

Perspectives of Nurse Practitioners on Health Care Needs Among Latino Children and Families in the Rural Southeastern United States: A Pilot Study

YeounSoo Kim-Godwin, PhD, RN, & Megan J. McMurry, BS, RN

ABSTRACT

Introduction: The purpose of this study was to explore perspectives of nurse practitioners on health care needs among Latino children and families in the rural Southeastern United States.

Method: This qualitative research used semi-structured interviews with seven nurse practitioners (NPs) practicing in the rural southeastern part of North Carolina. Flanagan's critical incident technique was used to describe the experiences of NPs providing health care for Latino children and parents.

Results: Data analysis indicates that the most commonly reported illnesses by Latino children are upper respiratory infections and asthma, followed by otitis media, obesity, anemia, pneumonia, leukemia, and tumors. Barriers to health care for children included language and cultural differences, lack of access to care (e.g., lack of insurance, cost, and

transportation), and health illiteracy/low education level of parents. The findings also suggest that Latinos are preserving their traditional health practices when treating their children's illnesses, such as through use of foods, hot/cold items, herbs, coin on "belly button," traditional juices, healing bracelets, and evil eye.

Discussion: The findings of the study imply the need to incorporate culturally sensitive care when providing care for Latino children and parents. *J Pediatr Health Care.* (2011) ■, ■-■.

KEY WORDS

Latino children, health care needs, barriers to health care, culturally sensitive care

YeounSoo Kim-Godwin, Associate Professor, School of Nursing, University of North Carolina, Wilmington, NC.

Megan J. McMurry, Staff Nurse, Trident Medical Center, Charleston, SC.

Conflicts of interest: None to report.

Correspondence: Yeoun Soo Kim-Godwin, School of Nursing, University of North Carolina Wilmington, 601 South College Rd, Wilmington, NC 28403; e-mail: kimy@uncw.edu.

0891-5245/\$36.00

Copyright © 2011 by the National Association of Pediatric Nurse Practitioners. Published by Elsevier Inc. All rights reserved.

doi:10.1016/j.pedhc.2011.02.013

Latinos are the fastest growing minority group of the U.S. population (Maldonado & Farmer, 2007) and represent a significant growing segment of the U.S. rural population (Saenz, 2008). Migrant farm worker families in the United States are primarily (90%) of Latino ethnicity (Kilanowski & Trapl, 2010). The term "Latino" is used to refer to any persons whose origins can be traced to the Spanish-speaking regions of Latin America (Flores et al., 2002), while the term "Hispanic" refers to region, not race, and describes any person, regardless of race, creed, or color, whose origins are Latin American or of some other Hispanic origin (U.S. Census Bureau, 2000). According to the U.S. Census Bureau (2008), the Hispanic population is made up of primarily Latinos (91.2%); most are Mexicans (65.8%), followed by Puerto Ricans (8.8%), Central Americans

(7.6%) or South Americans (5.5%), and Cubans (3.5%). Texas, New Mexico, and North Carolina, respectively, have the largest rural Latino populations. The Latino populations in these areas are very young; approximately three in 10 Latinos in rural areas are younger than 15 years (Saenz, 2008).

Latino children in rural areas have disproportionately high rates of health problems, including active asthma, tuberculosis, intestinal parasites, chronic diarrhea, vitamin A deficiency, otitis media, delayed development, anemia, and hospitalization or death due to injuries (Flores et al., 2002; Harrison & Scarinici, 2007; Kilanowski, 2009; National Center for Farmworker Health [NCFH], 2004). For example, Latino children are almost twice as likely to be hospitalized for asthma as are White children; however, considerable differences exist among ethnic groups. Puerto Rican children have the highest prevalence rates of asthma at 20%, compared with 7% for Mexican American children (U.S. Environmental Protection Agency, 2008).

Latino children in rural areas experience negative health outcomes, reflected in lower rates of immunizations and screenings and higher rates of overweight and obesity, depression, domestic violence, phobias/fears, anxiety, refusal to attend school, and suicide, compared with African American or White children (Harrison & Scarinici, 2007; Kataoka, Xhang, & Wells, 2002; Kilanowski & Moore, 2009; National Child Traumatic Stress Network [NCTSN], 2007). However, lack of health insurance, language, environmental access to care, and cultural differences have served as barriers to health care (Ames, 2007; Butler, Kim-Godwin, & Fox, 2008; Cristancho, Garces, Peters, & Mueller, 2008; Harrison & Scarinici, 2007).

