Meeting the Health Promotion Needs of Hispanic Communities

National Coalition of Hispanic Health and Human Services Organizations (COSSMHO)

Abstract

This paper conducts a review of the demographic and health status data for Hispanic communities and relates them to the role of culture in health care. The author's recommend that promotion programs for Hispanic communities should focus on specific community data (morbidity rather than mortality), understand the impact of culture and language (cultural competency training and staffing), develop strong outreach components (establish community advisory boards, identify credible community spokespersons and incorporate community residents as health educators), and work in partnership (sharing funds and resources) with community-based organizations. (Am J Health Promot 1995;9[4]:300-11)

Key Words: Hispanics, Health Promotion, Minority, Underserved

INTRODUCTION

The ability to meet the health promotion needs of underserved Hispanic communities has been a major challenge for health care professionals. The challenge arises in large part because health services models are based on conceptual frameworks developed for the general population. In delivering health promotion services, more often than not, practitioners and planners depend on models that have been successful in non-Hispanic white communities rather than models developed to meet the needs of Hispanic communities. The result is that well-intentioned health providers have often been frustrated with the lack of success these models have had when dealing with Hispanic communities.

The purpose of this article is to provide health promotion professionals with a general understanding of the health status of the Hispanic population and recommendations on what needs to be considered in developing culturally competent services that address the unmet needs of underserved Hispanic communities. The article provides a demographic profile of Hispanic communities, a description of some of the critical health issues for Hispanics, and a discussion of misconceptions that act as barriers to meeting the health needs of Hispanic populations. It also recommends strategies for addressing the health and health promotion needs of Hispanic communities. This information makes clear

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that culturally competent models must be developed to meet the unique health and health promotion needs of Hispanic communities.

DEMOGRAPHIC PROFILE

The importance of developing culturally competent models that address the specific needs of Hispanic communities is evident in selected demographics of the population. Overall, demographic data demonstrate that Hispanics in the United States are a significant proportion of the population. In 1994 Hispanics represented 1 in 10 persons in the United States, including the island of Puerto Rico.[1,2] Furthermore, the growth rate of the Hispanic population is seven times greater than the general population.[1] This growth is caused by high fertility rates and increased legal immigration, with a small percentage caused by illegal immigration. Indeed, live births and legal immigration are projected to represent approximately 90% of the growth of the Hispanic population through the year 2050.[2] Some of the important demographic elements of this growing population are described below.

Diversity

Like non-Hispanic whites, rather than a single population group, Hispanics are a heterogeneous mixture of cultures, race, and ethnicity. The largest population group is Mexican Americans, who comprise most (63.7%) of the population. The second largest group is Central and South Americans, representing 14.0% of the population followed by Puerto Rican (10.6%) and Cuban Americans (4.7%). The Puerto Rican population figure represents the 2.6 million persons living on the mainland; however, there are 3.4 million persons living on the Commonwealth of Puerto Rico. Central and South Americans are the fastest growing Hispanic population group, with the largest segments being Dominican, Salvadoran, and Colombian.

State Population

The Hispanic population lives in all 50 states, the Commonwealth of Puerto Rico, and U.S. territories; it represents at least 10% of the population in eight states: Arizona, California, Colorado, Florida, New Jersey, New Mexico, New York, and Texas.[1] Long before the Pilgrims landed on Plymouth Rock, many Hispanic communities of the Southwest lived on lands that were to become part of the United States. For example, Juan de Oñate began colonizing what is now New Mexico 22 years before Pilgrims landed at Plymouth Rock.[5]

Age Composition

The age composition of the Hispanic community is marked by its youthfulness. The median age of the Hispanic population is 26.0 years compared with a median age for non-Hispanic whites of 35.5 years.[2] The young age of the Hispanic population will help shape the demographics of the nation in the generations to come. In the year 2040 Hispanics are projected to comprise one in four of the preschool-age population.[2]

Housing and Family Composition

Hispanics are less likely than other racial/ethnic groups to own their residence.[4] The average number of persons per Hispanic household is 3.5 compared with 2.6 persons per non-Hispanic household.[5] Two-parent families remain the most common family structure. A majority of Hispanic children (59.2%) live with their biologic mother and father.[4]

Educational Status

From their earliest days, Hispanic children are less likely than their peers to take advantage of educational opportunities. For example, of children enrolled in Head Start, 14.2% are Hispanic and 38.0% are black, despite the fact that Hispanic and black children are similarly represented among preschool children living in poverty.[6] Hispanic youth are twice as likely as their white peers to drop out of school in all high school grades. In the ninth grade 4% of Hispanics drop out of school compared with 2% of white students.[7] This trend continues throughout high school, with 18% of Hispanic twelfth grade students dropping out of school compared with 9% of white twelfth grade students.[7] Although about 1 in 10 Hispanics (9.3%) earn a bachelor's degree or higher level of education, about one in four (23.2%) non-Hispanic whites complete a similar level of education.[8]

Economic Status

More than one in four (26.5%) Hispanic families live in poverty compared to 10.2% of non-Hispanic families.[9] The level of poverty among Hispanic families is not due to low participation in the labor force. Hispanics are just as likely as blacks and whites to participate in the labor force (66.5%, 63.3%, and 66.7%, respectively).[10] Indeed, even when only considering households with a working householder, Hispanic families are more likely to live in poverty (22.0%) compared with black (21.1%) and white (7.3%) households.[11]

These demographic characteristics form the framework in which Hispanic families seek to improve their health and well-being. Overall, demographic data for Hispanic communities tell the story of a large, diverse, youthful, and growing population, which, while participating in the labor force, continues to face housing, educational, and economic challenges and disparities with the general population. All of these selected demographic characteristics are important factors to be included in a culturally competent model of health promotion to address unmet needs of Hispanic communities.

