

NCLR
NATIONAL COUNCIL OF LA RAZA

Latino Health Beliefs:



**A Guide for
Health Care
Professionals**



THE NATIONAL COUNCIL OF LA RAZA (NCLR)

The National Council of La Raza (NCLR), the largest constituency-based Hispanic organization in the nation, exists to improve opportunities for the more than 28 million Americans of Hispanic descent. A nonprofit, tax-exempt organization incorporated in Arizona in 1968, NCLR serves as an advocate for Hispanic Americans and as a national umbrella organization for more than 200 formal “affiliates,” community-based organizations serving Hispanics in 37 states, Puerto Rico, and the District of Columbia. NCLR seeks to create opportunities and address problems of discrimination and poverty through four major types of initiatives:

- ▶ Capacity-building assistance to support and strengthen Hispanic community-based organizations;
 - ▶ Applied research, public policy analysis, and advocacy on behalf of the entire Hispanic community, designed to influence public policies and programs so that they equitably address Hispanic needs;
 - ▶ Public information efforts to provide accurate information and positive images of Hispanics in the mainstream and Hispanic media; and
 - ▶ Special catalytic efforts which use the NCLR structure and reputation to create other entities or projects important to the Hispanic community, including international projects consistent with NCLR’s mission.
- ▶ NCLR is headquartered in Washington, D.C. and has program offices in Chicago, Illinois; Los Angeles, California; Phoenix, Arizona; and San Antonio, Texas.

LATINO HEALTH BELIEFS:

A GUIDE FOR HEALTH CARE PROFESSIONALS

PREPARED BY:

SHELLEY KARLINER, M. S.W.

WITH:

SANDRA EDMONDS CREWE, PH.D.

HENRY PACHECO, M.D.

AND

YANIRA CRUZ GONZALEZ, M.P.H.

HISPANIC HEALTH PROJECT
CENTER FOR HEALTH PROMOTION

RAUL YZAGUIRRE
PRESIDENT

NATIONAL COUNCIL OF LA RAZA
1111 19TH STREET, NW, SUITE 1000
WASHINGTON, DC 20036
TELEPHONE (202) 785-1670
FAX (202) 776-1792

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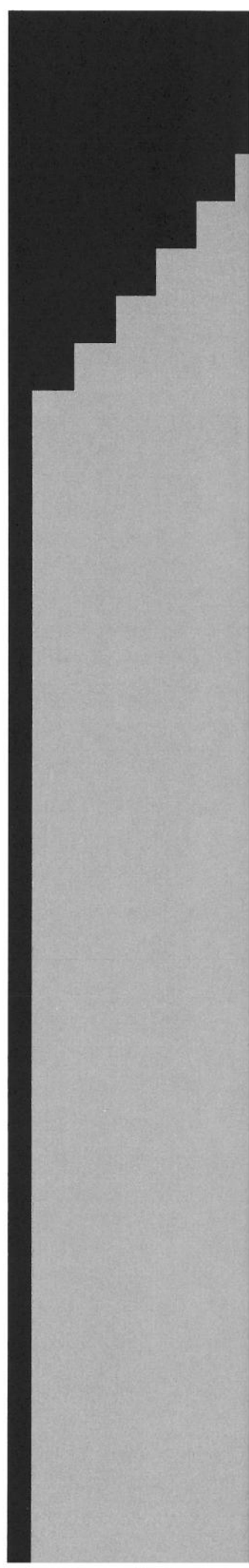
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I. INTRODUCTION

The purpose of this guide is to provide health care professionals in the United States with a basic introduction to the Hispanic/Latino¹ community and some of their cultural beliefs and health care practices. This guide is designed to help health care providers establish more effective patient-provider relationships with their Latino patients by utilizing the information provided to design health care interventions that are more congruent with the belief systems and practices of the patients they are serving. Gaining an understanding of Latino health beliefs can be instrumental in decreasing the disproportionate numbers of Latinos who are dying from diseases that can be prevented by modifying risky behaviors.

We recognize that the cross-cultural issues that arise in the patient-provider relationship on the mainland do not necessarily arise in the same fashion in the patient-provider relationship in Puerto Rico, where patient and provider would tend to share the same cultural framework in relation to the Anglo culture.

This guide presents an overview of Latino health issues, including demographic information on the Latino population in the United States, the incidence of disease in the Latino community, modifiable risk factors that contribute to the leading causes of death among Latinos, and the need for socially and culturally appropriate health promotion. The guide considers barriers to health promotion and disease prevention for Latinos such as distrust of the health care system, language and cultural differences, poverty, immigration status, and perceptions about food and body weight.

The Latino concept of health, as well as Latino cultural beliefs, are discussed extensively. The reader will be introduced to the concepts of *familismo*, *fatalismo*, *respeto*, and *persona-lismo*, and will see how they shape Latino health practices. The reader will also be acquainted with alternative forms of viewing and treating illnesses that appear in Latino cultures. Helpful culture-appropriate theoretical frameworks including value expectancy theory, culture care theory, and Pender's health promotion model are presented. Examples of community models that utilize Latino cultural beliefs in their design are provided, as well.

Gaining an understanding of Latino health beliefs can be instrumental in decreasing the disproportionate numbers of Latinos who are dying from diseases that can be prevented by modifying risky behaviors.

1 Endnotes
The terms "Latino" and "Hispanic" are used interchangeably in this report.

The information in the guide was compiled through a combination of research methods, including an extensive literature review; input from Hispanic health care providers working at community-based health care facilities, including Asociación Centros de Salud Primaria de Puerto Rico, Inc. of Rio Piedras, Puerto Rico, Association for the Advancement of Mexican Americans (AAMA) of Houston, Texas, Mary's Center for Maternal and Child Care, Inc. of Washington, D.C., La Clinica del Pueblo of Washington, D.C., Rio Grande Community Health Center of Rio Grande, Puerto Rico, Concilio Latino de Salud of Phoenix, Arizona; a focus group conducted at La Clinica del Pueblo in Washington, D.C.; and a series of oral interviews conducted with a member of the Latino community in Washington, D.C.

The Latino community is diverse and contains various cultures, with their own unique traditions and beliefs. Although Spanish is a common language shared by Latinos, some Latinos have grown up in the U.S. and do not speak Spanish at all. Hispanics are a racially and ethnically heterogeneous population; Hispanics may be White, Black, Mulato (of Black and European ancestry), Mestizo (of Indian and European ancestry), Indian and/or Asian. Hispanics often self-identify by their country of origin, saying, for example, that they are Cubans, Puerto Ricans, Mexicans, Ecuadorians, Salvadorans, etc.

II. OVERVIEW OF LATINO HEALTH ISSUES

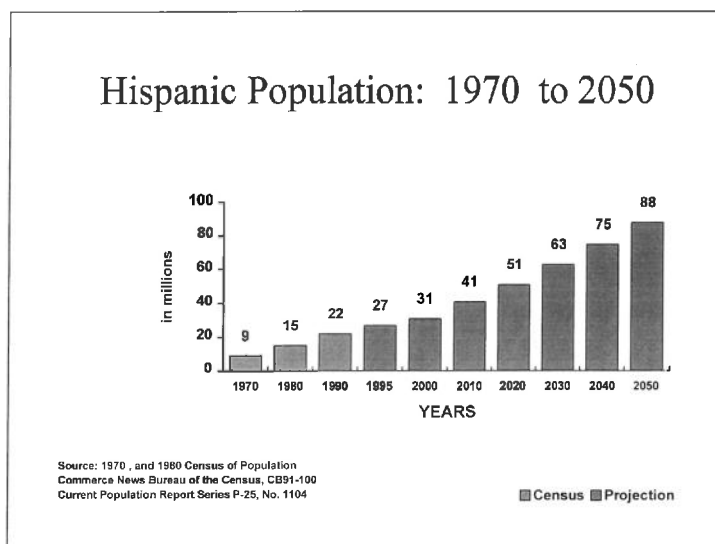
This overview includes demographic information on the Latino population in the United States, data on the major health problems experienced by Latinos, an examination of the risk factors that contribute to the leading causes of death among Latinos, and a discussion of socially and culturally appropriate health promotion among Latinos.

DEMOGRAPHIC INFORMATION

Latinos constitute the second largest minority population in the United States, numbering approximately 31 million people (National Council of La Raza [NCLR], 1997a). Between 1980 and 1990, people in the United States of Latino descent increased in numbers by 53%, a rate of growth more than eight

times that of non-Latinos in the U.S. population. It is estimated that by the year 2010 Latinos will become the largest minority group in the United States. Persons of Mexican, Puerto Rican, and Cuban descent make up 75% of the Latino population in the U.S., with the remaining 25% being individuals of Central American, South American, Dominican and Spanish ancestry (U.S. Bureau of the Census, 1993).

Latinos live in all 50 states and the District of Columbia. However, 90% of the Latino population resides in just 10 states. California, Florida, New York, and Texas have the largest proportion of Latino residents. Other states with significant Latino populations include Arizona, Colorado, Illinois, Massachusetts, New Jersey, and New Mexico. More than half of Latinos live in just two states - California and Texas. (U.S. Bureau of the Census, 1993).



More than 91% of Latinos live in urban areas; nearly 66% are younger than age 35; a little more than half of those age 25 or older have a high school education; and 9% have a bachelor's degree or education above that level. Nearly 30% of Latino households live below the poverty line, and Latinos experience an unemployment rate 62% higher than that of the general population (U.S. Public Health Services [USPHS], 1996).

