



LATINA INFANT MORTALITY AWARENESS PROJECT

**Latina Health in North Carolina:
Knowledge, Attitudes and Practices**

Focus Group Research Report

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Report written by:

Monica C. Sánchez, M.A.
Focus Group Coordinator

Based on data gathered by:

Marina Ribó
Focus Group Facilitator, and
Monica Sánchez, M.A.

Table of Contents

- Table of Contents 1**
- Acknowledgements 2**
- Executive Summary 3**
- Methods..... 5**
- Demographic Characteristics of Participants 7**
- Results 10**
 - 1. Health and Wellness 10
 - 2. Sources of Health Information..... 11
 - 3. Family, Friends and Relationships: Implications for Health 12
 - 4. Health-Promoting Behaviors and Practices 14
 - 5. Barriers to Adopting Health-Promoting Behaviors 16
 - 6. Perceptions and Use of U.S. Healthcare Services..... 17
 - 7. Preventive Health Services: Barriers to Access and Use..... 19
 - 8. Barriers to Healthcare Service Access and Use..... 22
 - 9. Latinas and Alternative Healthcare Services 23
 - 10. Pregnancy and Reproductive Health..... 24
 - 11. Mental Health: Stress, Depression and Latina Health 25
 - 12. Self-Report Health Status 27
 - 13. Conclusions and Recommendations 29
 - 14. Directions for Future Research 31
- Appendices..... 33**
 - Appendix A Project Timeline 33
 - Appendix B Focus Group Guide – Spanish..... 34
 - Appendix C Focus Group Guide – English..... 38
 - Appendix D Consent Form – Spanish 42
 - Appendix E Consent Form – English..... 44
 - Appendix F Survey and Demographic Information – Spanish..... 48
 - Appendix G Survey and Demographic Information – English 46

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Executive Summary

The Latina Infant Mortality Awareness (LIMA) project, a qualitative research project on which this report was based, was undertaken in 2007 to improve our understanding of Latina health knowledge, attitudes and practices in North Carolina. Between 1990 and 2000, the number of Latinos living in North Carolina more than tripled, increasing from 105,963 to 378,942 (U.S. Census, 2000). Such a swift demographic transition is often accompanied by changes in health status and use of health services, and merits close attention on the part of social service and public health professionals. Drawing upon the paradigm in health research that women's health is intimately linked to the health and well-being of their children, this project sought to better understand Latina health behaviors (both preventive and healthcare-seeking), issues related to healthcare access, and barriers to preventive and other healthcare service usage.

Methods

Seven focus groups (including one practice session), which we called “platicas” in Spanish, were conducted in seven North Carolina counties characterized by large Latino populations: Wake, Duplin, Forsyth, Johnston, Chatham, Randolph and Harnett. Criteria for participation were: self-identifying as Latina, ability to speak Spanish, and being a woman between the ages of 18 and 49. Sixty-two women participated in the focus groups. Convenience samples were formed with existing groups of Latinas and special consideration was given to sampling both women who were already accessing social and public health services, as well as those who were not. All focus groups were conducted in Spanish by a native Spanish speaker. In addition to the focus groups, eight key informant interviews were conducted with community leaders, providers and public health staff.

Topics included in all focus group discussions included:

- Defining “health” and “healthy”
- Preventive health behaviors
- Sources of health information
- Access and barriers to healthcare services
- Preventive healthcare
- Social support networks
- Pregnancy and reproductive health
- Mental health, stress and depression
- Health disparities

Results

Participants expressed a holistic view of health that included physical, mental, emotional and spiritual well-being. Health was understood not simply as the absence of disease or pain, but was also defined by positive attributes. Health was perceived as central to participants' lives and as something which merited (but did not always receive) attention and care. Women perceived of themselves (and were perceived by others) as the foundation for their family's health, yet women

reported that their own healthcare needs were secondary to the physical, emotional and financial needs of their families.

Barriers to using preventive health services and other health services mentioned by participants were: financial concerns or inability to pay, lack of insurance, language barriers, lack of trust in the ability or training of the provider, fear, and “racist” attitudes of staff and providers. Such barriers prevented or delayed service-seeking for adults, but not, according to our participants, for their children. Children’s health and women’s health during pregnancy were perceived as very important and women reported complying with all standard care recommendations for children and pregnant women. Mental health issues, including stress and depression, were perceived to be significant health problems in the communities studied (for adults, adolescents and children), and participants expressed concern at the lack of mental health services available in their communities.

The focus group discussions revealed that social support networks played an important role in disseminating health information and advice and that personal communication was the preferred method of receiving information about health-related issues. Other identified sources of health information included Spanish radio, television, newspapers and printed health literature, used to varying extents – particularly when they were in Spanish, of an acceptable reading level (basic) and were visually appealing.

Conclusions and Recommendations

Latinas in North Carolina face many challenges to caring for themselves, their families and their children. This qualitative study reaffirms that knowledge is not always sufficient to change behavior, and that issues associated with immigration and poverty, as much as “cultural difference,” accounted for many of the problems faced by Latinas in our study related to access to healthcare services.

Practical recommendations based upon this research include:

- 1) Improve cultural competency of healthcare providers through training, monitoring and evaluation
- 2) Increase linguistic competency
- 3) Improve patient advocacy and education for Latinas
- 4) Support health education and outreach efforts in the Latino community and enlist key community leaders in this effort
- 5) Change the way Latinas think about and prioritize their own health through target social marketing campaigns
- 6) Address gaps in service usage, availability and access for Latinas including mental and behavioral healthcare services

Future Research

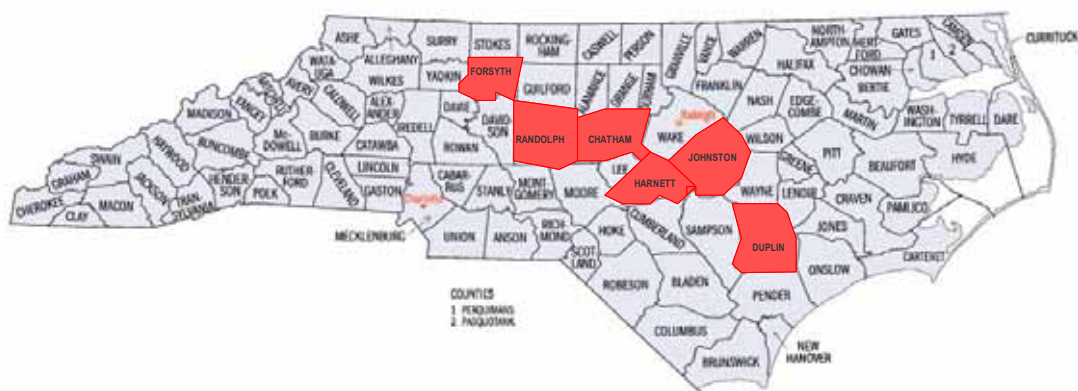
This report suggests the need for additional qualitative research that may yield valuable information about Latinos’ health-related practices and needs. Three areas identified include:

- 1) Children’s health services – identifying what is working well for children
- 2) Mental health – the scope of the problem and potential interventions for Latinos
- 3) Acculturation – the scope and the effect of acculturation on Latinos’ health

Methods

Our target participants included Latinas (of any county of origin) of reproductive age (regardless of parity), who were able to speak Spanish. In an effort to capture women who were already using key health resources (women “integrated into the system”) as well as those who may not be, we decided to recruit participants from both “in-system” agencies and organizations (public health departments, social service agencies, community health groups) and “out-of-system” organizations such as churches, Latino community centers and private businesses. Effort was made to sample Latinas from sites with diverse economic bases, and effort was made to include participants living in rural, semi-rural and urban locations. Using 2000 U.S. Census data, six of the North Carolina counties with the highest Latino populations were selected for inclusion in the study. Within those counties, cities and towns were selected based on the availability and interest of already existing groups of Latinas which fit our predetermined sample characteristics. These “convenience sample” groups were contacted and organized via site coordinators (ministers, nurse practitioners and hospital staff) and arrangements were made to conduct the focus groups, which we called “platicas” in Spanish. In addition to the focus groups, key informant interviews were conducted with providers and community leaders with experience working with Latinas in North Carolina. A total of eight telephone interviews were conducted. These interviews provided valuable insights and helped shape the course of the study. A total of six focus groups (and one test) were conducted. See Figure 1 for a map of the geographic distribution of the focus groups.

FIGURE 1



Asheboro – Randolph County
 Kenansville – Duplin County
 Winston-Salem – Forsyth County
 Raleigh – Wake County (test)

Dunn – Harnett County
 Smithfield – Johnston County
 Siler City – Chatham County

The focus group coordinator and focus group facilitator attended each of the sessions. All sessions were tape recorded, as there were no objections. All participants signed an informed consent form which was read to them (Appendix D). And all participants filled out a self-report survey (Appendix F). All project material including tapes, informed consent forms and completed self-report surveys are stored at the North Carolina Healthy Start Foundation.

All focus groups were conducted in Spanish by a native Spanish speaker (of Mexican descent). During the sessions, the facilitator asked questions using the interview guide (Appendix B). The facilitator was given the freedom to explore in depth certain areas of interest to particular groups, so there is some variation of topics covered among the groups. Focus groups lasted an average of two hours.

Topics covered in all groups were:

- Defining “health” and “healthy”
- Preventive health behaviors
- Sources of health information
- Access and barriers to healthcare services
- Preventive healthcare
- Social support networks
- Pregnancy and reproductive health
- Mental health, stress and depression
- Health disparities

Focus group participants received a \$25 gift card for their participation. Gift cards were also provided for the site coordinators and childcare providers, as needed. A meal was provided during each session and each participant received a North Carolina Healthy Start Foundation gift bag.

Demographic Characteristics of Participants

Demographic information was gathered from our focus group participants using a self-report survey. Fifty-two women, out of a total of 62, completed and returned the demographic self-report survey. Because the report was completed (individually or as a group, depending on the expressed preference of the participants) at the beginning of each focus group session, late-comers frequently did not complete the survey. We also presume some women did not complete the survey because of very limited Spanish reading or writing ability. The sampling for this research project was non-random, and this information is intended to be descriptive of our participants rather than representative of Latinas in North Carolina.