HEALTH STATUS

Because of the increasing number of Hispanics within the U.S. population, it has become crucial to analyze available data on Hispanic Americans and ensure that the unique Hispanic health profile is taken into account with the delivery of preventive health services. This is a difficult

task because limited data is available about the health status, use of services, and practices of Hispanic communities. Consequently, many of the programs that have been developed for Hispanics are based on fragmented data or data made to fit a minority model of health. For example, a review of 21 major health data systems of the U. S. Department of Health and Human Services (DHHS) found that only one data system, the National Vital Statistics System, collected data adequate for analysis for all four major Hispanic population groups.[12] Of the 21 data systems, the survey also found that 6 do not collect data adequate for analysis for Hispanics or for any of the four major Hispanic population groups.[12] This lack of data collection led the General Accounting Office to report to Congress in 1992 that, "the health status of Hispanics, especially Hispanic subgroups, is imprecisely known and thus far been insufficiently analyzed. As a result, a comprehensive view of the morbidity and mortality trends of different Hispanic subgroups is not available at this time."[13]

What data are available, however, indicate that issues of morbidity rather than mortality are of greatest concern to Hispanic communities. Life expectancy for Hispanics is similar to that of non-Hispanic whites[14] despite the fact that 39% of Hispanics are uninsured compared with 14% of non-Hispanic whites.[15] Nevertheless, for all Hispanic age groups, health status is characterized by morbidity concerns that can be addressed by access to culturally competent health services, especially primary care and health promotion programs. Some of the morbidity issues of greatest concern to Hispanic communities over the life span of an individual are discussed below.

Birth Outcomes

The birth outcomes of Hispanic women present a challenge to long-held notions of maternal and child health. Maternal and child health policies have been based on a "minority" model of health rather than incorporating the unique needs and experiences of specific racial and ethnic groups. Such a minority model is based on maternal and child health research that has either looked at minority groups as a whole or applied research done with black communities to all other racial and ethnic groups. Under this minority model, measures of access to prenatal care, poverty, and educational status have traditionally been used to identify communities at risk for infant mortality and for low birth weight births. However, these indicators are not useful when used with Hispanic communities.

Hispanic mothers are 3.5 times as likely as non-Hispanic white mothers (11.0% and 3.2%, respectively) and as likely as non-Hispanic black mothers (10.7%) to have late or no prenatal care.[16] The percentage of Hispanic mothers with late or no prenatal care was lowest among Cuban Americans (2.4%), a rate similar to that for non-Hispanic white mothers (3.2%), and highest for Mexican American mothers at 12.2%.[16] Despite the fact that Hispanic mothers have the highest rates of late or no prenatal care, their infant mortality rate is similar to that of non-Hispanic white mothers who report much higher levels of prenatal care (7.5 and 7.1 per 1000 live births) and lower than that of non-Hispanic black mothers (17.5 per 1000 live births).[14] There is variation by each Hispanic population: Cuban American mothers have an infant mortality rate (5.9 per 1000 live births) lower than that of non-Hispanic whites (7.1 per 1000 live births), and Puerto Ricans have the highest infant mortality rate (9.0 per 1000 live births) among Hispanic groups.[14] Mexican American, Cuban American, and Central and South American mothers also have levels of low birth weight births (5.6%, 5.6%, and 5.9%, respectively) similar to those of non-Hispanic white mothers (5.7%).[14] Puerto Rican mothers have a rate of low birth weight births of 9.4%, and non-Hispanic black mothers have a rate of 13.6%.[14]

Clearly, indicators of poverty, educational status, and prenatal care use cannot explain the birth outcomes of Hispanic women. One factor that has not received enough attention is the prenatal practices of Hispanic women. Hispanic mothers are less likely to use alcohol during pregnancy (28%) than black (30%) or white mothers (47%).[17] Hispanic women of childbearing age are less likely to abuse illicit drugs (8.5%) than are non-Hispanic black (11.9%) or non-Hispanic white (11.2%) women of childbearing age.[18] Hispanic mothers are also less likely to smoke during pregnancy (6.7%) than are black (15.9%) or white (21.0%) mothers.[19] As a result, Hispanic children have the lowest level of prenatal exposure to cigarette smoke.[20] Furthermore, Hispanic women tend to have healthier diets than other women; in particular, Hispanic women report having more servings of fruits and garden vegetables in their diets than do non-Hispanic women.[21] These are all factors in healthy birth outcomes for Hispanic women that deserve the attention of health promotion programs so that it may be better understood how to support and continue these practices among Hispanic women during pregnancy.

Another factor that deserves the attention of health promotion professionals is the lack of a link between prenatal care and well-baby care services. Rather than only focusing on a healthy birth, there are indicators that prenatal care services need to be incorporated into a comprehensive well-baby program to be successful in Hispanic communities. For example, one study found that 44% of Hispanic mothers who did not have adequate prenatal care reported that they did not seek such care because there was "no need, I was healthy."[22] This finding would seem to indicate that a stronger case needs to be made for prenatal care as prevention in Hispanic communities.

In addition, attention needs to be paid to the generational difference in birth outcomes in Hispanic communities. For all Hispanic populations, the infant mortality rate is lower for immigrant mothers

than for mothers born in the United States, and in the case of Puerto Ricans it is lower for mothers born on the island than for mothers born on the mainland. For example, the infant mortality rate for Mexican Americans born in 1 of the 50 states is 9.0 per 1000 births compared with 7.6 for Mexican American immigrant mothers. The same trend also holds with regard to the level of low birth weight births among Hispanic populations. It is important that health promotion programs gain an understanding of the better birth outcomes of Hispanic immigrant mothers to support these lessons and improve the birth outcomes for nonimmigrant Hispanic mothers.