DISEASE AND THE LATINO POPULATION

Major health problems are experienced by Latinos at a rate disproportionate to their numbers in the population (NCLR, 1997a; NCLR, 1997b; NCLR, 1997c; USPHS, 1996). The following facts illustrate this circumstance:

- ▶ While in 1996 Latinos comprised only 10% of the U.S. population, they accounted for 17.5% of all AIDS cases reported through July of that year; in 1996, Latino children under the age of 13 represented 23% of all pediatric AIDS cases; in 1995, the rate of AIDS cases among Latinos was 46.2 per 100,000 population, as compared to 15.4 per 100,000 among non-Hispanic Whites (NCLR, 1997c).
- ▶ The rate of decline in heart disease mortality rates observed in the general population in recent years has occurred to a lesser extent among Latinos. While death rates from heart disease in the general population declined by 13.5% between 1985 and 1991, the death rates for heart disease among Latinos declined by only 7% (USPHS, 1996).
- ▶ The prevalence of diabetes was two to three times greater for Mexican Americans and Puerto Ricans surveyed in the 1982-84 Hispanic Health and Nutrition Examination Survey (HHANES) as for non-Latinos surveyed in the 1976-80 National Health and Nutrition Examination Survey (USPHS, 1996).
- ▶ The five-year breast cancer survival rate for Latino women is 15% lower than the rate for White women in the U.S. population. Latino women have twice the incidence of cervical cancer that non-Latino White women do. Latino and African American women have the highest death rates due to cervical cancer (NCLR, 1997b).

DISEASE AND EXTERNAL RISK FACTORS

McGinnis and Foege argue that while medical conditions such as heart disease, cancer, cerebrovascular disease, chronic obstructive pulmonary disease, diabetes, chronic liver disease, and human immunodeficiency virus (HIV) infection have been identified as the leading causes of death in the United States, these medical conditions actually result from a combination of genetic and modifiable external risk factors. McGinnis and Foege observed that analyses of the roles of various external risk

factors in these medical conditions suggest that the most prominent identifiable contributors to death among U.S. residents are tobacco, diet and physical activity patterns, alcohol, microbial agents, toxic agents, firearms, sexual behavior, motor vehicles and illicit use of drugs.

The ten leading causes of death among Latinos, in descending order, are: cardiovascular disease, cancer, accidents, HIV infection, cerebrovascular disease, homicide, diabetes, chronic liver disease, pneumonia and influenza, and chronic obstructive pulmonary diseases (CDC, 1996). Cigarette smoking, diet, obesity, physical inactivity, alcohol and unsafe sexual practices have been identified as significant external risk factors for Latinos, as well (NCLR, 1995; NCLR, 1997a; NCLR, 1997b, USPHS, 1996).

Among Latino women ages 20-74, 41.4% of Mexican Americans, 39.8% of Puerto Ricans, and 31.9% of Cuban-Americans are overweight, while 31.2% of Mexican American men, 25.7% of Puerto Rican men, and 28.5% of Cuban-American men are overweight. Intake of dietary salt is a contributing factor to high blood pressure, and members of all racial/ethnic minority groups, including Latinos, tend to exceed the recommended daily intake level. A smaller percentage of Latinos engage in regular moderate physical exercise. Smoking behaviors are increasing at a greater rate among Latino women than among the general population, and Puerto Rican and Cuban men are not experiencing the same sharp decline in smoking rates that non-Latino White men are. While self-reported prevalence of chronic drinking among Latino women is similar to that of women of non-Latino origin, chronic drinking for Latino men is seven times higher than for Latino women (USPHS, 1996).

AIDS often comes last in terms of priority in a series of life issues faced by low-income Latinos.

Surveys of AIDS knowledge and beliefs among the general population have revealed that Hispanic respondents have less knowledge than Black or White respondents and more erroneous beliefs about AIDS (Karlner, 1996). Religious beliefs among Hispanics present barriers to safe sex practices against the transmission of HIV. The Catholic church, to which 90% of Hispanics belong, opposes birth control and has typically opposed efforts at teaching safer sex practices such as the use of condoms. AIDS often comes last in terms of priority in a series of life issues faced by low-income Latinos. Poverty impacts on the ability of some Latinos to focus on HIV, as it does in the general population.

SOCIALLY AND CULTURALLY APPROPRIATE HEALTH PROMOTION

Many authors have expressed the need for social and cultural sensitivity in addressing groups who are accorded less power in the dominant U.S. culture, and who have often been ignored, blamed, or dealt with in a culturally inappropriate manner in health-related educational settings (Karliner, 1996). There is a growing opinion in the literature that health prevention programs must incorporate the belief systems, whether traditional or not, held by the population being targeted. Programs must be conducted in the language and vernacular of the population, through materials that are written at the appropriate educational level. Personnel who are perceived as peer leaders within the population must be incorporated as part of the health team.

Many health promotion campaigns attempt to change people's behavior. What goes unacknowledged is that people's behavior is often shaped by their belief systems, regardless of their levels of education. Successful health promotion must address the balance between respecting cultural practices and interfering when these practices can cause irreversible harm. Modifying the behaviors that make people vulnerable to disease requires understanding the belief systems that shape those behaviors. Understanding Latino health beliefs can be instrumental in decreasing the disproportionate rate at which Latinos are dying from diseases that can be prevented by modifying risky behaviors.



III. BARRIERS TO HEALTH PROMOTION AND DISEASE PREVENTION

The evidence that people do not depend on doctors and nurses for most of their care is substantial (Dehn, 1990). The majority of symptoms experienced by people are largely self-treated. International studies affirm that approximately two thirds of people with symptoms of various illnesses do not consult their physicians (Champion, Austin and Tzeng, 1990). In a study on the relationship between cross-cultural health attitudes and community health indicators, Champion et al. found an unexpected negative correlation between attitudes toward health care professionals and services and attitudes toward body and life. "Medicine," "nurse," "doctor," and "hospital" were associated with death and disease, not with health, life, or health promotion. In fact, the more contact populations had with health care providers, as evidenced by higher scores on life expectancy and net social progress, the more negative their attitudes.

This negative attitude toward health care providers and services exists among Hispanics in general (Aguirre-Molina, Ramirez and Ramirez, 1993; Burk et al., 1995; Caralis, 1990; Flores, 1998; Lantz, Dupuis, Reding, Krauska, and Lappe, 1994; Mantini-Briggs, 1998; Medina, 1998; Mikhail, 1994; Sennot-Miller, 1994). A study of Hispanic mothers in central California revealed that only 32% mentioned physicians and nurses as a source of initial advice or help regarding children's illnesses, while relatives or friends, mother, mother-in-law or grandmother, and husband were the source of initial advice for 67% of the mothers (Mikhail, 1994). Sennot-Miller (1994) identified three categories of barriers that contribute to the disenchantment of Hispanics with health care providers and services: availability, accessibility, and acceptability. Availability barriers refers to long waits and inconvenient hours in health care settings. Accessibility barriers includes problems such as lack of transportation, cost, lack of health insurance, fear of deportation, loss of pay for losing work to attend a medical appointment, and no one to care for children. Acceptability barriers refers to issues involving language and discrimination.

The limited supply of bilingual and bicultural health care personnel available makes it difficult for Latinos and the health care professionals who are treating them to communicate and understand each other.

The limited supply of bilingual and bicultural health care personnel available makes it difficult for Latinos and the health care professionals who are treating them to communicate and understand each other (Mantini-Briggs, 1998; Medina, 1998; Ruiz, 1998). The lack of educational materials that are accurately translated, written at appropriate literacy levels, and contain concepts that reflect the cultural norms of the population being addressed, pose additional communication barriers (Aguirre-Molina et al, 1993; Lantz et al., 1994). Misunderstanding the importance and role of family and social supports within the Latino culture, and failing to integrate family and social supports into health promotion and disease prevention interventions, can be a barrier to effectively reaching and treating the Latino population (Burk, Wieser and Keegan, 1995).

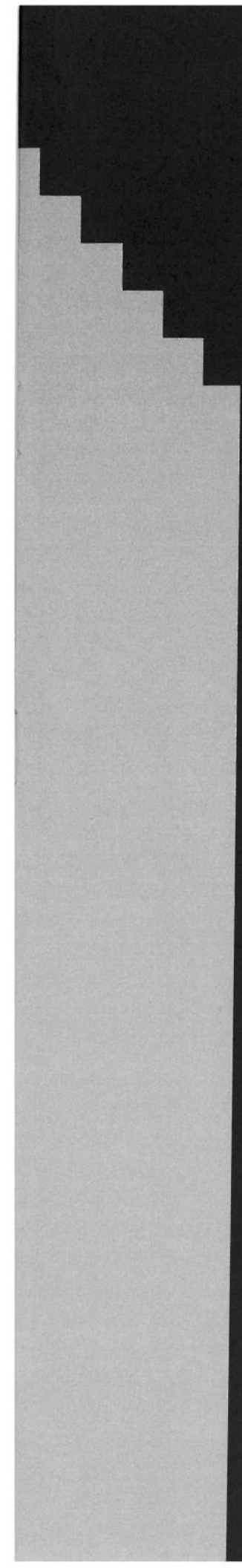
Latinos often feel that health care professionals are insensitive to feelings of shame, embarrassment, and discomfort that are associated with disrobing, being attended to by a health professional of the opposite sex, or being subjected to tests that invade personal privacy (Lantz et al., 1994). Overlooking intergenerational variations and acculturation among

Latinos for the purpose of program planning, and discounting intragroup diversity among Mexican Americans, Puerto Ricans, Cubans, Central Americans, South Americans, and Caribbeans can lead health care professionals to discount important differences among Latinos (Aguirre-Molina et al, 1993).

