culture and power may be barriers to maintaining safer sex practices with a primary partner. Therefore, HIV prevention strategies must target both women and men in heterosexual couples and address gender norms in sexual decision-making. For example, women are more likely to protect themselves from pregnancy using methods that do not depend on partner cooperation, such as oral contraceptives (Díaz, 1995).
In this vein, a greater understanding of and respect for Latino culture will lead to better HIV prevention efforts. Prevention programs for Latinos must take into account cultural characteristics including familismo, simpatía, and personalismo (Díaz, 1995; Hacki, et al., 1997; Needle, Trotter, Singer, Bates, Page, Metzger & Marcelin, 2003). Familismo, or the importance of the family as a social unit and source of support, can be a barrier to educators, with whom Latino clients may not share their concerns. On the positive side, family support can be a powerful factor to motivate behavior change. Simpatía refers to the importance of polite social relations that shun assertiveness, negative responses and criticism. With regards to therapeutic practice, counselor educators need to be aware that because of cultural variables such as this, Latinos may appear to agree with a counseling directive or educational message that they may not understand or intend to follow. Personalismo refers to the preference for relationships that reflect familiarity and warmth. Similarly, HIV information and service delivery may be most effective when helping professionals establish warm and trusting relationships and ask questions about family and shared experiences (Arredondo, 1999; Britton, Rak, Cimini & Shepard, 1999).

**Farmworker Health, Safety, & Environmental Hazards**

When going to the grocery store one expects a fresh produce section, and a variety of fresh, frozen, and canned fruits and vegetables to choose from. However, what a person may not know is that the availability of these goods depends on a complex cycle of agricultural production and distribution. Over 85% of the fruits and vegetables produced in the United States are hand harvested and cultivated. Without the seasonal influx of migrant farm labor during peak periods of production, many fruit and vegetable crops would not be possible (United States Department of Health and Human Services, 1999). At the heart of this cycle is the migrant farmworker. Estimates of the farmworker population vary, but what is known is that each year a large group of workers and their families (between 3 to 5 million) leave their homes to follow the crops (National Commission on Migrant Education, 1999). Agricultural labor requirements in any given area vary greatly between the different phases of planting, cultivating, harvesting, and processing. Farmworkers' labor is crucial to the production of a wide variety of crops in almost every state in the nation, and especially to California (Committee on Economic Development, 1997; Food Research and Action Center, 1996).

The migrant population is a diverse one, and although it is ethnically and culturally diverse and its composition varies from region to region, it is estimated that 85% of all migrant workers are ethnic minorities, with the overwhelming majority of migrant and seasonal farmworkers from Mexico or of Mexican decent-- that is U.S. citizens or legal residents of the United States (Acuña, 1988; Axelson, 1998; Greenberg, 1999; Martinez & Cranston-Gingras, 1996). There is little factual information to support the media furor over the reputed tax burden imposed by immigrants. In fact, two studies found that immigrants generate more in taxes paid than they consume in services received (Bartlett & Steele, 1994; Jackson, 1997). Eliminating the presence of farmworkers or switching to less labor intensive crops has been found to negatively impact regions economically, while reducing the number of jobs available to permanent local residents (Martinez & Cranston-Gingras, 1996). Although not frequently reported, farmworkers' presence enhances local economies through tax revenues from retail sales and property taxes; which in turn is an important part of state, national, and global export economies. Yet, most farmworkers earn annual incomes below the federal poverty level, and half earn wages below $7500.00 per year (Greenstein & Barancik, 1990). In addition, these farmworkers rarely have access to state benefits such as workers compensation coverage, occupational rehabilitation, or disability compensation (Tan, Ray & Cate, 1991).

Farm labor is seasonal and intensive (National Advisory Council on Migrant Health, 1993). Migrant work hours accommodate the crops, not vice versa. Planting, thinning, and harvesting are not year-round activities; however, they are crucial to crop production, and the timeframe in which they must occur is determined by the seasons and the weather. Failure to perform any of these activities at the appropriate time can result in a lost crop. Therefore, the urgency to accomplish tasks according to nature's timetable pushes farmworkers to labor in the fields in all seasons and in all weather conditions, including bright sun, extreme heat, damp cold, and rain. The work often requires stoop labor, working with the soil, climbing, carrying heavy loads, and direct contact with plants. Some plants, such as
tobacco and strawberries, exude chemicals that are toxic to humans or that can cause severe allergic reactions such as contact dermatitis (Tan, Ray & Cate, 1991). Likewise, the plants and the soil are frequently treated with pesticides and chemical fertilizers. Air pollution due to pesticide sprays are also a serious problem in the agricultural fields, where weather conditions may fail to sweep the atmosphere of pollutants. This is compounded when the poor burn highly polluting materials for cooking and warmth. As a result, high lead levels and frequent respiratory illnesses are commonly found among children and adolescents (Children's Defense Fund, 1990; National Commission on Migrant Education, 1999).

Anecdotal clinical reports indicate that many cases of pesticide poisoning are unreported because patients do not seek treatment due to lack of health care coverage, or they are misdiagnosed because the symptoms of pesticide poisoning resemble those of viral infection (Tan, Ray & Cate, 1991; Weissbourd, 1996). Interestingly, the EPA has laws on the books which apply to migrant and seasonal farmworkers. A 1988 study of 460 hired farmworkers in Washington State found that 89% did not know the name of a single pesticide to which they had been exposed, and 76% had never received any information on appropriate protection measures. Serious implications for environmental pollution and disease plague migrant farmworkers struggling without adequate housing, sewage management, and health care in regions where growing industrialization draws increasing numbers of impoverished migrant families (Jansson, 2000). A survey conducted in North Carolina found that only 4% of farmworkers surveyed had access to drinking water, hand washing facilities, and toilets. Yet, OSHA regulations require that agricultural employers of eleven or more farmworkers provide drinking water, and hand washing facilities, and toilet facilities for their employees. Compliance with the regulations is poor. Farms with ten or fewer employees are exempt from these requirements. According to the National Association of Community Health Centers, the intention of this exemption is to avoid placing an undue financial burden on small farm owners.

According to the Department of Agriculture (as cited in Wilk, 1996), agricultural labor is one of the most accident-prone industries in the United States. Other data sources indicate even higher accident and fatality rates in agriculture. Although the occupational fatality rate for all private sector industries is 4.3 per 100,000 full-time employees, the rate for the broad category of agriculture, forestry, and fishing was 23.9%. Tragically, although migrant workers live and work in one of the richest nations on earth, they have been identified as holding a Third World health status, (National Advisory Council on Migrant Health, 1993). According to measures developed by the American Academy of Pediatrics Community Health Services (1999), 10 out of 24 counties evaluated along the United States-Mexico border were considered "double jeopardy" because they were both medically underserved and poor. Moreover, these counties faced a poor health status among their residents, as well as a shortage of primary care physicians. They also found that the leading causes of death (i.e., accidents, diabetes, and infectious disease), were higher in this region than in the rest of the country. The majority of these health concerns have been attributed to the occupational hazards of farm work. Furthermore, frequent mobility, low literacy, limited language acquisition, and residency status were other barriers found to impede access to social services and effective primary health care (Adair, 1991).

The absence of toilet facilities leads to urinary retention, which is in turn has been linked to urinary tract infection. Not surprisingly, farmworkers suffer such urinary infections more often than the general population. According to Tan, Ray and Cate (1991), the ability of migrant farmworkers to obtain health services is hampered by low income, lack of health insurance, and their transient lifestyle. As a result, essential and much needed services are often fragmented or substandard (National Advisory Council on Migrant Health, 1993; United States Department of Health and Human Services, 1999). Moreover, Weissbourd (1996) found that poverty increased the likelihood of migrant families not having access to basic health, dental care and eye care. Common health concerns among migrant families include respiratory illness, bacterial and viral gastroenteritis, skin infections, anemia, head lice. Tuberculosis alone leads to 2 ½ times more deaths among farmworkers than the rest of the population in the United States (Moynihan, 1989b). Similarly, the occurrence of reproductive disorders and birth defects among women from both sides of the (U.S.-Mexican) border illustrates that health problems recognize no national boundaries (National Advisory Council on Migrant Health,
Comparisons between the health status of migrant infants, children and adolescents from the general population on the West Coast suggest that they are almost 3 times more likely to be reported in poor health. Moreover, the incidence of several types of communicable diseases is very high in border areas (National Advisory Council on Migrant Health, 1993; United States Department of Health and Human Services, 1999). When compared to the general U.S. population, these border areas also show high incidences of water borne diseases, such as *shigellosis*, high rates of hepatitis A, tuberculosis, and measles. With regards to basic health and nutrition, the migrant farmworker experience often includes hunger and malnutrition due to limited food resources for consumption (National Advisory Council on Migrant Health, 1993). The importance of nutrition during childhood has been known to affect changes in physical stature, brain development, and motor skills (Ashford, Lecroy & Lortie, 2005). It is also well known that malnourished adolescents encounter considerable health risks and obstacles to normal physical, social, and cognitive development (Brown & Politt, 1996; Gardiner, Mutter, & Kosmitzki, 1998; Sewell, Price, & Karp, 1993). Cranston-Gingras (1990) reported that malnutrition among migrant children and adolescents was ten times higher than the national rate. Over time, this malnutrition can lead to extreme weight loss, retarded growth, weakened resistance to infection, and early death (Ashford, Lecroy & Lortie, 2005; Brown & Politt, 1996). Migrant communities using the water for cooking often face serious health threats, as the lack of safe drinking water has also been found to contribute to dehydration in infants and children (National Advisory Council on Migrant Health, 1993). and heat stroke in adults (Lichter & Landale, 1995). Environmental stressors and their effect on prenatal development have the potential for hazards on the unborn child (Ashford, LeCroy & Lortie, 2005; United States Department of Health and Human Services, 1999). Not surprisingly, the infant mortality rate among migrant families is 25% higher than the national average. Similarly, birth injuries due to pesticide toxins have been linked to many cases of cerebral palsy and mental retardation (National Advisory Council on Migrant Health, 1993).

The migrant lifestyle also imposes mental stress on all members of the family unit (Bruno & Isken, 1996). Regardless of their residency status, many migrant farmworkers report experiencing prejudice and hostility in the communities in which they live and work (Arrendondo, 1984; Axelson, 1998). As a group that has been readily exploited both in Mexico and the United States, it is not surprising to find signs of withdrawal, defeatism, and fatalism (Alvirez & Bean, 1998). Depression is common among migrant adults and their offspring. This disorder has been linked to isolation, economic hardship, seasonal weather conditions, and repeated victimization. In addition, poverty, seasonal mobility, cramped living conditions, homelessness, and the lack of recreational opportunities make migrant families especially vulnerable to substance abuse and chemical dependency (Wycoff & Cameron, 2000). Day (1975) applied Maslow's hierarchy of needs to the life situation of migrant children. He found that basic physiological needs such as shelter, food, and clothing, were often scarce in impoverished migrant family homes. Consequently, conflict was observed when the internal need of the child was not compatible with an external demand. When the personal needs of the child could not be met because of other family crises or priorities, stress occurred due to the child's unfulfilled needs. Day concluded that migrant children were susceptible to stress and anxiety due to the frequent geographic moves, which included the inability to attain permanent material objects due to financial strain.

Although some hired farmworkers live in well-kept housing, much of the housing currently available for the majority is deficient, crowded, and unsanitary, making farmworkers vulnerable to health conditions that are no longer considered to be threats to the general American public. Sanitation and the hazards of raw sewage and pesticide runoff are also environmental hazards. Standard health indicators bear out the consequences. Agricultural employers recognize that the lack of housing is a serious problem, but they face several disincentives to providing adequate housing for migrant farmworkers. The need of the farmworker population to find temporary housing has traditionally been met by growers through the establishment of state-funded labor camps. But construction and maintenance of housing is expensive, especially if the housing is only occupied during a short harvest season. Some employer-provided housing does exist, but ironically, attempts to enforce housing standards have created a trend toward agricultural employers' discontinuing the provision of housing (National Advisory Council on Migrant Health, 1993). As a result, farmworkers may share a small, grower-provided room with several other people. In the absence of housing, farmworkers may be
forced to sleep in tents, cars, ditches, or open fields. Private housing is not subject to federal regulation. The private housing that is available to migrant workers tends to be substandard and many times expensive.

Migrant health centers provide accessible care for farmworkers, but the capacity of existing centers serve fewer than 20% of the nation's farmworkers. In many cases, the frequency or intensity of a health problem is greater within the migrant population than in the population at large (National Council on Migrant Health, 2003). While this access problem is in part due to a lack of insurance, it has also been attributed to barriers to access (e.g., an uneven distribution of physicians willing to work in migrant health centers, insensitive systems of care, lack of transportation, shortage of bilingual health information and health providers, legal status of the person or family needing treatment). Another factor includes farmworkers who do not understand that they are eligible for certain benefits. For those farmworkers who fit the eligibility profile for assistance, few can actually obtain benefits. This is because enrollment and eligibility standards are not designed to accommodate individuals and families that must move frequently to find work, or whose income may fluctuate dramatically during the agricultural season even though their annual wages are below the poverty level (Bartlett & Steele, 1994; Greenstein & Barancik, 1990).

**METHODOLOGY**

**Preparing Future Counselors for Research & Consulting via Community Based Service Learning**

As a major metropolitan university, Sacramento State (CSUS) is committed to providing leadership in addressing significant regional needs while enriching student learning by providing opportunities for faculty and students to engage in service through various needs-based activities. One such activity is service learning – which is the integration of community service through academic coursework. It is a method of teaching and learning that allows students to synthesize their readings, lectures, and discussions, with application and practice. To this end, graduate students enrolled in Dr. Wycoff's EDC 250 research course became part of a unique group of individuals who worked in partnership with a community based agency as research consultants and program evaluators while developing the following course competencies:

- Understand the importance of research, including the opportunities and difficulties of conducting research in the counseling profession;
- Understand the general principles and methods of quantitative, qualitative, and mixed methods research – including validity, reliability, and triangulation;
- Demonstrate the use of technology and internet tools necessary to access information available on-line, thus enhancing computer literacy;
- Describe principles, models, and applications of needs assessment, program evaluation, and use of findings to make effective program modifications;
- Understand the ethical and legal standards of practice related to research and evaluation;
- Understand the impact of age, gender, sexual orientation, ethnicity, language, disability, culture, spirituality, & other factors related to the collection and analysis of individuals, groups, and specific populations;
- Understand the steps to implement research to improve counseling effectiveness.