Place of Birth

A total of 62 Latinas participated in our focus groups. The majority was from Mexico and had been in the U.S. for 8.5 years or less. We should note that the overrepresentation of Mexican-born women in our study is reflective of a general demographic trend in North Carolina, as is the pattern of relatively recent immigration reflected in this self-report. Seven participants cited countries in Central America (Honduras 6; Guatemala 1) as their country of birth. One participant was born in South America (Colombia). Six women were born in the United States.

Table 1 Place of Birth

<i>Where were you born?</i>	N	%
United States	6	9.7
Mexico	38	61.3
Honduras	6	9.7
Guatemala	1	1.6
Colombia	1	1.6
No answer	10	16.1

Children

Women between the ages of 18 and 45 were recruited for the study. The ages of our participants ranged from 18-55, with a mean age of 31. The vast majority of our participants reported having children, and 4 of the 8 who reported that they did not have children were pregnant at the time of the interviews.

Table 2 Children

<i>Do you have children?</i>	N	%
No	8	12.9
Yes	43	69.4
No answer	11	17.7

Language Preference and Ability

Participants were asked to report on language preference and English proficiency. The vast majority of our participants spoke Spanish at home. Several reported speaking both Spanish and English (9) and only two reported speaking primarily English at home. More than half (51.6%) of women rated their ability to speak English as very poor (“none” to “a little”) and only 27% of women reported being able to read more than “a little” English. This is in great contrast to the majority of women (61.3%) reporting that they can read in Spanish “well” or “very well.”

Table 3 Language Used at Home

<i>What language do you speak at home?</i>	N	%
Spanish	41	66.1
English	2	3.2
Spanish and English	9	14.5
No answer	10	16.1

Table 4 Ability to Speak English

<i>Which of the following describes your ability to speak ... read in English?</i>	Speak English		Read English	
	N	%	N	%
None	14	22.6	15	24.2
A little	18	29.0	20	32.3
O.K.	2	3.2	1	1.6
Good	6	9.7	6	9.7
Very good	7	11.3	6	9.7
No answer	15	24.2	14	22.6

Table 5 Ability to Read in Spanish

<i>Which of the following describes your ability to read in Spanish?</i>	N	%
None	0	0.0
A little	4	6.5
O.K.	6	9.7
Good	15	24.2
Very good	23	37.1
No answer	14	22.6

Family, Income and Education

More than half of women were married or had a partner (62.9%). We did not ask them to specify whether or not they lived with their husband or partner. Fifty-seven percent (57%) of respondents did not have a high school degree or GED.

Table 6 Relationship Status

<i>Relationship status</i>	N	%
Single	6	9.7
Have partner	7	11.3
Married	32	51.6
Separated	2	3.2
Divorced	2	3.2
Widowed	0	0.0
No answer	13	21.0

Table 7 Level of Education

<i>Educational attainment</i>	N	%
No formal schooling	0	0.0
Primary	14	22.6
Middle School	14	22.6
High School	7	11.3
Diploma or GED	7	11.3
University	5	8.1
Technical school	1	1.6
Licenciatura (license)	1	1.6
No answer	13	21.0

Table 8 Annual Household Income

<i>My annual household income is:</i>	N	%
Less than \$15,000	30	48.4
\$15,000 to \$29,999	5	8.1
\$30,000 to \$45,000	3	4.8
No answer	24	38.7

Results

1. Health and Wellness

Participants expressed a holistic view of health that included physical, mental, emotional and spiritual well-being. Health was understood not simply as the absence of disease or pain but also as defined by positive attributes such as “feeling well,” “being happy” and “having a positive outlook.” The ability to work and “to do the things you need to do” was central to participants’ definitions of health and well-being. “Being strong” was equated with being healthy for many women in our groups. Participants recognized their ability to control, or at least influence, their health (and that of their families) through diet, exercise (especially walking), regular health check-ups and stress management. Women also acknowledged their susceptibility to various health problems such as diabetes, high blood pressure and heart disease. Health was perceived as central to participants’ lives and as something which merited (but did not always receive) attention and care.

Many women strongly identified with their roles as wives and mothers and suggested that as wives and mothers, they must “put everyone else’s needs” before their own. The idea of sacrifice emerged central to women’s ideas of the ideal Latina wife and mother. This ideal also significantly affected women’s health behaviors. Women often reported that their own health needs such as routine exams or other preventive care services were secondary to any needs of their family members, particularly their children’s needs. Women consistently reported that their needs “came last” even while many also reported that an important aspect of being healthy is “balancing the different parts of your life.”

Aspects of good health mentioned by participants:

- Ability to work
- Being physically strong
- Ability to do the things you want to do
- Not being sick
- Pain free
- Worry free
- Having energy
- Happiness
- Maintaining a healthy weight: not too fat, not too skinny
- Maintaining good hygiene (washing hands, brushing teeth, bathing everyday)
- Being well groomed
- Looking good
- Clear complexion
- Shiny hair
- Getting enough sleep
- Feeling good about yourself
- Going for regular check-ups
- Healthy relationship with God
- Eating balanced diet
- Walking and exercise
- Not depressed or too stressed
- Avoiding alcohol, cigarettes and drugs
- Having friends you can talk to
- Not having diabetes or high blood pressure
- Getting out of the house
- A healthy relationship with your husband or partner
- Balancing the different parts of your life
- Having a positive outlook on life

Relevant Quotes

“If you’re healthy, you can work, and we all need to do that.”

“Health is absolutely the most important thing, if you don’t have your health, you don’t have anything.”

“Being healthy is about more than just not being sick, it’s about feeling good.”

“You have to eat right, fresh fruits and vegetables, not just sweets or bread or too much meat and fat.”

“Diabetes is a big problem for Latinos and we need to take better care of ourselves.”

“When you get out of bed in the morning you feel like you’re ready to start the day, full of energy and happy, not worried.”

2. Sources of Health Information

Participants accessed health information from a number of sources. Participants expressed a strong preference for personal communication or TV and radio over written sources of health information. Family members, friends, neighbors and colleagues were mentioned as valuable sources of health information. Secondary to receiving health information from a trusted person, participants mentioned TV and radio as very valued and accessible sources of information. Written forms of health communication were mentioned during the focus group discussions, but participants expressed concern over the quality and accessibility of these sources. Such a finding is not unexpected given that according to their self-report, just over half of the participants reported their ability to read in Spanish was “good” or “very good” and most reported they could read English “very little” or “not at all.”

The participants’ expressed preference for the personal communication of health information, however, should not be interpreted to mean that written sources are not valued at all. Participants commented that much of the health information they encountered, such as brochures or flyers in waiting rooms, was print material, and was primarily written in English for native English speakers. Women expressed frustration at the lack of health materials in Spanish and reported that they would use these materials if they were in Spanish, easy to read, and attractive. Bilingual participants further suggested that the written materials available in Spanish often did not contain the same messages or information as the English materials, and that these were generally perceived as being “of a lower quality” than their English counterparts.

Access to and use of the Internet was variable, with younger, more acculturated and affluent Latinas using the Internet with great frequency and others not at all.

Sources of health information mentioned included:

- Family members
- Friends
- Colleagues
- Ministers/pastors
- Health professionals (doctors/ nurses)
- Television
- Pharmacists
- Radio shows
- Informational brochures (in Spanish) at health clinics, hospitals, and social service agencies
- Internet
- Magazines (from Mexico)
- Spanish-language newspapers
- People who work in Latino stores that sell imported remedies and medicines

Participants expressed confusion when it came to evaluating the relative quality of health information from different sources. Latinas suggested that “it is difficult to determine what is true and who or what to trust.” This skepticism extended to all potential sources of health information, including health professionals.

Relevant Quotes:

“It is difficult to determine what is true and who or what to trust.”

“I always ask my neighbor first. She was a nurse.”

“Latinos do not read much – we would prefer to watch TV or listen to the radio.”

“Sometimes the brochures say one thing in English and then another in Spanish.”

“Sometimes the nurse will say one thing and then the doctor will say something completely different.”

3. Family, Friends and Relationships: Implications for Health

Health knowledge, attitudes and practices are part a larger social and cultural context which extends beyond the individual. As part of our investigation we questioned Latinas about the way health decisions were made in their families, and the role of family members, friends and other community members in shaping health behaviors and decisions. Several key themes emerged during this discussion and are discussed in this section.

Women as Gatekeepers for Family Health

Participants consistently acknowledged that women, rather than men, were responsible for making important health decisions for their families. Younger women frequently said that their mother or mother-in-law helped make important health decisions for their families, especially when people lived together in an extended-family, multi-generational household (which was often the case). Women reported that because they spend more time with their children, they were better able to notice if there was a problem, keep track of routine visits, and “stay on top” of the family’s health needs. Women were also perceived (and perceived themselves) as “knowing more” about health and as “better able to deal” with problems should they arise. While health decisions were largely viewed as being within women’s purview, many Latinas

also recognized the role of their husbands or partners in, at the very least, supporting their decisions. Latinas reported that their husbands and partners “respected” their health decisions, even when significant money was spent on healthcare services, over-the-counter medications or prescriptions.

Relevant Quotes

“It’s not like I’m going to call him at work if I need to take [my child] to the doctor immediately.”

“He’ll respect my decision.”

“It is always the woman that deals with these things. We’re better at it anyway.”

Social Support Networks

The role that support networks play in the lives and health of Latinas cannot be over emphasized. Latinas recognized the role of close family members, friends, colleagues, community members and church members in helping to make health decisions, finding sources of health information, identifying potential health problems, recommending health services, and in supporting them emotionally, and often financially, particularly when it came to health issues. While most frequently perceived as having positive health impacts, several participants were quick to point out that the advice or recommendations of such support people is often “followed blindly” and may not always be appropriate or safe. Participants were idiosyncratic in their expressed ability to “filter” health information provided by members of their support networks. Some participants suggested that they “always do what my mother [neighbor, aunt who was a nurse, minister ...]” recommends while others approached most recommendations with caution and reported double-checking advice with health professionals, the Internet, or other sources. It should be noted that the health advice received by physicians and other health providers was not immune from such “filters.” For some, receiving conflicting health information from friends, family, or healthcare providers was a great source of stress and frustration.