There have been a few attempts to modify these barriers created by language and cultural differences. The Association for the Advancement of Mexican Americans (AAMA) in Houston, Texas was able to create trust of the health care system by members of the Latino community by designing its alcohol prevention program to address issues of language and cultural mores (Flores, 1998). The AAMA goes out into the community with a mobile unit and prepares community residents to come to their center. The Association has decorated their facility to reflect the culture of the community. Personnel dress as members of the target population dress. Community members are greeted in Spanish when they arrive; they are met with warm smiles; and are offered coffee or something cold to drink.

Poverty has also been identified as a major barrier to health care (Mantini-Briggs, 1998; Medina, 1998, Ortiz, 1998). Medications are expensive, particularly for chronic diseases. High-blood pressure medication can cost two dollars per pill. For a client who takes one pill per day, that amounts to \$30 per month just for one prescription (Ortiz, 1998). Latinos are least likely to have medical care benefits such as

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health insurance, Medicaid, and regular sources of care (Aguirre-Molina et al, 1993). Thus, \$30 per month for just one prescription can be prohibitive for a person without any health insurance. Low-fat diets that are recommended for persons with diabetes or hypertension can be costly. It is sometimes cheaper for people to eat in fast-food establishments than to buy fresh fruits, fresh vegetables, and fish (Medina, 1998.) Many Latinos find themselves having to work two or three jobs to bring in enough income to support themselves and their families. There is often no time to prepare meals and no time to eat properly (NCLR, 1998).

Illiteracy and low literacy may accompany poverty among the Latino immigrant community (Flores, 1998, Medina, 1998). Limitations in literacy lengthens the health education process. It takes longer and involves more individual attention to teach an illiterate or low-literacy person how to take medications, carry through a treatment plan, and change health habits (Medina, 1998). Sensitivity to low literacy among clients requires simplification of paper work and methods for acquiring information that do not embarrass illiterate clients (Flores, 1998). Poverty also creates barriers to continuity of care. Newly-arrived immigrants find temporary places to live, and tend to change residence often as they attempt to stabilize themselves economically. Constant changes in residence make it difficult to track clients for ongoing treatment (Medina, 1998).

In some geographic areas, the Latino community is comprised primarily of persons who are not U.S. citizens or permanent residents. While a spouse or children may have U.S. citizenship or permanent resident status, the illegal status of one member of a family may prevent the entire family from seeking health care for fear of deportation of that family member (Flores, 1998; Medina, 1998). Recent welfare reform legislation has also made immigrants with permanent resident status ineligible for Medicaid (Medina, 1998).

Perceptions about food and body weight that are shaped by a cultural framework also constitute barriers to health promotion (Keefe, 1997; Medina, 1998; NCLR, 1998; Ortiz, 1998). Some Latinos have made statements like “food prepared in the native way tastes better” or “salad isn’t food” (NCLR, 1998.) Other Latinos have expressed the belief that “a fat baby is a healthy baby” (Keefe, 1997) or “normal weight for a woman is anything under 200 lbs.” (Ortiz, 1998). Moreover, it has also been expressed by some Latinos that it is harder to carry out a healthy life style in the United States (Medina, 1998; NCLR, 1998). In many Central, South American and Caribbean countries, the population is accustomed to eating home-grown vegetables that they find tastier. The diet is simpler, and contains more grains and vegetables than meats. In the United States, meat is more accessible, foods are more processed, and diets, accordingly, are more complex.



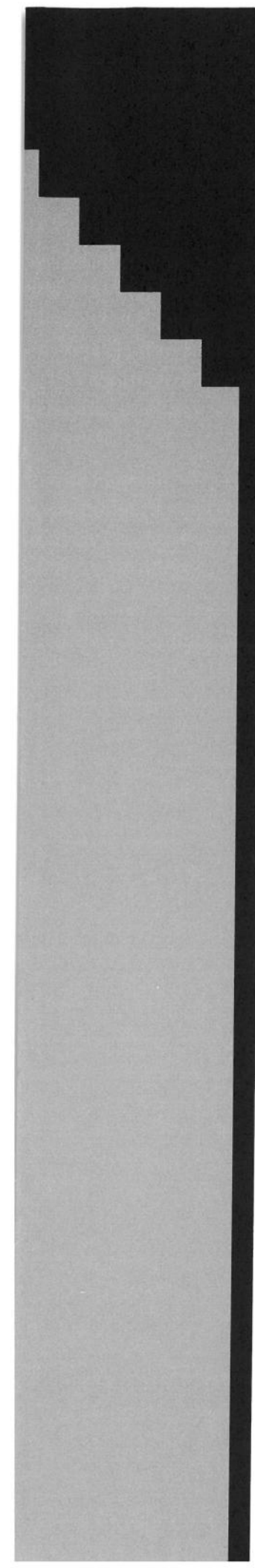
IV. LATINO CONCEPT OF HEALTH

In modern Western societies, many people attribute illness largely to physical causes such as bacteria, pollutants, degenerative processes, chemical imbalance, lack of exercise, heredity and other factors (Congress and Lyons, 1992). As a result, they are receptive to diagnoses and treatment that match their expectations. Many Americans, for example, are familiar with and accept treatments with medications and hormones, as well as surgical interventions, radiation, and chemotherapies. This biomedical model, however, may be inadequate for understanding the perception of illness and health behaviors of some Latinos and other ethnic minorities (Caralis, 1991; Dehn, 1990; Luyas, 1991).

Although health care professionals are taught various concepts of health in their professional education, they may not consider that their client's health concept is culturally defined and may differ from their own (Ailinger and Causey, 1995; Champion, et al., 1990). Ailinger and Causey (1995) found that older Hispanic immigrants include dimensions of health in their thinking that may not be addressed by the dominant health care system. Hispanics tend to have a holistic approach in which the mind and body are seen as one (Congress and Lyons, 1992). Their view integrates physical, mental and spiritual health. This challenges the idea that health is unidimensional (physical) and suggests that health is a complex construct. Health care assessments, planning, and interventions, therefore, must be congruent with the patient's cultural beliefs and expectations (Burk et al., 1995). When there are differences, setting mutual goals toward health may be difficult and can result in low adherence to the treatment plan suggested by the health care professional.

In developing a program designed to prevent heart disease among older Hispanic immigrants, Ailinger and Causey (1995) found that the Latino definition of health is multifaceted. Hispanic seniors attributed multiple factors to achieving a state of good health. Physical aspects of good health included feeling well, and the absence of suffering and illness. Having good mental health went hand-in-hand with enjoying tranquillity, being in good spirits, not being bored, doing intellectual work, enjoying life, having spiritual peace, feeling happy and enthusiastic, having positive people around, enjoying good interpersonal relationships, and having family members that are supportive and understanding. Being able to do things independently, being

Hispanic seniors attributed multiple factors to achieving a state of good health.



active, and taking care of one's self in the form of exercising, eating well, and taking medicines were considered a sign of good spiritual health. Integrating the physical, mental and spiritual aspects of one's life all contributed to "being healthy" in the view of this sector of the Latino population. The views of Hispanic elders are important to note because the elderly are held in high esteem in the Latino culture. The view of an elder member of the family contributes significantly to the cultural framework developed by other family members.

These themes become important in planning health care programs for the Hispanic population. For example, Ailinger and Causey (1995) suggest that it is important to discuss heart disease in the context of how it would affect one's emotional and spiritual well-being, how it would affect one's ability to care for oneself, and how it would affect one's family, in addition to discussing the pathophysiology of heart disease.



V. LATINO CULTURAL BELIEFS AND THEIR IMPACT ON HEALTH PRACTICES

FAMILISMO (FAMILISM)

The importance that Hispanics place on the family as a primary social unit and source of support for individuals has been discussed extensively in the literature (Ailinger and Causey, 1995; Burk et al., 1995; Diaz de Leon, 1997; Keefe, 1997; Lantz et al., 1994; Luyas, 1991; Sennott-Miller, 1994). The collective needs and achievements of the family take precedence over those of the individual members of the family. Help and advice are usually sought from within the family system first, and important decisions are made as a group. For this reason, medical conditions and medical treatment are considered a family matter, and not solely the business of the individual (Valdez, 1997).

In working with pregnant Mexican American women of the Lower Rio Grande Valley of southern Texas, Burk et al. (1995) found that family is valued as an interdependent network of individuals who are closely connected for the good of the family as a whole. The network may include nuclear family members or may extend to grandparents, aunts, uncles, cousins, friends and *compadres* (godparents). In areas such as Washington, D.C., where the Latino community is comprised primarily of recently-arrived immigrants whose families have remained in their country of origin, those who come from one's home town are regarded as family members (Romagoza, 1998). In some instances, where a Latino immigrant does not have members of his or her family of origin or country of origin upon whom to rely for support, Latinos from other countries of origin become an extended family (Ruiz, 1998).