Childhood Health

One of the defining characteristics of childhood health is a lack of access to primary care. For all age groups, few Hispanic children have a regular provider of care, with rates being lowest after the first 3 years of life. Between the ages of 3 and 5, only 5.6% of Mexican American children have a regular provider of care compared with 22.7% in the first 3 years of life.[23] Furthermore, for a number of childhood illnesses, Hispanic children are the racial/ethnic group least likely to see a physician. For example, Hispanic children are less likely to have pneumonia (3.8%) than their non-Hispanic black (4.8%) or non-Hispanic white (7.7%) peers.[24] However, of children with pneumonia, 67.5% of Hispanic children saw a physician compared with 92.2% of non-Hispanic white children.[24] A result of this lower level of care is that of children with pneumonia. Hispanic children are much more likely to miss school days because of illness (16.3 days) than their non-Hispanic black (5.0 days) and white peers (5.0 days).[24] For all racial and ethnic groups of children, the most common childhood infectious diseases are repeated ear infection, repeated tonsillitis, and pneumonia.[24]

Of course, health promotion efforts go hand in hand with primary care services. One area in which a lack of adequate health promotion and primary care in Hispanic communities has been dramatically demonstrated is vaccine-preventable illness. In the 1990 and 1991 U.S. measles outbreaks, Hispanic preschool children were respectively 7.3 and 5.8 times as likely as non-Hispanic white preschool children to contract the illness.[25] Although national data are not available, state and local data indicate that the incidence of measles among Hispanic children is tied to a lack of immunizations. For example, a retrospective survey of kindergarten students in California found that in 1991 only 43% of Hispanic children had completed their immunization series at age 2.[26]

Another area in which both health education and primary care services are important is the adequate and early treatment of chronic conditions that develop in childhood. Overall, Hispanic children are less likely than non-Hispanic black and somewhat more likely than non-Hispanic white children to have a chronic medical condition.[27] However, when looking at selected chronic conditions, a number of chronic illnesses are of greater concern for Hispanic children, including asthma, bronchitis, and elevated blood lead levels. Hispanic subgroup data indicate that these conditions are particularly prevalent among Puerto Rican children. For example, childhood asthma is twice as high for Puerto Rican children as for other Hispanic groups. The rate of asthma among children 6 months to 11 years old is 11.2% for Puerto Rican children compared with 5.9% for non-Hispanic blacks and 3.3% for non-Hispanic whites.[28]

Health promotion efforts are also important to proper nutrition in Hispanic childhood. There are a number of nutritional concerns regarding the diets of Hispanic children. Most Mexican American children consume less than the recommended servings of bread, fruits, and vegetables.[29] With regard to specific nutritional intakes, data show that mean iron intake of Mexican American children 6 months to 2 years of age is below the recommended level.[29] Furthermore, most groups of Hispanic children age 2 and older consume more than the recommended daily cholesterol intake, a dietary characteristic that is associated with increased risk of coronary artery disease.[29]

Health promotion is particularly important in the area of childhood safety. Annually, 1 in 10 Hispanic children have an accident, injury, or poisoning episode. For Hispanic children the death rate from accidents and adverse effects (15.4 per 100,000) is similar to that for non-Hispanic white children (15.1 per 100,000) and lower than that for non-Hispanic black children (23.6 per 100,000).[30] When looking at deaths caused by motor vehicle accidents, however, the death rate for Mexican American children (9.4) is higher than that for both non-Hispanic black (7.9) and non-Hispanic white (7.2) children.[30] The rate of motor vehicle deaths may be due, in part, to the fact that 25.0% of Hispanic parents report that their children seldom or never wear a seat belt compared with 17.0% for non-Hispanic white children.[31] By promoting safety during childhood, these lessons may follow into adulthood and be transferred to other family members, improving the health of both the individual and the family.

Adolescent Health

Addressing the risks to the health and well-being of Hispanic adolescents requires early preventive and supportive services. Adolescence is a time when many choices are made and the consequences of those choices affect both the immediate and long-term health of the individual and the community. Program research has shown that two successful strategies for dealing with issues in adolescence for Hispanic communities are family-focused and peer-based health promotion programs.[32] Among the Hispanic adolescent health and well-being risks that can be addressed by health promotion programs are lack of exercise, unprotected sexual activity, abuse of

alcohol and other drugs, and suicide attempts.

In Hispanic communities a need exists for health promotion programs that address physical activity and health status. Half of Hispanic male (49.9%) and one in five female (20.9%) high school students report vigorous physical activity.[33] Hispanic adolescents spend twice as many days restricted to bed as black adolescents (5.9 days compared with 2.9 days) because of physical health problems.[34] Hispanic adolescents are also more likely than their white peers to have bed disability days (3.6 days) in a year.[34]

Hispanic adolescents are the group least likely to use family planning services (47%) compared with their non-Hispanic black (75%) and non-Hispanic white (61%) peers.[34] Indeed, data show that one third of Hispanic adolescent women who make their first gynecologic visit do so for a pregnancy test compared with one tenth of non-Hispanic women. Of all Hispanic births, 16.8% are to Hispanic adolescents compared with 23.2% of non-Hispanic black and 9.6% of non-Hispanic white births.[16] At the same time, sexually active Hispanic adolescent males are more likely to report ineffective or no contraceptive use at last sexual intercourse (31.3%) compared with their black (20.0%) and white (23.4%) peers.[35]

Health promotion programs are particularly important in the area of substance abuse prevention, including tobacco and alcohol use. Despite the focus on illicit substances, tobacco and alcohol are the most abused single substances by Hispanic adolescents, with 8.4% reporting cigarette use in the past month.[36] Also, Hispanic adolescents are about as likely as their non-Hispanic white peers (16.2% and 16.7%, respectively) and more likely than their non-Hispanic black peers (13.2%) to have used alcohol in the previous month.[36] Rates of any illicit drug use (marijuana, cocaine/crack, and inhalant use) in the past month are higher among Hispanic adolescents (9.3%) than among non-Hispanic black (6.5%) and non-Hispanic white (6.3%) adolescents.[36] Furthermore, aculturation seems to play a role in substance abuse among Hispanic youth. Analysis of Hispanic Health and Nutrition Examination Survey (HHANES) also showed that increased English language use by Hispanic youth was associated with higher rates of illicit drug use even after sociodemographic variables such as gender, age, income, and education were considered.[37]