Immigration poses a threat to these social support networks. For example, while several women said they “always trust what [their] mother says,” many acknowledged that their mothers now lived thousands of miles away. Particularly for recent immigrants, the social support networks they once relied on may be entirely absent in the U.S., and new means of social support have yet to be organized.

Relevant Quotes

“I have no one to help me [here in the U.S.]”

“I used to ask my aunt about everything ... but she’s in El Salvador.”

“It’s hard when you’re in a new place. Very, very hard.”

Domestic Violence

Participants recognized social isolation, stress and financial hardship, all of which are potential consequences of immigration, as playing a large role in domestic violence. They also recognized domestic violence as a significant barrier to health and healthcare-service seeking. One participant explained how domestic violence (and lack of strong social support networks) can affect health behavior in the following way:

“Here’s what happens. A woman comes here [to the U.S.] with only her husband – no family, no friends. Probably no money. She doesn’t speak the language. She doesn’t know how to drive. She has a different culture. Her husband is her everything. She cannot go out without him. She can’t go to the grocery or to the doctor. She is stuck in the house. If he is abusive, there is no help.”

Participants acknowledged stigma associated with being a victim of domestic violence as a barrier to seeking help. It should be noted that domestic violence was only discussed at two (of the six) focus groups, and most often indirectly, as a potential barrier to health. There was not a question directly addressing domestic violence on our guide.

4. Health Promoting Behaviors and Practices

Many examples of behaviors and activities that promote and maintain good health were elicited from participants. Diet, moderate exercise, stress management and routine doctor visits were the most commonly mentioned items. Participants were knowledgeable about the types of behaviors and activities that can prevent illness and promote good health. Again, diet (eating a healthy, well-balanced diet with plenty of fresh fruits and vegetables), and to a lesser extent exercise, emerged as a central themes in health promotion. Participants recognized the role of routine health visits in maintaining and promoting health. A third category elicited from this discussion which is particularly relevant to this population included “occupational health” issues such as avoiding coming into contact with harmful substances such as pesticides and fertilizers, frequent hand washing, and avoiding injury while on the job. Many of our participants reported that they, or their partners, worked in meat processing plants, nurseries, in construction or on farms.

Behaviors and activities that promote good health included:

- Eating a healthy diet
- Avoiding fried foods
- Eating less
- Praying
- Not eating too many sweets
- Avoiding fast food
- Eating fresh fruits and vegetables
- Maintaining or reaching a healthy weight
- Walking
- Exercising
- Controlling your stress
- Avoiding pregnancy when you don't want another baby
- Breastfeeding
- Taking a multivitamin every day
- Having a Pap test every year
- Having a breast exam every year
- Going to the dentist
- Staying active
- Getting outside every day
- Avoiding going out in the cold
- Avoiding drugs, alcohol or cigarettes
- Having a healthy relationship with your partner
- Maintaining good hygiene (wash hands, brush teeth, bathe everyday)
- Avoiding dangerous substances at work (pesticides and fertilizers)
- Taking precautions with dangerous substances at work (pesticides and fertilizers)
- Avoiding injuries at work
- Following your doctor's orders
- Getting enough sleep
- Learning about healthy habits

Relevant Quotes

"Most women know what we should be doing [to keep ourselves healthy]."

"Latinas take pride at being very healthy and strong."

"It's the women that take care of everyone else. We have to keep ourselves healthy."

"It's 'mejor prevenir que lamentar.' [It's better to prevent than to lament]"

"We don't always know what's happening in our bodies, so we have to go to the doctor for checks like for cancer."

"If you catch things early, you might have a better chance of surviving."

"Most things we can do for ourselves, like eat a good diet and exercise, keep ourselves clean. You have to take care of yourself."

5. Barriers to Adopting Health Promoting Behaviors

While recognizing the importance of many of the behaviors listed above in promoting good health, participants were quick to point out that Latinas, many of themselves included, did not always “practice what they preach.” Participants consistently identified diet and exercise and lack of use of preventive healthcare services as major barriers to taking care of themselves “in the way we know we should.”

Diet and Exercise

Participants recognized diet, defined as a “well-balanced” diet with plenty of fresh fruits and vegetables and moderate amounts of fat, as central to maintaining good health. Despite this knowledge, participants mentioned “not eating well” as a major problem within the Latino community contributing to weight problems, obesity, diabetes, high blood pressure, high cholesterol and heart disease.

Barriers to healthy eating included:

- High price of fresh fruits and vegetables
- Relatively low cost of canned foods
- Poor food choices available in the grocery store
- Low cost of fast food which is readily available
- Not having enough time to prepare meals and eat well
- Pervasive junk food advertising (especially aimed at children)
- Switching from “traditional” foods to “American” foods (perceived to be poorer in quality, nutrition, “less filling,” high in fat and in “unnatural” ingredients)
- Laziness

Barriers to exercise included:

- Laziness
- Absence of a “culture” of exercise in the U.S. – [In the U.S.] “*walking is only for crazy people or poor people.*”
- Lack of time – “*The only exercise I get is picking up after my family.*”
- Lack of money – “*We don’t have money to join a gym.*”
- Cultural differences – “*Latinas don’t run, that’s crazy.*”

Relevant Quotes

“The food in the U.S. is very bad – all canned and unhealthy. We’re used to making fresh foods, but here this is very expensive.”

“We eat too much here [in the U.S]. It’s like you eat something, and then you’re hungry again right away because what you ate was not healthy or satisfying.”

“Even my children are gaining weight here. This would not have happened in Mexico.”

“Nobody walks here. It’s like, if you walk somewhere you are crazy.”

“All my exercise I get at home – cleaning!”

“Even children do not get enough exercise here. They watch TV and play video games instead of playing outside.”

Latinas considered poor food choices and lack of exercise to be reflective of a general lifestyle in the U.S. which they perceived to be unhealthy. Coupled with a culture (the U.S. culture) where the high cost of living demands people work “very, very, hard,” little time, money or energy is left for diet and exercise. Women in our groups lamented about the weight they have gained since coming to the U.S., and expressed fear at the weight their children have gained as a result of this “unhealthy lifestyle.”

6. Perceptions and Use of U.S. Healthcare Services

Participants reported receiving healthcare services “when absolutely necessary” from providers at:

- Community health clinics
- Health departments
- Hospital clinics
- Urgent care centers
- Emergency rooms

As mentioned previously, effort was made to conduct our focus groups in rural, semi-rural and urban locals. Not surprisingly, where women lived, or more specifically, in what type of environment they lived, appeared to influence healthcare-seeking behavior. Most noticeably, participants from rural areas often mentioned just one source of healthcare services (i.e., community health clinic), whereas women from urban areas mentioned several. Interestingly, having a host of potential sources of health services did not appear to equate into satisfaction with their care. In our investigation, Latinas from rural areas who most often mentioned just one source of healthcare service reported being “very satisfied” with their care, and reported highly positive experiences. In these cases, the community health clinics where women reported receiving care had a largely Latino client base, and tailored their services accordingly by providing high degrees of culturally competent care. They have Spanish-speaking staff and providers, on-site certified medical interpreters, and have most health forms available in Spanish and English. Participants also reported that they “trusted” in the ability of their providers at these clinics to provide competent care, and also “trusted” that their providers and clinic staff “were not interested in legal and immigration matters, just our health.”

Considerations for Selecting a Medical Home or Provider

Language

In areas where several options for healthcare services existed, Latinas reported that they were most likely to select a provider that spoke Spanish (even if just a little bit), and where one was not available, they preferred to go where there were medical interpreters available. While long waits in the waiting room were reported as barriers to seeking service, most participants agreed that they would rather wait for Spanish-speaking providers, and secondary to them, professional

interpreters. Others reported that they would travel to neighboring cities and towns to receive care from bilingual providers.

Financial concerns

Latinas expressed a preference for clinics and providers that had “reasonable” fees and sliding fee scales based on income and ability to pay. Women also mentioned monthly payment plans as a positive aspect of some health centers.

Recommendations of family and friends

Many participants reported that recommendations from friends and family members greatly influenced where they received (or did not receive) care. For a full discussion of the role and influence of family and friends on health behaviors (see Section 3: Family, Friends and Relationships).

Proximity to home

Transportation was a concern for some women in our focus groups, and most expressed a preference for receiving care at a clinic or hospital close to home.

Comparing Healthcare Systems: U.S. and Latin America

Comparing health services in the U.S to those in the women’s countries of origin provided a good starting point for discussing participant’s perceptions and use of U.S. healthcare services. When asked about the differences between healthcare services in the U.S. and those in Latin America, participants consistently focused on three areas of difference: cost of services, payment and provider training.

Cost of Services and Payment

Women reported that in Mexico and other countries in Latin America, it is necessary to pay for services before you receive them. If you cannot pay, you do not receive care. In contrast, women reported that in the U.S you can receive care “regardless of whether or not you can pay for it.” Women perceive this as a positive aspect of care in the U.S. Conversely, women report frustration at not knowing the cost of services up-front. One participant explained it in this way:

It’s like this: in Mexico, going to a doctor is like going to a restaurant. You look at a menu and depending on what you’re feeling like, you say ‘I’d like this and this and this. You see the price right there on the menu and you know how much you’ll have to pay. The trick is, you have to have your money in your pocket. No credit cards accepted!

Women reported that services are “very expensive” in the U.S. and are “much more expensive” than the same services in Mexico and other countries in Latin America.

Provider Training

Women reported that physicians and other healthcare providers are better trained in Mexico and other Latin American countries. Women based this assumption on the observation that providers in Mexico take more time to examine the patient, order more tests such as blood tests and urine tests, and ask more questions. In almost all focus groups, women reported frustration at what

they perceived to be provider incompetence, some even going as far as to suggest that physicians in the U.S do “very dangerous” things like use dirty needles.

“They [providers] don’t do anything. You can be practically dying and they say ‘Oh, it’s just a virus [she touches her head, sticks out her tongue, pokes her stomach to demonstrate what the doctor does] Here, take a Tylenol!’ For the cost of that visit, I could have bought a lot of Tylenol! My husband, he says ‘for the cost of that Tylenol, we could have gone to Mexico!’”