Because there is an upward trend in the growth of the Latino population along with poor health outcomes, particularly among children, it is important for nurse practitioners (NPs) to be aware of major health care barriers in order to provide culturally appropriate care to this population. Several studies have examined health care needs for Latino children in general, focusing on the Midwestern United States; however, research about Latino children specific to southeastern rural areas is limited. The purpose of the current study was to explore perspectives of NPs on health care needs among Latino children and families in the rural Southeastern United States. Rural Latinos in the Southeastern United States have some of the lowest insurance rates in the nation, compounding the problems of their being able to obtain appropriate health care (Sherrill et al., 2005).

LITERATURE REVIEW

Although a number of studies have focused on health concerns of Latinos, few of these studies have included disparities for Latino children. Health care disparities are differences in the quality of care due to race or ethnicity and are not related to other factors such as access

or preferences (Institute of Medicine, 2003). Many health disparities among Latino children are reflected in lower rates of immunizations and vision screening, receipt of prescriptions, and receiving adequate treatment for pain, asthma, or gastroenteritis (Flores et al., 2002; NCFH, 2004).

At the same time that Latino children are experiencing disproportionately high rates of health problems, they have unique obstacles to health care, including cultural differences, language barriers, and low socioeconomic status. First, different cultural values and practices between health practitioners and Latino families serve as barriers for effective care. A lack of understanding of the Latino culture and folk remedies by health care practitioners has frequently been a deterrent for parents in seeking health care for their children (Kemp, 2005; Lassetter & Baldwin, 2004). As Latino immigrants arrive from a variety of ethnic subcultures with a mixture of religious and folk beliefs concerning health and illness, it is important

for health care providers to be aware of potential barriers posed by these beliefs to the practice of Western health care system (Sherrill et al., 2005). Latino women often negotiate encounters between their family and the health practitioners of Western medicine because of cultural different differences in perspectives on health (Sherrill et al., 2005).

Although diversities exist among Latino subcultures, a fundamental value among Latinos is *confianza* (trust/confidence) (Aguado Loi & McDermott, 2010; Kemp, 2005). A health care provider who is not indigenous to the culture might encounter resistance from patients if trust is not established prior to provision of care. Latino patients expect nursing care actions that are friendly, personal, and respectful (Jones, 2008). The concepts of *simpatia* (compassion) and *respeto* (respect) are also highly valued in the Latino culture (Flores et al., 2002; NCTSN, 2007). The idea of *simpatia* emphasizes courtesy and politeness, and *respeto* represents the respect of and respect for health professionals. Verbal and nonverbal communications from Hispanics usually are characterized by *respeto*, and communications to Hispanics also should be respectful, especially when older persons are involved (Kemp, 2005).

At the same time that Latino children are experiencing disproportionately high rates of health problems, they have unique obstacles to health care, including cultural differences, language barriers, and low socioeconomic status.

Over-familiarity that is physical (e.g., touch by strangers) or verbal (e.g., the casual use of first names) is not appreciated early in relationships (Kemp, 2005). When a health care provider fails to use respectful terms, negative perceptions may develop, leading to dissatisfaction with care. In addition, *personalismo* is the importance of personal relationships rather than institutional ones and places an emphasis on family (Jones, 2008). Use of *la platica* (small talk) could facilitate cooperation and emphatic relationship by enhancing *personalismo* (Davila, Reifsnider, & Pecina, 2010). Finally, *familismo* (importance of family) is also a major theme influencing Latino health behaviors. Commitment, loyalty, and obligation to family are perceived as important by Latinos, who also mostly adhere to traditional gender roles: men as providers and women as caretakers of the family (Davila et al., 2010). Therefore health care providers need to be aware the traditional gender role of families and the importance of family in caring for Latino families.

In addition to different cultural expectations between health care providers and patients, language and communication barriers affect health outcomes. Limited English proficiency of parent(s) may lead to adverse outcomes (Butler et al., 2008; Cohen, Rivara, Marcuse, McPhillips, & Davis, 2005; Lassetter & Baldwin, 2004). Spanish-speaking pediatric patients whose families had language barriers were two times more likely to experience a serious medical event than were those whose families spoke English. Yu and colleagues, who analyzed the 2001 National Survey of Children with Special Health Care Needs, reported that the likelihood of Hispanic children experiencing health care access barriers compared with non-Hispanic children was reduced when language was controlled for, and several disparities between Hispanic children and other children became insignificant (Yu, Nyman, Kogan, Huang, & Schwalberg, 2004). Therefore minimizing these language barriers may be an important key to limiting medical errors in hospitalized pediatric patients (Cohen et al., 2005). Morales, Elliot, and Hayes (2006), who examined the impact of interpreters on parents' experiences for their children, reported that the use of interpreters reduced White-Hispanic health disparities in report of care by up to 28%.