One of the most critical areas for prevention programs for Hispanic adolescents is suicide prevention. Hispanic high school students are more likely to have made at least one suicide attempt (12.0%) compared with their non-Hispanic black (6.5%) and non-Hispanic white (7.9%) peers.[38] Hispanic high school students are also more likely to report suicidal thoughts than their non-Hispanic peers. Particular efforts need to be made in this area with regard to the needs of Hispanic female adolescents. Hispanic female high school students are more likely than their male peers to have made at least one suicide attempt (14.9% and 9.1%, respectively).[38]

Violence is an increasing challenge to the health and well-being of Hispanic youth. The death rate from homicide and legal intervention for Hispanic adolescents and young adults is more than five times greater than that for their non-Hispanic white peers.[30] Although Hispanic teenagers are less likely than their non-Hispanic peers to be victims of an assault or violent crime, they are more likely than their white peers to be victims of a robbery.[39] One in five Hispanic high school students (22%) report that they fear attack when going to and from school.[40] Most (60%) Hispanic parents report that they worry "a lot" that their child will get shot.[41]

Adult Health

Access to health services, particularly services related to management of chronic and disabling conditions, are of primary importance to Hispanic adults. Hispanic adults are the racial/ethnic group least likely to see a physician. The number of physician visits per year for persons 45 to 64 years of age adjusted for health status was 4.8 for Mexican Americans, Cuban Americans, and Puerto Ricans compared with 5.6 for non-Hispanic blacks and 6.5 for non-Hispanic whites.[42] This lack of access to health services complicates chronic conditions prevalent in adulthood. Among the conditions most prevalent among Hispanic adults are heart disease, cancer, diabetes, and liver disease. Of importance to health promotion professionals is that all of these conditions are affected by lifestyle and environment, and it is these factors that need to be addressed by health promotion programs.

Smoking is a risk factor in both heart disease and cancer, the two leading causes of death for Hispanics. The percentage of Hispanic adults age 35 and older who smoke (21.5%) is lower than non-Hispanic black (28.0%) or non-Hispanic white adults (23.4%).[36] This is due, in part, to the lower rates of smoking among Hispanic women. However, there is evidence that smoking is increasing among Hispanic women. Although only 17.0% of Hispanic women are current smokers, 27.2% of Hispanic female high school students report being current smokers.[43] Furthermore, a recent survey in San Francisco found that whereas 23% of second-generation Hispanic women reported smoking, only 15% of first-generation Hispanic women reported smoking.[44] Although lower rates of smoking have helped to promote the health and well-being of Hispanic communities, the increasing rates among Hispanic adolescent women and higher rates among second-generation women need to be addressed with specific health promotion efforts.

Another factor in chronic illness among Hispanic adults is diet and exercise. Low levels of physical activity and high fat consumption are associated with cardiovascular disease and diabetes. Diabetes rates are particularly high among Hispanic adults. Mexican American and Puerto Rican adults have rates of diabetes approximately twice that of

non-Hispanic whites. The prevalence of diabetes among persons 45 to 74 years of age is 23.9% for Mexican Americans, 15.8% for Cuban Americans, and 26.1% for Puerto Ricans compared with 19.3% for non-Hispanic blacks and 12.0% for non-Hispanic whites.[45] Mexican American men are more likely than non-Hispanic black and non-Hispanic white adults to have high serum cholesterol levels(20.3% compared with 16.6% and 19.1%).[46] However, Mexican American women are somewhat less likely than non-Hispanic black and non-Hispanic white women to have high serum cholesterol levels (19.4% compared with 20.7% and 20.0%).[46] Furthermore, the incidence of overweight among Hispanic groups is higher than that for non-Hispanic whites, particularly among women. The age-adjusted prevalence of overweight among women is 39% for Mexican Americans, 34% for Cuban Americans, and 37% among Puerto Ricans compared with 24% for non-Hispanic whites and 44% for non-Hispanic blacks.[3]

An additional lifestyle factor in the health status of Hispanic adults is alcohol use, which is a factor in chronic liver disease and cirrhosis. Although liver disease is the third leading cause of death for Hispanics 45 to 64 years of age, it is the sixth leading cause of death for non-Hispanic whites.[30] About one in two (47.1%) Hispanics report alcohol use in the past month compared with 35.5% of non-Hispanic blacks and 51.5% of non-Hispanic whites.

In addition to lifestyle factors, the environment plays a role in the health of Hispanic adults, although the extent of this role is unknown. For example, Hispanics are three times as likely as non-Hispanic whites (18.5% and 6.0%, respectively) to live in areas identified by the Environmental Protection Agency as not meeting lead air pollutant standards.[47]

CULTURE AND HISPANIC HEALTH

To understand how pervasive the influence of culture is in health care, imagine yourself in need of health care in a part of the world where you don't understand the language spoken and very few of the locals understand the language you speak. Your physical characteristics cause you to stand out from the crowd. The values and beliefs of the local population are much different from your own. The health care system based on the values and beliefs of the locals seems hopelessly bureaucratic and sometimes hostile to you. Welcome to the culture of the US Health Care System as viewed by many Hispanics. Too often, in an attempt to be rigorous and impartial, providers do not take culture into account. The impact of culture, however, should be seriously considered along with biologic indications when providing health care. This requires primary health care providers to revisit the concepts of culture.