Health Tourism

Women reported they travel to Mexico to receive non-urgent healthcare services for themselves as well as for members of their family, including children. As discussed above, women believed Mexican physicians were more competent, the services were less expensive, and they were able to communicate with their provider in their own language without relying on a translator.

Positive Experiences

While women reported many negative experiences with care in the U.S., it should be noted that they also had positive things to say about their experiences with healthcare services in this country.

These positive experiences included:

- Receiving care “even if you cannot afford it”
- Experiences with friendly doctors who speak “a little” Spanish
- Quality care
- Sliding fee scales
- Experiences with competent and courteous providers for children
- Medicaid for children

7. Preventive Health Services: Barriers to Access and Use

Participants consistently acknowledged the importance of preventive services such as routine gynecological exams, cancer screenings, dental exams, eye exams and routine doctor visits in promoting and maintaining good health. Despite this knowledge, most participants reported that they often did not seek preventive services. Women often reported that they “know the things we should be doing, but we just don’t do them.” Barriers to access and use of preventive health services included money, time, sacrifice and notions of the ideal woman, general health beliefs, language, trust, racism, fear and fatalism.

Barrier: Money

“It’s embarrassing to say, but sometimes we just can’t afford to go – it is not the top priority, especially if nothing is wrong.”

“Good health is not a right, it’s a luxury, and some people cannot afford it.”

“It is very expensive, especially if you don’t have insurance or Medicaid.”

“It is too expensive, and you know we don’t qualify for Medicaid, even though we pay taxes.”

“You never know how much it is going to cost you, so you can’t really plan for it.”

Barrier: Time

“We put off going because it is hard to get time off from work, you want to make sure you have the time.”

Barrier: Sacrifice and the Ideal Woman

“Women take care of everyone else, and then we don’t have time to take care of ourselves. We come last.”

“If I had all the money in the world, of course I would go, but as it is, we have to budget, and we [women] come last, plain and simple. It’s not right, it just is.”

Barrier: General Health Beliefs:

“We don’t take proper care of ourselves por flojera [laziness]!”

“If it isn’t broken, leave it alone.”

“I think I would know if there is really something wrong.”

Barrier: Language

“I’d prefer to go to someone who speaks Spanish, so sometimes I don’t go because this is hard.”

“I feel very scared when I am at the clinic and I don’t really know what is going on because I can’t understand everything they are saying.”

“What’s the use of going if you can’t communicate with [my provider].”

“Interpreters do not always say the right things. You can’t always trust them.”

“It’s really hard when they don’t speak Spanish.”

“I don’t trust the interpreters [to interpret correctly].”

Barrier: Trust and Perceptions of Service Quality

“You can’t always trust [your provider]. The training here [in the U.S.] is not very good. I trust doctors in Mexico more.”

I don’t know if they [providers] really know what they are doing. If I thought they knew what they were doing, I might go more.”

“I just wait until I go back to Mexico. It’s cheaper and you can trust the doctors.”

Barrier: Racism

They see you [a Latina] coming, and they just roll their eyes a little, and you just know what they are thinking: you can’t pay your bill, you don’t speak English, even if you do! You are treated poorly by everyone from the receptionists to the doctors and nurses.

“I take my dog to the vet and they treat her so well! Sometimes they even kiss her! Well, when I go to the doctor, I am treated worse than my dog. This much I can say.”

“I hate the looks [you get for being Latina]! What’s a look? Well, it’s a lot, really, it’s a lot.”

“You can tell when you walk in that they think you are less than them, even if the person working at the desk is Latina.”

Barrier: Fear

Women reported that they often did not seek preventive services such as routine cancer screenings such as Pap tests and breast exams because they were afraid that something really would be wrong with them. Fear of pain and embarrassment were also mentioned. Additionally, several women reported that some Latinas may fear going to the hospital or community health clinic because they were undocumented and were afraid they would be reported to the Immigration and Naturalization Service.

“Sometimes we don’t go because we don’t want to get bad news.”

Barrier: Fatalism

The idea of fatalism or lack of control over one’s life is pervasive in Latino culture, and it was often echoed in our focus group discussions. Some women reported, for example, that “whatever will happen to me, will happen,” and that their health was “in God’s hands.”

“It’s hard, being an immigrant, as an immigrant, you just hope and pray you don’t get sick.”

Health Services on the Job

Participants reported that health services such as routine screenings and (required) physicals were available to them (or their partners) at some employment sites. While they reported receiving required services (such as physicals), women suggested that such screenings were used to “weed out” employees who may have potential health problems and that it was really not to their benefit to take advantage of any of the health services offered on job sites.

Preventive Care for Children

While many women reported that they “didn’t go to the doctor unless they were dying,” participants cited that they “always, without fail!” take their children to their routine health visits. These included well-baby visits, visits for vaccinations and visits for “whatever else the pediatrician says we should do.” Preventive healthcare services for infants and children were perceived as being “very important,” especially since “children cannot always tell you that they hurt or what they need.” Women reported that the previously cited barriers such as financial concerns, getting time off from work, or perceptions of provider ability did not influence whether or not they seek preventive health services for their children. “Whatever the cost, I will make sure that my daughter’s health is taken care of.” In sharp contrast to their own experiences with providers, women reported liking, trusting and even “having a good relationship” with their children’s healthcare providers.

Relevant Quotes (regarding preventive health service for children)

“All children need their vaccinations. It is very important for their health.”

“I always took my infants to their health checks – it’s fun to see how they grow and if they’re gaining weight and just see that everything is good.”

“You have to be very vigilant with children’s health.”

“I like my child’s pediatrician. She’s very nice and takes the time to talk and answer questions. We don’t have to wait too long.”

“For our children, we do everything. That’s part of being a mother.”

“Cost doesn’t matter when it comes to my children’s health.”

“There are different services like Medicaid for children that help with costs.”

8. Barriers to Healthcare Service Access and Use

In an effort to understand why Latinas in our focus groups delayed or did not seek care when they knew or suspected something was wrong with their health, we questioned women about the things that prevented them from seeking care. The list elicited from participants and the discussion generated on this topic were nearly identical to those for preventive care services. Barriers to seeking care included: money, time, sacrifice and notions of the ideal woman, general

health beliefs, language, trust, racism, fear and fatalism. Discussion on this topic revealed, to some extent, that participants truly did not want to use healthcare services, even when they were in discomfort, pain or feared for their health, as well as the devastating effect of the previously mentioned barriers on healthcare-seeking.

Relevant Quotes

“I don’t go to the doctor unless I really, truly think that I am at death’s door.”

“I put off going until someone says, hey, you have to go.”

“I need a mammogram, I have a lump in my breast, but I can’t afford one. I’ll have to wait until we have the money. You know, winter is a hard time [for farm workers].”

“Nobody wants to have to go to the hospital, but sometimes you just have to, even if you’re scared or worried about how you will pay for it.”

Infants and Children

Participants reported that they seek care for their children “whenever they need it, no matter the cost or anything else.” While they reported that they often delayed seeking care for themselves “until they are dying,” the Latinas in our groups reported that timely care for children, especially very young infants, is very important. “Children’s health can change in an instant – one minute they’re fine and the next they have a high fever – you can’t delay with them.”

9. Latinas and Alternative Healthcare Services

Latinas acknowledged that several alternative sources of health care are available to them in their communities.

Alternative sources included:

- Herbal teas and other “home remedies” “remedios caseros”
- Imported medications (especially from Mexico)
- Medications available for purchase at Latino stores throughout the state
- Borrowed medicines
- “Health tourism”
- Injectable medications purchased on the Internet
- Lay midwives “parteras” during pregnancy
- Curanderos (healers)
- Spiritual healing

Most women in our focus groups reported using herbal teas and other home remedies as a first line of defense in the event of an illness. Likewise, many reported self-medicating as a primary method of care. Women reported using medications that they (or friends or family members) brought back with them from Mexico (or other countries). It is worth noting that many medications available over-the-counter in Mexico are only available in the U.S with a prescription. The sale and use of expired medications can be a potential area for concern. Participants reported that they have or would “share” medications among close family members

(for example, one woman stated that if one of her children is sick and is prescribed an antibiotic, she might give some to her other child if he too becomes sick). Participants also acknowledged the availability of medications (imported) at Latino markets and stores in the state, but tended to view these as “risky,” as you were “not certain of what exactly what you were getting.” Medications (particularly injectables) for sale on the Internet were also viewed with a great deal of skepticism, yet acknowledged as a method of self treatment for “some people they know.”

In addition to various self-medicating practices, participants noted the availability of several types of “lay practitioners” in their communities including “spiritual healers,” “curanderos” (healers) and “parteras” (lay midwives).

Use of these alternative healthcare services varied considerably among our participants and depended upon factors such as length of time in the U.S., place of origin, age, education level, social economic status (SES) and level of acculturation.

10. Pregnancy and Reproductive Health

While having children was not a requirement for inclusion in the focus groups, the majority of women did report having children or currently being pregnant. Latinas largely viewed pregnancy as a normal life event (rather than a “medical condition” or illness) and as a “special time” for women during which special care should be taken to protect the health of the mother and baby. Most women reported that pregnancy made them think differently about their health and led them to take better care of themselves for the duration of their pregnancies. Latinas were very knowledgeable about how to take care of one’s health during pregnancy and about current health guidelines for pregnant women. It should be noted that one focus group was comprised entirely of pregnant women then-enrolled in a prenatal class. All groups, however, demonstrated high levels of knowledge about standard health recommendations during pregnancy.

Women reported that during pregnancy one should:

- Not smoke, drink or do drugs
- Take a multivitamin every day with folic acid
- Not lift heavy things
- Stay active, but not push it
- Drink lots of water
- Be positive, try not to let things stress you out
- Eat a healthy diet
- Go to all your prenatal appointments
- Do whatever your doctor tells you
- Not trust everything you read
- Walk and get moderate exercise
- Get plenty of fresh air
- Talk to your baby and develop a relationship with her/him
- Stay away from second hand smoke
- Learn about breastfeeding
- Learn about how to care for a baby
- Relax and enjoy being pregnant
- Let other people help you around the house
- Drink milk

Relevant Quotes

“During pregnancy, you are no longer just taking care of yourself. It’s not just about you anymore.”