According to the National Service Learning Clearinghouse (2005), the combined method of instruction and learning:

- Links academic study to community service through intentional learning goals and structured reflection to enhance both learning and service;
- Emphasizes active hands-on learning in different environments;
- Values reciprocity with the community and university partners - sharing the role of learner, server and educator to meet both academic and community goals;
- Engages students in responsible and challenging community service that meets identified community needs;
- Allows students to reflect critically on their experiences and academic learning;
• Is integrated into the course and not an “add-on” or extra work. Courses are designed so that any out-of-class time is equivalent to that required for a non-service learning course;
• Students are graded on the learning related to the service, and not on the service itself (i.e., it is not receiving credit for doing community service).

Findings from previous studies (California Department of Education's service-learning initiative, 2000; CSUS Office of Community Collaboration, 2005; UC Berkeley Service-Learning Research & Development Center, 2001) on the efficacy of service learning include:

• Richer learning opportunities by applying classroom knowledge to real events in the community;
• Increased critical thinking and problem solving skills;
• Increased information retention and higher grades;
• Increased awareness, combined with a sense of community “connectedness” and civic engagement;
• Enriched experiences that strengthen professional resumes.

By working through the CSUS Office of Community Collaboration, Dr. Wycoff incorporated a service learning component in her graduate research course, whereby counselor education students were engaged in challenging community service that met identified community needs and linked academic study through learning goals related to applied research. The Office of Community Collaboration at Sacramento State University provides assistance to students and faculty in service to the community that enhances student learning, creates knowledge, and improves the quality of life for people of the Sacramento region. To this end, students selected one of two options which allowed them to engage in vital facets of counselor education-- including: direct agency services (via data collection or agency evaluation); indirect program services (via influencing policy); and indirect client service (via client advocacy).

Data analyses were multi-fold. Using meta-analysis, Dr. Wycoff and her graduate students drew upon findings from recently published national survey data of Latino and non-Latino/White populations, including studies by state-wide health indices, and available figures taken from county survey and community-based monitoring projects. Specifically, Dr. Wycoff and her graduate students assisted MAAP with two projects. The first project included administering and analyzing via post-session evaluations (N=500) from the 2005 Bi-National Latino Health Symposium sponsored by MAAP, the California Department of Health Services, Mexico's Secretariat of Health, the Secretariat of Foreign Affairs, the Mexican Institute for Social Security, and the Mexican Consulates in California. The second project included analyzing and reporting the results of MAAP’s Community Health Center Planning Questionnaire as part of a needs assessment on community-based medical/mental health service delivery for proposed federal funding through agencies such as the United States Department of Health and Human Services.

**Data Collection Procedures**

Because of issues related to literacy and reading comprehension for both options, there were two methods used to collect data: (1) surveys were completed directly by the subjects who possessed functional literacy; and (2) face-to-face interviews were conducted for those subjects who requested or were offered assistance (non-functional literacy) by trained bilingual facilitators/interviewers. With this second method, questions were read and responses recorded by the trained facilitators/interviewers.

<table>
<thead>
<tr>
<th>Option I: Bi-National Health Week’s Northern California Latino Health Symposium</th>
<th>Option II: Sacramento Community Health Center Planning Questionnaire</th>
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<td><strong>Objective</strong></td>
<td><strong>Objective</strong></td>
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<td>To administer/collect, analyze and report the findings of 1) pre/post symposium learning assessment, and 2) evaluation form assessing the quality of each presentation at the Bi-National Latino Health Symposium.</td>
<td>To analyze and report findings from the Community Health Center Planning Questionnaire – to be used for requesting federal funding in preparation for expansion of MAAP’s Sacramento Community Health Center.</td>
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**Student Tasks**

- To learn more about the Symposium’s of Latino health in the United States and Mexico, students conducted a literature search, identifying and examining the leading medical & mental health-related issues & disparities among Latinos - nationally, statewide, and in the Sacramento Region. Ultimately, the collected journal articles were synthesized into a meta-analysis by Dr. Wycoff.
- On Friday October 14, 2005, students checked in at Symposium registration 30 minutes before scheduled to collect data, secured a specially prepared ribbon/name tag identifying them as Symposium Evaluators. Students joined their data collection team/assigned a conference room, ensuring that evaluation forms were placed on each seat. Pre-selected student addressed audience (script) requesting completion of evaluation at conclusion of presentation.

**Student Tasks**

- To learn more about community health service delivery, students conducted a literature search identifying and examining problems related to medical/mental health service delivery to vulnerable urban populations, including issues related to public policy and strategies for improved service delivery. Ultimately, the collected journal articles were synthesized into a meta-analysis by Dr. Wycoff.
- MAAP designed/administered its own need-assessment surveys and conducted a series of open-ended focus group discussions with diverse groups throughout the South Sacramento community. The raw data was then retrieved by Dr. Wycoff and taken to the classroom for Option II students who tabulated and analyzed the 2-page survey (one for service providers/one for clients) that included transcribed feedback about existing healthcare services, future needs and service barriers.

**FINDINGS**

The collected data from both projects was tabulated and analyzed in class by Dr. Wycoff and her students using a mixed methods design that included descriptive statistics and content analysis. Thereafter, the results were analyzed and students assisted in the write up of their respective reports (Option I & Option II) which were submitted to MAAP in December, 2005 at the conclusion of the Fall semester at CSUS.

**Bi-National Latino Health Symposium**

The concept of Bi-National Health Week originated with a successful vaccination campaign in Mexico in 1991. Since 1993, Mexico's Secretariat of Health has carried out three National Health Weeks per year directed to populations with low-income and/or limited access to health services. In October 2001, The California-Mexico Health Initiative in coordination with California’s Department of Health Services, Mexico’s Secretariat of Health, Secretariat of Foreign Affairs, the Mexican Institute for Social Security, and the Mexican Consulates in California inaugurated the first Bi-National Health Week Symposium. MAAP and the Mexican Consulate, in coordination with Sacramento, San Joaquin, and Yolo Counties created the Northern California Latino Health Symposium, held during Bi-National Health Week (2nd week in October). The goal of the Bi-National Latino Health Symposium is to improve the health and welfare of resident and immigrant Latinos in Northern California by disseminating research, and best practices among health and social service providers and their clients/patients. Over 250 local, state, federal, and international leaders, including MAAP staff, clients, & patients attended the day long Symposium. Dr. Wycoff and 14 graduate students from the Department of Counselor Education at Sacramento State University evaluated the following panel sessions:

- Youth
- Substance Abuse
- Health Care
- HIV/AIDS
- Latino Mental Health
- Closing Session

The data was derived using two different 1-page Symposium evaluation forms created by Dr. Wycoff following consultation with the MAAP program director. All evaluation forms were offered in both English and Spanish languages [double-sided]. Translation was initially provided by Mary Reyna of the California Agribility Project, and then online, using AOL Research and Learn Translator (http://reference.aol.com/translator, 2005). At the conclusion of each panel session, Symposium Evaluators collected evaluation forms completed by audience members. The
evaluation form consisted of two closed-ended/forced-choice statements using a 3 category-type scale, and 4 open-ended questions related to the panel session. In addition, Dr. Wycoff also developed an exit evaluation that was administered at the conclusion of the Symposium’s Closing Session. On the exit evaluation, audience members were asked to rate 9 aspects of the overall Symposium using a 4 category-type scale.

**Youth Panel Presentation**

**I. Presenters’ Level of Preparedness**

The majority of participants (73%) rated the presenters and their preparedness as “excellent,” while 22% rated the preparedness of the presenters as “good.” No audience members rated the presenters “poor” in their level of preparedness (see graph below).

Reaching the Latino youth population about health related issues is no easy task, but professionals and community members alike agree on certain areas that must not be ignored. For example, substance abuse, and tobacco use appear to be primary health-related issues. Furthermore, problems arise in combating the issue of recovery, namely, barriers in language and culture and difficulty obtaining appropriate healthcare with follow-up. As such, the following recommendations include:

- Develop programs that involve family and community that tackle specific problems
- Improve substance abuse/tobacco education, awareness, prevention
- Increase knowledge of available resources
- Actively seek out culturally competent members of the community who have knowledge of healthcare related issues

**II. Most Important Thing Learned About Healthy Behavior...**

Using content analysis of audience evaluative feedback, the following themes emerged:

**Theme 1: Tobacco/Smoking**

“The later you start smoking, the less likely chance for you to become addicted.”

“Kaiser had a great presentation on prevention of smoking "don’t buy the lie."

“Kaiser showed good stats on tobacco $.”

“Youth in CA smoke less than many other states. Respiratory Infections ulcer, high blood pressures, scorpion bites are major issues for Latino immig. go to the doctor.

“More importantly I would like more information on how to implement that behavior. The Kaiser presentation was informative. At last some action is taking place.”

**Theme 2: Nurturing Youth Via Family and Community Involvement**

“That cultural competency [sic] doesn’t always just mean that you speak the language.”

“Engaging children/youth and valuing their identity.”

“Health is very broad without nutrition, religion work a good place to live and eat corn all affect [sic] your health.”

“We need to continue [sic] to work together in collaboration to help make improvement [sic] and change.”

“Their diverse knowledge and humor as well as their flexibility.”

“Lisen [sic] to the youth assist the youth and the community in culture. Identity awareness each speaker needs more time”
“Turn the tv off, open a book, [sic] listen! cultivate spirituality.”

“The state of California does not do enough to provide health care for our communities of color.”

“I can begin to become involved in the solution and if I can inform one youth on the lie of the mistakes of our past actions about “it’s ok to do drugs”. It’s not ok! It will rob us and them of their future.”

“Cultural insight to the multi-faceted latino cultures.”

“Parent involvement is key for healthy behaviors.”

“It’s the later generations of immigrants’ families that are experiencing the more severe health issues; something needs to be done about now & in the earlier generations to prevent the issues from occurring. Immigrants 2X more likely to die of diabetes.”

“Parent involvement, prevention, knowledge sharing.”

“Parents are not all involved in the education of their children & it is important because the children are influenced by culture & impacted by the culture clash. Experience loss of ID & self-esteem. It’s important to understand this to understand behavior.”

“The cultural barriers & generational differences need be addressed more within the communities.”

### III. The Most Serious Latino Health Problem In My Community Is...

Content analysis was used to understand audience comments, and the following themes emerged:

#### Theme 1: Barriers in Language and Culture

“Adults who do not know how to help their teens bridge the cultural [sic] gap.”

“I ask of health care providers understanding of the hispanic [sic] culture lack of communication among.”

“Wow! I live in a region where there is no local Spanish news, local paper or radio. Every health problem is serious in the latino community.”

“Lack of culturally competent health care providers and lack of health care. The obesity epidemic is striking all culture currently. Childcare must be taught better eating habits.”

“Not enough Bilingual/Bicultural workers to make bigger difference in Latino Health Services.”

“They don’t have health benefits or don’t have affordable health plans.”

“Not enough Bilingual/Bicultural workers to make bigger difference in Latino Health Services.”

#### Theme 2: Substance Abuse

“drugs ...STI-undiagnosed.”

“diabets [sic] II in youth and tobacco use of those between 11-15yr.s”

“smoking drugs and gangs.”

“tobacco, “wanna be's gangbanger, [sic] drug.”

“alcholismo [sic] y la falta de recursos para abtener [sic]”

#### Theme 3: Difficulty Obtaining Healthcare

“lack of access, diet & exercise.”

“I ask of health care providers understanding of the Hispanic [sic] culture lack of communication among.”

“Wow! I live in a region where there is no local Spanish news, local paper or radio. Every health problem is serious in the latino community.”

“lack of health insurance for families, high cost of dental services.”

“Knowledge of what services are available to them. Preventive health actions (physical, Dr. visit when symptoms are felt, etc.) equal stable health.”

“Lack of healthcare, lack of proper teaching styles (e.g., bilingual edu.) for immigrants (i.e., English Learners), lack of identity or connection to their heritage.”

“Lack of culturally competent health care providers and lack of health care. The obesity epidemic is striking all culture currently. Childcare must be taught better eating habits.”

“Lack of health insurance and places that provide healthcare to those that don’t have coverage.”

“One clinic for Sacramento County is not enough, plus not offered after hours or on weekends (when needed the most and working latino community available).”

“Obesity and lack of information dealing with health coverage of low cost/free for undocumented people.”

“Ability to be aware of programs available (free), lack of interpreters, obesity, heart disease, diabetes, high blood pressure.”

“No health care, obesity, high blood pressure, lack of health education.”

“Lack of education. Fear of seeking help. Lack of knowledge about proper health & nutrition and no services to provide that education or information.”
IV. Did The Presentation Change Your Perception of Immigrants?
Participants were asked whether or not the presentation changed their perception of immigrants. They reported that their perception of immigrants did not change. The following comments highlight this topic:

“No, but a good point that was made throughout the day was just because you know how to speak the language doesn’t mean you know/understand the culture (b/c there are different cultures w/in Mexico). Most people don’t see this but it’s true.”
“No, I already care about the immigrants. I am a social work intern and I will do what I can to help by continuing to learn to by culturally competent.”
“No, I have always been down with the struggle.”

The following comments highlight the respondents who answered yes:

“Yes. Don’t assume the immigrants want you to do everything for them. Acknowledge that guidance is what’s sought.”
“Yes! You are right on track but we need our program leaders to come to this symposium. So they can see and address the issue of cultural competency. They always send the Bilingual employee who is in the trenches. And expects them to be the solution in here our communities. Bring the Shot Callers who need to be educated – so we don’t have to go back and educate them. We are already doing the work.”
“Yes, reaffirming the struggles, barriers and potential.”

V. For Next Years’ Symposium...
Participants requested that the following information be presented next year, and are described in two themes:

Theme 1: Learning About Other Communities
“Outer line areas, area focus outside of Sacramento smaller communities.”
“Presenters from diff. communities what are we doing differently? What are we doing the same? Success? failures?”
“Tried and true programs [sic] that have worked in other communities.”
“Health services for immigrants in other communities outside of Sacramento [sic], great information.”
“Insurance programs information [sic] learn about community partners that can help migrant families----- all migrant farmers documented and undocumented.”

Theme 2: Latino Resources and Services
“I would like information on how to work w/ clients for example. I work w/ a Mexican family who is not making their children go to school and get H.S. educations. Their attendance is so poor that 2 have not graduated because Mom let’s them stay home because they say they’re sick, and so on.”
“How professionals can assist immigrants/Latino Americans in achieving their goals. How we can improve social services for this population. Work on the time issue.”
“Tools for working with Latino population – lots of info presented but need to focus on methods/tools.”
“I would like more information on Domestic Violence prevention. How do we better help Latinos/Latinas in rural areas where resources are limited. This is a taboo issue in general. Undocumented individuals have many barriers in escaping a violent environment and dying. This is a health issue in the latino community.”