The concept of culture developed from the work of Max Weber and Emile Durkheim, who in the early 1900s began to look to non-Western European societies to see how those societies understood themselves. Weber and Durkheim recognized that other people do not necessarily view the relationship of the individual to society in the same way as either Western Europeans or their cultural progeny (e.g., most of the United States) do. The specific components of culture are difficult to articulate because they are made up of language, experiences, and knowledge intangibles that do not lend themselves to any sort of easy delineation. Some of the major cultural underpinnings of populations are sometimes encapsulated as values. Thus experience and knowledge regarding family form a particular family value that varies from culture to culture.

Culture functions as a framework within which one operates throughout his or her daily life and that serves as a means of defining the relationship of the individual to the environment and to other individuals. Thus culture has been variously described as the "seamless web" of understanding that colors the way one sees the world or as a set of values that helps determine responses to a variety of stimuli.

For example, if one's cultural framework contains a value (a set of experiences and knowledge) that places a premium on physical nearness of extended family, a married individual with his or her own family is more likely to choose to live under crowded conditions so that a parent could live with them rather than having the parent far away. The value of nearness to family in one culture takes precedence over the value for privacy that may be more important in another culture. Thus people sharing the same culture may have a tendency to live under more crowded conditions, and this will become associated with the group as a cultural trait. It is in this same fashion that culture, operating as a framework with values, helps to determine what foods to eat, what clothes to wear, how to behave toward certain people, and even where to go when ill.

Of course, cultures themselves are remarkably varied. For example, mainstream Anglo-American culture strongly values the nuclear (not extended) family, the individual, and traditionally relies on the written word for transmitting information. This compares to non-Western European cultures, such as Hispanic cultures, which strongly value the extended family and the community, rely on the spoken word for transmitting information, and put significant emphasis on religion in everyday life.

Concepts of Family and Community

In many non-Western cultures the concept of what constitutes family is more all encompassing, with the distinction between immediate and extended family virtually nonexistent. The words "immediate family" elicit images not only of spouse and child but also parents, in-laws, siblings, aunts, uncles, and even nonblood kin. It is not uncommon for many of these relatives to share a common home. Furthermore, these societies generally subordinate the needs of individuals to the needs of the

family. Indeed, the concept of a fulfilling life may not have any meaning for the individual outside of the context of family. As a result, many people from non-Western cultures put the maintenance of the family and their role in it above their own needs as individuals.

Among Hispanics this is a prevalent theme. In Hispanic culture the family is conceived of as more than the immediate family. Rather it is primarily thought of as ". . . an emotional support system, composed of a cohesive group of lineal and collateral relatives, where members can find help on a regular basis and rely on relatives more than on external sources of support."[48] So important is this concept of familialism that even among highly acculturated Hispanics—those whose cultural frameworks contain a large number of American values—the emphasis on family persists.

This compares to the Anglo-American conception of family, in which the distinction between immediate and extended family is more sharply drawn. Family is commonly thought of to mean the nuclear family—spouse and children—and not taken to automatically include a large number of extended family relatives. In addition, individualism is of overriding importance among Anglo-Americans and does not easily allow subordination of individual interests to those of the family as a whole, as is common among Hispanics.

Hispanic conceptions of family also extend to how Hispanics view their communities and their role in them. Among Hispanics the surrounding community is viewed in largely the same terms, functionally, that mainstream Anglo-Americans view their extended families. That is, the members of the surrounding community are relied on and interacted with in much the same way as Anglo-Americans rely on and interact with their extended families. This compares to an Anglo-American conception that views the surrounding community principally as a loose social network and not as a primary source of reciprocal support, advice, and assistance. Among Anglo-Americans, the surrounding community is used as a support network infrequently or only in emergencies. Thus Hispanic communities tend to be much more tightly knit.

Preemptive Cultural Factors

These values of family and community, although laudable, may also make access to care problematic for Hispanics. First, the nature of the cultural values of family and community function to preempt Hispanics from seeking professional care from the institutions that have not served them well and are not trusted. Thus rather than turning to public hospitals or health agencies, Hispanics are more likely to turn for advice to those sources that are receptive. Indeed, a study of Puerto Ricans revealed that ". . . in seeking help, the Puerto Rican will approach family members, friends, neighbors, shopkeepers, *compadres,* or acquaintances who have some degree of expertise or authority in the area of concern . . . ."[49] This is also true for Mexican Americans, Cuban Americans, Central and South Americans, and other Hispanics.

The overriding importance of family also causes Hispanics to subordinate their own individual needs, including health needs, to the general good of the family—resources spent on preventive care or going to see a professional once a problem arises are critical resources directed away from working for the common good of the family. Thus the strong family value also creates a predisposition not to engage in other activities when they are for the exclusive benefit of the individual or interfere with the family responsibilities of the individual.

The value Hispanic culture places on religion also creates a particularly strong preemptive force. Most Hispanics are Roman Catholics, and many believe that spiritual elements have a strong effect on their everyday lives. Prayer, for example, is thought to have a profound impact on health. Such beliefs often exhibit themselves as a strong sense of fatalism. Common expressions among Hispanics typify this fatalism: . . . *que sea lo que Dios quiera,* meaning, . . . *it's in God's hands,* or . . . *esta enfermedad es una prueba de Dios,* meaning, . . . *this illness is a test of God.* With their ultimate fate in God's hands, Hispanics often see little use in subjecting themselves to a large, culturally alien institution to seek professional advice and direction regarding their health.

By virtue of culture and experience, Hispanics may be less likely to seek professional care. The barriers themselves arise from the natural operation of these values and are thus functional barriers. They result from Hispanics acting pursuant to their values in a way that often preempts them from even making contact with American health care institutions. They are to be distinguished, however, from interactive cultural barriers, which equally block Hispanic access to care.

