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Rural Hispanic Women in Missouri: A Needs Assessment

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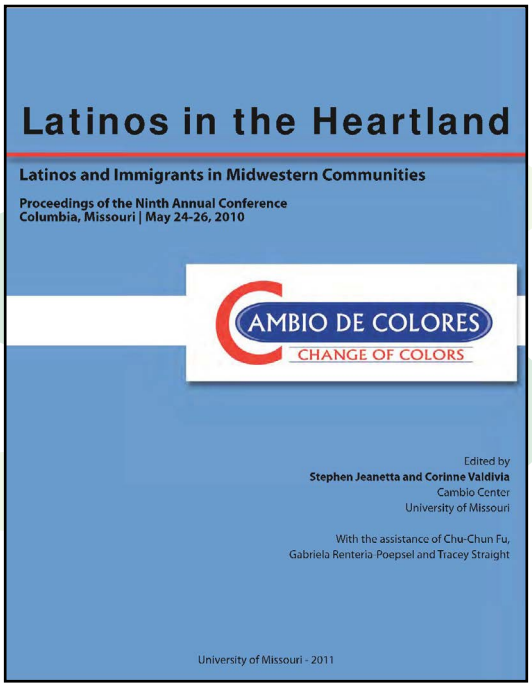

Abstract

An interdisciplinary team of public health researchers in women's health from the University of Missouri Sinclair School of Nursing, School of Social Work and the University of Missouri-Kansas City School of Nursing received funding from the Missouri Foundation for Health to perform an assessment of health and health services among rural-residing women 50 years and older in specific counties of rural Missouri. Focus groups occurred with groups of Spanish-speaking Latinas in two rural counties. A total of 25 women between the ages of 50-65 (12 in one group and 13 in the other) were queried about the health status of women in their community. They were also asked about facilitators and barriers to health care services for women in their age group. Common health disorders that were reported were 24 obesity, diabetes mellitus, depression, poor nutrition, high blood pressure, chronic pain, stress, and difficulty sleeping. Several women noted that they did 'not like' going to see a physician and others that they were afraid to go because of what the doctor might find and what the findings might mean related to financial concerns ('because of so many bills', who would care for their children, and missing work). One participant noted that she is afraid to go to the nurse at her place of work when she has symptoms because the nurse will send her home and she will miss a day of pay.

Many participants expressed the idea that women's health services should be available free of charge and geographically accessible, noting that 'in Mexico they do it for free.' Although free mammograms had been available with the 'truck' in the past, they were no longer available. Further, transportation to places in which services are available is problematic, and many physicians and health services require multiple visits. Acquiring dental services is acutely problematic since money is typically expected prior to treatment and treatments, including cleaning, may require more than one visit. In general, lack of confidence in health care providers and prescribed treatments were frequently expressed opinions. Older Hispanic women in rural communities of our state share many of the challenges to health faced by urban women. However, distance, a greater need for transportation and even more limited resources suggest that targeted programs are in order if we are to improve their health status. These findings should inform policy decisions and the development of appropriate interventions for this population.

Keywords: health care access, Latino health care, women's health services

We feel that our strategies have worked well for our program, given the difficulties associated with recruiting Latino immigrant couples during these politically sensitive times. The time invested in building rapport with the couples made a real contribution and helped us change an unfamiliar relationship into one that was culturally recognizable.

As a final note, special thanks to Roxana Meneses and the program "Comenzando Bien" for the space that she opened for this program to have a presence in the Latino community. Roxana and Luis Huaman are dedicated Community Trainers that take heart in the job of delivering this curriculum to our Latino families.

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▶ Rural Hispanic Women in Missouri: A Needs Assessment

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Rural residence and health are inextricably intertwined. Compared with urban dwellers, rural individuals are at higher risk for health problems (Achincloss & Hadden, 2002). Nationally, in rural areas all-cause, age-adjusted mortality was higher and increased by a factor of 10 between 2000 and 2004 (Cosby et al., 2008). A number of variables contributed to this excess morbidity and mortality: 1) Differences in specific health behaviors have been documented between rural and urban dwellers (Parks et al., 2003; Wilcox); 2) The disproportionate distribution of health care providers, despite considerable efforts by federal and state governments since 1979 and shortages of other health care providers — nurses, nurse practitioners, dentists, mental health professionals, and physician's assistants (Hart et al., 2002; Yarbroff et al., 2005); 3) The mediating factors of poverty and ethnicity (Achincloss & Hadden, 2002; Liu,2007) reported that residence in areas designated as Health Professional Shortage Areas (HPSA) is associated with poor physical health, lesser general health status and reduced access to primary and outpatient health care services. This may be particularly problematic for female rural residents in that women's unequal social and economic status is well-documented to be associated with compromised