HIV/AIDS Panel Presentation

I. Presenters’ Level of Preparedness
Forty four percent of the participants rated the presenters’ preparedness as “good.” In addition, 40% rated them as “excellent.” The Q-&-A segment that was to have been facilitated by a moderator was limited in its scope due to the opening session and keynote address running over. As a result, when asked to rate the audience’s ability to ask questions from the presenters, 9% rated the process as “poor,” while 37% rated it as “excellent.” One possible explanation for 23% not completing the evaluation may be related to lunch being delayed by nearly 90 minutes due to the opening session running over. after its originally scheduled time.
The following themes emerged through the process of the content analysis. Four open-ended questions were asked at the end of each panel presentation.

II. The Most Important Thing I Learned About Healthy Behavior Was...
The three major themes that emerged from this question were in the areas of awareness/education, prevention, and prenatal/health care. Some responses overlapped into more than one category. The following comments were expressed by audience participants.

“Being aware [sic]/statistics on AIDS cases an Sacramento county.”
“Outreach! Prevention with education.”
“The need for the awareness to get out the community.”
“The importance of continued education to break the cycle.”
“Not be have sex without a condom.”
“Use protection!”

“The information about MSM was new to me. The information about pregnant women and availability [sic] of prevention on delivering HIV negative babies with medication was crucial to my work.”
“HIV prevention at birth using medicine.”
“WE need to have medical help even if we are low income - health for all not just for some.”

III. The Most Serious Latino Health Problem In My Community Is...
Comments from this question had to do specifically with diabetes and education/knowledge. Participants dialogued their concerns regarding problems in the Latino community with the majority of input concentrating on education/knowledge. This seemed to be a common area of concern. Below are highlights of comments received:

“Lack of knowledge about HIV.”
“The lack of knowledge and education.”
“The lack of ecucation [sic] to learn English.”
“Diabetes”
“Diabetes alchohlim [sic]/addiction HIV (obesity in children)”
“Diabetes & Obesity HIV – IS A DISEASE OF CHOICE

IV. Did The Presentation Change Your Perception of Immigrants?
The majority of participants answered “No” for this question. Although, there were some who answered “Yes” and commented that their perceptions were changed in the areas of information/education and compassion. The following comments are direct quotes from those questionnaires:

“Si, necesitar [sic] mar informacion.”
“Yes it helps to be updated with current information.”
“Be more understanding and copassionate [sic].”
“Yes we need to be more compassionate toward them.”

V. For Next Years’ Symposium...
In this final item, participants identified the following:

“AIDS, Hepatitis (all kinds).”
“More on HIV & risky behavior.”
I. Presenters’ Level of Preparedness
The majority of respondents believed the presenters were well prepared throughout their presentations, with 70% of participants rating them as “excellent.” Twenty three percent of the participants rated the preparedness level of the presenters as “good,” while no one rated the preparedness level as poor.

A review of the literature related to substance abuse and the Hispanic population revealed consistent parallels in emerging themes. First, the Latino population has unique cultural factors that must be considered when addressing risk reduction and treatment of substance abuse/addictions. It is important to note that Latinos experience a higher proportion of illness related to substance abuse than Whites; but they have less treatment resources available due to economic discrepancies, and have more difficulty accessing services.

II. The Most Important Thing I Learned About Healthy Behavior...

Theme 1: The Importance of Youth Interventions
A majority of participants indicated that substance abuse interventions for youth are an important component of combating addiction problems. An understanding that the younger a child is when they first use a substance, the greater their risk of addiction, emerged in participants responses. Finally the need for educating youth about substance abuse and addiction was also voiced. The following quotes illustrate this theme:

“If you start trying drugs at 10 to 12 years of age, you have a higher chance of being a drug addict.”
“Young abusers start really young and maintain as addicts.”
“We need to educate our children because addiction starts in our youth.”
“The idea that early onset of substance use is the single significant factor to predict adult future AOD problems.”

Theme 2: The Statistics Presented Were Meaningful
Many of the audience participants cited statistics from the panel presentation as the most important and meaningful things learned. Interestingly, the statistics clearly impacted the participants and were retained as evidenced by their ability to recall them in response to the evaluation item:

“75% of all addicts are gainfully employed.”
“Year of 1st use is a predictor of future problems with drugs and alcohol, 10 to 12 years.”
“Dr.Inaba’s [sic] stats were fascinating, great perspective on addiction and enlightening.”
III. The Most Serious Latino Health Problem In My Community Is...

**Theme 1: Importance of Cultural Competency & Sensitivity to Cultural Variables**
Several respondents mentioned that cultural factors were the most important thing they took with them from the presentation. They were aware of the problem of substance abuse in the Latino community and the necessity of culturally competent interventions and treatment. The following quotes illustrate this theme:

“Latin Americans suffer a larger portion of substance abusers.”
“Getting over myths.”
“Cultural understanding.”

**Theme 2: Lack of Services and Barriers to Accessing Services**
Many participants indicated that they felt they were not enough resources for dealing with substance abuse and addiction. Audience members also cited difficulties in accessing available services primarily due to lack of money. The following quotes illustrate this theme:

“Not enough programs to help uninsured Latinos.”
“Not enough resources for the community to get help.”
“Lack of access to affordable healthcare.”
“Access to services.”
“Lack of Medical insurance.”

IV. Did The Presentation Change Your Perception of Immigrants?

**Theme 1: Perception of Immigrants Was Changed**
About half of the audience members reported that their perception of immigrants had changed based on the panel presentation. Many felt that the information presented on topics such as acculturation, the physiological properties of addictive brains, and cultural shock changed their perception of immigrants with regard to substance abuse. A number of the participants believed the information helped their understanding of immigrants. The following participant comments illustrate this theme:

“Yes, Didn’t know properties of addictive brains.”
“Yes. Cultural shock, depression effects & biases placed on Hispanic populations.”
“It really opened my eyes to the struggles that affect them.”
“Yes. Acculturation spurs AOD problems and reflect mainstream.”

V. For Next Years’ Symposium...

**Theme 1: More Resources**
Some reported that there should be more resource information provided on the topics discussed. Several suggested that there be other topics discussed at the next Symposium that are of importance, such as domestic violence, poly-cultural substance abuse, Latino child safety, etc. The following participant comments illustrate this interest:

“More on health problems and resources.”
“Drug prevention and substance abuse for teenage 10/12 years of age.”
“The health treatment prison inmates get.”
“Domestic Violence.”
“Issues related to women.”
“American Indian alcohol and drug treatment issues.”
“Poly-Cultural substance abuse, treatments and their outcomes.”
“Latino Children Safety.”
Latino Mental Health Panel Presentation

I. Presenters' Level of Preparedness

The quantitative results indicate that overall, the audience found the presenters well prepared during the Latino Mental Health Session. Sixty seven percent of the audience rated the presenters as “excellent,” while 8% perceived the level of preparedness as “good.” It is important to note that no translation service was provided during this session. As a result, one may infer that a segment of the audience was unable to comprehend the presentation, which may have been a factor in 25% of the audience opting not to respond to this particular item, and 32% not responding to the second item. Feedback suggests that the audience would have preferred more opportunity to interact with the presenters.

II. The Most Important Thing I Learned About Healthy Behavior Was...

The following themes emerged through the process of qualitative analysis:

Theme 1: Interest in Traditional Medicine
The majority of participants reported that they had benefited from learning about traditional medicine as presented by the panelists from Mexico. Audience members seemed to be fascinated by the possibilities presented, including its use in the treatment of mental health challenges. Many of the participants were impressed enough by the discussion to clearly advocate for a more inclusive, holistic approach to mental health treatment for Latino clients. The following participant comments highlight this theme:

“There is no one way to approach the treatment of mental health/mental illness. We have much to learn from “traditional” medicine’s approach and much to gain in terms of a holistic and cultural inclusive construct in treating mental health/illness.”
“One advocated: “Open-mindedness, when it comes to healthcare obtained by Latinos. One model with three levels of care: traditional, Curandero, and Western.”

Theme 2: Greater Sensitivity to Cultural Issues
Another theme that surfaced revealed the participants’ interest in the connection between promoting greater awareness for cultural sensitivity with regards to mental health issues for the Latino community. The sense among some was that immigrants face many barriers due to cultural barriers. Below is some commentary that highlights this desire:

“Respect every person’s belief”
“Try to understand instead of criticize other cultures”
“Mental health issues-the lack of communication between doctors and patients by language”
III. The Most Serious Latino Health Problem In My Community Is...

Theme 1: Substance Abuse Combined With Other Issues
Conference participants were clearly concerned about the connection between the mental health issues Latinos in the community face and the increasing problem of substance abuse in the community. Participants found it hard to distinguish one problem and often listed issues such as socioeconomic conditions and other health issues often connected to mental health and substance abuse issues, as evidenced by the following responses:

“Alcohol, drugs and mental health.”
“Drugs, alcohol and low social economics.”

Theme 2: Mental Health and Cultural Discrimination
It is probably not surprising that those attending a Latino Mental Health panel would cite this challenge as the major one facing the community. Some participants linked this issue with statements suggesting that the difficulties of adapting to a new culture and facing invisible discriminatory barriers amplified the mental health crisis in the community. Below are some of these statements:

“Mental health approach-due to non-understanding language and culture.”
“AOD (alcohol/drug issues) and cultural disruptions (acculturation screw-ups).”
“Depression and having a false knowledge of culture.”
“Mental health and cultural sensitivity.”
“Ignoring physical and mental illness-there is a need to break down stigma and stereotypes.”

IV. Did The Presentation Change Your Perception of Immigrants?

Theme 1
The majority did not feel the presentation changed their perception as much as it may have confirmed their concern about immigrants. In addition, about one-third reported that their perception of the issue had been changed through the presentation:

“No. But it confirmed some things.”
“No. But the information presented was very helpful.”
“No. I already know the immigration problems need to change”
“Yes-I realize how difficult it is to be in need of mental health services and not be understood.”
“Yes. Depression if often part of immigrants’ health challenge, even before in the US. The County of Sacramento is limited in mental health resources.”

Theme 2: Understanding of Latino Mental Health Challenges
The majority expressed a greater sense of compassion toward this marginalized and vulnerable group. Others expressed a need for greater involvement in dispelling myths and stereotypes of mental illness, as evidenced by the following comments:

“Yes, I am a lot more sympathetic and wanted to help. I don’t need to feel that “I” can’t make a difference. I would like to volunteer and give more of my talents and time to the community.”
“Yes, I will try to understand immigrants, they go through a lot when they come here and this symposium has opened my eyes.”

V. For Next Years' Symposium...

Theme 1: Enthusiasm for Conference with Creative Suggestions
Audience participants offered some useful suggestions for the formation and structure of next year’s Symposium. These included:

“More on mental health and teach Americans not to judge and criticize when they don’t really know the Latino culture. Teach them to be nice to clients when they are trying to communicate the best they know how.”
“Specific explanation on bipolar, dual diagnosis.”
“Start to present success story of an immigrant who was able to benefit from MAAP service.”
“More on forms of traditional medicine.”
“More on how other youth gangs Asian & Black affect Latino youth in the schools-mentally.”
“Invite Latino undergrad. And grad students from local colleges; universities.”
“Have a resource center, a separate room, not just a table.”
“Sessions focus on case studies and promising practices.”

**Health Care Panel Presentation**

I. Presenters' Level of Preparedness
An overwhelming percentage (86%) of the audience participants rated the presenters as "excellent." An equal percentage (7%, respectively) of participants reported that the presenters were good when it came to being prepared.

![Bar chart showing presenter preparedness]

Participants were asked to respond to four open-ended evaluation questions regarding Latino healthcare.

II. The Most Important Thing I Learned About Healthy Behavior Was...
- “The information on traditional medicine was good, but will it possibly be legalized in the future.”
- “The importance of health care in the Mexican community.”
- “Prevention is the key to staying healthy.”
- “The importance of educating the community about good health practices.”
- “The need for mental health Spanish-speaking therapists who understand the Latino culture.”
- “What are the signs, symptoms and the severity of depression in the Mexican communities?”
- “Mental health and the physical symptoms of depression within Mexican immigrant community.”
- “How difficult is it for Mexican migrants to obtain health care?”
- “Many Mexican immigrants often suffer with depression which leads to use of alcohol and drugs.”

III. The Most Serious Latino Health Problem In My Community Is...
There were many common concerns reported by audience members with regards to health care and health problems faced by Latinos. Access to health care was ranked as the top health problem impacting Latinos. Obesity and diabetes were ranked equally. Depression was the next serious problem affecting Latino health. Finally, there were three other health concerns that were equally ranked, as follows: high blood pressure; sex education; and dental care:

![Healthcare concerns pyramid]

IV. Did The Presentation Change Your Perception of Immigrants?
The majority of the participants reported that their perceptions changed about immigrants in relation to health care
as a result of the presentation. The following comments illustrate this change:

“Diabetes and depression are serious problems for immigrants.”
“We are all the same, but stereotypes can be overcome.”
“Immigrants are not appreciated. They have needs that are not being met.”
“I changed my opinion about immigrants and about the stress they experience.”
“Call them laborers not immigrants.”

V. For Next Years’ Symposium...
There were a number of audience members who urged MAAP to offer this Symposium again in 2006, including more attention given to mental health issues from both Western and indigenous perspectives. Due to the importance of this Symposium, many audience participants suggested that there be more effort in the area of community outreach and promotion in order to increase awareness about existing about available agency/program services. The following comments are offered:

“We have a great necessity of this symposium.”
“Promotion for the program.”
“More mental health”
“LONGER session for mental health!”
“Spread the word to get more to attend.”

Discussion
The Symposium demonstrated a successful outreach to the community. The flow of the schedule reflected both flexibility and adaptability to unforeseen circumstances. When planning for future symposiums, it will be advantageous to explore ways in which to better monitor and manage the schedule/timing of events as evidenced by the ratings and narrative feedback from audience members, thus providing adequate time for speakers to complete their presentations, and allow audience members time for Q-&-A. Other aspects to consider include ensuring the Symposium is accessible to people with disabilities (sign language interpreters), the need for translators to have a temperament that is conducive to working with large audiences in small spaces, the potential for on-site childcare while parents attend panels, and offering family-centered topics concerning mental health issues. Finally, MAAP is to be commended on how it creatively and inclusively brought together health & social service providers, and client/patient recipients with the goal of disseminating information in the form of research, and best practices, which was evaluated as a very positive process. In general, attendees highly praised the Symposium, commenting on the high quality of the presentations, enthusiasm generated by exposure to Latino-specific topics and practices, and the subsequent discussions generated from acquired knowledge.