“You do everything to take care of yourself while you are pregnant.”

“Prenatal care is very important and it is very important to go to all of your visits.”

“Folic acid prevents birth defects in the baby’s spine.”

11. Mental Health: Stress, Depression and Latina Health

Participants agreed that mental health (stress and depression) were important issues in their communities. Latinas acknowledged that among Latinos there is a “stigma” associated with these “problems” but that it is important to talk about them and get them “out in the open” so that people are more comfortable getting help if they need it. Participants reported that “all kinds of people” suffer from stress and depression and that immigrants are often affected because of “how difficult the life of an immigrant can be.” Participants also reported that teenagers and postpartum women “suffer a lot” from stress and depression.

Mental Health

Most Latinas were not familiar with the term mental health (in Spanish, “salud mental”). It should be noted that this is not a problem with translation but is reflective of a more general gap in knowledge. Participants suggested that the term “mental health” had very negative connotations associated with it.

Negatives included:

- “Locura” (madness/ craziness)
- Being crazy
- Being sick in the head
- Being “very sick emotionally”
- Being a “very bad person”

Stress

Participants consistently called attention to the relationship between stress and health. The inability to manage stress effectively emerged as a key factor contributing to poor health.

Participants reported that stress:

- Makes you unable to do the things you need to do keep yourself and your family healthy”
- [Makes you] feel like sleeping and everything else falls to the side
- Makes you sick
- Can cause you to get colds
- Makes your back and neck hurt, gives you all kinds of pains in your body
- Can cause you to stop menstruating
- Makes you unable to have a baby
- Makes you sad
- Makes you nervous or anxious
- Is bad for your heart
- Can cause problems in your relationship with your partner or with your friends
- Can be taken care of on your own – does not require professional help

Depression

Depression was perceived of as a more severe form of stress requiring professional care.

Depression:

- Is like stress, but much worse
- Is an illness
- Makes you not want to get out of bed
- Makes you very tired
- Makes you cry, even if you don’t know what you’re crying about
- Makes it difficult to care for your family
- Can happen after giving birth – postpartum depression
- Can be helped with medication
- Can be helped by talking to a therapist
- Makes you not want to eat anything
- Makes you eat too much
- Makes you lose weight
- Makes you gain weight
- Can lead to suicide
- Requires professional help

Behavioral Health Issues: Children and Adolescents

Several focus group participants mentioned that their children and adolescents had behavioral problems. Women said their children had problems at school (fighting, acting up in class, not playing well with other children), problems at home, and even showed signs of stress and depression. Key informant interviews also identified child and adolescent behavioral problems as a significant issue facing Latino families. Latinas in our focus groups cited immigration (coming to a new place with a different culture) and language barriers (faced by children in school) as factors contributing to these behavioral problems. Latinas expressed frustration at not being able to identify sources of help in their communities.

Mental and Behavioral Health Resources

Despite acknowledging that depression is an “illness” that is amenable to treatment, many participants were unaware of mental healthcare services that may (or may not) be available in their communities and reported that they “would not know where to refer a close friend or relative.” Of the few participants who reported that they knew a source of help, most of these reported that it was an English speaking provider and acknowledged that this would be a very difficult way to receive help.

12. Self-Report Health Status

Participants were asked to provide pertinent health information using the self-report survey. Fewer than half (35.4%) of our respondents reported their health was “good” or better. The most frequent response was “OK.” More than half (56.5%) reported that they did not have health insurance; 22.5% of participants reported that they had private insurance. Only one participant reported receiving Medicaid. None of the pregnant women (N=8) reported having Medicaid or private insurance.

Of our participants, 16.1% reported having had a miscarriage, abortion or stillbirth; 9.7% reported having had a premature birth and a baby born low birthweight. One woman reported having had an infant die in the first 12 months of life.

Table 9 Self-Perceived Health Status

<i>My general health is...</i>	N	%
Excellent	3	4.8
Very good	10	16.1
Good	9	14.5
O.K.	27	43.5
Poor	1	1.6
No answer	12	19.4

Table 10 Health Coverage of Participants

<i>What kind of insurance or medical coverage do you have?</i>	N	%
Private	14	22.5
Medicaid	1	1.6
Medicare	0	0
No insurance	35	56.5
Other	2	3.2
No answer	10	16.1

Note, more than half of all respondents had no insurance.

Table 11 Use of Vitamins

<i>How many times have you taken a multivitamin/prenatal vitamin in the last seven days?</i>	N	%
Never	18	29.0
One to three times	5	8.1
Four to six times	4	6.5
Every day	23	37.1
No answer	12	19.4

Table 12 Visit to the Doctor

<i>When was the last time you visited a doctor or health professional? In the last...</i>	N	%
Last 30 days	19	30.6
Last 90 days	6	9.7
Last 6 months	10	16.1
Last year	8	12.9
More than two years	3	4.8
No answer	16	25.8

Table 13 Last Gynecological Visit and Pap test

<i>Date of last Pap test and gynecological exam was:</i>	N	%
In the last 6 months	23	37.1
In the last 12 months	18	29.0
In the last 2 years	3	4.8
More than 2 years	4	6.5
No answer	14	22.6

Table 14 Miscarriage, Abortion and Stillbirth

<i>Have you ever had a miscarriage, abortion or stillbirth?</i>	N	%
No	34	54.8
Yes	10	16.1
No answer	18	29.0

8 of the 10 “Yes” reported miscarriages. 1 abortion and 1 stillbirth.

Table 15 Premature Birth

<i>Have you ever had a baby born premature?</i>	N	%
No	37	59.7
Yes	6	9.7
No answer	19	30.6

Table 16 Low Birthweight

<i>Have you ever had a baby born with a low birthweight (less than 5lbs 8 ounces)?</i>	N	%
No	37	59.7
Yes	6	9.7
No answer	19	30.6

Table 17 Death of infant in first 12 months of life

<i>Have you ever had a baby die during its first year of life?</i>	N	%
No	45	72.6
Yes (specified)	1	1.6
No answer	16	25.8

13. Conclusions and Recommendations

Knowledge does not always change behavior

Latinas were generally knowledgeable about standard health recommendations, health promotion and maintenance and moreover, they acknowledged the importance of preventive care and services. Despite this, most reported that they did not use preventive services available to them and delayed seeking care for health problems. Most models of behavioral change take into account the complexity of human behavior and the structural, psychological, and social factors that affect change, and such a finding, however puzzling, is not unusual. Latinas in North Carolina face many real and salient challenges to caring for themselves, their families and their children. Here we provide several recommendations for improving healthcare services and access for Latinas which emerged from this research.

1. Improve cultural competency through training, monitoring and evaluation

- Evaluate and improve the cultural competency of staff and providers at public hospitals, health centers and health departments through self-review, outside review, training, monitoring and evaluation.
- Ensure Title VI compliance. This includes components of cultural and linguistic competence.

2. Increase linguistic competency

This research identified limited English fluency as a major barrier to healthcare service-seeking among Latinas. To improve linguistic competency in healthcare settings, the N.C. Department of Health and Human Services, Division of Public Health should:

- Staff county health departments, hospitals and community clinics with Certified Medical Interpreters, the “gold standard” in medical interpretation.
- Increase the number of Spanish-speaking providers in North Carolina.
 - (1) Promote hiring practices that appeal to bilingual practitioners.
 - (2) Hire native Spanish-speaking Latino practitioners through special staffing services currently available.
 - (3) Increase the linguistic capacity of current practitioners through intensive Spanish-language workshops, and provide incentives for participation.
- Ensure all patient forms (medical history forms, patient bill of rights, billing forms) are available in high quality Spanish translations.
- Increase and maintain diversity in the health workforce across the state. Doctors and healthy professionals should reflect the communities they serve.

- Ensure that the development of Spanish health educational materials are culturally and linguistically appropriate. Straight translations from English are often in higher reading levels and do not include cultural components for the target audience.

3. Improve patient advocacy for Latinas

This research identified lack of trust in the ability and training of healthcare providers as a major barrier to healthcare service-seeking among Latinas. Additionally, this research identified perceived differences between healthcare services in the U.S and Latin America as a significant source of dissatisfaction among Latinas that resulted in distrust of American providers. The N.C. Department of Health and Human Services, Division of Public Health can minimize the barriers posed by these by items and should:

- Empower Latinas to be responsible patients through patient education that focuses on patient rights and responsibilities.
- Let Latinas know that they should request a medical interpreter should they need one.
- Teach Latinas that they can and should question their providers.
- Prepare new immigrants for encounters with the U.S. health system by producing and distributing high-quality, Spanish-language materials about “what to expect at the doctor’s office.”
- Consider using community and faith-based groups to support and advocate for Latinos as they interact with the healthcare system (to help individuals make appointments, provide transportation, help review print materials/prescriptions, etc.). Provide training and financial support for such initiatives.

4. Support Latino outreach activities and programs

This research revealed that Latinas do not frequently seek preventive healthcare services and often delay necessary health care. While the barriers to healthcare service-seeking identified by this research are many and to be certain, complicated, community outreach can alleviate some of these and can go a long way in improving trust and alleviating some of the fear associated with going to the doctor. The N.C. Department of Health and Human Services, Division of Public Health should:

- Partner with churches and Latino community organizations to reach more difficult to access clients.
- Consider faith-based and community-based health initiatives.
- Enlist key community leaders in outreach activities. The influence and role of key community leaders in disseminating health information should not be overlooked. This research revealed that ministers, priests, churches, respected community members and leaders, regardless of formal health backgrounds or training, played significant roles in providing health information and health advice for members of their communities.
- Use creative health communication strategies for Latinos. Consider radio, television and Spanish newspapers as valuable means of health communication. Social marketing campaigns (such as the Ana María Latino Campaign developed by the North Carolina Healthy Start Foundation) which employ a combination of personal communication, radio, TV and print materials are successful models.
- Ensure that Spanish-language health materials are high-quality publications and are of an appropriate reading level.