In a study interviewing Latino immigrants, it was found that the lack of adequate training of medical interpreters results in the potential for miscommunication that can result in medical error and compromised patient safety (Cristancho et al., 2008). Likewise, Flores (2005), who conducted an extensive literature review on the impact of medical interpreter services, concluded that optimal communication, patient satisfaction, and outcomes and the fewest interpreter errors occur when limited English proficiency patients have access to trained professional interpreters or bilingual providers.

Although the use of interpreters is necessary, several factors may affect the health outcomes. Lee, Batal, Maselli, and Kutner (2002) suggested that avoiding the use of untrained interpreters, including family or ad hoc interpreters, enhances patient satisfaction. The ad hoc use of family and friends of patients as interpreters has long been a fallback for health care settings, but they may lack appropriate language skills and knowledge of medical terminology, leading to significant errors in communication. The use of family members is especially problematic because confidentiality is compromised, vital information may be censored, and internal family dynamics may be jeopardized, especially when children are used to interpret (Kemp, 2005; Roddick, 1998). It has been reported that use of a language phone line is a better alternative than the use of family and friends of patients as interpreters. Lee and colleagues (2002), who surveyed 233 English-speaking patients and 303 Spanish-speaking patients, reported that the Spanish-speaking patients using AT&T telephone interpretation are as satisfied with care as those seeing language-concordant providers, while patients using family or ad hoc interpreters are less satisfied.

Finally, factors such as low socioeconomic status, lack of health insurance, and lack of a regular source of health care are all associated with a higher rate of health problems and poor health access (Butler et al., 2008; Cristancho et al., 2008; Harrison & Scarinci, 2007; Sherrill et al., 2005). Sherrill and colleagues (2005) stated that rural Latinos in the South have the lowest levels of health insurance in the United States; for example, 87% of the Latino population in South Carolina was uninsured. In a qualitative study conducted by Cristancho and colleagues (2008), participants expressed concern that most health care providers in rural communities were not currently accepting new Medicaid patients, resulting in the need to travel to other cities to get services. Among Latinos who have some form of health insurance, the high cost of insurance premiums and policy payments discourage the full use of health insurance coverage (Documet & Sharma, 2004).

In summary, the literature suggests that multiple internal and external factors have a great impact on the health status of Latino children, and language barriers, along with cultural differences, appear to be significantly related to health care needs for Latinos in rural areas. Harrison and Scarinci (2007), who interviewed Latino parents from 16 focus groups in rural Alabama, reported that the most frequently identified barriers to health care for children were financial barriers (cost and lack of insurance), lack of confidence in health care providers, and communication barriers. In addition, the perception of racism or disrespect was also found to be an important barrier. Similarly, Ames (2007), who interviewed 16 practitioners who were providing services to medically underserved children,

identified major barriers to health care for underserved children such as poverty, transportation, insurance, lack of education and language skills, having no regular source of care, parental time constraints, and complexity of the health care system.

The current study aims to explore perspectives of NPs on health care needs among Latino children and families in the rural Southeastern United States. The study questions were derived from information found during the literature review: (1) their experiences with Latino children; (2) barriers and resources to overcome barriers; (3) common diseases seen in Latino children; (4) important elements in providing culturally competent care; (5) types of folk remedies encountered in the Latino population; and (6) any memorable incident while caring for Latino children.

METHODS

Design

This qualitative research study utilized the critical incident technique developed by Flanagan in 1954. The critical incident technique pulls facts out of interviews and reduces personal opinions and biases (Flanagan, 1954). The intention of this method is to allow the participant to be as specific as possible in describing incidents from memory (Flanagan, 1954). The critical incident technique allows the researcher to gather information quickly and offers flexibility (Flanagan, 1954). The method has been used in health care settings to identify patient's responses in studies of health care quality (Kemppainen, 2000). Schluter, Seaton, and Chaboyer (2008) stated that the critical incident technique is a practical method that allows researchers to understand complexities of the nursing role and function, as well as the interactions between nurses and clinicians. Although the face-to-face interview is most effective for collecting data, questionnaires, telephone interviews, and workshops can be used as well.

Sample

A convenience sample of seven NPs practicing in rural southeastern North Carolina participated in the interview process. Among the seven NPs, five were certified pediatric NPs and two were certified as family NPs. The age of the NPs ranged from 30 to 59 years, with a mean of 44.5 years. The average years of practicing with Latino children as an NP was 13 years. One of the NPs has a history of practicing in Florida for an extensive period of time. Two of the seven NPs reported 10% or less of their patient population as being Latino children, while two others said that Latino children made up 25% of their patient population. One of the last three NPs reported a pediatric Latino population of 90%, and the final two had percentages of 60% and 70%. Six participants reported not having a Latino background, and one NP was born in Panama and lived there for 25 years. Two NPs could not speak Spanish,

one was at an elementary Spanish-speaking level, two were at intermediate Spanish-speaking levels, and one spoke Spanish fluently. Three NPs currently work in a primary care clinic, two NPs work in a hospital setting, and two work in community health settings.