Keefe (1997) found that the immediate kinship group was the center of the world for Puerto Ricans living in a Western New York State community. The concept of family ties was very strong among this population. It was expected that the father would give monetary and social support to his children, whether married or unmarried. It was a common custom to have every male child in the family named after the father (and be called by their middle name or a nickname). While traditionally the Hispanic male has been acknowledged as the unquestioned authority figure in the family, contemporary research proposes that gender roles in Hispanic families are changing (Burk et al., 1995). Women are still considered the center of the family and are still in charge of the family's health (Romagoza, 1998). Women, however, are

assuming more authority for decision-making within the family, and they generally feel that decisions about when to have children, the use of contraception, and the decision to have an abortion should be made by the woman and not the man (Burk et al., 1995).

FAMILISMO AND PREGNANCY OUTCOMES

Mexican Americans have lower rates of low-birthweight births and infant mortality than the general population despite underutilization of prenatal care services, younger ages at childbearing, and generally lower socioeconomic conditions (Burk et al., 1995). Although Mexican American women born in Mexico are at greater risk of not receiving prenatal care, they tend to have lower rates of low-birthweight births than U.S.-born Mexican American women do. Paradoxically, as Mexican American women become more acculturated and receive more adequate prenatal care, the rates of low-birthweight and infant mortality begin to rise.

Researchers in low-birthweight and prenatal care have inferred that perhaps the single most significant influence on Mexican American pregnancy outcomes stem from elements of familismo, including a caring and supportive family network, presence of the father, and high regard for parental roles. Children are highly desired and valued, and pregnancy is regarded as an important family event. The pregnant woman receives extensive physical and emotional support from immediate and extended family members. The father of the infant is generally living in the home. Older more experienced women in the family serve as role models to teach and advise younger women about pregnancy and to help with child care (Burk et al., 1995).

FAMILISMO AND UTILIZATION OF PREVENTIVE AND TREATMENT SERVICES

The problem of late cancer diagnosis and resulting lower survival rates among Hispanic women has been noted (Lantz et al., 1994; Sennot-Miller, 1994). Research suggests that under-utilization of preventive services may lead to later diagnosis. Not only do Latinos present with more advanced disease, but they also appear to wait longer after diagnosis before they receive treatment (Lantz et al., 1994). Familismo may be one factor contributing to late cancer diagnosis and delayed treatment. Attention to family needs may cause a woman who has child-care responsibilities or a man who has work responsibilities to postpone cancer screenings and/or follow-up appointments (Sennot-Miller, 1994). On the other hand, it has also been noted that for many Hispanic men and women, knowing that they have to stay healthy to care for their families provides strong motivation to see a physician (Lantz et al., 1994). It is often the case that a Latina woman has a strong sense that as a wife and mother

she is responsible for the family's health, and therefore must remain healthy. At the same time, a Latino man may feel that as the father of the family he must remain healthy to support the family economically.

FAMILISMO AND UNDERSTANDINGS ABOUT DIABETES ONSET

Luyas (1991) found that the informants in an ethnographic study of low-income Mexican American women with type 2 (formerly known as non-insulin-dependent) diabetes, considered economic and family problems to be focal points in the factors that triggered the onset of diabetes and influenced the course of the disease. Informants perceived family conflict as one of the factors that contributed to their developing diabetes, as well as a factor in their chronic elevated blood sugar.

Valdez (1998) indicates that family support among Mexican Americans acts as a buffer to sociocultural and economic stress. The prevalence of extended families among Latinos means concerns about more family members and more chances for stress. In health care settings, however, economic and family problems are generally referred to social workers and social service agencies, as these problems are not considered directly relevant to the treatment of physiological problems. Valdez (1998) argues that the integration of body, mind, and soul for the Latino person makes it impossible to treat the physiological problem without engaging the sociocultural and economic problems the person is facing.

Central and South Americans participating in a focus group on Latino health beliefs (NCLR, 1998) also perceived little distinction between the physical and social dimensions of the person. In responding to a question about the cause of diabetes, focus group members attributed the onset of diabetes to the change in culture experienced in emigrating (NCLR, 1998). Shock, tension, depression, and low morale were all factors that focus group participants cited as contributors to stress, which they believed made one more vulnerable to diabetes.

FAMILISMO, ALCOHOLISM, AND MENTAL HEALTH

Family integration has been instrumental in treating certain health conditions, like alcoholism and mental health, which are considered taboos in the Latino community. At the alcohol and substance abuse out-patient facility of the Association for the Advancement of Mexican Americans (AAMA) in Houston, Texas, family members are invited to monthly cultural events that are organized to celebrate holidays. The events are used to reinforce family support for the person under treatment without ever mentioning alcoholism at the event. The understanding here is that the activity of reinforcing membership in the family and family support contributes to the treatment of alcoholism (Flores, 1998).

In a similar fashion, La Clinica del Pueblo, a comprehensive community-based health care facility in Washington, D.C., brings family members into the treatment plan for clients suffering from emotional problems. When clients present with physical problems that are related to emotional stress in their lives, the family is involved in identifying the source of the emotional stress. Without mentioning the words “mental health,” “emotional problems,” or “therapist,” family members are helped to see that the emotional problem of the identified client affects everyone in the family. This process provides support for the identified client to continue in treatment, turns the “problem” into something that can be accepted by the family, and makes it easier for the client to ask for family support (Romagoza, 1998).

FATALISMO (FATALISM)

Traditionally, many Hispanics classify illness as either “natural” or “unnatural” (Congress and Lyons, 1992; Diaz de Leon, 1997). Natural illness is thought to be caused by God’s will or fate, while unnatural illnesses originate from evil done to one by another. In either case, the person feels that control over what has happened - and will happen - has an external locus, and hence is wholly out of his or her hands. This leads to a fatalistic view of life and death; the individual perceives little personal ability or responsibility for success or failure in matters of health and illness. There is very little - or nothing - a person can do to prevent or survive disease.

Fatalismo can also be traced to Roman Catholicism, the predominant religion among Hispanics (Burk et al., 1995). Within this religious worldview, God controls all, and faith is essential to recovery from illness. Whether or not a person develops disease or is cured is God’s will. The strong religious convictions among many Hispanics has led them to believe that life and health are controlled by divine will, fate, and the environment, generating a sense of personal powerlessness.

FATALISMO AND CANCER TREATMENT

An intense fear of cancer, coupled with a strong sense of fatalismo regarding its treatment and course, was found among Hispanic migrant agricultural workers who had migrated to Wisconsin from the Rio Grande Valley of Texas for summer work (Lantz et al., 1994). Lantz’s findings were similar to what had been reported for other minority and low-income populations: compared with Whites, Latinos were significantly more likely to agree with several myths regarding cancer etiology, to believe that having cancer was synonymous with death, that cancer is God’s punishment, and that there is very little one can do to prevent getting cancer or to treat it successfully. Migrant workers who participated in Lantz’s focus groups perceived cancer as a single disease that progressively eats away at the entire body, and treat-

ment as resulting in severe disfigurement and multiple amputations. Strong fears were associated with death, pain, suffering, and the mutilation of a person's body.

Delays in seeking medical attention for cancer symptoms and higher rates of advanced disease at diagnosis among Hispanics have been noted in the literature (Lantz et al., 1994; Sennot-Miller, 1994). It is difficult to overcome the fatalistic attitudes that are prevalent until people witness more of their friends and family members surviving cancer through use of medical treatment (Lantz et al., 1994). The use of role models (persons from the community who have survived cancer through successful treatment or early detection) is needed to help counteract the fatalistic attitudes that prevail.

RESPECTO (RESPECT)

Latinos are highly contextual people (Valdez, 1998). Latinos think and make decisions in the context of their environment, i.e., culture, family, religion, socio-economic conditions. Latinos think globally, in a non-linear, holistic way. For this reason, relationships between people are very important. Latinos place a high value on interpersonal relationships. *Respeto* refers to a quality of self which must be presented in all interpersonal relationships (Keefe, 1997). It signifies attention to proper and moral behavior and indicates an expression of deference to the person one confronts. Deferential behavior toward others is determined on the basis of sex, social position, economic status, and position of authority.

Hispanic clients respect health care providers as authority figures. Drawing upon their experiences in their countries of origin, Hispanics tend to view doctors on a par with the town mayor and the parish priest (Romagoza, 1998). The doctor does not only play the role of health care provider, but also of provider of emotional and spiritual support as well as defender of the poor. The doctor merits great respect. This may cause the Hispanic client to be hesitant to question a health care provider or disagree with the plan of care (Keefe, 1997). Clients may state they "understand" the medical regimen when they do not, because they do not want to hurt the provider's feelings. If they don't think the medicine prescribed is helpful, they may stop taking it and return to a different provider, so as not to show disrespect for the first provider. Many Latino clients also defer to the health care provider by looking down and not looking at the person directly. Some doctors interpret this as the client's trying to hide something (Romagoza, 1998).

Conversely, Latinos expect to be treated with respect by health care providers (Burk et al., 1995; Keefe, 1997; Sennot-Miller, 1994). Many Latinos have complained that the clerical persons at social service and medical facilities "have no respect," which feeling compels them to leave and return another day to another person, or not to return at all. Older Hispanics, for example, prefer not to be called by their first

name by younger or unfamiliar providers. On the other hand, once an older Hispanic client develops a close relationship with a health care provider, he/she may ask if it is all right to address the provider as *mijo* (mi hijo) (my son) or *mija* (mi hija) (my daughter), to denote the familiar relationship that has developed (Braña, 1998).