- Incorporate health literacy strategies to help communicate health information to Latinas whose formal education in Spanish may be limited and who may have no ability or confidence to communicate in English.
- Make more ESL classes available in communities.

5. Prioritize women’s health

This research revealed that women’s health is often not prioritized by women themselves. The N.C. Department of Health and Human Services, Division of Public Health, should foster new ways for how women think about their own health, particularly preventive health, and make it easier for them to access the services available to them. Some ways to do this are:

- Initiate a social marketing campaign promoting the importance of Latina health with the message “take care of yourself first, so you can be there for your family.”
- Combine services for children (which this survey’s participants reported they are using) and women in one building and arrange appointment scheduling that promotes women’s and children’s health. For example, a mother’s annual exam could coincide with her baby’s one-year and two-year well-baby visits.

6. Improve availability of mental and behavioral healthcare services for Latinos

Access issues, rather than stigma associated seeking mental healthcare services, appear to be the central problem preventing use of mental health services and resources. The N.C. Department of Health and Human Services, Division of Public Health should:

- Increase the number of qualified Spanish-speaking mental health practitioners.
- Integrate mental health services into county Department of Public Health facilities and community health clinics. This would make services more accessible and may reduce stigma associated with mental health.
- Do not use the term “mental health.” This research found that the term mental health is not widely understood and is often associated with very negative connotations.

14. Directions for Future Research

Future research in the area of Latino health might address:

1. Children’s health

Our findings suggest that while women may delay seeking care or preventive services for themselves, they almost always seek care and preventive services for their children. They also reported high levels of satisfaction with the services available for children and the care they received. Additional research is needed to identify what precisely it is that is working well for children’s healthcare services in North Carolina, and to ensure that this level of care continues for the increasing numbers of Latino children who will be cared for in North Carolina in the coming years.

2. Mental and behavioral health (for adults, adolescents and children)

Our findings, and recent research in the area of mental health, suggest that mental health problems (including stress, depression, post-partum depression and psychiatric disorders) are significant burdens for Latinos in the U.S. Special problems associated with immigration,

isolation and social disadvantage may exacerbate the problems. Additional research is needed to fully understand the scope of the problem as well as to identify potential interventions. While our focus group participants were able to access and take advantage of preventive and other healthcare services for their children, women expressed that they were at a loss when it came to dealing with their children's behavioral and mental health needs. Additional research is needed to fully understand the scope as it related to children and adolescents and identify potential interventions.

3. Acculturation and Latina health

Recent research shows that Latina health declines with increasing levels of acculturation. While our sample was comprised largely of recent immigrants (and was not unrepresentative of Latinas in North Carolina), additional research is needed to understand the scope and effect of this well documented health phenomena among Latinas in North Carolina, as well as to identify potential areas of intervention, particularly as the demography of the Latino population in North Carolina shifts in coming years.

Appendices

Appendix A Project Timeline

LIMA Focus Group Research Project Timeline

<i>Activity</i>	<i>Start Sate</i>	<i>Completion Date</i>
Project Coordinator Interviews	--	December 2006
Facilitator Interviews	--	December 2006
Project Coordinator Hired	--	January 2007
Facilitator Hired	--	January 2007
LIMA Project Meeting	--	January 2007
Written Project Materials	--	January 2007
Translate Project Materials	--	January 2007
Facilitator Training	--	January 2007
Practice Focus Group	--	January 2007
Provider Interviews	January 2007	March 2007
Focus Groups	January 2007	March 2007
Written Report	--	March 2007
NCHSF Presentation	--	April 2007
DPH Presentation	--	April 2007

Appendix B Focus Group Guide – Spanish

Guía para los Grupos de Enfoque

1. ¿Qué significan las palabras “salud” y “sano (a)”?

¿Qué significa para ustedes la palabra salud?

Describan qué hace sana a una persona. Describan qué hace sana a una mujer.

¿Qué tan importante es su salud? ¿Es algo a lo que le da prioridad, o tiende a dejarlo a un lado? ¿Qué le diría a su madre (hija, hermana o amiga) sobre estar sana o mantenerse sana?

2. Prevención

[Definición: dejar de fumar, nutrición, vitaminas, ejercicio, comportamiento y opciones sexuales, manejo de estrés, relaciones hombre-mujer, redes de apoyo social y familiar, cuidado dental, cuidado personal (belleza, pelo, masaje, etc.)].

¿Qué cosas debería hacer la gente para mantenerse sana? [Haga una lista] ¿Cuáles son algunas cosas que ustedes saben que la gente debería hacer para mantenerse sana?

¿Qué hacen para mantenerse “sanas”? ¿Qué hacen para cuidarse? ¿Qué es lo que les hace posible hacer esas cosas?

¿Cuáles son algunas cosas que ustedes saben que deberían hacer para cuidarse o para mantenerse sanas, y no las hacen? [Refiérase nuevamente a la lista] ¿Qué les impide hacerlas? [Para realizar un sondeo sobre los factores externos como la falta de acceso al sistema de salud, transporte, falta de seguro médico, falta de dinero, etc.].

3. Información y Consejos de Salud

¿En quién o qué confían ustedes para que les aconsejen sobre su salud? [Haga una lista] y ¿Sobre la salud de su familia?

¿De qué manera les gusta recibir información sobre su salud? Hay muchas fuentes de información sobre salud - ¿Qué es lo que hace que una fuente de información sea buena? ¿Cómo pueden ustedes saber que es confiable? [Sondeo: recomendaciones del doctor, revistas, páginas de Internet, noticias o programas de televisión, amigos y familia, etc.].

4. **Uso de los Servicios de Salud**

[Definición: cuidado primario, clínicas de la comunidad, sala de emergencias, cuidado dental, ginecología, estudios (incluyendo papanicolaou, mamografías, ETSs, exámenes de la densidad de los huesos, colesterol, presión arterial), curanderos tradicionales, medicina tradicional o remedios caseros, curaciones religiosas o espirituales (rezo, meditación, etc.)].

¿**Dónde** reciben cuidado médico? [Haga una lista. Sondeo: clínica de la comunidad, consultorio del doctor, familia o amigos, trabajo, sala de emergencias, etc.] ¿Por qué van a estos lugares y no a otros? [Sondeo: traductores, confianza, proximidad, costo].

¿**Cuándo** van a la clínica/doctor? ¿Qué hace que ustedes vayan a la clínica/doctor? [Sondeo: preguntar por las visitas de rutina para ellas y los niños)].

¿Qué cosas **evitan** que ustedes vayan a un doctor? [Sondeo: dinero; transporte; miedo; situación legal; problemas de comunicación; falta de respeto del doctor, enfermeras o personal; actitudes críticas del doctor, enfermeras, o personal; miembros de la familia; violencia doméstica, etc.].

Para las mujeres que son inmigrantes: ¿Hay diferencias entre los servicios de salud en los Estados Unidos y los servicios de salud en el país de su nacimiento? Si es así, ¿cuáles son las diferencias?

Describan una experiencia positiva con un profesional del cuidado de la salud, como un doctor, una enfermera, un técnico de laboratorio, o un consejero de salud. Experiencia negativa.

Si pudieran cambiar algo sobre sus experiencias con los profesionales del cuidado de la salud, ¿qué cambiarían? Cuando van al doctor/clínica, ¿se sienten cómodas haciendo preguntas? ¿Entienden bien lo que dice el doctor/enfermera sobre su salud o sobre el tratamiento?

Además de las clínicas, ¿Hay otros medios de curación disponibles en su comunidad? [Para realizar un sondeo sobre el uso de plantas medicinales, medicamentos de México, medicinas compartidas, curación espiritual] ¿Bajo qué circunstancias ustedes utilizarían estos servicios? ¿Otras personas en su comunidad utilizan estos servicios?

5. **Familia, Amigos y otras Relaciones**

¿Cómo se toman las decisiones sobre salud en su casa? ¿Quién toma las decisiones sobre salud (para usted, su pareja, sus niños)? ¿Qué factores toma en cuenta la persona que toma las decisiones? (Para realizar un sondeo sobre problemas financieros, transporte, tiempo fuera del trabajo, gravedad de la enfermedad).

¿Cómo influye la relación con su esposo, novio o compañero en sus decisiones sobre su salud; sobre la salud de sus hijos; sobre la salud de su esposo, novio o compañero? [Sondeo: violencia doméstica].

6. Embarazo y Salud Reproductiva

Ahora vamos a hablar un poco acerca del embarazo y la salud.

¿Qué es un “embarazo sano”? ¿Qué significa? ¿Qué significa un “parto sano”, una “familia sana”?

¿Qué tipo de cosas debe hacer una mujer para tener un embarazo sano? [Haga una lista. Sondeo: Antes de quedar embarazada. Durante el embarazo].

[Para las mujeres que han estado embarazadas:] ¿Qué hicieron cuando estaban embarazadas para cuidarse? ¿Para mantenerse sanas? ¿Qué cosas sabían que debían hacer mientras estaban embarazadas, y no las hicieron (o no pudieron hacerlas)? ¿Por qué no las hicieron? [Para realizar un sondeo sobre los factores externos. Ejemplo.: trabajo, situación económica].

¿Qué cosas no deberían hacerse durante el embarazo?

Cuando estaban embarazadas, ¿con quién (o con qué) contaban para obtener información sobre su salud? ¿En quién (o en qué) confiaban?

¿El embarazo les hizo pensar de manera diferente acerca de su salud? ¿Cómo?

¿Qué tipo de cosas eran estresantes durante su embarazo? (Sondeo: sentirse cansada, sentirse enferma, trabajo, escuela, estar embarazada sin haberlo planeado, cuidar otros niños, la relación con el marido o el padre del bebé, violencia doméstica o abuso). ¿Cómo manejaron ese estrés? ¿Qué cosas hicieron para aliviar el estrés?

¿Qué tipo de cosas debería hacer una mujer para mantenerse sana después del nacimiento de su niño? [Sondeo: comer bien, ejercicio, ácido fólico, anticoncepción].

7. Salud Mental y Depresión.

Ahora quisiera hacerles algunas preguntas acerca de la salud mental.

¿Qué significa para ustedes el término “Salud Mental”?