Procedure

The study was approved by the University Institutional Review Board. After obtaining informed consent, a demographic questionnaire was given to each of the seven participants at the beginning of the interview. The questions included their age, ethnicity, years of practice, percent of pediatric Latino patients, and if the participant had a Latino background or could speak Spanish. After the completion of the demographic questionnaire, the participants were asked to describe their experiences with Latino children regarding health care barriers and resources. In addition, they were asked to explain important elements in providing culturally competent care. Interviews took place through e-mail ($n = 3$), telephone ($n = 2$), or at the NP's place of practice ($n = 2$).

The interviews were transcribed for data analysis. Major categories were identified based on the responses to each interview question. The researchers independently sorted the interview responses to determine major categories of barriers. Disagreements were used to refine and determine the final set of major categories for each interview question.

RESULTS

Major Illnesses and Health-seeking Behavior Among Latino Children

Nineteen incidents were reported for the category of major illness, which included upper respiratory infections ($n = 4$, 21.1%), asthma ($n = 4$, 21.1%), otitis media ($n = 3$, 15.8%), obesity ($n = 2$, 10.5%), anemia ($n = 1$, 5.3%), pneumonia ($n = 1$, 5.3%), leukemia, acute lymphoblastic leukemia (ALL), acute myeloid leukemia (AML) ($n = 1$, 5.3%), and muscle/bone tumors (grouped as one category) ($n = 1$, 5.3%).

When NPs were asked to describe the children's condition when the patients come to see them, five of the NPs found that the children were coming in for sick visits but were brought to them in an appropriate amount of time for treatment. Of these five, one NP said, "most have just started symptoms; very few had symptoms for more than 1 to 3 days." For the NPs who worked in settings with follow-up appointments, many stated that the families and children do come back for their appointments. One NP stated, "they are very conscious about coming back and want the best for their children." Another NP found that if transportation was readily available to them, they would come back. Two NPs also said that if the families understood the illness and the importance of the follow-up appointment, they would make it a priority to come back.

One of the NPs found that there are two sides of the spectrum: “You get the ones who are very deeply concerned and very trustful of what you do and then you have the other ones that are kind of like this isn’t necessary.” She stated, “I have a 2-year-old that I’ve been seeing long term for failure to thrive. He’s probably the only Latino child you’ll see underweight, and his mom has been excellent about bringing him in for weight checks and doing what they ask her.” On other hand, the NP said,

Two days ago I had a little girl come in who has asthma, who tested positive for the flu, who sounded like she had pneumonia and sounded really really bad, and I asked the translator to tell them to come in tomorrow, and the mom kind of rolled her eyes at me like yeah, right. We actually had to call her again that afternoon and call her yesterday morning to make sure she came in. She finally came in yesterday afternoon and the daughter ended up being admitted.

In summary, the NPs perceive that the Latino parents generally seek treatment in a timely manner when their children are sick. However, the parents’ limited understanding of the seriousness of illnesses or their physical barriers (e.g., transportation) may prevent them from receiving adequate care, which may sometimes result in adverse outcomes.

Barriers and Resources for Latino Children

Table 1 lists barriers experienced by Latino families as reported by the NPs. For this category, a total of 16 critical incidents were reported. The critical incidents included language and cultural differences, lack of access to care (e.g., lack of insurance, cost, and transportation), and health illiteracy/low education level of parents.

Language and cultural differences

The most commonly reported category was a language barrier, which made up 37.5% ($n = 5$) of the critical incidents. The NPs mentioned several resources to overcome this barrier, including hospital staff translators, the actual patients or family members, Spanish/English dictionaries, and a 1-800 translator phone line. Related to this issue, one NP found that a lack of additional time needed for interpretation is a major barrier “if you have a family and need a translator, instead of a 15-minute trip to the doctor it might be an hour appointment and you have to allow for that.” Another NP who could not speak Spanish stated, “I had a lot of translators where I worked, but it is still a barrier if you don’t speak it yourself because you’re still going through somebody else.” The NP further explained, “very often we used families as translators and there was a lot of misinformation; in fact, with one child the doctor said your son only has a 20% chance to get rid of the neuroblastoma, and the uncle translating passed along that he had an 80% chance. The family and child did not find out until a month later and I had to tell them that this was not accurate.”