Respeto is demonstrated by using formal rather than informal Spanish language, and by listening attentively to clients and providing information in a courteous manner. It is important that the primary care provider's nonverbal communication, such as body language, be consistent with his/her verbal communication. Respeto incorporates diplomacy and tactfulness and discourages confrontation (Burk et al., 1995).

PERSONALISMO (PERSONALISM)

Personalismo emphasizes that the client's relationship is with the individual provider rather than with the institution (Burk et al., 1995). It also presupposes formal friendliness on the part of the health care provider (Sennot-Miller, 1994).

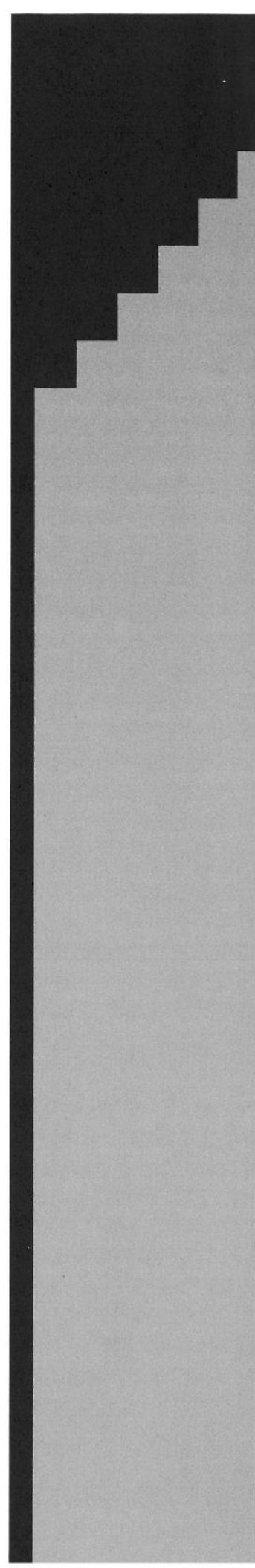
Personalismo can be conveyed by greeting the client by name and inquiring about his or her general well-being or family before getting to the actual business of the visit. Personalismo helps build an atmosphere of trust and intimacy, and enhances self-disclosure by the client. An abrupt, hurried approach on the part of the provider might be construed as a failure of personalismo, causing a client not to return for a scheduled appointment. Latinos value physical touch as part of communication (Burk et al., 1995). Open affection and embracing are common among family and friends, especially women. While Latinos are more conservative with strangers, the health care provider can enhance personalismo by offering a handshake as a greeting or touching the head of a child.

TIME ORIENTATION

Hispanics may view time differently than non-Hispanics (Burk et al., 1995; Keefe, 1997). Their concept of time is loosely defined and structured. Burk et al. (1995) found that the Mexican American women being attended at a Texas birth center had a present time orientation, as compared to the future time orientation of the U.S. health care culture. Some clients were unable to tell time or did not own clocks. Others who may have been more aware of the importance of time had to walk several miles to reach the clinic or rely on friends or neighbors for transportation, making it difficult for them to be on time for appointments. Keefe (1997) observed that Puerto Ricans attending a health center in Western New York State divided the day into morning, afternoon and evening; hours, minutes and seconds were not considered important. Some clients would arrive at the health center just before noon to keep an appointment made for 9:00 AM or 10:00 AM.

The present-time orientation of Mexican Americans and other Latinos may work against health promotion and disease prevention. Latinos tend to seek care only when they feel sick, and make fewer health promotion and disease prevention appointments than the general population (Burk et al., 1995). Pregnant women may delay or discontinue prenatal care because they feel well; some clients may not take medications as prescribed, at the exact times or at the time intervals indicated; some may not understand acute versus chronic illness; and clients may find it difficult to adhere to long-term care plans.

At the same time, present-time orientation can be used positively (Valdez, 1998). A person can be encouraged to take prescribed medications because the medication will have an immediate effect on how they feel. Prenatal care messages can be designed to focus on the risks that are particular to specific stages of pregnancy. The immediate effects of chronic illness can be emphasized over long term effects.





VI. ALTERNATIVE FORMS OF VIEWING AND TREATING ILLNESSES

Perceptions of illness causation among Hispanics vary and include traditional folk beliefs as well as Western scientific biomedical explanations (Braña, 1998; Burk et al., 1995; Caralis, 1991; Champion et al., 1990; Congress and Lyons, 1992; Dehn, 1990; Diaz de Leon, 1997; Keefe, 1997; Mikhail, 1994; Romagoza, 1998). Traditional folk beliefs include understanding illness as a result of an imbalance between hot and cold, the impact on the body of natural forces, including air, food and/or heat, and the existence of supernatural forces such as spirits. Some Hispanics may use folk medicine as an alternative to Western medicine for minor illnesses or as an adjunct when chronic conditions persist despite medical treatment. Rather than rely exclusively on folk medicine or Western medicine, Latinos may seek the services of folk healers and orthodox health care providers simultaneously.

The roots of Latino folk medicine can be traced to the humoral medicine of 16th century Spain, the ancient indigenous cultures of Central and South America, and African cultural practices (Braña, 1998; Burk et al., 1995; Mikhail, 1994; Romagoza, 1998). Humoral medicine originated with Hippocrates and was based on the theory that health exists when the four body humors — blood, phlegm, black bile, and yellow bile — are in balance. The Conquistadores introduced these beliefs, along with Catholicism, to the New World in the 1500s (Burk et al., 1995; Mikhail, 1994). Indigenous culture links health with natural forces such as the land, sea, moon, and stars (Romagoza, 1998). In the Caribbean, where the importation of African slaves flourished for four centuries, Africans adapted Spanish and indigenous practices to their cultural beliefs (Braña, 1998). The Spanish Catholic, indigenous, and African cultures have assimilated over the past few centuries, creating a blend of humoral, herbal, and spiritually-based medicine that has been passed down through the generations.

HUMORAL MEDICINE

Illness results from an imbalance in the humors, and treatment is based on restoring balance through the means of traditional folk remedies or folk healing practices. Illnesses, medications, and foods are placed along a hot/cold continuum. Hot and cold refer to the intrinsic nature of the illness, not the patient's temperature (Caralis, 1991). A "hot" disease needs to be treated with "cold" remedies and a "cold" disease with "hot" remedies.

Many Hispanics, as well as others, associate getting a cold with the imbalance between hot and cold, for example (Dehn, 1990; Keefe, 1997; Mikhail, 1994). Sudden change of weather or temperature, walking with bare feet, cooling or chilling of the chest, being improperly dressed for the weather, getting wet, drinking or eating cold things, and hot weather make an individual susceptible to contracting a cold (Mikhail, 1994). Some mothers give milk or formula when a child has diarrhea (Keefe, 1997). Diarrhea is considered a hot disease and milk is a cold remedy. One process used to cure an earache is holding an ignited cone of paper close to the ear to draw out bad air (Dehn, 1990). Cough is considered a cold illness; as in many other cultures, soups, herbal teas, and honey, which are considered warm substances, are used to cure it (Mikhail, 1994).

Several studies involving Latino folk beliefs about high blood pressure have revealed the common folk belief among Latinos that hypertension is caused and/or contributed to by nervousness, anger, excessive stress, and too much blood (Caralis, 1991). All of these are considered hot conditions that must be treated with cold remedies. Treatment beliefs included, according to the studies' findings: change in climate (73%); eating certain fruits, particularly bananas and lemon juice (65%); drinking chamomile tea (39%); and drinking ice water (24%). Of those patients studied, only 25% thought hypertension could be cured, and only 47% mentioned use of antihypertensive drugs.

Folk healers attempt to correct the imbalance that is causing the illness through the use of folk remedies. Commonly-used folk healers include the curandero (healer), yerbero (herbalist) and sobador (masseuse) or santigüador (person who does massage in the name of a saint) (Braña, 1998; Burk et al., 1995). Curanderos are the most respected folk healers. They are believed to be chosen and empowered by God. They live in the community and practice out of their homes. They use teas, herbs, prayers, and rituals to correct imbalances, but generally will not treat people who have serious or incurable diseases. Curanderos charge no fees for their services but accept donations. Yerberos specialize in the use of herbs and spices to treat and prevent illness. Sobadores or santigüadores use massage to correct imbalances in the muscles and skeletal system, as well as the abdomen and thorax where maladies are thought to be harboring.

INDIGENOUS WORLD VIEW

In Latin America's indigenous cultures, there is a strong belief in and love for natural forces (Romagoza, 1998.) The three most important gods in the indigenous cultures are the gods of the Sun, the Moon, and the Earth. Each of these plays an important role in the well-being of people. Respect for the power of these gods is considered integral to a healthy life.

In Latin America's indigenous cultures, the earth may be considered the most important source of well-being (Romagoza, 1998). People do not look up to the heavens for succor, but down to the ground. When an infant is born, for example, the umbilical cord must be buried. There must be a connection with the earth. Something of the newborn infant must return to "Mother Earth." A child whose umbilical cord has not been buried is a child who will not last, who will be weak, like a tree with no roots that can be swept away by the wind. When a woman is experiencing heavy bleeding during menstruation, or when a person has a heavy nose bleed, they may be counseled to bring damp dirt up to their nostrils and breathe.