health and well-being (Kawachi, Kennedy, Gupta, & Prothrow-Stith, 1999). Service jobs, seasonal employment and self-employment, the mainstays of many rural areas, are low paying and without benefits (Findeis & Jensen, 1998). Those women from ethnic minorities are at particular high-risk. In recent years, the pattern of immigration for Latinos has shifted from mainly urban to more rural communities where more jobs for unskilled labor may be available but where communities have limited experience with immigrants, particularly those with language differences. Public health initiatives to extend public health and primary health care services to Hispanic adults and children have met with variable success leaving many people without access to services. Harari, Davis, and Heisler (2008) reported that Latino immigrants often are unaware of available services and further that language barriers, lack of insurance, and isolation exacerbated barriers to access. A reason Hispanic immigrants are considered a major concern as well is not because they are only found to have poor health outcomes, but also because their health status worsens as their duration of stay increases in the United States and also because 33% of them have been found to be without health insurance coverage (CDC, 2008).

Methods

The purpose of this assessment, funded by the Missouri Foundation for Health, was to 1) assess perceived access to health services and 2) document the perceived health status of older rural Missouri women. We conducted 11 focus groups with for a total of approximately 120 women. This paper gives a report of two focus groups with 25 Hispanic women related to perceived health status and access to health care services in rural Missouri.

Results

Using a semi-structured interview guide, women were queried about personal issues as related to health issues and norms in their communities. Specific health issues noted often by women included hypertension, diabetes, stress including anxiety and sleeplessness, chronic pain, and issues related to menopause. Analysis of focus group transcripts found four major themes that women discussed about health issues and access for older women in rural Missouri:

- The interrelated challenges of minimal personal and infrastructure resources
- Denial
- A badly stretched primary care system
- Need for improved health literacy

These themes were reinforced in the key informant interviews. Each of these will be discussed in turn with representative quotes from the focus groups and key informant interviews. In the interest of brevity, the majority of this proceedings paper will be devoted to the first and third themes.

Personal resource limitations were discussed multiple times in each focus group and key informant interview. Low incomes and lack of health insurance were mentioned frequently, often in tandem with transportation problems experienced when trying to access health services.

Time, expenses, and transportation were viewed as interacting and overlapping factors contributing to lack of health services access.

> *One must look for someone to take you, interpret what you have, and pay the person. If you do not have someone to take you, you have to find someone to take you and pay. Because there is not even a bus here. Anyway there is not even a doctor. And then you lose a day of work and you need to look for the person to take you. Lose one day you get a point and then they fire you because of the points. You even lost a job for going to the doctor. Many do not go to the doctor for not losing points at work.*

Access to prescription medications was an important issue both in terms of expense and of availability. It was noted that after paying for the consultation, there was no money left to buy the prescription. The cost of medications was discussed by a number of participants, and pharmacies in rural areas are open limited hours, closing early on Saturdays and seldom open on Sundays. Transportation to larger communities to fill prescriptions was limited. Further, over the counter preparations that were available in Mexico were not similarly available in the States.

Women felt that medications such as antibiotics and oral contraceptives were sold only by prescription therefore unavailable to them. A result of this perception women noted "it is difficult and you feel compelled to self-medicate." In fact, one woman related an incident where she obtained oral contraceptives without a prescription and without medical supervision and as a result became ill.

Lack of personal resources leads women to neglect both acute and chronic conditions. As one woman reported:

> *Then again, often our fear is that some weekend or at midnight we can be serious or something and we are afraid to go to the hospital because we do not have money to pay; no facilities that is our fear. We are afraid to die at home, but more afraid to go to the hospital." and "like me. I have diabetes and I have no medicine, no money to pay for the consultation and then I wait up to 3 or 4 months go to, really, one has to pay for a visit and the medicine too. So I try to endure and then when I got the doctor scolds me. How will I pay? I prefer to put up with it and when I go, I have worse diabetes, more intense.*

Denial. Whether from fear, lack of knowledge or sense of fate, most of the focus group discussions mentioned that there were women in their communities who just did not want to have any screening tests done or to see a health care provider about any issue. For example, one participant noted that, "there are many people who do not do checkups because they don't want to know if they have something wrong. But with time anything can be healed. Everything can be healed with time." And another "I'm afraid because when I go to a doctor he will say I have bad things, serious, and I will have real problems. Some women expressed the idea that thinking about getting sick will make you sick so it is better not to consider the possibility of illness at all. "Thinking like that, thinking 'what if I get sick of it?' And then it comes and one gets sick of what one is thinking."