¿Qué significa para ustedes la palabra “Estrés”? ¿Qué tipo de cosas son estresantes para ustedes? ¿Cuáles son algunas formas que conocen para manejar el estrés?

¿Qué significa para ustedes la palabra “Depresión”? ¿Cómo saben si ustedes, o alguien que ustedes aman, está deprimido? ¿Qué fuentes de ayuda para la depresión están disponibles en su comunidad? ¿Cuándo acudirían a ellas? ¿Qué les impediría buscar ayuda para la depresión? [Sondeo: estigma, “yo puedo solo”].

8. Disparidades de la Salud

[Para generar discusión e interés en esta sección, presentar información sobre disparidades de la salud y sobre la salud de la comunidad latina].

Las mujeres latinas tienen mejor salud que las mujeres de otros grupos étnicos. Pero aún cuando esta es una gran noticia, las investigaciones han demostrado que mientras más tiempo pasan en los Estados Unidos, peor es su salud. ¿Cómo explicarían ustedes esto?

¿Pueden pensar en algunos problemas que los latinos en particular enfrentan cuando cuidan de su salud - cuando necesitan obtener servicios de salud- (para sí mismos o para sus familias)? [Sondeo: situación legal, idioma, diferencias culturales, estrategias de supervivencia].

¿Quisieran compartir con nosotros algo más acerca de su salud, sus experiencias con el sistema de salud, o acerca de la salud en la comunidad latina?

Appendix C Focus Group Guide – English

1. What do “health” and “healthy” mean?

What does “health” mean to you?

Describe what makes a person “healthy”. Describe what makes a woman “healthy.”

How important is your health? Is it something you give a lot of thought to or does it tend to fall to the back burner?

What would you tell your mother (daughter, sister or friend) about being healthy or staying healthy?

2. Preventive Health Behaviors

[Definition: smoking cessation, nutrition, vitamins, exercise, sexual behavior & choices, managing stress, male-female relationships, social & kin networks-support, dental care, personal care (beauty, hair, massage, etc.)]

What things should people do to stay healthy? [Make a list on flipchart.] What are some things you know that people should do to stay healthy?

What do you do to keep yourself “healthy”? What do you do to take care of yourself? What makes it possible for you to do these things?

What are some things you know you should do to take care of yourself or to stay healthy, but you don’t? [Refer back to list on the flip chart.] What keeps you from doing them? [Probe for external factors like lack of access to healthcare system, transportation, lack of health insurance, lack of money, etc.]

What are some things your mother or grandmother did to take care of you and help you stay healthy? to take care of themselves? to take care of other family members? Do you do the same things for your family?

3. Health Information & Advice

Who do you rely on for advice about your health? [Make a list on flipchart.] About your family’s health?

How do you like to get information about your health? There are many sources for health information out there ... what makes a good source? How can you tell it’s trustworthy? [Probe: doctor’s recommendation, magazines, websites, news/talk shows, friends and family, etc.]

4. Use of Healthcare Services

[Definition: primary care, community clinics, ER, dental care, OB/GYN, health screenings (including pap smears, mammograms, STDs, bone density exams, cholesterol, blood pressure), traditional healers, traditional medicine or home remedies, religious or spiritual healing (laying on of hands, prayer, meditation, etc.)]

Where do you get your health care? [Make a list on flipchart. Probes: community clinic, doctor's office, family or friends, work, ER, etc.] Why do you go to these places rather than somewhere else? [Probes: translators, trust, proximity, cost]

When do you go to the clinic/doctor? What makes you go to the clinic/doctor? '[Probe: ask about "well" visits for self and children]

What things prevent you from going to a doctor? [Probes: money, transportation, fear, legal status, communication problems, lack of respect from doctor, nurses, or staff, judgmental attitudes of doctor, nurses, or staff, family members, domestic violence, etc.]

For women who are immigrants: Are there any differences between healthcare services in the U.S. and healthcare services in the country of your birth? If so, what are the differences?

Describe a positive experience with a healthcare professional, like a doctor, nurse, lab technician, or health advisor. Negative experience.

If you could change something about your experiences with healthcare professionals, what would it be? When you go to the doctor/clinic, do you feel comfortable asking questions? How well do you understand what the doctor/nurse says about your health or about the treatment?

Besides clinics, are there any other sources of healing available in your community? [Probe for use of botanicas, use of medications from Mexico, sharing meds, spiritual healing] Under what circumstances would you use these services? Do others in your community use these services?

5. Family, Friends and Relationships

How are decisions about health made in your household? Who makes decisions about health (for you, your partner, your children)? What factors does the person making the decisions consider? [Probe for financial probes, transportation, time off work, severity of illness.]

How do your relationships with family members and close friends influence your decisions about your health? About your children's health? About your husband's/boyfriend's/partner's health? [Probe: domestic violence]

6. Pregnancy and Reproductive Health

Now, we're going to talk a little about the experience of pregnancy and health.

What is a "healthy pregnancy?" What does that mean? A "healthy childbirth?" A "healthy family?"

What kinds of things should a woman do to have a healthy pregnancy? [Make a list on flipchart. Probes: Before getting pregnant? During pregnancy?]

[For women who have been pregnant:] What did you do when you were pregnant to take care of yourself? To stay healthy? What things did you know that you should do while you were pregnant, but you didn't or couldn't? Why didn't you do them? [Probe for external factors, e.g., work, economic situation.]

What things did you do during your pregnancy that you knew you shouldn't do, but you did?

When you were pregnant, who/what did you rely on for information about health decisions? What/who did you trust?

Did pregnancy make you think differently about your health? How?

What kinds of things were stressful during your pregnancy? [Probes: feeling tired, feeling sick, work, school, being pregnant without having planned it, taking care of other children, relationship with husband or father of fetus, domestic violence or abuse] How did you handle this stress? What things did you do to relieve stress?

What kinds of things should a woman do to stay healthy after the birth of her child? [Probes: eat well, exercise, folic acid, contraception]

7. Mental Health and Depression

OK. Now I would like to ask you some questions about Mental Health.

What does the term "Mental Health" mean to you?

What does "Stress" mean to you? What kinds of things are stressful to you? What are some ways that you know to handle stress?

What does "Depression" mean to you? How do you know if you, or someone you love, is depressed? What sources of help for depression are available in your community? When would you seek them? What would prevent you from seeking help for depression? [Probes: stigma, tough it out mentality]

8. Health Disparities

[For this section, present some information about health disparities and Latino health to help generate discussion and interest]

Latinas generally have better overall health than women of other ethnicities. This is great news. But, according to research, the longer Latinas have been in the U.S., the poorer their health gets. How would you explain this finding?

Can you think of any problems Latinos in particular face in taking care of their health and getting the care they need (for themselves or for their families)? [Probes: legal status, work-related exposures, language, cultural differences, survival strategies]

Is there anything else about your health and experiences with the healthcare system or about Latina health in general that you feel that you would like to share with us?

Appendix D Consent Form – Spanish

Consentimiento para participar en un grupo de enfoque sobre salud de la mujer latina

¿Cuál es el propósito de este grupo de enfoque?

El propósito del grupo de enfoque es aprender sobre las actitudes, creencias y sentimientos de la mujer latina con respecto a su salud, incluyendo las cosas que las mujeres hacen para mejorar su salud y la de sus familias. Esta información será utilizada por la North Carolina Healthy Start Foundation para mejorar sus campañas de educación pública. La información también será utilizada por los investigadores y la State Infant Mortality Collaborative para aprender más sobre la relación que existe entre la salud de las mujeres y la salud de sus bebés.

¿Por qué le hemos pedido participar?

Le hemos pedido estar en este estudio porque usted pertenece a un grupo de la comunidad que fue elegido por los organizadores del grupo de enfoque, o porque usted expresó interés en participar.

¿Qué le pediremos hacer?

Le estamos pidiendo participar en una plática que tomará cerca de 2 horas de su tiempo. Le preguntaremos sobre sus creencias y sentimientos acerca de la salud y los comportamientos de la mujer. Sus ideas y opiniones son importantes para nosotros, así que por favor sólo díganos lo que piensa. No hay respuestas correctas o incorrectas a ninguna de las preguntas que vamos a hacerle.

¿Cuáles son los beneficios de participar?

No le prometemos ningún beneficio directo por participar. Sin embargo, el grupo de enfoque puede permitir que usted explore sus sentimientos y creencias sobre la salud y lo que significa estar sano. Otras personas podrían beneficiarse en el futuro, porque la información de este grupo de enfoque puede ayudarnos a comprender y encontrar mejores maneras para hablar con la gente sobre temas de la salud.

¿Existe algún riesgo?

No. No existen riesgos por participar en el grupo de enfoque.

¿Tiene algún costo?

No. No tiene ningún costo participar.

¿Usted recibirá remuneración?

Sí. Usted recibirá una tarjeta de regalo de \$25 en agradecimiento por su participación.

Derecho a rechazar o retirarse del Grupo de Enfoque

La participación en este grupo de enfoque es voluntaria. Usted tiene el derecho de retirar su consentimiento o terminar su participación en cualquier momento sin ninguna penalidad.

Confidencialidad:

Si usted acuerda participar en este grupo de enfoque, entienda por favor que su participación es voluntaria. Toda la información que usted proporcione será considerada confidencial. A excepción de si usted expresa el intento de hacerse daño a usted mismo o a otros. Esta forma firmada de autorización y su nombre se mantendrán separados de la información del grupo de enfoque. Usted no necesita decirnos su nombre, podría utilizar un nombre falso si lo quisiera. Todas las conversaciones de los grupos de enfoque son grabadas, sin embargo, usted puede pedir que se detenga la grabación en cualquier momento. Todas las cintas serán transcritas (mecanografiadas) sin los nombres o la información que la identifica para proteger su confidencialidad. Haremos todo nuestro esfuerzo para proteger la identidad de los participantes en el grupo de enfoque. Sin embargo, no hay garantía de que la información no pueda obtenerse a través de un proceso legal u orden judicial. Usted no estará identificado en ningún informe o publicación de este grupo de enfoque o sus resultados.

¿A quién puedo contactar para contestar preguntas sobre el grupo de enfoque?