TABLE 1. Barriers to health care among Latino parents reported by nurse practitioners (N = 16)

Barriers	No. of incidents	%
Language barrier	6	37.5
Cultural difference	3	18.8
Health access (no insurance/cost)	2	12.5
Health illiteracy	2	12.5
Low educational level of parents	1	6.25
Lack of transportation	1	6.25
Lack of additional time needed	1	6.25
Total	16	

Another NP agreed that using family members as interpreters is surely not the ideal situation. She said, “In some cases a child speaks better English than their parents do and they are used as translators, but sometimes this is all that is available.”

One NP stated, “There should be a lot more opportunities for health care providers within the hospitals to offer Spanish because there is such an influx of Latinos and migrant workers in Southeastern NC and the United States in general.”

The second most commonly reported critical incident for this category was cultural difference, which accounted for 18.75% ($n = 3$) of the incidents. There are diverse Latino populations residing in the United States. An NP stated that “Cultural beliefs are a big issue because we see patients from a variety of backgrounds; not only Mexicans, but Guatemalans and patients from Ecuador, Panama, and Puerto Rico, and they all do things a little differently.”

Health access (lack of insurance, cost, and transportation)

Another commonly reported barrier was the lack of access to health care, such as lack of insurance and transportation. One NP stated, “Most of the kids I see qualify for Medicaid because they were born here, but there are some kids that show up because they are extended family kids and they were born in Mexico. These children don’t have access to care, but they can go to the health department, for that you just don’t ask don’t tell.”

Another NP stated, “Many Latino families do not have insurance, and there are resources available, such as Medicaid; however, they do not know how to utilize these resources.” Another NP shared her concern of the current health care system as follows:

Health insurance is a huge issue, and a lot of the families we saw were not U.S. citizens. They were illegally in the country and we had to fight to treat them. A lot of U.S. citizens get mad about this because the hospitals can write them off, whereas if it were me, my insurance would have to cover it. But it does bring up a lot of issues like how do things get paid for and how do those decisions get made.

The same NP further explained,

I'm sure there's a lot of families who have no way so they just don't go for care, and I think that's why we would see these huge tumors because they would wait until the tumors got too big and then they would use all of their savings; but as soon as you walk through the ER you are going to get treated, and once you are in the system then our director could fight to get the child seen.

Finally, lack of transportation was also reported as major barrier for Latino pediatric patients. "If families are able to find transportation or use the bus route, they will come back for follow-up appointments."

Health illiteracy and educational level of parents

Another commonly reported barrier was not understanding the health care system, which decreases the pediatric patients' access to health care. Two NPs (28.6%) reported this problem as a major barrier to care. One NP said, "the major barrier is helping them understand the health care system here, because lots of times they just walk in and think they need to be seen because that is how it is in their culture."

Additionally, one barrier mentioned by an NP was the low level of education of parents. The NP said, "Not all parents can read, even in their own language, so the parents' education level is a big issue." According to her, the children's condition and care depend on the education level of the parents and the resources available to them. Sometimes these children would come in having trouble breathing and a lot of wheezing but were able to be stabilized and would not need to be admitted. She explained that "most of the time the exacerbations could have been prevented if they had an asthma action plan, all of their medicines at home, and understood how to use their medications."

In summary, cultural differences, language barriers, and lack of health access and health literacy were reported by the NPs caring for Latino families. Staff translators, telephone interpreters, or ad hoc family members are used to overcome language barriers.

Common Folk Remedies and Cultural Considerations in Providing Care to Latino Children

Common folk remedies

As shown in Table 2, common folk remedies found among Latino families were reported, with a total of 17 critical incidents. Folk remedies that were reported include foods, hot/cold items, herbs, coin on "belly button," traditional juices, healing bracelets, antibiotics from Latino stores, enemas, and "evil eye." One of the most commonly reported folk remedies was traditional foods, which accounted for 23.5% ($n = 4$) of the critical incidents. An NP stated that "most of the families would cook and bring in certain traditional foods." The other

TABLE 2. Folk remedies commonly used by Latino parents reported by nurse practitioners (N = 17)

Barriers	No. of incidents	%
Traditional foods	4	23.5
Hot/cold items	4	23.5
Herbs	2	11.8
Coin on belly button	2	11.8
Traditional juices	1	5.9
Healing bracelets	1	5.9
Antibiotics from Hispanic store	1	5.9
Enemas	1	5.9
Evil eye	1	5.9
Total	17	

most commonly reported folk remedy was the use of hot/cold items, which also accounted for 23.5% ($n = 4$) of the critical incidents. One NP stated, "They are practicing very much hot and cold; they believe that hot things cure certain things and cold things cure certain things." Another NP found, "There are some hot and cold things, like some things you give for fever and some things you give for colds."