The sea is also considered to have healing properties. At first menstruation, when suffering from fever, or when experiencing emotional problems, people are counseled to bathe in the sea. The sea will help a woman have regular menstrual cycles, will bring down fever, and will relieve emotional stress. Phosphorous from fish bones and iodine are used to make potions to strengthen bones, teeth, and skin.

In Latin America's indigenous cultures, the sun and moon also have powers (Romagoza, 1998). Many Hispanics believe that exposure of a pregnant woman to an eclipse will cause her infant to have a cleft lip or palate (Burk et al., 1995; Diaz de Leon, 1997; Romagoza, 1998). One indigenous belief is that during an eclipse, the sun and moon are making love, increasing the energy that emanates from them. Mortals must protect themselves from these natural forces. The most vulnerable who must be protected is the child in a mother's belly (Romagoza, 1998). The Aztecs believed that an eclipse occurred because a bite had been taken out of the moon (Burk et al., 1995). If a pregnant woman viewed the eclipse, her infant would have a bite taken out of his or her mouth. Aztec practice was to place a knife on the woman's abdomen before she went out at night to protect her baby. Today, a key or safety pin is used for protection.

AFRICAN INFLUENCES

African slaves were brought to the New World beginning in the 1500s. The largest concentration of descendents of African slaves can be found in the Caribbean islands and Brazil. In the Spanish-speaking Caribbean, cultural practices such as herbal remedies, spiritual healing, and magic are all African-influenced. Many of the cultural practices that are considered to be of African origin are adaptations of combined Spanish and Caribbean indigenous cultural practices by African slaves (Braña, 1998). The *baquiné*, for example, is a celebration held at the death of an infant practiced in the Black townships of Puerto Rico. This ritual is generally considered to be descended from African culture. Researchers, however, have found that the *baquiné* actually has its origins in the *florón*, a ritual for infant death originating in Spain, which was adapted by African slaves. The African influence in Caribbean

culture has great prestige. A spiritual healer, for example, is more respected and more trusted if she/he is Black rather than White (Braña, 1998).

FOLK ILLNESSES AND FOLK REMEDIES

Hispanics not only use traditional folk medicine to treat Western-recognized illnesses, but also to treat folk illnesses that are not recognized by Western medicine (Braña, 1998; Burk et al., 1995; Dehn, 1990; Keefe, 1997; Mikhail, 1994). Some examples of folk illnesses and remedies include:

- ▶ **Susto (fright)** - Results from a state of anxiety (Braña, 1998) or an emotionally traumatic event such as an accident, death, or any real or imagined scare (Burk et al., 1995).
- ▶ **Empacho (blocked intestine)** - Occurs when food sticks to the wall of the intestine and results from eating improperly cooked foods or eating certain foods at inappropriate times (Burk et al., 1995; Dehn, 1990). A cure for empacho with children may consist of giving the child herbal tea (usually mint) and one teaspoon of olive or resin oil, massaging the stomach and back, and then pulling the skin along the spine three times in three different areas. This is believed to dislodge whatever is sticking to the stomach wall creating the empacho (Mikhail, 1994). Among adults, laxatives may be taken to clean out the body and relieve the sense of having “a full stomach” (Braña, 1998).
- ▶ **Mal de ojo (evil eye)** - An illness usually affecting children, caused by excessive admiration or envious looks by others (Braña, 1998; Burk et al., 1995; Mikhail, 1994). Newborn babies in Puerto Rico, for example, are often given a gold bracelet or necklace with an azabache (a black or red coral charm in the form of a fist) to wear to protect them from the evil eye (Braña, 1998). Home remedies for eliminating the evil eye include “egg sweeping,” which consists of sweeping the child’s body with a whole raw egg while simultaneously praying, then placing the egg in a cup under the head of the bed where the child sleeps. On the next day the egg is crushed open and if it appears cooked and dark it indicates that the child had mal de ojo. This process takes the evil eye away (Mikhail, 1994). Evil eye may also be treated by a folk healer who conducts a spiritual cleansing of the body (Braña, 1998).
- ▶ **Caida de mollera (fallen fontanel)** - When an infant’s anterior fontanel - the soft, boneless area in the skull - becomes visibly depressed or fallen (Burk et al., 1995; Mikhail, 1994). This is believed to be caused by dropping or bouncing an infant roughly, or by removing an infant from the breast or bottle abruptly. When an infant has symptoms such as fever, irritability, vomiting, diarrhea, or lack of appetite, an Hispanic mother may perceive these symptoms to be caused by caida

de mollera. Fallen fontanel, however, is usually the result, not the cause, of these symptoms.

- **Antojos (cravings)** - The belief that an infant may be born with marks characteristic of something the mother may crave during pregnancy if the craving is not satisfied (e.g. infant may have strawberry spots if the mother craves but does not eat strawberries during pregnancy) (Burk et al., 1995).
- **Cuarentena (forty days)** - The period following birth during which certain dietary and activity restrictions are observed to allow the mother time to recover from pregnancy, to bond with the newborn, and to prevent certain illnesses from occurring later in life (Burk et al., 1995).

HERBAL REMEDIES

An amazing variety of special foods, herbs, and teas are used by Latinos to cure illnesses (Braña, 1998; Dehn, 1990; Keefe, 1997; Mikhail, 1994; Ruiz, 1998). These include: cactus juice to control diabetes; chamomile for ulcers; asafetida and garlic to ward off colds; grapefruit for menstruation, arthritis, and diabetes; aloe vera for diabetes, cuts, and colds; pineapple or peppermint for stomach problems; whiskey with salt for toothaches; aloe tea for asthma; anise tea for colds, colic, and empacho; oregano tea for colic and muscle pain; oatmeal baths for rashes; cilantro, “agua de linasa,” and “agua de carey” for kidney ailments; raw or lightly cooked garlic and onion for hypertension; thinly sliced potatoes on forehead for headaches; and coffee grounds wrapped in a paper towel for sties and “pink eye.”



VII. CULTURE-APPROPRIATE THEORETICAL FRAMEWORKS

VALUE-EXPECTANCY THEORY

In order to make a decision to adopt a preventive behavior such as a low-fat diet or regular screening for breast or cervical cancer, one must connect the consequences of these changes with reduced personal risk. People must decide whether or not to adopt behaviors while they are still uncertain about the results of adopting these behaviors. Value-expectancy theory is a social-psychological theory that has been used to explain these types of decisions (Becker, 1974). It holds that, when confronted with a choice of behaviors, individuals will use their beliefs and experiences to evaluate what will be the positive and negative consequences of adopting alternative behaviors. When applied to recommended health behaviors, the theory holds that the likelihood of adoption is a multiplicative function of the value of the goal (avoiding illness) and the expectancy that the recommended behavior will achieve it.

Sennot-Miller (1994) found that difficulty in adopting a behavior was a stronger predictor in changing cancer prevention behaviors among older Hispanic women than perceived effectiveness of the new behavior. This finding for Hispanic women and cancer prevention behaviors followed a similar finding for White clients relative to risk-reducing behaviors for heart disease. This research provides support for a health behavior change intervention based on reducing the difficulty of the recommended activity. The intervention would entail helping clients identify their own individual barriers and focusing attention on ways to reduce the difficulty of adopting desired changes in their health behavior. Barriers do not need to be known and addressed on a global level; rather, the focus is on the particular situation of an individual client who can participate in examining his or her own situation and determining what barriers make changing health behaviors difficult.

CULTURE CARE THEORY

This is a broad theoretical framework defined by Leininger (1978, 1991) for understanding the cultural and social dimensions of individuals, families, and groups that influence health care values, beliefs, patterns, and practices, and provides care that fits with the cultural beliefs and practices of people of different cultures. Culture care theory seeks to discover what is diverse and what is universal in relation to people's world view, social structure, ethnohistory, socio-cultural institutions, environmental context, and language uses. Culture care practice considers religious, educational, political, technological, and economic factors, as well as cultural and

kinship values, in order to appreciate a person's perspective of health care (the emic view). The planning and provision of health care services is a dynamic interface between the professional (or etic) perspective of health care and the popular (or emic) view.

Keefe (1997) found Leininger's theory of culture care conducive to developing substantive knowledge and understanding of the cultural context of health and illness in a Puerto Rican community in Western New York State. The knowledge and understanding derived from this study led to the formulation of three major modalities for providing culturally appropriate health care: 1) cultural care preservation; 2) cultural care accommodation; and 3) cultural care repatterning or restructuring. Within this framework, the following recommendations for health care practice were made:

CULTURAL CARE PRESERVATION:

- ▶ Reinforce family caring values of nurturance
- ▶ Respect use of religious symbols and protective care symbols
- ▶ Treat the family with respect

CULTURAL CARE ACCOMMODATION:

- ▶ Use the Spanish language
- ▶ Promote respect and confidence by accommodating family and community values
- ▶ Encourage introduction of traditional health foods, linking their use with nontraditional health foods

CULTURAL CARE RESTRUCTURING:

- ▶ Include grandmother and family in a coparticipative approach to care
- ▶ Emphasize cultural ideology and beliefs in explaining how a new approach will contribute to health
- ▶ Develop Spanish language pamphlets linking emic and etic health practices
- ▶ Create outreach programs utilizing bilingual Hispanic mothers
- ▶ Design classes for mothers, fathers, and grandmothers with a cultural theme linking etic and emic health practices

PENDER'S HEALTH PROMOTION MODEL

Pender extended Becker's Health Belief Model (1974) to include health-promoting behavior. The Health Belief Model (HBM), which was developed in the early 1950s by Rosenstock, Hochbaum, and Kegeles and refined in 1974 by Becker, provided a

framework for exploring why some people who are well take actions to avoid illness, while others fail to take such protective actions. This model assumed that “good health” was a common goal of all people, with differences in preventive health behavior being due to differing perceptions that influenced an individual’s motivation to take certain actions to reach their health goals. The Health Belief Model was seen as an appropriate paradigm for health-protecting or preventive behavior, but inappropriate as a paradigm for health-promoting behavior.