Si usted tiene preguntas sobre este grupo de enfoque, usted puede llamar a Monica Sánchez, Coordinadora de LIMA Focus Group, al 919-782-5187 o a Janice Freedman, Directora Ejecutiva de la North Carolina Healthy Start Foundation al 919-828-1819.

Acuerdo del Participante

He leído la información proporcionada arriba y acuerdo voluntariamente participar en este grupo de enfoque. Entiendo que me darán una copia de esta Forma de Consentimiento.

Nombre del Participante del Grupo de Enfoque

Firma del Participante del Grupo de Enfoque

Fecha

Nombre de la Persona

Firma de la Persona

Fecha

Appendix E Consent Form – English

Consent to participate in a focus group on Latina health

What is the purpose of this focus group?

The purpose of the focus group is to learn about attitudes, beliefs and feelings about Latina health, including things women do to improve their health and the health of their families. This information will be used by the North Carolina Healthy Start Foundation to improve their public education campaigns. The information will also be used by researchers and the State Infant Mortality Collaborative to learn more about the relationship between women's health and having a healthy baby.

Why have you been asked to take part?

You have been asked to be in this study because you belong to a community group, which was chosen by the focus group planners, or because you expressed interest in participating.

What will you be asked to do?

You are being asked to participate in one focus group discussion that will take about 2 hours of your time. We will ask you about your beliefs and feelings about women's health and behaviors. Your ideas and opinions are important to us, so please just say what's on your mind. There are no right or wrong answers to any of the questions we are asking.

What are the benefits of participating?

We do not promise you any direct benefit from participating. The focus group, however, may allow you to explore your feelings and beliefs about health and what it means to be healthy. Other people may benefit in the future because, the information from this focus group may increase our understanding of the best ways to talk to people about health issues.

Are there any risks?

No. There are no known risks from participating in the focus group.

Are there any costs?

No. There is no cost to participate.

Will you receive any compensation?

Yes. You will receive a \$25 gift card to thank you for participating.

Right to Refuse or Withdraw from the Focus Group

Participation in this focus group is voluntary. You have the right to withdraw your consent or stop participating at any time without penalty.

Confidentiality

If you agree to participate in this focus group, please understand that your participation is voluntary. All the information you provide will be kept confidential. The only exception is if you express the intent to harm yourself or others. This signed consent form and your name will be kept separate from the focus group information. You do not need to tell us your name and you may use a fake name if you wish. Audio-taping is preferred for all focus groups, however, you may ask to stop the tape recording at anytime. All tapes will be transcribed (typed up) without names or other identifying information to protect your confidentiality. Every effort will be taken to protect the identity of the participants in the focus group. However, there is no guarantee that the information cannot be obtained by legal process or court order. You will not be identified in any report or publication of this focus group or its results.

Who can I contact to answer questions about the Focus Group?

If you have questions about this focus group, you may call Monica Sánchez, LIMA Focus Group Coordinator, at 919-782-5187 or Ms. Janice Freedman, Executive Director of the North Carolina Healthy Start Foundation at 919-828-1819.

Participant’s Agreement

I have read the information provided above and voluntarily agree to participate in this focus group. I understand that I will be given a copy of this consent form.

Name of Focus Group Participant (Print)

Signature of Focus Group Participant

Date

Name of Person Administering Informed Consent (Print)

Signature of Person Administering Informed Consent

Date

Appendix F Survey and Demographic Information – Spanish

1. ¿Qué tipo de seguro médico o cobertura médica tiene?
 - Seguro privado
 - Medicaid
 - Medicare
 - No tengo seguro médico o cobertura médica
 - Otro (Describa) _____
2. En los últimos 7 días, ¿cuántas veces tomó un multivitamínico o vitaminas prenatales?
 - No tomé ningún multivitamínico o vitaminas prenatales
 - 1 a 3 veces
 - 4 a 6 veces
 - Todos los días
3. Usted diría que su salud es en general:
 - Excelente
 - Muy Buena
 - Buena
 - Regular
 - Mala
4. ¿Cuándo fue la última vez que usted visitó a un doctor o a un profesional del cuidado de la salud, ya sea en un consultorio, una clínica o en un hospital?
 - Hace 30 días
 - Hace 90 días
 - Hace 6 meses
 - Hace 12 meses
 - Hace 2 años
 - Hace más de 2 años
5. a.) ¿Tiene hijos?
 - No → Continúe en la pregunta 6
 - Sí
 - b) ¿Cuáles son las edades de sus hijos?
6. ¿En qué año nació usted? _____
7. ¿Dónde nació?
País _____
8. Si usted no nació en los Estados Unidos ¿Cuánto tiempo lleva viviendo en los Estados Unidos?
 - Menos de 1 año
 - Número de años _____
9. ¿Qué idioma habla en casa?
 - Español
 - Inglés
 - Otro _____
10. ¿Cuál de las siguientes opciones describe mejor su habilidad para HABLAR en inglés? :
 - Nada
 - Un poco
 - OK
 - Bien
 - Muy bien
11. ¿Cuál de las siguientes opciones describe mejor su habilidad para LEER en inglés? :
 - Nada
 - Un poco
 - OK
 - Bien
 - Muy bien
12. ¿Cuál de las siguientes opciones describe mejor su habilidad para LEER en español? :
 - Nada
 - Un poco
 - OK
 - Bien
 - Muy bien

13. ¿Cuál de las siguientes opciones describe su estado civil? (Señale sólo una.)

- Soltera
- Unión libre
- Casada
- Separada
- Divorciada
- Viuda

14. ¿Hasta qué grado estudió?

- Sin estudios
- Primaria
- Secundaria
- Preparatoria
- Preparatoria con certificado o GED
- Universidad
- Carrera técnica
- Licenciatura
- Otro _____

15. ¿A qué se dedica? _____

16. ¿Cuáles son sus ingresos anuales?

- Menos de \$15,000
- \$15,000-\$29,999
- \$30,000-44,999
- \$45,000-\$60,000
- Más de \$60,000

17. ¿Cuál es su Código Postal? _____

18. ¿Cuándo fue la última vez que visitó al ginecólogo y se realizó el examen del papanicolaou?

- Hace 6 meses
- Hace 12 meses
- Hace 2 años
- Hace más de dos años

19. ¿Ha estado embarazada?

- No → Gracias! Ha terminado la encuesta.
- Sí. → Continúe en la pregunta 20

20. ¿Cuántas veces ha estado embarazada? _____

21. ¿Ha sufrido alguna vez una pérdida, aborto, o nacimiento de un bebé muerto?

- No
- Sí. Especifique.
- Nacimiento de un bebé muerto
- Pérdida
- Aborto

22. ¿Ha tenido alguna vez un parto prematuro (Un bebé que nace más de 3 semanas antes de la fecha)?

- No
- Sí

23. ¿Ha tenido alguna vez a un bebé con bajo peso de nacimiento (Un bebé que pesó menos de 5lbs. 8oz. o 2.5 kilos al nacer)?

- No
- Sí

24. ¿Alguno de sus hijos ha muerto durante su primer año de vida?

- No
- Sí

25. ¿Está embarazada actualmente?

- No
- Sí

Appendix G Survey and Demographic Information – English

1. What kind of health insurance or medical coverage do you have?
 - Private insurance
 - Medicaid
 - Medicare
 - I do not have health insurance or medical coverage
 - Other (If other, describe) _____
2. In the past seven days, how many times did you take a multivitamin or prenatal vitamin?
 - I didn't take a multivitamin or a prenatal vitamin.
 - 1 to 3 times
 - 4 to 6 times
 - Every day
3. Would you say that, in general, your health is:
 - Excellent
 - Very good
 - Good
 - Fair
 - Poor
4. When was the last time you visited a doctor or healthcare professional for yourself, whether in a medical office, clinic, or hospital?
 - Past 30 days
 - Past 90 days
 - Past 6 months
 - Past 12 months
 - Past 2 years
 - Longer ago than the past 2 years
5. a.) Do you have any children?
 - No → Go to Question #6
 - Yes.
 - b.) What are your children's ages?
6. What year were you born? _____
7. Where were you born?
Country _____
8. If you were born somewhere other than the U.S., how long have you lived in the U.S.?
 - Less than 1 year
 - # Years _____
9. What language do you use at home?
 - Spanish
 - English
 - Other _____
10. Which of the following best describes your ability to SPEAK English:
 - Not at all
 - Very little
 - OK
 - Good
 - Very good
11. Which of the following best describes your ability to READ English?
 - Not at all
 - Very little
 - OK
 - Good
 - Very good
12. Which of the following best describes your ability to READ in Spanish?
 - Not at all
 - Very little
 - OK
 - Good
 - Very good

13. Which of the following best describes your relationship status? (Select only one.)

- Single
- Living with significant other, not married
- Married
- Separated
- Divorced
- Widowed

14. What is your highest level of education?

- No formal education
- Elementary school
- Middle school
- Some high school
- High school diploma or GED
- Some university
- Associate's degree
- Bachelor's degree
- Master's degree
- Ph.D. degree

15. What is your occupation? _____

16. What is your annual **household** income?

- Less than \$15,000
- \$15,000-\$29,999
- \$30,000-44,999
- \$45,000-\$60,000
- Over \$60,000

17. What is the postal zip code at your home? _____

18. When was the last time you had a gynecological check-up and pap smear?

- Past 6 months
- Past 12 months
- Past 2 years
- Longer ago than the past 2 years

19. Have you ever been pregnant?

- No → Thank you!
You've completed the survey.
- Yes. → Go to Question #20

20. How many times have you been pregnant? _____

21. How many live babies have you given birth to? _____

22. Have you ever had a stillbirth (baby born dead near full-term), miscarriage, or abortion?

- No
- Yes. If "yes," check all that apply.
 - Stillbirth
 - Miscarriage
 - Abortion

23. Have you ever had a premature birth (baby born more than 3 weeks before your due date)?

- No
- Yes

24. Have you ever had a low birth weight baby (baby weighed less than 5lbs. 8oz. or 2.5 kilograms at birth)?

- No
- Yes

25. Have you ever had a baby die during its first year of life?

- No
- Yes

26. Are you currently pregnant?

- No
- Yes