Another commonly reported folk remedy was tying a coin around the "belly button" and the use of herbs (e.g., chamomile and spearmint), which accounted for 11.8% ($n = 2$) of the critical incidents, respectively. An NP stated, "If a child has an umbilical hernia, they will tie a coin on their belly button, a quarter or 50-cent piece."

Additionally, one NP stated that enemas were used by some Latino patients: "This one particular family that went back to Puerto Rico, their folk doctor used a lot of enemas—clearing out the colon, he thought, somehow that would get rid of the cancer." The same NP expressed concern about the harmful effect of enemas for a pediatric cancer patient.

Another NP reported that pediatric Latino patients use "healing bracelets that the kids will come in with depending on where they are from." "Evil eye" was also found to be a cultural belief of some Latino families. An NP stated, "If you look at a child or family in a certain way they think you've given the child an evil eye, and it just depends how long they've been Americanized or how long they've been in the United States that will depend on how much they believe these things."

Cultural considerations

Many cultural considerations were reported by the NPs. Communication was a major consideration that NPs must be aware of while caring for Latino children. An NP stated that "communication is probably at the top, so finding a way to communicate is important. I had two (bilingual) social workers who I trusted, and I knew they would pass along everything I said and

they would tell me everything the family said.” Another NP said, “I think the cultural thing is being consistent and telling them and not being judgmental in how they raise their children and telling them it’s okay to go to WIC and it’s okay to access care.”

Five of the seven NPs said that a major cultural consideration is asking them what types of things they have tried at home. One NP stated that an important cultural consideration is “knowing where patients are from and when you are trying to treat them with Western medicine, you also want to ask them what things have you done at home.”

Another commonly reported cultural consideration was how Latino families tend to communicate with health care workers, particularly doctors. An NP noted, “I think that the Latino culture really puts doctors on a pedestal. This is why they ask nurses and NPs questions, because they are afraid to ask the doctors, because they don’t want to take up his time because he’s so busy. This makes it even more important for nurses and nurse practitioners to communicate effectively.” Another NP stated,

One particular family has a little girl who is 6 or 7 and the father is American and the mother is Latino. The mother doesn’t speak any English, and when they come to see us the father does all of the speaking—the mother is very submissive and subdued and sits in her chair with her head down and doesn’t make very much eye contact with me.... But no matter how long it’s been she hugs and kisses me every time she sees me at the beginning and the end of the visit with the child. Even though she doesn’t talk to me or look at me, you can tell that she really appreciates the relationship and me taking care of the little girl.

One of the NPs stated that her most memorable incident was at a well-check for a 4-year-old. She said, “I always enjoy when they come for their well-check because the year after their birthday the little girls will show up in their birthday dress because it’s respectful to show up dressed nicely for the doctor.”

A common cultural finding is that the Latino patients are very family focused. One NP stated, “I find that Latino families are very family oriented and take very good care of their children. They are almost always a two-parent family; it’s rare to not have the father in the room too, whereas that is the norm for the rest of the population, they are very involved.” Another cultural finding was described as follows: “Latino parents seem very interested in getting their child immunized. I don’t find that many families don’t get their child immunized; they want

everything they can get for their kids. Whereas with some of my other families, I struggle to explain why it’s important.”

In summary, the findings of the interviews suggested that NPs need to consider traditional Latino values when interacting with Latino parents. NPs also need to be aware that Latinos are preserving their traditional health practices when treating their children’s illnesses.

DISCUSSION

The current study explored NPs’ experience of the health care needs of Latino children in rural Southeastern North Carolina. Upper respiratory infection, asthma, and otitis media were the top three illnesses encountered in Latino children. This finding is consistent with the findings of previous studies. For example, [Harrison and Scarinci \(2007\)](#) found that the most commonly mentioned Latino children’s health problems in Alabama were upper respiratory infections, fever, ear infections, asthma, and gastrointestinal problems. Considering that these illnesses are also common in the general population as well as in Latino children, developing clinical competencies to deal with these common illnesses would be helpful to treat Latino children as well.

It has been reported that multiple personal, social/cultural, economic, and environmental factors determined the health status of Latino populations ([U.S. Department of Health and Human Services, 2009](#)). The NP participants seem to be aware of these barriers, which limit access to appropriate care. Although the barriers of lack of insurance or finances may not be preventable, some barriers could be reduced by offering evening clinics with flexible schedules or use of an outreach van for transportation. These interventions also would reduce emergency department visits for non-urgent medical care.

The findings of the study imply that NPs are experiencing communication barriers when interacting with Latino parents. NPs working with Latino populations are encouraged to learn basic Spanish. Offering basic Spanish courses in agencies is suggested to reduce the miscommunication between Latino families and health care providers.