The Health Promotion Model (Pender, 1982) defines health as a positive, dynamic state in its own right, not merely the absence of disease. The Health Promotion Model (HPM) emphasizes well-being, personal fulfillment, and self-actualization rather than reaction to the threat of illness. While preventive behaviors are directed at decreasing the probability of illness, promotive behaviors are directed at sustaining or increasing one’s level of well-being, self-actualization, and personal fulfillment. Examples of health-promotive behaviors are routine exercise, leisure activities, rest, optimal nutrition, stress-reducing activities, and development of social support systems (Pender, 1987).

The likelihood that health-promoting behaviors will occur is determined by a combination of individual perceptions, independent variables and barriers, and/or signs that trigger action. Individual perceptions include the importance assigned to health, health status, and barriers or benefits of health-promoting activities. Independent variables include age, race, gender, ethnicity, education, income, and occupation. According to the model, health-promoting behavior is the result of an individual’s making a decision and then taking action on that decision. Making a decision involves an interplay between the person’s perceptions and the impact of independent variables specific to that person, and taking action involves both barriers and signs that discourage or trigger action.

A mother’s perception of her own health, her perceived control of health, and her perceived self-efficacy were found to predict a mother’s health-promoting behavior among Latino mothers of childbearing age from the Washington Heights-Inwood area of New York City (McGuire, 1995). Latino mothers were more likely to use self-actualization, exercise, and interpersonal support, and less likely to exhibit nutrition, health responsibility, and stress management behaviors in promoting their own health. McGuire suggests that since health perceptions are correlated with health-promoting behaviors, it is important for health care practitioners to assist Latino women in making a realistic assessment of their health. Health perceptions may be used to screen Latino mothers who may need to alter their health behaviors. Alternatively, health perceptions may constitute a variable that health care practitioners can modify through the design of appropriate interventions, since perceptions precede enactment of behavior, according to Pender’s model.



VIII. COMMUNITY MODELS

There is no single best way to design a health promotion campaign. Some programs involve community leaders and community volunteers. Some programs involve community resources such as churches, schools, community centers, local health clinics, social clubs, and local businesses as partners. Other programs use local television, radio, and print media. Research has revealed that on a typical day, 67% of Latinos in the United States watch Spanish-language television; 47% listen to Spanish-language radio; 21% read Spanish-language newspapers; and 19% read Spanish-language magazines (Ramirez and McAlister, 1988).

What follows are a few examples of successful health promotion interventions that can be replicated. The reader is encouraged to find other success stories and to create her/his own health promotion campaigns.

A SU SALUD

A Su Salud was a mass media health promotion program for smoking prevention and cessation that targeted Mexican Americans in Southwest Texas (Ramirez and McAlister, 1988). The A Su Salud study distinguished itself from other mass media public health promotion campaigns in its employment of role models within the message design. Individuals from the community were recruited to model desirable health practices, which were authentic representations of personal health decisions they had made. This program identified the importance of media as a means of communication among Hispanics and, in particular, TV and radio as sources of health information. In addition, it used target group members in survey administration, formative evaluation sessions, local program promotion activities, and community social service support. Natural social networks were used to increase encouragement and reinforcement of smoking cessation and prevention. A program of individual attention and support was developed, as well.

The mass media campaign was designed in response to information gathered from focus groups that were conducted. The focus groups revealed four themes: 1) fatalism - no control over likelihood that they would contract cancer from smoking; 2) skepticism - whether smoking cessation really affects longevity; 3) prohibitive cost of medical services; and 4) a significant lack of knowledge of preventive health care.

Cessation messages covered the three stages of cessation - preparation, taking action, and maintenance. Role models from the community were recruited for TV programs. One grocery store owner, two housewives, and one local public official discussed what made them decide to stop smoking, how they stopped, and how they felt after they stopped. Nonsmoking teenagers were recruited to discuss why they

didn't smoke and how they avoided and/or overcame pressures to start smoking from their peers or from advertising. Fifteen five-to-ten minute TV programs and four thirty-minute TV programs were produced. Five-to-ten minute programs were in news format; thirty-minute programs were mini-documentaries.

The mass media program enlisted the assistance of local television stations, which helped to prepare the programs that were aired on their stations. The sponsoring stations provided production time free of charge and air time for a nominal fee. A press conference with the mayor and community leaders was held to kick off the campaign, and flyers to announce times of TV programs were distributed in local newspapers and to 5,000 homes. The flyer, entitled "Six Important Assassins are Loose in Maverick County," described the six as lifestyle habits associated with premature death as assassins. These were alcohol abuse, cigarette smoking, obesity and inadequate diet, lack of medical check-ups, lack of seat belt usage, and pollution. The flyer also provided a checklist of preventive steps readers could take.

PRENATAL CARE MESSAGE CAMPAIGN

A University of California, Los Angeles-Universidad Autónoma, Tijuana, Mexico research team used communication theories and ethnographic and survey research data to design cross-cultural health education messages concerning prenatal care among pregnant, low-income women living in Tijuana, Mexico (Alcalay, Ghee and Scrimshaw, 1993). This team developed educational materials, including a poster, calendar, health pamphlet, and two popular songs on the radio, to increase awareness of appropriate prenatal care behaviors and promote behavioral changes during pregnancy.

The researchers conducted ethnographic interviews with 40 pregnant women whom they met at health clinics or who were referred by school teachers. The information gathered was used to prepare a survey distributed to 451 pregnant women from four selected Tijuana communities. The ethnographic interviews gathered information on health care beliefs and behaviors, including women's use of formal and informal sources of prenatal care, frequency of prenatal care visits, recognition of potentially high-risk conditions, stress associated with pregnancy, and self-care behavior during pregnancy; nutrition behavior, including patterns of nutrition behavior during pregnancy, and use of vitamin supplements during pregnancy; and communication, including media preferences and preferred and actual sources of prenatal health information.

Qualitative data obtained from the ethnographic interviews were used to a) construct a survey using the language, issues, and concept categorization relevant to the target population; b) make decisions about the selection of messages, language, and

media for the communication intervention; and c) provide examples of specific situations that were then used to guide the messages developed. The survey gathered quantitative data on sociodemographic characteristics, patterns of use of prenatal care service, behaviors and perceptions during pregnancy, and use of media and sources of health information.

The ethnographic research found that among the mass media, television, radio, and pamphlets were the primary sources of health information; among interpersonal communication, relatives, neighbors, and friends were considered primary sources of health information, equal to doctors and nurses. The women placed emphasis on their mothers as a source of advice. Some women avoided prenatal care because they experienced embarrassment when at medical offices or hospitals. Some women believed it was unseemly for young wives to go out alone. There existed dissatisfaction with public health services and preference for private practitioners. The concept of trimesters was meaningless. Instead, the conceptualization for stages of pregnancy was *al principio* for first few months, *al ultimo* for last month or two, and *los mediados* for the period in between. The word *peligro* (danger) emerged as the one word to express risk during pregnancy. The reasons given for bleeding during pregnancy included *susto* (fright), *coraje* (anger), a fall, and lifting heavy things. Some women believed that eclipses cause deformities or other birth defects.

The education campaign was designed to encourage use of early prenatal care, provide information regarding appropriate weight gain during pregnancy, promote good nutrition plus the use of vitamins, and improve women's skills in identifying and managing risk factors. The poster and calendar responded to the preference for visual materials. The pamphlet was selected because the audience identified this medium as an important source of health information. Radio was selected as the mass-communication medium because it is a much cheaper medium to use and is more widely used among the target population than television.

SALUD PARA SU CORAZÓN

In April, 1995, the National Heart, Lung and Blood Institute (NHLBI) of the National Institutes of Health conducted seven focus groups to determine knowledge and attitudes about heart disease and associated risk factors, identify media usage and preferences, and assess publications usage and preferences among Spanish-speaking Latino immigrants living in the Washington, D.C. metropolitan area (Moreno et al., 1997). This information was gathered to assist in the development of key messages and strategies for the NHLBI Latino Community Cardiovascular Disease Prevention and Outreach Initiative, *Salud Para Su Corazón*, a campaign to improve heart health in the Latino community.

From the information provided by focus group participants, the researchers concluded that many actions could be taken to increase the chances that a heart disease prevention program targeting Latinos could effectively reduce the risk of cardiovascular disease among this population. These actions include: 1) reinforcing correct information that is already known, and introducing new information; 2) developing very specific, concrete, and concise messages; 3) developing easy-to-read materials in both Spanish and English; 4) using consistent medical and health terminology; 5) developing materials and programs that reflect the lifestyle of the target audience; 6) focusing on positive behavior changes; 7) demonstrating recommended health behaviors in a “hands-on” way; 8) using television, radio and newspapers to convey messages; 9) employing a modified “focus group” format as an educational technique; 10) emphasizing that heart disease prevention is within an individual’s control; and 11) involving community members in the planning and implementation of the campaign.