Interactive Cultural Barriers

Interactive cultural barriers are those that arise from an active conflict between the values of two disparate cultures. Just as the values of Hispanic culture are expressed through institutions (such as strong community-based organizations) and people in the Hispanic community, so too the values of Anglo-American culture are expressed through its institutions and people. Unfortunately, in the context of health care, there are often significant conflicts of cultural values when Hispanics seek care from health care institutions created to serve the majority culture. However, despite this conflict it is important to note that folk systems of care are not necessarily the main health services choice made by many Hispanics. Indeed, according to data from the HHANES, only 4.2% of Mexican Americans (18 to 74 years of age) reported consulting a folk medicine practitioner in the year before the survey.[50]

Again, it is useful to examine this conflict in the context of two values critical to all Hispanic subgroups—family and community. Because Hispanics traditionally turn to family and community for help and advice, including advice on health issues, Hispanics are accustomed to dealing

with health problems by using personal relationships established and developed over time. Those that Hispanics deal with know of them, their life situations, their problems, and because of this knowledge are perceived by the seeker of care to have a genuine interest in the total person. This element of *personalismo* is important to Hispanic patients, even if only as a matter of politeness, but is incongruent with the relationships fostered by mainstream American health care institutions. Rather, such institutions tend to be comparatively distant and impersonal. For example, clients are generally faced with large institutions like hospitals that require one to immediately recount one's prob-lem's and personal history to a re-ceptionist, an intake worker, or other health worker more interested in administratively processing the case than in the people needing care.

The lack of *personalismo* permeates the entire process, from intake to service delivery to discharge, and is frequently cited by Hispanic patients as a major source of dissatisfaction. The values of Hispanic clients create in them expectations about how health care should be delivered, and in seeking care from the typical American institution, their values and expectations conflict with countervailing Anglo-American values that place less emphasis on family and community and relatively more on individualism and efficiency. The emphasis on individualism does not create a mind-set that will naturally consider the patient in the context of family and community, and the high premium placed on efficiency creates an environment in which the patient is treated as something to be processed, and not as a person, much less with *personalismo*.

This interaction between disparate cultural values and their disconcordant expectations creates a negative experience for both the client and provider. For the client the negative experience serves as the barrier that will prevent them from returning when treatment is needed or preventive care ought to be obtained. Furthermore, it can frequently serve as a barrier to effective treatment if the treatment will interfere with the duties of the client to their family. Because the typical provider, both Hispanic and non-Hispanic, is trained by institutions reflecting Anglo-American culture, it usually will not even occur to the provider to consider a prescribed treatment vis-à-vis the patient's role in their family.

The provider also comes away with negative experiences arising from the interaction of disparate value systems. Because the operation of the cultural conflict is such that the first encounter is unlikely to be followed-up with another visit, and because treatment will often be ineffective for the reasons outlined above, the provider must deal with clients who have consistently poor health outcomes despite their efforts. The provider, faced with the seeming obliviousness of Hispanic clients regarding their own health, is often motivated to approach each Hispanic client with more detachment, oftentimes even more so than is customary for Anglo-American culture. Of course, this in turn reinforces the negative experiences of the client.

Language

Numerous studies have found language to be one of the principal barriers for Hispanics who need access to health care.[52,53] For Hispanics the family and the community are often the first source of advice and support used in dealing with outside society. Expressing feelings and concerns about health to friends and family is part of an intimate relationship, and as a result, a certain amount of empathy and advice is expected in a friend or relative's response. In this traditionally spoken mode of medical care, a tremendous amount of importance is placed on *how* one expresses advice and the specific content of that advice. Obviously, speaking the same language as the individual becomes critical. Given the importance of interpersonal relationships, it becomes essential to have a match between the individuals' language and the various persons who will interact with them in a health care institution.

Spanish is the language of most of the Hispanic community. Spanish is spoken in the home by more than 17 million people, and Spanish speakers represent 54% of all non-English speakers in the United States.[1] Hispanics are likely to report a preference for speaking Spanish in a variety of settings, particularly the home, where 78.3% of Hispanics report they are most comfortable speaking Spanish.[54]

Research indicates that the quality of care afforded to Spanish-speaking patients is improved by having a language concordant physician. Analysis of asthma patients of a faculty group practice of the Presbyterian Hospital in New York City found that patients, with extended follow-up, cared for by a language-discordant physician were more likely to omit medication, more likely to miss office appointments, and were slightly more likely to make an emergency department visit than patients with concordant physicians.[55] Additionally, there is a strong preference that information programs be given in Spanish.[56] Hispanics may be uncomfortable discussing their health concerns in English if they do not believe they have mastered enough English to express their feelings about their illness appropriately. Furthermore, a national survey of adolescent pregnancy prevention programs found that one of the critical elements defining successful programs was the presence of bilingual and bicultural staff.[57]

Despite the clear need for more Spanish-speaking and Hispanic health professionals, there is a shortage of linguistically and culturally concordant health providers for the Hispanic community. Hispanics currently represent 10% of the total US population but are only 4% of the US physician workforce and 2% of nurses.[58] In 1985 it was reported that only 37% of Hispanics go to a Hispanic physician, and 45% go most often to a physician who is not Hispanic, whereas 18% do not have a regular physician at all.[56] Furthermore, although the enrollment of

Hispanics in medical school has increased by 35.4% since 1980, the Hispanic population has also grown 38.9% since that time, which means there has been no real gain in the representation of Hispanics in medical school.[55]

Experts in the field of health service delivery to Hispanics advocate inquiry about the family and the patient's duties and even strongly recommend incorporating other family members into an overall treatment program for the family.[49,51] Health care providers should avoid dispensing advice in a dry, curt manner to Hispanics because they may be misinterpreted as not caring about them. Indeed, a number of studies have reported that many Hispanic patients do not feel comfortable discussing physical and emotional problems with strangers and that they do not feel that health professionals really care about their well-being.[49,51,56]