Sacramento Community Health Center Planning Study
Since October 2003, MAAP has offered medical and dental services at its Sacramento Community Health Center, serving more than 5000 patients/clients in the South Sacramento area from the following ethnic groups and communities: African American, American Indian, Chinese, Caucasian, East Indian, Hmong, Latino, Russian, Ukrainian, and Vietnamese. With a need to expand these services, MAAP will apply for long-range federal grants [FQHC]. As part of the grant proposal process, it must provide data about the needs of the community it serves. In an effort to include the community in their planning process, MAAP developed a 2-page Community Health Center Planning Survey that asked questions about healthcare needs, barriers to service, and feedback on existing services. The surveys were administered between July and August, 2005 to both community residents and community service providers at a number of their satellite facilities in South Sacramento.
Following the completion of the survey, a series of small focus groups were conducted, whereby participants responded to several open-ended questions that were recorded by a facilitator, and later transcribed. Data from the focus groups was collected between August and September, 2005 by various MAAP personnel. Once completed, the raw data was retrieved by Dr. Wycoff, and thereafter, she and 15 graduate students from the Department of Counselor Education at Sacramento State University, transcribed, tabulated, calculated, and analyzed the data using descriptive statistics and content analysis. Presented in this next section are the results and discussion in three sections: 1) Demographics, 2) Service Delivery, and 3) Focus Groups.

Income & Household Residence
Participants were asked: What is your family's monthly income? Although 64% failed to answer this question, the results are still of importance when considering health issues related to poverty. For example, 16% of those who did respond reported making $1,000-$1,500 per month. Twelve percent reported making $500-$1,000 per month, 8% reported an income of more than $4,000 per month. The American Community Survey for Sacramento County, for California (2004) has stated that low socioeconomic status is a significant problem in the South Sacramento area, with 26.5% falling 100% below the federal poverty level, and 53.96% falling 200% below the federal poverty level. Sixteen percent earn less than $500 and only 18% earning more than $4,000 dollars.

<table>
<thead>
<tr>
<th>Monthly Income</th>
<th>Income by %</th>
<th>Monthly Income</th>
<th>Income by %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Less than $500</td>
<td>6%</td>
<td>$3,500-$4,000</td>
<td>3%</td>
</tr>
<tr>
<td>$2,500-$3,000</td>
<td>3%</td>
<td>$1,500-$2,000</td>
<td>7%</td>
</tr>
<tr>
<td>$500-$1,000</td>
<td>12%</td>
<td>More than $4,000</td>
<td>8%</td>
</tr>
<tr>
<td>$3,000-$3,500</td>
<td>3%</td>
<td>$2,000-$2,500</td>
<td>7%</td>
</tr>
<tr>
<td>$1,000-$1,500</td>
<td>16%</td>
<td>No Response</td>
<td>64%</td>
</tr>
</tbody>
</table>

Interestingly, the highest percentage of individuals who completed a survey reported that they lived alone. Family support can be therapeutic in that the family has the potential to serve as a support system, a social unit, and at times an accountability partner. However, there are many stereotypes about low SES ethnic minority families. For example, the traditional Hispanic family has been described as very inter-dependent. Mindel's study compared Mexican American, African American and Caucasian families, and found Mexican Americans to be the most familialistic in both attitudes and behaviors, followed by African Americans. Kim and McKenry (2003) lead a study comparing the three largest U.S. ethnic minority groups (and Caucasian) in terms of social supports using a national data set. They found that the "educational level was related to lack of support or receiving support from children and other relatives, and the more highly educated were less likely to seek support from friends, neighbors, co-workers, or parents" (p. 329). These findings are similar to other findings that have found connections between Mexican American health problems and their support systems, or lack thereof. Finch and Vega (2003) found that greater numbers of peers and family members in the United States, and a higher reliance on religious support mechanisms decreased the likelihood of reporting fair/poor health. These studies reveal a common theme which suggests a connection between a lack of family support, low education, and fair/poor health.

Service Delivery Results

Do You Have Health Insurance?
Thirty nine percent of the participants reported that they did not have any health insurance. The next highest response was 20% who reported having some type of private insurance such as Blue Cross, Molina, Health Net, Kaiser, etc. Of the remaining participants, 17% indicated that they used Medi-Cal, 8% identified using county clinics (CMISP), and 1% used Healthy Families. Nationwide, while Latinos represent about 13% of the total population, they make up 30.4% of the
nation’s uninsured, making them the largest portion of uninsured persons in the country (National Center for Health Statistics, 2002).

### Which of the Following Services Do You Need Better Access?

In response to this question, the top health services that people said they needed access to were dental (43%), followed closely by health services for adults (42%). Twenty eight percent reported needing better access to medication, 26% reported needing better access to eye glasses, and 25% reported needing more health-related services for their children. In the 20--23% range were drugs and alcohol treatment (23%), mental health counseling (23%), x-ray (22%), physical examinations (21%), foot doctor (21%), lab tests (20%), family planning (20%), and help with broken bones (20%). Finally, 18% reported needing better access to health education, while 16% identified prenatal care and 13% identified care during pregnancy. Lastly, 10% identified “other” services but failed to specify.

<table>
<thead>
<tr>
<th>Service</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health services for adults</td>
<td>42%</td>
</tr>
<tr>
<td>Health services for children</td>
<td>25%</td>
</tr>
<tr>
<td>Prenatal</td>
<td>16%</td>
</tr>
<tr>
<td>Medication</td>
<td>28%</td>
</tr>
<tr>
<td>Lab tests</td>
<td>20%</td>
</tr>
<tr>
<td>X-ray</td>
<td>22%</td>
</tr>
<tr>
<td>Health education</td>
<td>18%</td>
</tr>
<tr>
<td>Family planning</td>
<td>20%</td>
</tr>
<tr>
<td>Other (none specified)</td>
<td>10%</td>
</tr>
<tr>
<td>Eye glasses</td>
<td>26%</td>
</tr>
<tr>
<td>Dental need better access to</td>
<td>43%</td>
</tr>
<tr>
<td>Physical exam</td>
<td>21%</td>
</tr>
<tr>
<td>Foot doctor</td>
<td>21%</td>
</tr>
<tr>
<td>Help with broken bones</td>
<td>20%</td>
</tr>
<tr>
<td>Drug and alcohol treatment</td>
<td>23%</td>
</tr>
<tr>
<td>Counseling</td>
<td>23%</td>
</tr>
<tr>
<td>Care during pregnancy</td>
<td>13%</td>
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</tbody>
</table>

Though none of the responses were statistically significant the responses do provide some insight into the needs of this population. For example, there are many barriers for people of lower SES backgrounds -- including but not limited to transportation, insurance, cost, cultural barriers and language. According to a recent article in the *Journal for the Poor and Underserved* (Adams, 2005), one factor that seemed to increase people’s use of services were having foreign physicians or physicians from diverse backgrounds working in the clinics.

### Which Hospital or Clinic Do You Usually Use?

Asked which hospital or clinic participants usually used, they reported from highest to lowest the following:

- Medi-Cal
- Healthy Families
- Private Insurance
- CMISP
- No Insurance
- No Reply
Twice as many participants have used Kaiser, which may have something to do with the facility being located in South Sacramento, whereas the other major facilities (U.C. Davis, Mercy and Sutter) are geographically further in distance. The only other substantial service used was Primary Care. Those participants that did not utilize the services of a clinic or hospital shared the following:

"I just moved here, and haven’t had to use anyplace, yet."

"I don’t have any coverage, but if there’s an emergency, I go to ER for help."

"Nowhere. Have an appointment for medical. It doesn’t look like I’ll get coverage."

The inability to utilize a local hospital or clinic may be a transportation issue. In a survey by Weathers, Minkovitz, O’campo, and Deiner-West (2004), it was found that 80% of the subjects did not have transportation and 20% did not have knowledge of where to go for help when needed. One might surmise that if clients cannot get to a facility or do not know where they should go, then the system may need to be more accessible.

**Do You Feel You Are Receiving Good Care?**

Participants were asked whether or not they felt they were getting good health care. Although no statistical significance was found, 39% reported in the affirmative—that is—they were getting good care. Seventeen percent reported that they did not feel that they were getting good care. Unfortunately, 44% did not reply to this question. One possible reason could be that the question needed better clarification, including the need to defining the term “good care” with concrete criteria. For example, those participants who did not use a hospital or clinic may not have a gauge in which to define what constitutes “good care” or “poor care.”

**Emergency Room Usage: Need & Frequency**

Of the participants that responded to this item, 33% reported that they had used a hospital emergency room within the last year. Forty two percent responded that they had not used a hospital ER within the last year. Frequency of emergency room use ranged from 12 visits (15%) to one visit in the past year (5%). Since Latinos are almost 3 times less likely to have a consistent source of medical care, they rely more heavily on emergency room treatment. Thus, they are 1.5 times more likely to use the hospital ER as their primary source of care than the general population (American College of Physicians, 2000).

**What Are The Biggest Problems In Getting The Health Care You Need?**

Thirty seven percent of participants reported that their biggest problem in getting health care was that they didn’t have health insurance (see graph below). Twenty nine percent of the participants felt doctors charged too much, 23% reported they couldn’t get there (no transportation). Twenty one percent reported, that doctors did not speak their primary language, and another 20% believed that the doctors did not understand their culture. Nineteen percent reported that, it took too long to get what they needed, while 15% reported that, they had so many other problems that they didn’t have time to go to the doctor. And finally, 10% checked off “other.”
The cost of healthcare was reported as a barrier that emerged from the “other” category. Becker (2004) reported that Latinos delay seeking health insurance because of the cost -- especially those that are not insured. This was conveyed in the narrative examples expressed by survey participants in the present study. Another theme that was reported among participants in the “other” category were problems related to the interaction/treatment by health care professionals. The following illustrate these two themes:

“Cost and expense sometimes keep me from getting medical help.”
“b/c I was a drug addict, that’s all the doctors see, they won’t treat. If you need narcotic legitmalty [sic]”
“Doctors are ‘know it alls’ and don’t listen to what I say”

Consistent with this qualitative feedback is a previous study by Thomas, Fine, and Ibrahim (2004) who reported that one of the root causes of health disparities is the knowledge and attitudes of providers. The examples provided by the participants in the present survey suggest that the treatment they receive from doctors in the region has an impact similar to that found in the earlier 2004 study.

Do You Know That The Sacramento Community Health Center Provides Medical and Dental Services In South Sacramento?

Seventeen percent reported that they were aware of the services, and 53% of those surveyed reported that they did not know that the Sacramento Community Healthy Center provided medical and dental services for those residing in South Sacramento. The most frequent comments included the following:

“Didn't know about the service”
“Not familiar with the center.”
“I was unaware of the program.”
“Never knew about it.”
“I didn’t know about what you had.”
“New in the area.”
“I was told I’m not eligible to get services here.”

“Never knew it existed.”
“I did not know that i could use the services here.”
“Didn’t know it existed.”
“I just found out about it.”
“Never knew that there was a community health care center.”

That 53% of the participants did not know that the Sacramento Community Health Center provides medical and dental services to South Sacramento could imply two things. First, that there needs to be more advertising done to get the word out that the Health Center exists within the community. The second possibility is that the participants may not know the name of the agency, recognize its logo, or understand how to use the available services through partnering agencies. If asking this question in future surveys, further exploration about understanding the sites and services available is suggested.
Do You Use The Services At The Sacramento Community Health Center?

When participants were asked if they used the Sacramento Community Health Center for their healthcare needs, 77% responded “No.” Although a small percentage indicated that this was because they had some form of health insurance, the majority reported they were unaware of the services provided at the Sacramento Community Health Center. Twelve percent reported they had previously used the services, 8% were not aware of the available service, and 4% did not answer the question (see below).

It appears that the Sacramento Community Health Center would benefit by developing a more active strategy for informing the community of their existence through a variety of creative marketing and outreach campaigns in targeted locations and venues. Some outreach locations may include, but not be limited to: public transportation sites, hospital emergency rooms, schools, and small area markets, radio and Sacramento access cable television. In *Health Disparities: The Importance of Culture and Health Communication*, the authors (Thomas, Fine, & Ibrahim, 2004) propose that cultural awareness and communication needs to take place so the gap in health care can be narrowed and easy access to health clinics such as Sacramento Community Health Clinic becomes the norm.

When asked how they would rate the services they received at the Sacramento Community Health Center, 75% did not answer the question, 18% responded that the services were “poor” and did not meet their needs, 5% reported the services were “good” and met their needs, and 2% reported the services were “excellent and outstanding.” Since 77% of the participants had never been to Sacramento Community Health Center, it would be reasonable to understand how 75% may have left the corollary question blank. One method of improvement may be to have an immediate after-service evaluation completed in order to identify patient needs and expectations and for monitoring overall quality of services.
What Services Do You Most Need At The Sacramento Community Health Center?

When asked about the services most needed at the Sacramento Community Health Center, four themes were identified, including the following narrative feedback:

1. General Medical Care with Periodic Follow-up
2. Medication for General Medical and Psychological Problems
3. Vision
4. Dental Services

“Sometime i need to see a doctor for headache. Glasses, my sight is bad, i need new glasses every other yr. but if they are not broken they don't replace them.”

“We need more awareness & education services, how to prevent pregnancy, alcoholism, drug abuse, etc.”

‘Adult and child care, and dental services.”

“Dental and now my back and neck.”

“Dental and gastrointestinal treatment.”

“Quicker response time with medications and more in depth physical treatment & xray.”

“Health and dental insurance care during pregnancy.”

“Vision and dental.”

“Lose weight program.”

“Dental, x-rays, lab tests, and psych counseling.”

“Dental and vision and care for bone spurs and arthritis in my knees and ankles.”

“Help for mental problems.”

“I need psych meds, and to get my kidney checked out.”

“General health care, medications, dental and eye doctor.”

“I have an old motor cycle injury that I live with because I feel nothing will be done due to no insurance.”

“I cannot function properly due to this injury, and need long term care.”

“Ongoing check ups on ulcerative colitis medication for ulcerative colitis so that I don’t get inflamed and bleed internally.”

“Treat chronic injuries – 2 months of constant pain.”

“I had an Head injury that caused me REAL bad HEADACHES, so having follow-up is real good.”

“Long term medication.”

“Glasses, I need eye glasses.”

When Addressing Health Care, Which of The Following Is Most Important?