A Badly Stretched Primary Health Care System. Primary care, the basis of the health care system and the place where women can expect to receive appropriate health screening and education, would seem to be heavily overloaded in many of the counties in which we conducted interviews. For some women, a clear lack of trust in the health care systems also surfaced. For example "Well, when you think of health for example here in this place, it is scary because you don't know if they are going to help you or if they are not going to help you." Another individual noted "They treat you badly for being Hispanic."

Participants noted there is a need for someone who speaks both English and Spanish. "Sometimes there is no one to translate for you. One does not go because one does not know how to say anything. Better not to go."

A number of women noted that preventive health services are available free of charge in Mexico. "The free mammograms and the pap smear are free. For the person who has early symptoms of something, I will say bad….They go to your house, you leave a telephone, address they go to your house and they take you to be checked. And its' free. The treatment is free. If it was done here it would make it better."

The lack of available preventive services was clearly noted. "They asked me several times to do mammograms. I have not gone, its' been a year of not going because they tell me from her, from there and

I don't drive you know. Or sometimes I don't have a way and up to now I haven't gone. It's always out of the way." And

"When I went to the doctor he told me: Have you not done a mammogram. No, I said. The truck is no longer coming. A truck used to come. It came here to the church but they took the service away."

Need for Improved Health Literacy. Women expressed interest in learning more about health and preventing health problems. Several women expressed interest in taking a nutrition class, learning how to take blood pressure, and learning how to control personal stress. Post-menopausal women felt that education relating the menopause would have been very helpful to them.

Discussion and Conclusion

All comments were not negative. Instances were related of health facilities that provided interpreters and providers that were bilingual. One woman reported that she had a wonderful physician who even telephoned her at home to check on her. Where these kinds of services and courtesies were provided, women were most appreciative of the special attempts made to assist them. Women also had many ideas about what types of services were needed including some type of affordable transportation to health services and clinics that were open on weekends and evenings that would not force them to miss work.

The next steps in this project is to 1) define their needs by securing and by exploring solutions to these health issues; 2) examine options for meeting those needs with the women and community leaders; and 3) identify how interventions can best be implemented and supported through community discussions with the target population, key stakeholders, and local health care providers. We hope to report back to the communities by meeting with community service councils, health departments, and other helping agencies in the communities and regions. Our central idea is to help people find ways to build community strength. We would like to work with agencies and individuals to brainstorm the possibility of developing ideas for priority actions to help the community and to point them in the direction of potential funding sources.

Two particular ideas that have emerged from this initial analysis are the potential for building a Health Promotoras program that would recruit older women from the community to train them as part-time case finders and health educators within their own communities. The second idea relating to the Health Promotoras program is to help community women build social support for stress reduction and mental health promotion.

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▶ Casa de Salud: A Community and University Partnership

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Abstract

DuBard and Gizlice (2008) reported that Spanish language preference is a marker for poorer access to care and preventive health services. Carr (2006) cited fear of detection and cultural/language barriers to care as major factors influencing access to care by the immigrant population. When La Clinica in St. Louis closed its doors in the spring of 2009, there was a void left for the immigrant population seeking health care. Just as the Guadalupe Centers in Kansas City are community-based social service agencies, bridging the gap between the newly arrived Hispanic immigrants and the health care system, so too Casa de Salud seeks to bridge that gap in St. Louis by providing community-based health and wellness services. Casa de Salud, on the Saint Louis University campus, opened its doors on January 18, 2010. Championed by Father Biondi, President of Saint Louis University, and Bob Fox, Chair of the Casa de Salud Board of Directors, Casa de Salud is committed to welcoming the immigrant community in Saint Louis and integrating them into the existing and larger preventive health and primary care services provided by primary care homes of local community health centers. The aim of this presentation is to give an overview of the care processes involved in accomplishing this purpose:

- Describe the St. Louis context for the development of pre-access to primary care
- Provide abstractions of Casa's referral experiences
- Reflect upon the experiences
- Articulate and illustrate the current Casa referral template

Methods include four steps: context, experience, reflection, and action. The context in which Casa de Salud exists sets the stage for the article. Experiences accrued during the first three months since Casa's opening illustrate the learning that has occurred as well as the services provided. Reflection upon the experiences provides an opportunity to extract principles that guide the referral process. The lessons learned from our experiences resulted in the development of an action plan.

Introduction

The Hispanic immigrant community is heterogeneous, varying by nationality, culture, socioeconomic status, and occupation, with professionals, technicians, and those in sales or administration comprising about 75% of the total Hispanic workforce (http://www.fiscalpolicy.org/20100123_ElDiario.pdf). At the same time, the number of uninsured is three times that of the non-Hispanic white population (HRSA Office of Minority Health, http://www.raceandhealth.omhrc.gov/templates/browse.aspx?lvl=2&lvlID=5). In our society, lack of health insurance inhibits access to care.