Health professionals must also be aware of the cultural patterns of emotional expression for the specific community in which they are working: cultural differences associated with language, modes of expressing symptoms, meanings associated with experiences such as altered states of consciousness, typical idioms of distress, sociolinguistic patterns, and differences in explanatory models and value systems are often reported to lead to unintended but systematic bias in assessment and diagnosis of persons from very different life worlds of the clinician.[51] A thorough understanding of cultural emotional expression is critical particularly in the field of mental health, where minority patients have often been misdiagnosed with regard to depression and schizophrenia.[51,59]

DEVELOPING HEALTH PROMOTION STRATEGIES

Various societal institutions have increasingly recognized the value of disease prevention and health promotion. Health providers are now expected to encourage and assist clients in changing risk-associated behavior, and some employers have developed strong health promotion programs at the worksite. Designing strong health promotion programs for the Hispanic community is particularly important because Hispanics have not been targeted by mainstream prevention initiatives yet are the least insured of any major ethnic group. To develop strong health promotion efforts, establishing credibility with the community will be the key to success. Of course, credibility cannot be established overnight. It requires a sustained institutional commitment. This commitment can best find form in (1) identifying and working with community spokespersons and advisory boards, (2) increasing the cultural competency of health institutions and providers and employers, and (3) identifying and working with community-based institutional partners.

Spokespersons

In designing a prevention component to target the Hispanic community, health care institutions must again consider the implications of the unique aspects of Hispanic language, culture, and community institutions. Although the actual intervention may be similar across communities, it is always critical to understand the context in which the intervention takes place. Thus it is essential to create and fund community advisory boards to develop and to implement programs. These advisory boards typically include a cross section of the community, including leadership, service providers, consumers, parents, and youth. To be successful, institutions must work with existing leadership in the communities and use spokespersons in the prevention effort who are viewed as credible by the community. Often the most credible spokespersons are found locally. Key local intermediaries may include members of social service agencies, youth peers, elected and appointed officials, and the leadership of community organizations.

Identifying key local spokespersons can be a difficult process. It is important that questions about credible spokespersons be asked in the assessment phase of any health promotion program design. In this manner, consensus is more likely to be reached on credible spokespersons, and there is less risk of choosing a spokesperson who may be seen as credible by only one segment of the community. The community advisory board may also be used as part of this process with the added advantage of increasing community input into the initiative development.

Hispanic celebrity spokespersons have also been effectively used in some targeted health education campaigns. In particular, Hispanic celebrities were effectively used in the *¡Piensalo!* ¡Stay Smart! ¡Don't Start! substance abuse prevention campaign for Hispanic youth. In part, the positive response to the use of Hispanic celebrities in this campaign, particularly in poster materials, may be linked to the relative absence of Hispanics in promotional efforts. However, careful distinction needs to be made between materials that need a celebrity to call attention to the issue and those education materials that need an authoritative and credible figure to convey information or peers to serve as believable role models. Research in San Francisco on AIDS information sources preferred by Hispanics points to physicians, clinical workers, and persons with AIDS as appropriate, credible, or desirable spokespersons.[60] On the other hand, an assessment for a project to deliver inhalant abuse prevention information to Hispanic youth in the Southwest suggested a peer education model as the most effective health education model.[65] Once again, a community assessment and input is central to determining the appropriate source of information to be used.

Cultural Competency

The most important strategy health providers and employers can use to better deliver health promotion services to Hispanics is to have an organizational commitment to this mission rather than treating it

as a peripheral activity. This is best implemented by having bilingual and bicultural persons as policy-makers on the board, as senior managers, and as staff responsible for all levels of service provision. Additionally, non-Hispanic staff need to be provided with training on how to serve the target community.

Overcoming barriers to access for Hispanics means more than just providing health care. It means establishing trust and confidence between the Hispanic community, where such services are delivered, whether they be clinical or worksite settings, and the system. Health delivery relationships are based on trust, and trust can only be formed through reciprocal understanding and acceptance of value systems. Employers and health care providers should seek to understand the role of the Hispanic as an individual, as part of a family, and as a member of a community and make an effort to bring *personalismo* to the patient-provider relationship.

It is well-documented that many Hispanics have a high-level of distrust of the health care system and often believe that it discriminates against them: 27% believe they face discrimination in the quality of health care to which they have access; 30% believe they are not treated with respect at clinics; 28% believe that they do not have the same opportunities as others in obtaining health care information. Overall 22% believe they run into discrimination when seeking health care. Among Puerto Ricans, the figure is 38%.[56] Ruiz and others, have documented many examples of how the lack of cultural sensitivity leads to miscommunication between patient and health care provider and frequently to misdiagnosis of the patient's illnesses.[49,51,59] These attitudes may carry over to other delivery settings where health promotion is the issue of concern.

To counteract these negative experiences, health care providers need to be aware of and sensitive to the needs and concerns of Hispanic communities. If providers cannot accept the clients' belief system, they should at least listen and respect it, because ". . . a thorough knowledge of these cultural factors will certainly offer physicians a unique understanding of the patient's conceptualization of his illness, and thus will give him a better chance of insuring treatment, compliance and cure."[59] Although cultural explanations of illnesses may involve nonscientific superstitions, Ruiz has noted that ". . . when physicians, based on their Western medical training, try to convince their Puerto Rican patients that their conception of the cause of their illness has no sound scientific basis, these patients quickly become noncompliant with the medical regimens prescribed for them and seek help elsewhere."[59]

It has been found that using folk-labeled conditions can be useful in identifying children with at-risk health conditions. Trotter found that most children who had the folk-labeled condition *Caida de Mollera* were probably suffering from severe dehydration.[61] Acknowledging and working with local disease terminology increases patient-health care provider trust. As Ruiz notes, "[u]ndoubtedly, understanding these culturally bound diseases is of great importance to physicians who expect to gain the trust and confidence of patients from this Hispanic ethnic subgroup."[59]

Finally, employer and provider institutions should invest a good deal of time and resources into an assessment of the particular Hispanic community that they serve. This is because Hispanic communities are diverse and respond differently to health care services. Thus to deliver health services effectively in a given Hispanic community, primary care providers must have a thorough understanding of the particular linguistic, cultural, and institutional infrastructures of the target community.