This survey item posed different directive guidelines in the English and Spanish versions. In the English language version (below), participants were asked to rank order the most important health related problems. Results were as follows: The top two health related problems were cancer and heart disease at 24% respectively. Twenty two percent reported HIV/AIDS, and STD, while 21% indicated that diabetes was an important health-related problem to address. Alcohol or other drug use and high blood pressure were identified at 19% respectively, while problems with teeth ranked 18%, and mental illness at 16%.

In the Spanish language version (below), participants were asked to check off all areas that they believed were important. In these results, diabetes was the top priority with a 13% response. Twelve percent felt that cancer, heat stroke, heart disease, problems with teeth, and HIV/AIDS, STD all were a priority. High blood pressure and skin disorder at 11% and asthma at 10% also seemed a concern. While feeling sad, overweight, and mental illness received 8% of the responses and cold/flu received 7% of the responses, all other areas receiving less than 10% should still be viewed as important concerns.

<table>
<thead>
<tr>
<th>English Language Version</th>
<th>Spanish Language Version</th>
</tr>
</thead>
<tbody>
<tr>
<td>Participants were asked to rank order the top five health-related problems from 1-to-5 (1 being most important)</td>
<td>Spanish speaking participants were NOT asked to rank order the top five health-related problems. Instead, participants checked off those health-related problems they believed were important.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Health-Related Problem Responses</th>
<th>Other (Specify)</th>
<th>High Blood Pressure</th>
<th>Skin Disorder (Example: Rash)</th>
</tr>
</thead>
<tbody>
<tr>
<td>English Language Version</td>
<td>1%</td>
<td>19%</td>
<td>1%</td>
</tr>
<tr>
<td>Spanish Language Version</td>
<td>4%</td>
<td>11%</td>
<td>11%</td>
</tr>
</tbody>
</table>
As shown above, the highest health-rated problems with both the English language and Spanish language versions were cancer and heart disease. Salonen (1982) indicated that not being married, a lack of education, and low income were associated with an excessive risk of death from ischemic heart disease and any disease. These studies as well as many others reveal a strong relationship between low SES and a lack of education and suffering from health problems such as cancer and heart disease. Though the results may disclose that low SES and a lack of education may be correlated with suffering from cancer and heart disease, not all social and economically disadvantaged groups suffer equally from those health problems. Suarez and Ramirez (1999) found that Hispanics are less likely to die from heart disease and cancer compared to non-Hispanic whites and African Americans. Suarez and Ramirez (1999) instead found that “diseases that are very high among Hispanics, particularly Mexican Americans, are diabetes, obesity, and gallbladder and liver cancers.” In looking at the results of this study and other related articles, it is evident that cancer screening programs must take into account differences among Latinos in several different areas including age, gender, education levels, marital status, cancer history, risk behaviors, insurance, health status and health services utilization (Gorin, 2005). Although it is unclear how health literacy can influence health status and health service use, it is evident the Latino community needs more outreach services for their health care needs. In an effort to address the whole person, these health care services/treatments would need to range from cancer care to treating depression to addressing the repercussions of loneliness. McBride (2001) found that nonimmigrant minorities experience inequities in attaining quality health care. Similarly, Cheng (2005) reported that more restrictive state welfare policies were variously associated with lower likelihood of using dental care, visiting a physician and using prescriptions.

### Continued from previous page...

<table>
<thead>
<tr>
<th>Health-Related Problem</th>
<th>English Language Version Responses (%)</th>
<th>Spanish Language Version Responses</th>
</tr>
</thead>
<tbody>
<tr>
<td>Feeling Sad</td>
<td>3%</td>
<td>Feeling Sad 8%</td>
</tr>
<tr>
<td>Problems With Teeth</td>
<td>18%</td>
<td>Problems With Teeth 12%</td>
</tr>
<tr>
<td>Overweight</td>
<td>6%</td>
<td>Overweight 8%</td>
</tr>
<tr>
<td>Mental Illness</td>
<td>16%</td>
<td>Mental Illness 8%</td>
</tr>
<tr>
<td>Heart Stroke</td>
<td>4%</td>
<td>Heart Stroke 12%</td>
</tr>
<tr>
<td>Cold/ Flu</td>
<td>4%</td>
<td>Cold/ Flu 7%</td>
</tr>
<tr>
<td>Cancer</td>
<td>24%</td>
<td>Cancer 12%</td>
</tr>
<tr>
<td>Trouble Paying Attention (ADD/ ADHD)</td>
<td>5%</td>
<td>Heart Disease 12%</td>
</tr>
<tr>
<td>Heart Disease</td>
<td>24%</td>
<td>HIV, AIDS, STD 12%</td>
</tr>
<tr>
<td>HIV, AIDS, STD</td>
<td>22%</td>
<td>Asthma 10%</td>
</tr>
<tr>
<td>Asthma</td>
<td>8%</td>
<td>Alcohol or Other Drug Use 8%</td>
</tr>
<tr>
<td>Alcohol Or Other Drug Use</td>
<td>19%</td>
<td>Diabetes 13%</td>
</tr>
<tr>
<td>Diabetes</td>
<td>21%</td>
<td></td>
</tr>
</tbody>
</table>

As shown above, the highest health-rated problems with both the English language and Spanish language versions were cancer and heart disease. Salonen (1982) indicated that not being married, a lack of education, and low income were associated with an excessive risk of death from ischemic heart disease and any disease. These studies as well as many others reveal a strong relationship between low SES and a lack of education and suffering from health problems such as cancer and heart disease. Though the results may disclose that low SES and a lack of education may be correlated with suffering from cancer and heart disease, not all social and economically disadvantaged groups suffer equally from those health problems. Suarez and Ramirez (1999) found that Hispanics are less likely to die from heart disease and cancer compared to non-Hispanic whites and African Americans. Suarez and Ramirez (1999) instead found that “diseases that are very high among Hispanics, particularly Mexican Americans, are diabetes, obesity, and gallbladder and liver cancers.” In looking at the results of this study and other related articles, it is evident that cancer screening programs must take into account differences among Latinos in several different areas including age, gender, education levels, marital status, cancer history, risk behaviors, insurance, health status and health services utilization (Gorin, 2005). Although it is unclear how health literacy can influence health status and health service use, it is evident the Latino community needs more outreach services for their health care needs. In an effort to address the whole person, these health care services/treatments would need to range from cancer care to treating depression to addressing the repercussions of loneliness. McBride (2001) found that nonimmigrant minorities experience inequities in attaining quality health care. Similarly, Cheng (2005) reported that more restrictive state welfare policies were variously associated with lower likelihood of using dental care, visiting a physician and using prescriptions.

### What Kinds of Troubles Have You or Your Family Gone Through Over the Past Two Years?

Both English and Spanish language versions asked participants to check off family problems experienced within the past two years. Results were as follows: Alcohol or other drug related problems were identified by 37% of the participants.
Ranked at 24% and 21% were loss of job, and the death of family member, respectively. Other frequently marked responses were loss of home, mental illness, and diagnosis of a serious medical condition (HIV/AIDS, diabetes, cancer, etc) at 13%, and having no one to share life with was reported at 12%.

**What Kinds of Supports Do You & Your Family Have?**

Participants were asked about the kinds of supports they and their family had (see below). Thirty-five percent of the survey participants reported that open communication, reliability and trust were important elements of support. Thirty-three percent reported that they want a safe place to live. Thirty-three percent desire that their family and friends are well. Thirty-two percent want friends that they can talk to and trust. Thirty-one percent desire a job that keeps them occupied. As well as 31% of the survey participants get support from their children.

<table>
<thead>
<tr>
<th>Sources of Support for Self &amp; Family</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Trust Resources Reliability And Communication Family</td>
<td>35%</td>
</tr>
<tr>
<td>Good Doctor And/or Dentist</td>
<td>24%</td>
</tr>
<tr>
<td>Job That Keeps Me Busy</td>
<td>31%</td>
</tr>
<tr>
<td>A Counselor I Can Trust</td>
<td>16%</td>
</tr>
<tr>
<td>Safe Place To Live</td>
<td>33%</td>
</tr>
<tr>
<td>Faith In Life</td>
<td>28%</td>
</tr>
<tr>
<td>Faith In God</td>
<td>26%</td>
</tr>
<tr>
<td>My Children</td>
<td>31%</td>
</tr>
<tr>
<td>Family And Friends Are Well</td>
<td>33%</td>
</tr>
<tr>
<td>Interesting Things To Do</td>
<td>22%</td>
</tr>
<tr>
<td>Friends To Trust And Talk To</td>
<td>32%</td>
</tr>
<tr>
<td>Regular Attendance At Church/Temple/Mosque/Spiritual Place</td>
<td>13%</td>
</tr>
<tr>
<td>Volunteer Work/Helping Others In The Community</td>
<td>11%</td>
</tr>
<tr>
<td>Other</td>
<td>3%</td>
</tr>
</tbody>
</table>

MAPP serves the South Sacramento community which exists amongst high crime, gang violence, and varying degrees of low-socioeconomic level poverty. According to the findings, participants want to receive sources of support and comfort from their families – whether it be emotional comfort or financial resources (income), and quality family communication. Collectively, they desire employment, community safety, access to health and dental care for themselves, their family and friends. One significant problem that appeared to occur during the data collection process was in the significant percentage of participants that failed to complete the survey in its entirety. Potential explanations might include, the ease with which one could read and comprehend what was being asked, the chronology of questions on the survey, and completion time/interest in relation to literacy level. Another possibility is the way in which portions the survey were formatted. For example, the question on gender is the only question in the entire survey that is offset to the right, next to the question on age. Therefore, it is possible that as the majority of participants were scanning the questions and going down the survey, that they did not see this question off to the [right] side. Another problem with its development was that only two choices were offered. The result is that it may ostracize those in society who define themselves outside of the binary system of gender, and instead may identify as transsexual, transgender, intersex, etc. In addition, under the section, “Do you have health insurance?” there is a possibility that some of those who did not reply did not feel that the type of health insurance they had fit into one of the forced-choice categories, which may have created confusion. Lastly, under the question of Ethnicity, it is significant to note that the 4% who identified as “other,” specified themselves as being “Mexican”. This suggests that not all Mexican Americans or Mexicans identify as “Latino.” Therefore, it is possible that some participants may have avoided the question due to the fact that it was forced-choice rather than open-ended; and they did not see themselves mirrored in the available boxes nor did they feel inclined to fill in or specify the “other.” This is consistent with the fact that the U.S. Census Bureau also provides limited choices when it comes to collecting demographic statistics on “race” (ie., options are limited to White, Non-Hispanic-White, and Hispanic origin [any race], excluding those from diverse family backgrounds). Finally, given the
level of illiteracy, the data collection process may need to include interviewers who can record the information while interviewing each client, offering the potential for a better turn-around, numerically.

**Focus Group Findings**

Focus groups were recorded by group facilitators. Thereafter, the raw was transcribed by Dr. Wycoff and students, followed by content analysis. What follows are the various themes and patterns based on the findings.

In the first focus group question one participants were asked “If there was a death in your family, or a divorce, and someone got really depressed or suffered anxiety, did your family seek advice from a doctor, counselor, or pastor/priest?” The two themes that came up included religion and family. Some of the participants quotes that support the theme of family include:

“We're used to it; big family; someone always dying.”
“We talk to each other about it.”
“Go to the ministers – have 2 ministers in our family.”

Some of the participants' quotes that support the theme of religion include:

“We don’t seek help outside the family; no professional help.”
“Priest comes out to give the last rites.”
“If someone gets divorce, we say “Thank God she divorced him.”

As supported by the article Religion, Socio-demographic, and Personal Characteristics, and Self Reported Health In Whites, Blacks, Hispanics Living In Low Socioeconomic Neighborhoods a variety of support system are needed based on the culture of the individual. The article states that, African Americans reported higher organizational and non organizational religiosity than Whites while Hispanics reported higher non organizational religiosity. Our survey also demonstrates that although organized religion was important to some other individuals preferred keeping family problem inside the family or having the priest come to their home. We would recommend for counseling to be successful that it would take place at the home or a natural location.

Focus group participants were asked “what mental health issues are a concern in your community?” There were three themes that emerged from this question. These themes included parenting, inability to express past experiences, and drugs. Some of the participants' quotes that support the theme of parenting issues include:

“All of the things a woman has to deal with: life changes leaving addiction, parenting.”
“I learned that I don’t have parenting skills.”
“My kids didn’t know there’s another way of living.”

Some of the participants' quotes that support the theme of inability to express past experiences include:

“I had a lot of childhood drama; I was stuffing it; a lot of my using came from that.”
“I pushed it down and then it came out of nowhere; didn’t know how to deal with it; pissed off; I give it to God now: I gave this man power for 14 years, and I’m not doing it anymore.”

“Uncomfortable with past; people feel that you’ll never change; no one can look at me different; I feel like I can’t succeed/uncomfortable; I used to be a prostitute; I became a prostitute because I was molested as a child and felt I wasn’t good for anything else.”

Some of the participants' quotes that support the theme of drugs include:

“When I tried to stop smoking weed, I would eat a lot to compensate for the weed.”
“I just eat and eat for the time I used to smoke weed.”
Tell Us About A Time When You Had Trouble Getting To See A Doctor When You Needed

One of the strongest themes reported among participants was the element of “time.” Many reported having to wait for long periods of time, even during severe medical emergencies, while many others reported having to wait long periods of time to be able to access medical services.

The following participant comments illustrated this theme:

“I got stabbed in the leg was in emergency at Sutter for over 3 hours without being seen. I became so angry and upset I almost got kicked out for expressing how I felt about the care I was or was not receiving.

Blood was everywhere. Time factor!”

“Broke my arm a month ago and sat in UCD for over five hours, never seen me, I finally left...went to another hospital and went through the same process all over again.”

“I have HIV and it takes months and months to see a doctor/psychiatrist.”

“Appointment are not quick enough- takes 1-2 weeks.”

“Dental takes 3 months if you have anything with Medi-Cal: Access Dental, Delta.”

“Have to wait for approval to get referral and then have to wait for an appointment.”

Another theme that emerged among the participants was the lack of insurance and how that poses trouble in receiving medical attention when it is needed. The following participant comments illustrated this theme:

“Went to Primary Care and was told it would take a two month process before I could receive insurance to see anyone, because it wasn’t an emergency”

“Over crowedness, bad services for no insurance”

“Primary Care or Health Net wouldn’t see me because of insurance”

“I have CMISP”

The final theme that emerged among the participants was the inadequacy of the services that they did receive in the greater Sacramento region. Some participants reported that medical providers treated them badly and felt they didn’t care about them. The following participant comments illustrated this theme:

“Primary Care is giving me a hard time regarding my cancer situation...No follow up.”