Finally, this study suggests the need to incorporate culturally sensitive care in providing health care for Latino children and families. It would be beneficial for NPs to apply the common Latino cultural values (i.e., *simpatia*, *respeto*, *personalismo*, and *familismo*) when interacting with Latino families. Considering the traditional role of mothers as caretakers, NPs also need to be aware that fathers are the decision makers in Latino culture.

NPs also need to be educated about traditional folk remedies when assessing and treating Latino children. The findings of the study suggest that Latino families are preserving their traditional health practices. The findings of the current study are similar to those of

NPs also need to be aware that Latinos are preserving their traditional health practices when treating their children’s illnesses.

previous studies, which reported that Latino folk remedies are commonly encountered by health care providers (Flores et al., 2002; Lassetter & Baldwin, 2004).

The interview findings suggest that diversities exist among Latino subcultures. Although every NP may not know the language of his or her patients, it is important to understand the client's cultural background and unique cultural practices. A way to overcome the cultural barrier is through education about certain traditional health practices that are detrimental to the health of pediatric patients. This study suggests the need for cultural competence training for NPs in nursing schools and/or clinical agencies.

Limitations and Research Implications

The study used a small sample size, making it difficult to generalize the findings to the larger population. Additionally, this study was conducted in a specific rural area of southeastern North Carolina, limiting the implications of the findings to the rural southeastern United States. Furthermore, the sample characteristics may limit the credibility of the study. Two NPs reported that 10% or less of their patient population consisted of Latino children, and two NPs could not speak Spanish. Several NP participants did not have extensive experiences working with Latino children or Spanish language fluency. Interviews with a larger sample size of NPs who have extensive experience providing care for Latino children and/or are fluent in Spanish would have strengthened the findings.

The use of interview data from the NPs was a limitation; however, it does fit the purpose of the study, which was to explore experiences of NPs regarding health care needs among Latino children. Interviews with Latino parents to determine their views on health care barriers in this setting may also provide relevant information for future research.

Finally, the use of the critical incident technique may be another limitation. The method was chosen because it does not require a lengthy time to get desired information for each interview question. Although it is an effective method to explore health care barriers for NPs without interrupting their busy professional life, in-depth interviews with NPs and/or Latino parents would have strengthened the findings.

In conclusion, although this study is small, the findings provide valuable insights into the barriers to health care among Latino children and their families in rural Southeastern North Carolina. Health care disparities have been widening for the Latino population. Culturally competent care may alleviate these disparities (Jones, 2008). NPs need to recognize the Latino cultural and socioeconomic background and incorporate certain folk remedies and values in the plan and treatment of care. Therefore NPs need to possess cultural knowledge and skills to provide culturally competent care to Latino children and families.

REFERENCES

- Aguado Loi, C. X., & McDermott, R. (2010). Conducting program evaluation with Hispanics in rural settings: Ethical issues and evaluation challenges. *American Journal of Health Education, 41*(4), 252-256.
- Ames, N. (2007). Improving underserved children's access to health care: Practitioners' views. *Journal of Child Health Care, 11*, 175-185.
- Butler, C., Kim-Godwin, Y., & Fox, J. (2008). Exploration of health care concerns of Hispanic women in a rural southeastern North Carolina community. *Online Journal of Rural Nursing and Health Care, 8*(2), 22-32.
- Cohen, A., Rivara, F., Marcuse, E., McPhillips, H., & Davis, R. (2005). Are language barriers associated with serious medical events in hospitalized pediatric patients? *Pediatrics, 116*, 575-579.
- Cristancho, S., Garces, D., Peters, K., & Mueller, B. (2008). Listening to rural Hispanic immigrants in the midwest: A community-based participatory assessment of major barriers to health care access and use. *Qualitative Health Research, 18*(5), 633-646.
- Davila, Y. R., Reifsnider, E., & Pecina, I. (2010). Familismo: Influence on Hispanic health behaviors. *Applied Nursing Research*. Advance online publication.
- Documet, P., & Sharma, R. (2004). Hispanics' health care access: Financial and cultural barriers. *Journal of Immigrant Health, 6*(1), 5-13.
- Flanagan, J. (1954). The critical incident technique. *Psychological Bulletin, 51*(4), 327-358.
- Flores, G., Fuentes-Afflick, E., Barbot, O., Carter-Pokras, O., Calaudio, L., & Lara, M. (2002). The health of Latino children: Urgent priorities, unanswered questions, and a research agenda. *Journal of American Medical Association, 288*, 82-90.
- Flores, G. (2005). The impact of medical interpreter services on the quality of health care: A systematic review. *Medical Care Research and Review, 62*(3), 255-299.
- Harrison, L., & Scarinci, I. (2007). Child health needs of rural Alabama Latino families. *Journal of Community Health Nursing, 24*(1), 31-47.
- Institute of Medicine. (2003). *Unequal treatment: Confronting racial and ethnic disparities in healthcare*. Washington, DC: National Academic Press.
- Jones, S. (2008). Emergency nurses' caring experiences with Mexican American patients. *Journal of Emergency Nursing, 34*(3), 199-204.
- Kataoka, S., Xhang, L., & Wells, K. (2002). Unmet needs for mental health care among U.S. children: Variation by ethnicity and insurance status. *American Journal of Psychiatry, 159*, 1548-1555.
- Kemp, C. (2005). *Mexican and Mexican-Americans: Health beliefs and practices*. Retrieved from http://bearspace.baylor.edu/Charles_Kemp/www/hispanic_health.htm
- Kemppainen, J. (2000). The critical incident technique and nursing care qualitative research. *Journal of Advanced Nursing, 32*, 1264-1271.
- Kilanowski, J. (2009). Health-related quality of life in two itinerant samples: Carnival and migrant farmworker children. *Pediatric Nursing, 35*(3), 149-188.
- Kilanowski, J., & Moore, L. (2009). Food security and dietary intake in midwest migrant farmworker children. *Journal of Pediatric Nursing, 25*(5), 360-366.
- Kilanowski, J., & Trapl, E. (2010). Evaluation of the use of audio-enhanced personal digital assistants to survey Latino migrant farmworkers. *Research in Nursing & Health, 33*(2), 156-163.
- Lassetter, J., & Baldwin, J. (2004). Health care barriers for Hispanic children and provision of culturally competent care. *Journal of Pediatric Nursing, 19*(3), 184-192.
- Lee, L. J., Batal, H. A., Maselli, J. H., & Kutner, J. S. (2002). Effect of Spanish interpretation method on patient satisfaction in an