The Salud Para Su Corazón initiative was subsequently developed by an alliance of doctors, nurses, dieticians, mass media professionals, business leaders, and volunteers from local Latino communities in the Washington, D.C. area. The program developed a series of eight low-literacy bilingual pamphlets on risk factors related to heart disease, as well as a bilingual cookbook that contains twenty-three healthy recipes derived from traditional Hispanic dishes. The program also developed a mass media campaign which included twenty-one five-minute radio programs on heart disease prevention presented by Dr. Elmer Huerta, a prominent Hispanic physician; two twenty-four-minute television programs, one of which included the participation of journalist María Elena Salinas, that clarified questions about maintaining a healthy heart and demonstrated practical ways to buy and cook healthy foods; and bilingual television “novelas” (soap operas) and bilingual written “fotonovelas” (comic-book like novels that tell a story through photographs and captions) in which a typical Latino family deals with healthy heart issues in the context of daily life. A work book to accompany the television programs was developed to help members of the audience plan their own progress toward a healthy heart.

Recognizing the great emphasis placed on personalismo and respect in the Latino culture, the program developed a model for community discussions on heart health. A guide entitled From Heart to Heart was developed to help community groups organize discussion groups in churches, clinics, and other community venues. The one-and-one-half-hour discussion groups were conducted by health professionals, included showing the two television programs, and provided group participants with practical ways to help family members maintain healthy hearts. A bilingual manual for lay health workers that will provide training in healthy heart education is also being developed.

SU CLINICA FAMILIAR

This comprehensive community and migrant health center provides a full scope of primary care services to mostly indigent residents of the Lower Rio Grande Valley of southern Texas (Burk et al., 1995). Of the 30,000 clients served annually, 94% are Mexican American and approximately 50% are uninsured. Healthy women anticipating low-risk pregnancies and births receive comprehensive prenatal, intrapartum, post-partum, and newborn care services at Su Clinica Familiar's (SCF) state-licensed and nationally accredited Birth Center. Over the past two decades, the SCF Birth Center has developed and implemented various strategies to provide holistic, culturally appropriate care to Mexican American women.

While the majority of SCF Birth Center staff are Mexican American and bilingual, the certified nurse-midwives (CNM) that provide primary care are mostly non-Hispanic. During orientation, new staff members are required to read culture-specific information, such as the National Coalition of Hispanic and Human Services Organizations (COSMHO) manual *Delivering Preventive Health Care to Hispanics: A Manual for Providers*. New employees are asked to accompany the outreach workers on home visits to clients. Nonbilingual staff are encouraged to develop at least a basic familiarity with and use of the Spanish language.

Bilingual nursing staff, rather than client family members, serve as translators when necessary. Most of the teaching materials used at the birth center are developed by CNMs and bilingual staff members to ensure that the information is culture- and language-specific. Bilingual educational videos are available for clients who are illiterate. Teaching time is individualized to meet the needs of each client. Barriers to health care such as low socioeconomic status and lack of familiarity with use of the health care system are addressed by providing on-site Medicaid enrollment and assessment of any social, economic, family, or personal factors that might impact on the client's ability to receive care.

The clients' concept of time and the lack of adequate private or public transportation are considered when addressing client compliance with appointments. Every effort is made to see clients when they arrive, even if it is not at their appointed time. At the same time, the staff attempts to educate clients about the importance of time and the benefits of scheduled appointments, so that clients can more effectively negotiate the health care system.

Birth Center staff encourage family involvement to the extent the client desires. Family members and friends are encouraged to accompany clients to their prenatal visits and childbirth classes. Visiting hours are flexible and do not exclude children. Family input is elicited when assessing health care needs and developing care plans. Family participation and support is particularly sought when a client has been

assessed for possible risk factors. Family members are included in the process of teaching about health practices that are being recommended to reduce the risk factors. Including the family facilitates understanding by both the client and family when recommended health practices may conflict with traditional beliefs held by family members.

In general, folk beliefs and practices are encouraged as long as they enhance, rather than detract from the client's health care plan. Commonly-used herbs, such as cumin tea to stimulate labor or chamomile tea for colicky babies, are recommended by SCF staff. The SCF primary care provider educates clients regarding symptoms commonly attributed to folk illnesses, and clarifies when these symptoms actually represent a biomedical condition. When educating clients and families about negative aspects of folk beliefs and practices, the CNM takes care to present information in a respectful and nonjudgmental way.

Since 1992, SCF has conducted an outreach program to educate the community at large about health issues such as childbirth and parenting preparation, teen pregnancy, genetic and environmental risks, sexually-transmitted disease and AIDS prevention, contraception, and well-child care. Programs are presented in housing developments, churches, community centers, local industries, and colonias which are unincorporated, rural subdivisions that offer substandard sanitary and living conditions to indigent families. SCF has also been working to increase the number of culturally-diverse primary care providers by providing scholarships and loans to Rio Grande Valley Mexican American nurses to attend nurse-midwifery school.



IX. CONCLUSION

The author hopes that the information provided in this guide will help health care providers design health care interventions that are more compatible with the belief systems and practices of Hispanic patients. Gaining an understanding of Latino health beliefs can be instrumental in decreasing the disproportionate numbers of Latinos who are dying from diseases that can be prevented by modifying the behaviors that make them vulnerable to disease. The community models we have highlighted in this guide are only a few examples of how external risk factors such as cigarette smoking, diet, obesity, physical inactivity, alcohol, and unsafe sexual practices can be addressed successfully in the Latino community. Knowledge about the barriers to health promotion and disease prevention that exist for Latinos, the Latino concept of health, Latino cultural beliefs and practices, and alternative forms of viewing and treating illness can be an enormous asset to the health care professional.

Recommendations for health care practice derived from the information contained in this guide include:

- ▶ Hire and train more bilingual and bicultural health care personnel.
- ▶ Create outreach programs that utilize bilingual Hispanic health educators (promotores).
- ▶ Develop Spanish language pamphlets that are written at appropriate literacy levels, and that link biomedical and traditional health practices.
- ▶ Integrate family and social supports into health promotion and disease prevention interventions.
- ▶ Discuss treatment in the context of emotional and spiritual well-being and family considerations, in addition to the pathophysiology of disease.
- ▶ Use persons from the community who have survived disease through successful treatment as role models in health promotion.
- ▶ Pay attention to the high value that Latinos place on interpersonal relationships.
- ▶ Be aware of the present-time orientation of many Latinos.
- ▶ Appreciate that perceptions of illness among Hispanics vary and can include traditional folk beliefs as well as Western scientific biomedical explanations.



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NCLR CENTER FOR HEALTH PROMOTION

The NCLR Center for Health Promotion serves as an umbrella that integrates and coordinates major health-related activities, and offers a broad menu of services such as: **capacity-building assistance** to Hispanic community-based organizations (CBOs) with guidance in such areas as fund-raising, resource development, Board/governance, strategic planning, and program evaluation; **facilitating with** major health institutions through interactive networks; **information and resources**, developing and disseminating information guides, issue briefs/analyses, health education materials, and contacts for materials or information; researching and publishing Hispanic health statistics; and other **technical assistance and training**.

The NCLR Center for Health Promotion houses the following initiatives:

- ▶ The AIDS Center, established in 1988, carries out interrelated activities built around the concept of an interactive HIV/STD/TB network, including information sharing, development of program models, training, and capacity-building technical assistance.
- ▶ The Hispanic Health Liaison Project (HHLP), established in 1991, is designed to provide information, technical assistance, and support to Hispanic CBOs committed to increasing Hispanic involvement in preventive health efforts. HHLP focuses on breast and cervical cancer, diabetes, cardiovascular and respiratory diseases and other major health conditions affecting Hispanics, as well as increasing Hispanic access to health care.
- ▶ Maternal and Child Health Programs (MCH) focuses on combating the high rates of vaccine preventable diseases among Latinos and on training women to work as child health educators and advocates in their own communities.
- ▶ Other special projects such as a consultation on Hispanic disabilities, an analysis of Hispanic health insurance coverage, and seminars and workshops on substance abuse lay health educators and managed care.

SERVICES PROVIDED:

The NCLR Center for Health Promotion provides a wide variety of specialized training and technical assistance to Hispanic community-based organizations. Examples of available assistance include:

TRAINING SEMINARS:

- ▶ Coalition building
- ▶ Governance (Board of Directors)
- ▶ Policy analysis
- ▶ Childhood Immunization
- ▶ Resource development (fund-raising, public- and private-sector proposal writing)
- ▶ Community needs assessment
- ▶ Program evaluation methods
- ▶ Strategic planning
- ▶ Diabetes Cardiovascular disease and breast and cervical cancer prevention and education.

TECHNICAL ASSISTANCE:

- ▶ Computers/information management
- ▶ Fiscal management
- ▶ Materials evaluation
- ▶ Personnel development
- ▶ Program models
- ▶ Community needs assessments
- ▶ Liaison with health departments and mainstream organizations
- ▶ Program evaluation
- ▶ Program planning/development

In addition, the Center prepares informational materials such as information briefs and “how to” guides to educate NCLR affiliates and other Hispanic community-based organizations about Hispanic health status and the potential for and importance of becoming involved in health education, prevention, advocacy/referral, and coalition activities.