“Services at C Street clinic are not handling my migraine headaches. Kind of shuffling me around.”

“I went to the emergency room and they don’t want to do anything for me; treatment I get now is different than before I had HIV.”

“At the county (medical) clinic they really don’t care.”

“When I got off meth, I had a lot of stomach problems; doctors said they couldn’t do anything for me because I was a drug addict.”

Time, lack of insurance, and inadequate care was found to be the strongest barriers to receiving medical care. Becker (2004) reported that the delays that people experience in seeking healthcare have an adverse affect on people’s health. These adverse effects are illustrated in the examples given by participants. Lack of insurance also proved to be a very strong barrier in receiving health care. Researchers report that there are persistent disparities in the access of healthcare among minority groups and this is related to the lack of health insurance (Zuvekas & Taliaferro, 1999). Inadequate care received is also a big problem for ethnic groups. The difficulties that these various groups experience often result in disparities such as going without medication and experiencing racial discrimination (Becker, 2004) as was conveyed during the focus groups.

Quality of Services When Medical Attention Was Needed

The types of medical problems the participants were treated for varied. Overwhelmingly, participants who responded to this question reported that they had “good,” “great” and “excellent” care. The common theme that emerged from this question was the quality of care received at a clinic or hospital. Moreover, participants reported being seen right away when they went to a hospital; and in one case, even though the participant did not have health insurance, he or she
reports being seen and treated for their injury. The following themes emerged through the process of the qualitative analysis:

**THEME 1: Emergency Room Visits** -- Participants overwhelmingly stated having gone to a hospital or clinic for emergency procedures rather than preventive or primary care needs. This theme can be seen in the following examples:

“I got stabbed in the neck really bad. I went to the hospital and received great care, they hooked me up, and I was bleeding very badly.”

“Last November, when I tried to commit suicide Kaiser took care of me.”

“I went to Sutter with a head injury, they seen me immediately.”

“I had an abscess on my leg and was surprised of the service I received with no insurance.”

**THEME 2: Quality of Care** -- Participants reported having positive experiences when they needed to be seen at a hospital or clinic. The following are a few examples of this theme:

“When I had my baby. I was in labor for three days. I received excellent care.”

“Went to Mercy General with stomach problems, good experience.”

“I went to UCD with abscesses and they seen me within an hour and took care of my pain.”

**Potential Barriers**

The following themes emerged through qualitative analysis:

**THEME 1: Language Barriers** -- Participants stated that it is important to them to have a doctor who understands their language and with whom they can communicate their needs:

“Important that there is staff that is able to communicate in every language.”

“Staff needs to understand complaints.”

**THEME 2: Knowledge of Culture** -- Another theme that arose is the need for doctors to be able to know and understand potential risk factors for diseases that are culture specific, in order to better know and understand their patient's needs.

“Medical needs which may be higher for certain ethnicity, very important.”

**THEME 3: Comfort Level** -- Lastly, participants stated their preference for staff to be their same ethnicity or speak their same language in order to feel more comfortable with the health providers.

“Ethnicity does matter, it makes me feel more comfortable.”

The following themes emerged through the process of the qualitative analysis:

**THEME 1: Transmittable or Contagious Diseases** -- Participants reported that the biggest concerns in their community are diseases or viruses that can be transmitted and the fear of death that accompanies them.

“AIDS, TB- Makes me fear for my children.”

“West Nile disease, because of death.”

“Hepatitis, you never know who has it.”

“HIV, fear of catching it.”

“Colds and flu transmitted through air.”

**THEME 2: Genetic or Inheritable Conditions** -- Another common theme that participants reported is that of conditions that are predisposed in the family.

“Cancer because within my family it runs high.”

“Asthma, because high risk.”
In California, the scale of change – and therefore – the scale of our challenge with regard to health reform – is enormous. If the projections are accurate, our state’s population will continue to expand by almost one-third between 2000 and 2020, and its Latino population will increase while its White population decreases.

Meeting the needs of our diverse and expanding population poses complex challenges for both helping professionals and policymakers alike. Californians concerned about their state’s future will want to ensure that the state has adequate resources to serve its residents, including the flexibility to review, reassess and reshape needed health resources in response to shifting social and economic conditions. Indeed, California’s future economic health is intricately tied to the health and productivity of all its people.

From a solution-focused perspective, our challenge may be to consider ‘quality of life’ – taking into consideration that our society will continually grow and become more complex. As we seek options and solutions to the challenges, it may behoove us to re-examine and consider the physical, psychological, social, behavioral, and spiritual well being of individuals and their families at all stages of life, through clinical care, medicine, education, research, advocacy and outcomes based planning – ranging in scope from early childhood, childhood, adolescence, adulthood and older adulthood – it is our future.

**Conclusion**

“High blood pressure and diabetes, because of food we eat.”

“Cholesterol, history, foods.”
APPENDIX

Annotated Bibliography

To Learn More About Latino Health Related Issues...

QUALITY OF LIFE / HEALTH SATISFACTION
HEALTH EDUCATION & HEALTH PROMOTION


In the course of increased concerns about the adverse consequences of low health literacy, it remains unclear how health literacy affects health status and health service utilization. Moreover, studies have shown significant variation in individual adaptation to health literacy problems. This article proposes research hypotheses to address two questions: (1) What are the causal pathways or intermediate steps that link low health literacy to poor health status and high utilization of expensive services such as hospitalization and emergency care; and (2) What impact does social support have on the relationships between health literacy and health service utilization? Results revealed that low health literacy is considered as an individual trait independent of support and resources in an individual's social environment. To remedy this, research needs to take into account social support that people can draw on when problems arise due to their health literacy limitations. More targeted and cost-efficient efforts are suggested to identify and reach those who not only have low health literacy but also lack the resources and support to bridge the unmet literacy demands of their health conditions.


Through the administration of 2 self-report questionnaires aimed at assessing social support and psychological distress, the authors investigated the relationship between perceived social support and psychological distress in 1,341 18-80 year old primary care attendees. The results point out that, when compared to highly supported patients, lowly supported Ss showed higher scores on distress dimension (e.g., depression, anxiety, and phobia) and a higher prevalence of psychological morbidity. The findings imply that, in the setting of primary care, the general practitioners' assessment of their patients' social support system may be useful in identifying those more vulnerable to psychological stress.


Written health education materials can only be effective if they can be read, understood, and remembered by patients. The purpose of this article was to review the literature about features that should be incorporated into written health education materials to maximize their effectiveness, identify where there is consensus and debate about which features should be incorporated, and develop recommendations that health professionals can use when reviewing their existing materials and designing new materials. Literature review of published research and education articles. There is a large number of features that need to be considered when designing written health education materials so that they are suitable for the target audience and effective. Although there is consensus about the majority of features that should be included, further research is needed to explore the contribution of certain features, such as illustrations, to the effectiveness of written materials and the effect of well-designed written materials on patient outcomes. Health professionals need to provide their patients with written health education materials that are patient-orientated and designed according to the best practice principles in written health education material design.

This article reports that health disparities between children from urban minority backgrounds and children from more affluent backgrounds are well-recognized. Since schools are extremely important to children's intellectual, social, and emotional development, school connectedness may be a factor that contributes to their perception of HRQOL. The objective of this study was to examine children's perceptions of HRQOL in an elementary school-based population of urban children. The study population consisted of 2nd, 3rd, and 5th graders from 6 urban kindergarten to 8th grade schools and their parents. Children completed a survey on HRQOL and school connectedness. Parents completed a telephone survey that assessed demographics, the child's health, health care usage, and parental health status. Data on school absences and mobility from the computerized school database were linked to survey data. Of the 1150 eligible students, parent and child survey data were available for 525. Fifty-one percent of students were male and 89% were black. Ninety four percent of parents were female, 29% were married, and 62% had family incomes below $20,000 per year. Results suggest that the relationship of the "parent" to the child, employment, family income, type/presence of insurance, and school connectedness were significantly associated with the HRQOL total score.


This study reviews the major research and interventions concerning readiness and quality of care in family planning programs. It has three aims: to identify and describe the principal methodological research including conceptual frameworks, perspectives, and tools for measuring and improving quality; to describe the results from various intervention studies; and to assess what is known about the effect of such interventions. The review suggests that interventions that improve client-provider interactions show the greatest promise. Good quality of care results in such positive outcomes as clients' satisfaction, increased knowledge, and more effective and longer use of contraceptives. Rigorously documented evidence of the effects of interventions is sorely needed. The review indicates areas requiring additional research.


Discusses the challenges and opportunities of health care education. Need for improving opportunities for practice-based learning; Issues raised for public health education; Recommendations for educational programs that train public health workers.


This article sought to determine whether disparities in health-related quality of life exist between veterans who live in rural settings and their suburban or urban counterparts. The article determined health-related quality-of-life scores (physical and mental health component summaries) for 767 veterans who had used Veterans Health Administration services within the past three years. Rural/urban commuting area codes were used to categorize veterans into rural, suburban, or urban residence. The results showed that health-related quality-of-life scores were significantly lower for veterans who lived in rural settings than for those who lived in suburban or urban settings. Rural veterans had significantly more physical health issues, but fewer mental health issues than their suburban and urban counterparts. Rural-urban disparities persisted in all aspects of the survey. This article concluded that when compared with their urban and suburban counterparts, veterans who live in a rural setting have worse health-related quality-of-life scores.

The purpose of this article is to explore the relationship between perceived satisfaction with life and health-related quality of life (HRQOL) in a state-wide sample of 13-18-year-old adolescents (N=4914). The study took place in South Carolina. Questions were added to the self-report CDC Youth Risk Behavior Survey asking about perceived life satisfaction in six domains (self, family, friends, living environment, school), including self-rated health; and the number of poor physical health days, poor mental days, and activity limitation days during the past 30 days. The results concluded that self-rated health, whether poor physical days, poor mental health days, or activity limitation days were significantly related to reduced life satisfaction, regardless of race or gender; and as the number of reported poor health days increased, the greater the odds of reporting life dissatisfaction. This is the first study to document the relationship between poor physical health and perceived life satisfaction.

**RELIGIOUSITY: INFLUENCE ON WELL-BEING**


This study tested a theoretical model concerning religious, passive, and active coping; pain; and psychological adjustment among a sample of 200 Latinos with arthritis. Participants reported using high levels of religious coping. A path analysis indicated that religious coping was correlated with active but not with passive coping. Religious coping was directly related to psychological well-being. Passive coping was associated with greater pain and worse adjustment. The effects of active coping on pain, depression, and psychological well-being were entirely indirect, mediated by acceptance of illness and self-efficacy. These findings warrant more research on the mechanisms that mediate the relationship between coping and health. This study contributes to a growing literature on religious coping among people with chronic illness, as well as contributing to a historically under-studied ethnic group.


Studies in the area of religion and mortality are based primarily on data derived from samples of predominantly non-Hispanic Whites. Given the importance of religion in the lives of Hispanics living in the United States, particularly older Hispanics, we examine the effects of religious attendance on mortality risk among Mexican Americans aged 65 and older. Data from the Hispanic Established Populations for Epidemiologic Studies of the Elderly to predict the risk of all-cause mortality over an 8-year follow-up period was collected and analyzed. Overall, the results show that those who attend church once per week exhibit a 32% reduction in the risk of mortality as compared with those who never attend religious services. Moreover, the benefits of weekly attendance persist with controls for sociodemographic characteristics, cardiovascular health, activities of daily living, cognitive functioning, physical mobility and functioning, social support, health behaviors, mental health, and subjective health. Findings suggest that weekly church attendance may reduce the risk of mortality among older Mexican Americans. Future research should focus on identifying other potential mediators of the relationship between religious involvement and mortality risk in the Mexican-origin population.


Mexican immigrants, Mexican-Americans, and non-Hispanic white Americans all face different stressors. Stress-coping strategies may vary for each group as well. The researchers compared relationships among perceived stress, stress-coping strategies, and health-related quality of life (HRQL) in a rural sample of Mexican citizens living in the United States, Mexican-Americans, and non-Hispanic Whites. Health-related quality of life and stress-coping styles varied among the three groups. Mexican citizens reported significantly better physical functioning than did
non-Hispanic whites or Mexican-Americans. Mexican-Americans reported significantly better mental health functioning than did non-Hispanic Whites or Mexican citizens. Mexican citizens were more likely to use positive reframing, denial, and religion, and less likely to use substance abuse and self-distraction, as stress-coping strategies. Stress-coping style may be a potentially modifiable predictor of physical and mental HRQL, and may account for part of the Hispanic health paradox.


This study examines the multifaceted role of race/ethnicity in the relationship between religiosity and health. Comparisons were used to compare the means for health, religiosity, and personal characteristics in Blacks, Whites, and Hispanics. A simultaneous-equation model with five equations modeled the relationship between physical health, mental health, self-rated health, organizational religiosity, and non-organizational religiosity. Health outcomes, religiosity, reasons cited for being a member of a religious organization, and personal factors differed by race/ethnicity. Overall, individuals with more social resources tend to have higher organizational religiosity and better health, while individuals with fewer social resources tend to have higher non-organizational religiosity and poorer health. The model indicates the complexity of the relationships between race/ethnicity, religiosity, and health.

**BARRIERS TO ACCESS: THE POLITICS OF HEALTH CARE**

LINGUISTIC, SOCIO-ECONOMIC-STATUS, TRANSPORTATION


Community-based public health efforts to change health behaviors and health outcomes generally involve the implementation of complex, multi-pronged programs, which utilize many resources, both inside and outside a single community-based organization or agency. It is becoming more apparent that the organizational capacities of these agencies influence the implementation and success of health promotion programs. However, research is limited on the specific organizational capacities such as resources, training, workload, trust, communication that influence program implementation and, thus, the ultimate impact of these programs. This article seeks to address this gap in the needed literature by identifying the many health variables that influence health education, prevention, wellness and specific health related programs.


Full access to medical care includes cultural and linguistic access as well as financial access. The authors to identify cultural and linguistic characteristics of low-income, ethnic minority patients’ recent encounters with health care organizations that impede, and those that increase, health care access. The study focused on four groups with ethnically homogeneous African American, Latino, Native American, and Pacific Islander patients. Findings included African American and Native American patients in particular expressed overall satisfaction with their physicians’ services. Patients from all groups saw non-physician staff as frequently impeding access. Closer collaborations between health care organizations and ethnic minority communities in the recruitment and training of staff may be needed to improve cultural and linguistic access to care.


Researchers highlighted the difficulties for new Mexican origin clients as they face new cultural customs, language barriers and unfamiliar health czar system. Medical management systems also present issues for new immigrants. Researchers highlight key cultural competencies for mental health care providers.