- urban walk-in clinic. *Journal of General Internal Medicine*, 17(8), 641-646.
- Morales, L., Elliot, M., & Hayes, R. (2006). The impact of interpreters on parents' experiences with ambulatory care for their children. *Medical Care Research and Review*, 63(1), 110-128.
- National Center for Farmworker Health. (2004). *Maternal and child fact sheet*. Buda, TX: Author.
- Maldonado, C., & Farmer, E. (2007). Examining Latinos involvement in the workforce and postsecondary technical education in the United States. *Journal of Career and Technical Education*, 22(2), 26-40.
- National Child Traumatic Stress Network. (2007). Preliminary adaptations for working with traumatized Latino/Hispanic children and families. *NCTSN Culture & Trauma Briefs*, 2(3), 1-8.
- Roddick, S. (1998). Improving access for limited English-speaking consumers: A review of strategies in health care settings. *Journal of Health Care for the Poor and Underserved*, 9, S40-S61.
- Saenz, R. (2008). *A profile of Latinos in rural America*. Carsey Institute. Retrieved from www.carseyinstitute.unh.edu
- Schluter, J., Seaton, P., & Chaboyer, W. (2008). Critical incident technique: A user's guide for nurse researchers. *Journal of Advanced Nursing*, 61(1), 107-114.
- Sherrill, W., Crew, L., Mayo, R., Mayo, W., Rogers, B., & Haynes, D. (2005). Educational and health services innovation to improve care for rural Hispanic communities in the US. *Education for Health*, 18(3), 356-367.
- U.S. Census Bureau. (2000). *Hispanic population of the United States*. Retrieved from <http://www.census.gov/population/www/socdemo/hispanic/ho00def.html>
- U.S. Census Bureau. (2008). *The Hispanic population in the United States: 2008*. Retrieved from <http://www.census.gov/population/www/socdemo/hispanic/cps2008.html>
- U.S. Department of Health and Human Services. (2009). *Healthy people 2010*. Retrieved from http://www.healthypeople.gov/HP2020/advisory/PhaseI/summary.htm#_Toc211942897
- U.S. Environmental Protection Agency. (2008). *Children's environmental health disparities: Hispanic and Latino American children and asthma*. Retrieved from [http://yosemite.epa.gov/oehp/ochpweb.nsf/content/HD_Hispanic_Asthma.htm/\\$File/HD_Hispanic_Asthma.pdf](http://yosemite.epa.gov/oehp/ochpweb.nsf/content/HD_Hispanic_Asthma.htm/$File/HD_Hispanic_Asthma.pdf)
- Yu, S. M., Nyman, R. M., Kogan, M. D., Huang, Z. J., & Schwalberg, R. H. (2004). Parent's language of interview and access to care for children with special health care needs. *Ambulatory Pediatrics*, 4(2), 181-187.