Community-Based Partners

When working with black communities, providers have found it useful to rely on the system of Historically Black Colleges and Universities, black medical schools, black churches, fraternities, and sororities to develop the health care infrastructure of the black community. With HIV in the gay, non-Hispanic white community, the major infrastructures were gay organizations and loosely connected networks of gay men's health clinics that were created in the 70s to meet the health needs of the gay community. When planners tried to look for similar structures in the Hispanic community, they found that either these types of institutions did not exist (in the early 1980s there were no major national Hispanic gay organizations) or did not consider direct intervention to be part of their primary mission (Catholic Church). These planners falsely concluded that Hispanic communities do not have easily accessible infrastructures to support health programs. This conclusion is based on the idea that there is a minority model for health care delivery. No such model exists, and each community must be viewed as a unique entity; that is the challenge of accepting diversity.

The most important organizational infrastructure in Hispanic communities is the network of several hundred health and human service community-based organizations. These organizations operate in virtually every Hispanic population center and are one of the most credible resources available to health care providers. The importance of bringing Hispanic community-based organizations squarely into the devel-opment and operation of prevention programs was highlighted by the US Public Health Service in launching the *Healthy People 2000* initiative. *Healthy People 2000* presents the nation's disease prevention and health promotion goals for this decade. The report that launched the initiative stated, "recent research and demonstration projects addressing chronic diseases indicate that the preventive approaches that hold the greatest promise are community-based, community-wide and

focus on both individual and behavior and societal influences." The report went on to state that, "prevention programs for minorities are most effective if developed for and with the community."[62]

While recognizing the importance of community involvement, however, the *Healthy People 2000* initiative failed to fully include Hispanic communities. *Healthy People 2000* has set disease prevention and health promotion goals for the nation's health and well-being. However, under these goals a number of areas critical to the health and well-being of Hispanic communities contain no objectives for Hispanics. Under *Healthy People 2000* the priority areas without an objective or component objective focusing on Hispanic communities include alcohol and other drugs, mental health and mental disorders, unintentional injuries, occupational safety and health, environmental health, food and drug safety, and sexually transmitted diseases.[63] All of these are critical prevention areas for Hispanic communities. It is hoped that omissions in these areas will be corrected by a midcourse review of *Healthy People 2000*. The result of the current lack of Hispanic goals and objectives in *Healthy People 2000* is that adequate prevention programs targeted to Hispanic communities are not being developed at the state and local levels. It is this historical lack of inclusion of Hispanic communities in preventive health services that has often been at the root of the formulation of the network of Hispanic community-based organizations.

To a large extent, community-based organizations were established in response to community frustration with being denied access to mainstream health providers or resources. The history of many of these organizations is one of a local civil rights struggle. Born out of community organization and agitation, they remain governed by community boards and have established histories of providing linguistically and culturally credible services in their communities. It is this infrastructure that is the most appropriate to use when designing and implementing effective health promotion programs in Hispanic communities.[64] However, it is important to recognize the history that has lead to the formulation of many community-based organizations. To work effectively with community-based organizations, prevention programs must demonstrate a capacity and willingness to allow community priorities to guide program development and services. This translates into inclusion of community-based organizations at the outset rather than as an afterthought in the design and implementation of prevention programs. It also means allowing community governance of programs, making available culturally and linguistically competent services and providers, and demonstrating institutional commitment to ongoing partnership through shared funds and resources.

CONCLUSION

To effectively meet the needs of Hispanic communities, health promotion programs must target the specific community they seek to serve. This article indicates that areas of particular concern include linking prenatal care services to well-baby care; supporting positive prenatal care practices among Hispanic women, with particular attention to the generational differences in those practices; providing culturally and linguistically competent information for Hispanic parents on childhood immunization programs and early and adequate access to treatment for childhood infectious diseases; providing culturally and linguistically competent information for parents on adequate access and management of chronic childhood conditions, particularly asthma and lead exposure; delivering effective accident and injury prevention programs, including programs in traffic safety; developing peer and family-focused programs to support adolescents in positive life choices, with particular attention to the issues of family planning, substance abuse (including tobacco, alcohol, and inhalant use), violence, and suicide prevention; and developing health promotion programs for adults that support management of chronic and disabling conditions, with particular attention to the issues of diabetes, heart disease, cancer, HIV/AIDS, liver disease, and conditions arising from exposure to environmental hazards.

Based on these findings practitioners and researchers should focus on specific community data (morbidity rather than mortality), understand the impact of culture and language (cultural competency training and staffing), develop strong outreach components (establish community advisory boards, identify credible community spokespersons, and incorporate community residents as health educators) and work in partnership (sharing funds and resources) with community-based organizations. Each of these efforts is related to the others, and all are necessary to improve the delivery of preventive health care to Hispanics.

SO WHAT? Implications for Health Promotion Practitioners and Researchers

This review seems to indicate that the Hispanic population in the United States is highly diverse, has worse access to the medical systems than the general population, and has some health practices and some health conditions that are better and some that are worse than the general population. Furthermore, family and community, religion, interaction with other cultures, and language are critical cultural factors that must be considered in developing health promotion programs that will be effective for this population. There are many gaps in the health surveillance system for Hispanic populations; therefore these conclusions need to be considered with caution.

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