Anthropologist and UCSF researcher Gay Becker conducted ethnographic interviews with 176 African Americans and Latinos in San Francisco, California to explore how well the “safety net” met their needs. It is concluded that safety net health care facilitates the development of unhealthy practices, such as delays in seeking care. The inadequacy of safety net health care is thus injurious to people’s health.


The study examined geriatric mental health clinician’s experiences and their perceptions of the circumstances in which Mexican American and African American adults and what factors impede or facilitate such access. It was identified that minority older adults' lack the information on the referral process as a serious barrier. Support, transportation, doctor referral, and family support was a contributor to where identified as a contributor to access to health care.


Drivers are still not using child car safety seats (CSSs). In 2000, it is reported that 47% of occupant fatalities among children under the age of 5 involved to unrestrained children. Nonusers and part-time users of CSSs have not responded to intervention attempts. The study in the journal focus on individuals of violating the law involving CSSs. The majority of participants were Hispanics with an annual income of less than thirty thousand dollars a year. Factors for not using CSSs included life-style, parenting style, child's behavior, transportation and trip circumstances.


Researchers from the Graduate School of Public Health, University of Pittsburgh, PA conducted a structured questionnaire administered to a random sample of 206 Latinos. Language and culture showed no statistically significant effect on access measures, but qualitative data showed they were related to health care barriers.


Latinos needs are explored using an interview process with adults. The findings uncovered a gap in the services that are available such as medical care for Latinos. There seems to be an unmet need in the area of transportation and a sense of safety in the communities that he participants lived in.


Utilizing data from the Center for Studying Health System Change, researchers found that overall health insurance rates changed little among non-elderly black, Latino and White Americans between 2001 and 2003, sources of coverage shifted for Latinos from employment-based insurance to public coverage. Both low-income Latinos and Whites were particularly hard hit by the economic downturn, as employers began to limit or stop offering health insurance to their employees.


National Center for PTSD, Palo Alto, Department of Veteran Affairs researchers conducted a cross-sectional examination of a probability sample of 3,750 California women to identify perceived need, service seeking and service use. Hispanic women were less likely than white women to obtain services after adjustment for poverty
were. Concluded that need and enabling factors did not entirely account for observed disparities in access for services.

The underutilization of mental health services by Latinos has been a growing concern in research and clinical practice. To provide an understanding of the issues, this article provides an overview of risk factors that may influence the mental health of Latinos and examines prevalence rates of psychopathology and service utilization trends. This article then presents a comprehensive review of the socioeconomic, cultural, and psychotherapeutic barriers that prevent Latinos from receiving community mental health services.

Low-income Latino parents face many barriers to care when attempting to access health care services for their children. This study investigated the relationship between psychosocial variables that may be potential cultural barriers to care, such as parent health locus of control, health beliefs, self-efficacy, and acculturation, and health care utilization by low-income Latino and non-Latino parents of school age children.

The researchers from the conservative think tank RAND conducted a study based on data from urban areas for the period 1993-1998 to explore the state of the "safety net". Their findings suggested that contrary to those of researchers such as Becker cited above, the "safety net" remained a viable, strong alternative to low-income people seeking health care.

The researchers use the NHIS, a household, multistage probability sample survey (N=92,148) conducted annually by interviewers of the U.S. Census Bureau for the Centers for Disease Control and Prevention's National Center for Health Statistics. The source provides breakdowns by age, sex, race and Hispanic or Latino origin, family income, poverty status, education, place of residence, region of residence and health insurance coverage. The study found that about 34 million persons had chronic health conditions. The most common reason for lacking health insurance was cost, followed by change of employment.

This study aimed at investigating how income, culture, and language affect health care access. Data from a structured questionnaire administered to a random sample of 206 Latinos was analyzed using multivariate logistic regression. Qualitative data served to explain quantitative results. Language and culture showed no statistically significant effect on access measures, but qualitative data showed they were related to health care barriers.

The article correlates the unmet need for medial care among migrant children. It was found that the most common reason for unmet medical need was due to a lack of transportation and a lack of knowledge of where to get the needed care. Many of the access barriers among migrant children are largely non-financial. Decreasing forgone care among migrant children will likely require a combination of individual, health-system, and labor-policy modifications.

Disparities in early and adequate prenatal care and infant/maternal outcomes still exist between white and nonwhite populations. Although Medicaid expansions were intended to improve outcomes, eligible women often delay enrollment and access barriers remain. This study examines racial disparities among pregnant women in Florida, Georgia, New Jersey, and Texas. The disproportionate location of minorities enrolled in Medicaid in urban areas with greater physician supply was not found to increase office-based prenatal care among blacks. More local physicians, especially foreign medical graduates, sometimes increased access largely for Hispanics. The presence and use of safety net providers did increase prenatal care use among minorities. This evidence lends support to policies to maintain safety net providers, which are perhaps better equipped than others to serve low-income populations. However, policies should encourage participate in Medicaid should be considered.


The present study (a) reports rates of childhood trauma and abuse in this sample and (b) examines the association between a history of childhood trauma and poor functioning in adult relationships. Childhood trauma comprised three sub-categories of trauma, (1) childhood situational trauma, (2) childhood sexual abuse and (3) childhood physical abuse. 101 male chronic substance abusers were administered six measures [Relationship Questionnaire, Relationship Scales Questionnaire, Child Sexual Abuse Interview, Traumatic Experiences Questionnaire, Childhood Trauma Questionnaire and Conflict Tactics Scale] in both group and one-to-one, semi-structured interviews. Almost three quarters of the men reported a history of childhood trauma (74.25%). They were predominantly from minority groups (African American-46.7%, Latino-29.3% and White-7.3%). More than a third of the men reported a history of childhood sexual abuse (41.6%). Childhood trauma was associated with insecure attachment. History of childhood sexual abuse was associated with partner violence. History of childhood trauma was associated with not having a current partner. History of childhood trauma was associated with reporting drugs other than cannabis as the primary drug of abuse.


This study examines some of the psychosocial and sociocultural developmental theories along with current research regarding the delinquent achievement orientation of Latino gang members, which includes their involvement in gangs. This study demonstrates the main thesis that the Latino gang member orientation and motivation toward the achievement of delinquent behavior is largely perceived as deviant by mainstream society. This behavior is actually an alternative response to certain conditions the gang members are in. This type of response, is seen as negative by most of society, is seen as an actual achievement, which is misunderstood by most in our society. Behaviors discussed are as follows: dropping out of school or committing crime.


To examine to what extent Latino/Hispanic children with and without attention-deficit/hyperactivity disorder (ADHD) are receiving treatment and to identify variables that predict treatment with stimulant medication. Children with ADHD in this Latino/Hispanic population are not receiving the most efficacious treatments based on scientific findings and relevant clinical consensus. This population is under treated rather than over treated.

This study assessed parent expectations and goals in child health supervision and variability by SES, family size, social support, and pediatrician. Mothers' and pediatricians' goals in seven areas of health supervision were assessed. Mothers stated physicians were their main source of parenting information. Assurance of physical health and normal development were more important than discussion of behavioral, family, or safety issues. Mothers of low SES were more likely to feel that physical aspects of health should be the focus and were less interested in psychosocial issues. Physicians stressed interpersonal, safety, and behavioral goals more than mothers. Collected data suggest either those mothers do not feel that psychosocial and safety issues are the highest priorities in health supervision or that physicians are not effectively reaching mothers on these issues.


This article reviews research on the consequences of prenatal exposure to alcohol and cocaine on children's speech, language, hearing, and cognitive development. The review shows that cognitive impairment, learning disabilities, and behavioral disorders are the central nervous system manifestations of fetal alcohol syndrome (FAS), and cranio-facial abnormalities are also present. Delays in language acquisition, as well as receptive and expressive language deficits, are commonly reported. The cranio-facial abnormalities of FAS, which sometimes include cleft palate, make the child prone to effusion and conductive hearing loss. The family environment in which one or both parents is a heavy alcohol user presents challenges to a child with normal intelligence, but may be especially deleterious to the child with mental retardation. Prenatal exposure to cocaine results in subtle cognitive disabilities when measured at 4 years of age. The child with prenatal exposure to cocaine may be considered at increased risk for language delay or disorder. The strong effect of the home environment for ameliorating the effects of prenatal cocaine-exposure suggests that a family-focused approach for cognitive, language, and social-emotional habilitation would be beneficial to all.

Dorrington, C., Ell, K., Wachsman, L., & Zambrana, R. (1994). The relationship between psychosocial status of immigrant Latino mothers and use of emergency. *Health & Social Work, 19*, 93-102. Researchers identified and described the sociodemographic and psychosocial characteristics of 80 Latino immigrant mothers who use emergency pediatric services. A survey obtained data on reasons for emergency room visit, usual sources of care, child's health, and mother's physical and psychosocial health. Results reveal a clear pattern of delayed care for acute problems in the children, a high number of reported barriers to pediatric care, and high mental distress reported by mothers. The reported barriers to use of pediatric services show limited accessibility to non-emergency room preventive and primary care services in the Latino community.


Studied disparities in early childhood health and health care. Minority children were significantly less likely to be in excellent/very good health and were more likely to be uninsured. Minority parents more often reported that providers never or only sometimes understood their child-rearing preferences, while Hispanic parents most often reported that providers never or only sometimes understood their child's needs. Minority parents more often were asked about violence, smoking, drinking, and drug use. Hispanic and black parents averaged significantly fewer telephone calls to doctors' offices than did whites. Providers significantly less often referred Hispanic and black children to specialists. Most disparities persisted in multivariate analyses, and several disparities were found between children with parents who completed surveys in Spanish and those with parents who completed surveys in English. The researchers reached the conclusion that young minority children experience multiple disparities in health status and health care.


This document addresses the High School dropout rate of Latino youth. Using census data and Department of Education statistics, the author quantifies the number of Latino youth dropping out (2000) as more than three times greater than that of Non-Latino students.

The authors of this article surveyed almost 300 undergraduate programs about their service to children and families living below the poverty level in the United States. Their survey emphasized the need for access and reducing barriers to education that affect impoverished families. The information in this article demonstrates the lack of resources when income is below the poverty level, and the need to provide greater support to those families that cannot provide it.


This secondary data analysis of sampled physically abused, sexually abused, and physically and sexually abused Latino children (N=31), aged 6 to 12 years, was conducted to explore the relationship of posttraumatic stress disorder (PTSD) symptoms and the frequency of the abuse, the nature of the abuse, the abuser's familial affiliation, the victim's age, anxiety, depression, dissociation, and behavioral symptoms. In this study, victim's scores on the Famularo PTSD Scale were not significantly related to the victim's age, the frequency of abuse, the nature of abuse, or the abuser's identity, exclusively. However, PTSD symptoms were significantly higher when both the nature of the abuse was sexual and the abuser was a family member Famularo PTSD Scores were significantly associated with total scores on the Revised Children's Manifest Anxiety Scale, total scores on Children's Dissociation Checklist, as well as internal, external, and total scores on the Child Behavioral Checklist.


Examined the meaning of rape and sexual abuse from the points of view of women and suggested how rape research, prevention, and intervention strategies might become more culturally appropriate for them. Focus group approach was used to explore concepts related to rape and sexual abuse among 17 Mexican immigrant women 22-55 yrs old living in rural Arizona. The women discussed definitions of various forms of unwanted sexual experiences, their personal knowledge of someone who had been raped or sexually abused, and their perceptions of the roots of sexual abuse. Distinctions between rapto and violación, child vs adult rape (including marital rape), motivations for rape, and social factors contributing to victim silencing were identified. The meaning and perceived impact of rape reflected the gender relations of the culture. Keeping silent was a consistent theme, underscoring the difficulties of accurately assessing rape prevalence in Latinas. Research, prevention, intervention, and treatment programs need to recognize the social context and impact of rape and be designed accordingly.


Assessed cultural definitions of rape among 37 African-American, 36 Hispanic, and 28 non-Hispanic White female rape victims and among 89 nonvictims matched for ethnicity, age, marital status, and SES. Subjects responded to 2 measures assessing cultural belief systems about rape. These included 9 rape scenarios and a questionnaire to tap the social meaning of rape. Ss were also assessed for beliefs about sexuality and rape, psychological response to rape, and methods of coping with rape. Results show that Hispanic Ss scored the highest and that White Ss scored the lowest in both perceived community victim-blaming and in victims' psychological distress. Compared with Ss from other ethnic groups, Hispanic Ss had psychological distress characterized by significantly more obsessive/compulsive thinking and by use of denial/avoidance as a maladaptive coping response.

This study examined the relationships of dissociation and childhood trauma with ataque de nervios. Forty Puerto Rican psychiatric outpatients were evaluated for frequency of ataque de nervios, dissociative symptoms, exposure to trauma, and mood and anxiety psychopathology. Blind conditions were maintained across assessments. Data for 29 female patients were analyzed. Among these 29 patients, clinician-rated dissociative symptoms increased with frequency of ataque de nervios. Dissociative Experiences Scale scores and diagnoses of panic disorder and dissociative disorders were also associated with ataque frequency, before corrections were made for multiple comparisons. The rate of childhood trauma was uniformly high among the patients and showed no relationship to dissociative symptoms and disorder or number of ataques. Frequent ataques de nervios may, in part, be a marker for psychiatric disorders characterized by dissociative symptoms.

Choloization, is often mentioned in gang research on Latinos. Choloization assumes that gang members are less acculturated than non-gang members. However, this concept has yet to be tested, which is the purpose of this study. The authors use incarcerated youth in Los Angeles for their study and the findings are that the study's hypothesis was supported, providing empirical evidence for choloization.

Examined demographic, clinical, and attitudinal factors that affect anticipated infant feeding practices reported by postpartum women from a low-income, urban family practice setting. Data was analyzed using 66 participants, with only 3 Ss indicating that they planned to breastfeed exclusively, while an additional 11 Ss reporting plans to use combination of bottle-feeding and breastfeeding. Based on univariate analyses, women with less than 12 yrs of education were less likely to report anticipated breastfeeding. Otherwise, breastfeeding plans were not associated with S demographic features or with reproductive characteristics. Participants planning to bottle-feed noted that breastfeeding was too complicated. Logistic regression demonstrated an inverse relationship between level of maternal education and anticipated breastfeeding, and a direct association for encouragement from the baby's father or the woman's mother to breastfeed and anticipated breastfeeding. Findings from this study can be used to develop a family-centered educational intervention involving the mothers, grandmothers, and partners of pregnant patients to promote the benefits of breastfeeding in this community.

The authors surveyed 564 Latino and Non-Latino students and parents. They found a high rate of discriminatory experiences among the Latinos surveyed and that there were institutional barriers that create discrepancies between Latino and Non-Latino students. This survey also connects an indirect socioeconomic effect through parents that are unable to monitor their children’s studies and/or lack of involvement in their children’s schooling.

Among a sample of 176 low-income mothers from 3 ethnic groups in the United States, the authors investigated ethnic differences in attitudes toward preferred parenting strategies, or styles; ethnic differences in the potential for child abuse; and the relationship between parenting strategies, the potential for child abuse, and parental satisfaction. They distributed the Maternal Reactions to Child’s Deviant Behavior subscale, a shortened version of the Child Abuse Potential Inventory, and a Parental Satisfaction Scale to the participants. The results indicated no significant ethnic differences in preferred parenting styles. Mothers from all 3 ethnic groups ranked praise and reasoning as the 1st and 2nd preferred parenting strategies. There were no ethnic differences in the perceived potential for child abuse. Parental satisfaction was negatively related to 2 of the CAPI subscales-Loneliness and Problems. The parenting strategy reasoning was positively correlated with parental satisfaction.

We examined the relation between childhood sexual abuse and injection drug use initiation among young adult injection drug users. We used mixed effect linear models to compare age at first injection among 2143 young injection drug users by first sexual abuse age categories. The participants were predominantly male (63.3%) and White (52.8%). Mean age and age at first injection were 23.7 and 19.6 years, respectively; 307 participants (14.3%) reported childhood sexual abuse. After adjustment for gender, race/ethnicity, non-injection drug use before first injection drug use, and recruitment site, childhood sexual abuse was independently associated with younger age at first injection. Childhood sexual abuse was associated with earlier initiation of injection drug use. These data emphasize the need to integrate substance abuse prevention with post-victimization services for children and adolescents.


Prenatal care health promotion education is an important strategy for reducing perinatal health disparities. The purposes of this study were to (a) identify differences between the health promotion content women wanted to discuss and the content women reported discussing and (b) determine whether ethnicity was related to health promotion content. A cross-sectional study used face-to-face interviews to obtain data about 159 Mexican American and African American pregnant women's prenatal experience. Women wanted more health promotion content than they discussed. Despite wanting information about more health promotion topics than African American women, Mexican American women discussed fewer topics. Ethnicity, number of topics women wanted to discuss, whether a woman had a primary provider, and type of prenatal provider model were also related to content.

HEALTH DISPARITIES

ADDITION


Discusses trends in substance users and research, other selected studies, acculturation, and treatment and prevention of substance abuse. It is concluded that researchers who study substance use and dependency in the US must utilize culturally inclusive foci. Nor should researchers or practitioners disregard the potential for dysfunction inherent in the acculturation processes endured by too many ethnic minorities. Although substance abuse is found in all US populations, and it is predominant among White Americans, ethnic minorities need culturally-relevant prevention and treatment programs. Although the development of programs to treat Hispanic substance abusers is of paramount importance, they must not themselves incorporate risk factors such as dysfunctional staff members who trigger client's substance abuse. Identification and acknowledgement of stages of acculturation may further enhance assessment, prevention and treatment.


Presents key information based on current research and practice regarding the problem of alcohol and other substance abuse in the Chicana/o community. The chapter is divided into four interrelated sections on prevalence data, risk and protective factors associated with substance use, treatment and prevention programs and issues, and directions for future research.


The attitudes of Hispanic people toward the problem of substance abuse were investigated. Members of predominantly Hispanic communities in Midland, Texas, were interviewed about their perceptions and attitudes
Concerning the use and abuse of both licit and illicit substances and their views on the definitions of drugs, the use of drugs in their community, and the impact of drugs on abusive and violent behavior in their families. The results suggested that, although members of the Hispanic community hold views on drugs that are comparable to those of other communities, they put greater emphasis on the role of alcohol and tobacco in problem creation.


Researchers from RAND Corporation used a sample of 1576 Mexican labor migrants in Fresno, CA and detected high levels of frustration based on clinical criterion (DSM-III-R). Recommendations included community outreach programs that target labor migrants as essential for their mental health maintenance.


Data from the National Household Survey on Drug Abuse (NHSDA) for 1,865 12-17 yr olds: 200 Cubans, 1,133 Mexican Americans, 255 Puerto Ricans and 277 Central/South Americans was analyzed. Drinking patterns are measured using a quantity-frequency index, and analyses arc conducted using STATA. Results show that in the cross-tabulations, no ethnic differences in drinking patterns were found for males or females, nor was there evidence of gender difference within ethnic groups, although there were some age differences in alcohol use. In the logistic regression analyses, two ethnic differences emerged, although the factors most consistently associated with drinking behaviors in these analyses were age, Spanish language use, and urban residence.

**DIABETES**


Social support has been found to be a relevant factor in diabetes self-management, however, it has not been explored within a Hispanic community. This cross-sectional study was therefore conducted with 95 insulin requiring Hispanic adults to explore the composition of the support network, the type of assistance needed, the degree of satisfaction with support received, and the relationship between social support and diabetes self-management. The greatest need for assistance was associated with transportation or interactions that involved speaking English, and the assistance offered in these areas was viewed as highly satisfactory. Participants were least satisfied with the help they received for diabetes-related self-care, personal care, and financial assistance. Community health nurses must be aware that this population may have needs that are unsatisfactorily met.


Diabetes is a disease with menacing complications and demanding treatment regimes that confront those afflicted throughout their lives. Emotions are common responses to disease and illness. Unfortunately, few studies explore the emotions adults experience while living with diabetes. This qualitative study sought to identify the ordinary (non-pathological) emotions, specify their sources (causes, stimuli), and the effect of race (White, non-Latino/African-American) on these experiences. A total of 76 emotions from 38 different sources were described by 34 subjects (mean age=56 yrs) with type 2 diabetes. Race influenced both the quality and quantity of the emotions. The length of time with diabetes, the number of complications reported, and the subjects’ rating for diabetes self-management success also influenced emotion experiences.


Research on families and chronic illness has focused almost exclusively on European American families. In this prospective study we tested a multi-dimensional model of family influence on disease management in type 2 diabetes in a bi-ethnic sample of European Americans and Latinos. Specifically, we tested how baseline family
characteristics (structure, world view, and emotion management) predicted change in disease management over one year in 104 European American and 57 Latino patients with type 2 diabetes. We found that emotion management predicted change in disease management in both groups of patients as hypothesized, while family world view predicted change in both ethnic groups but in the predicted direction only for European Americans. Examining family context within ethnic groups is required to elucidate unique cultural patterns.

Latinos, who constitute the fastest growing ethnically distinct US group, experience disproportionately high rates of type 2 diabetes. At the same time, linguistic and economic barriers, differing cultural expectations between patients and physicians, provider reactions based on stereotypes, and managed healthcare shortfalls limit diabetes care. To address these issues we investigated predictors of culturally competent actions. They provided demographic information and completed questions assessing their cultural knowledge, cultural awareness, and culturally competent actions specific to Mexican Americans with diabetes. Participation in diverse educational settings, Latino ethnicity, bilingual skills, and cultural knowledge predicted cultural awareness. Culturally competent actions were only predicted by cultural awareness. Diverse educational experiences appear particularly helpful in this process.

MENTAL HEALTH

Researchers interviewed migrant farm-workers in Fresno, California (N=1001) to study the prevalence of and risk factors for 12 psychiatric disorders by sex and ethnicity. Subjects were aged 18 through 59 years. Lifetime prevalence of any psychiatric disorder was lower for migrants than for Mexican Americans and the US population as a whole. Results underscore the risk posed by cultural adjustment problems, the potential for progressive detonation of this population's mental health and the need for culturally appropriate mental health services.

Researchers conducted a review of 5 large-scale studies that examine the prevalence of mental disorders among Mexican-born immigrants and U.S-born Mexican Americans in the United States. Researchers suggest that better mental health profiles of Mexican immigrants include research artifacts such as selection bias, a protective effect of traditional family networks, and a lower set of expectations about success.

Researchers utilized data from San Mateo County, California, Prenatal to Three (n = 218). Of the sample of non-pregnant Hispanic women on Medicaid interviewed, 28 percent reported post-natal depression but less than half had discussed this with their provider. Researchers concluded that while maternal depression may be prevalent among Hispanic women, women and providers use different cues to identify depression, leading to communication discrepancies. Further study was advocated.

Researchers reviewed two of the largest groups of migrant women in the U.S., immigrant Mexican women (n=220) and refugee Southeast Asians women (n=163). Researchers substantiated depressive symptoms among both populations, but noted key resilience factors, related to family networks among both populations.


Researchers from the Child and Adolescent Services Research Center, Children’s Hospital and Health Center in San Diego, CA studied youth ages 6-18 (N=1256) from child welfare, juvenile justice, special education, alcohol and drug abuse and mental health service sectors. Both youths and caregivers were interviewed with established measures of mental health service use, psychiatric diagnoses, functional impairment, caregiver strain, and parental depression. Significant racial/ethnic group differences among formal outpatient services were identified as a major public health problem.


A cross-sectional analysis from a cohort study utilizing data from urban and rural counties of the Central Valley of Northern California (n =1789). The prevalence of depression was higher among immigrants and less-acculturated participants when compared with U.S.-born Mexican Americans, consistent with other findings that older Mexican Americans are at higher risk for depression than non-Hispanic Caucasians and African Americans.


Researchers used face-to-face surveys conducted in 2001-2002 throughout the United States for householders aged 18 years plus (N=43,093). Foreign-born Mexican Americans and foreign-born non-Hispanic whites were at significantly lower risk of DSM-IV substance abuse use and mood and anxiety disorders compared with their US-born counterparts. Further research was recommended to clarify the role of specific protective factors that can be applied in U.S. treatment models for the population as a while.


Using cross-sectional data from the 2001-2003 National Survey on Drug Use and Health (N=134,875) adults classified as white, African American, American Indian/Alaskan Native, Asian, Mexican, Central and South American, Puerto Rican, other Hispanic-Latino, researchers found significantly higher rates of mental health problems among American Indian/Alaskan native as compared to whites with lower rates of mental health problems and use among Hispanic-Latino groups. Further study is recommended to detect the underlying causes for the great variation among populations.


Research from this secondary analysis convenience sample of 315 women of Mexican descent identified a subset of 68 women reporting they sought help for feelings of depression. Women who sought help exclusively from family or from professionals had significantly higher depressive (CES-D) and PTSD (IES-R) symptoms than women who obtained help from multiple sources, including friends. Researchers suggested results are useful in designing future work on preferences of Latinas.
Researchers used questionnaires completed by a cross-sectional convenience sample of 315 women of Mexican descent, aged 21-40 years. Foreign born Latinas who had spent their entire childhood in Mexico revealed lower depressive levels and registered more satisfaction with life in general. Researchers suggested intrinsic strength factors might need to be studied as they relate to depression in women of Mexican descent, rather than traditional demographic risk factors.

Florida State University study examining the one-year prevalence of psychiatric disorders for Hispanics and Caucasians (N=4559). Researchers found Hispanic participants more likely than Caucasians to have met the criteria for psychiatric diagnosis in the past year but identified better interpersonal functioning among this group. These findings are discussed in terms of the importance of psychosocial variables for the prevalence of psychiatric disorders.

Researchers examined the prevalence of mental disorders and use of services among a random sample of adolescents aged 12-18 yrs (N=1,164) who were receiving public sector care. Although more than 50%of the Latino sample were receiving specialty mental health services, those with psychiatric disorders were significantly undeserved compared to their White counterparts.

Researchers examined a sample of Mexican farmworkers in the Midwest United States to examine the relationship between acculturative stress and anxiety and to determine the variables that predict anxiety. The overall findings of a tendency of this population to acculturative stress suggest the need for establishing prevention and treatment systems.

Researchers from Planned Parenthood, San Francisco, conducted an interdisciplinary review of the literature to outline the current state of knowledge regarding the mental health of UMIs in the United States. Researchers identified key psychosocial themes in the literature.

Researchers report rates of DSM psychiatric disorders derived from a population survey of immigrants and US-born adults of Mexican origin conducted in rural and urban areas of central California. Rates of 12-month total mood, anxiety, and substance disorders were nearly double for the US-born women and US-born men of the sample. Researchers attributed a social assimilation explanation with social assimilation increasing psychiatric morbidity.
OBESITY


The purpose of the article is to shed light on the association between overweight and cardiovascular disease behavioral risk factors in Mexican-American. Specially, attempt to identify physical conditions and life style behaviors which may distinguish overweight Mexican-Americans from their white counterparts. Cultural factors may play an important role on how Mexican-American show a high propensity toward overweight but also how overweight Mexican-American deal with their conditions in contrast to overweight Whites.


The Mexican-American population in the United States, both children and adults is showing trends in overweight and obesity over time that are similar to those seen in other segments of the U.S. population and in many countries. It appears that a permissive environment with few constraints on food intake and few requirements for physical activity, in combination with evolutionary forces adapted to a drastically different environment can lead to overweight and obesity. Obesity is a risk factor for many chronic conditions including diabetes, hypertension, high cholesterol, stroke, heart disease, certain cancers, and arthritis. Diabetes may be most closely linked to obesity and its prevalence appears to have increased as the prevalence of obesity increased.


The U.S. Hispanic population has a high prevalence of obesity and associated chronic conditions and they are changing their dietary practices as they acculturate. Hispanics were less likely to follow the fruit and cereal or sweets patterns and more likely to the starchy vegetables or milk patterns than non-Hispanics whites. Among Hispanics, acculturations were positively associated with the fruit and cereal pattern and negatively with the rice pattern. Total and center obesity were positively associated with the rice pattern. There is an ongoing transition from traditional to more “Americanized” diets.


The objectives were to describe the amounts of types of foods that children consume while watching television, compare those types with the types consumed at other times of the day, and examine the association between children’s body mass index (BMI) and the amounts and types of foods consumed during television viewing.


The study examined the association between acculturation and obesity-related behaviors-physical activity and fast-food consumption. It is possible that acculturation among Hispanics and Asian-American adolescence manifests as a preference for activities and foods classified as “American” including sedentary activities such as watching TV and playing video games, and eating fast-food such as hamburger and pizza. As ethnic minority adopt the social norms of the U.S. they also might internalize the ubiquitous media images that tout extremely slim body image ideals. Acculturation is a risk factors for obesity-related behaviors among Asian-American and Hispanic adolescence. Health promotion programs are needed to encourage physical activity and healthy diets among adolescence in acculturating families.
CITED SOURCES


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