Latino Health Care in Southern Appalachia
A Community-Engaged Examination

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ABSTRACT
Between 2007 and 2009, we created a research-based community partnership to identify and assess the health care needs of Latino families in the Appalachian Mountains of North Carolina. This report presents the survey and focus group findings for 159 Latinos concerning their views of health care services and barriers to accessing resources. Only 20 percent of the sample reported health as a major concern in their daily lives; however, notable proportions accessed health care within the last year through free or reduced-fee clinics (36%), hospital emergency rooms (25%), and individual doctors (18%). Most (82%) reported cost of care as the most significant barrier to accessing health care along with language fluency and facing discrimination. Many suggested they waited to seek care until symptoms worsened; hence the high number of hospital visits. Most (82%) did not have any health insurance. However, based on the focus groups, respondents felt that once a serious disease afflicted them, only faith and family could help them, as accessing American health care was a luxury they could not afford.

BACKGROUND
Within the last ten years, economic downturns in the United States overlie two major social issues: an increase in Latino immigration and a decrease in accessible health care. In 2009, the U.S. Census reported that there were 36.7 million foreign-born individuals in the United States, in which over half were born in Latin American countries and over a third were born in Mexico (Current Population Survey 2009). Passel (2006:ii) has estimated that an additional 12 million undocumented immigrants reside in the U.S., with Latinos representing about 78 percent of this estimate. Many Americans find this immigration wave frightening because of the sheer numbers, their supposed opposition to acculturation, and the stress immigrants place on the American economy and welfare system (Jacoby 2004; Lippard and Gallagher 2011).
However, the ethnicity of these newcomers and where many settle makes this immigration wave much different from past waves (Irish, Italians, and European Jews). Anrig and Wang (2006) suggest that within the last decade over two-thirds of the immigrant population settled in southern and
midwestern states, rather than traditional gateway states like New York and California. North Carolina saw over a 300 percent increase in the Latino population from 1990 to 2000 (76,726 to 378,963) (Kochhar et al. 2005). From 2000 to 2010, North Carolina saw another 111 percent increase in the Latino population, rising to 8.4 percent of the state’s population (Mackun and Wilson 2011). Researchers attribute much of this increase to the recruitment of migrant workers by agricultural and meatpacking industries in the area (Kandel and Parrado 2007; Kochhar et al. 2005; Lippard and Gallagher 2011; Massey 2008; McClain 2006; Parrado and Flippen 2009). This pattern holds true for Christmas tree farming in the Appalachian mountains of North Carolina, where the federal government allows owners to temporarily employ immigrants for seasonal agricultural work under the H-2A guest program (Brock 2000; also see http://www.dol.gov/compliance/guide/taw.htm). Subsequently, the Latino populations in Watauga, Avery, Ashe, and Alleghany Counties increased significantly from a few hundred to thousands. With a significant increase in Spanish-speaking Latinos across the state, North Carolina public and private institutions struggle to meet the needs of a more diverse population, especially in rural areas that face inadequate funding of services. More important, the Latino immigrant community finds itself abused, exploited, or completely isolated from services due to public outcry, restrictive legislation, Immigration and Control Enforcement (ICE) raids, and the lack of funding for bilingual public services (see Anrig and Wang 2006; Lippard and Gallagher 2011; Suarez-Orozco and Paez 2002).

Research and public professionals suggest that the most important issue facing Latino families is health information and access to health care. For instance, the Pew Hispanic Center (2002) reported that while most Latinos are generally healthier than White Americans, the more Latinos acculturate, the more they become unhealthy as a result of their adaptation to an American diet and poor health behaviors. Parrado and Flippen (2009) suggested that while the most common cause of death for Latinos in North Carolina is car accidents (49.3%), other untreated health conditions, such as diabetes and heart disease, are catching up to American citizen rates. Finally, like millions of American citizens, the Pew Hispanic Center (2004) found that over 42 percent of Latino immigrants and citizens are uninsured.

To understand and address health, economic and immigration issues in the Blue Ridge Appalachian mountain region of North Carolina (referred to as the High Country), we sought a collaborative effort with all relevant parties. We began by identifying and communicating with stakeholders in this issue: immigrant workers, health care organizations, social service organizations, housing and food agencies, education and child care institutions, churches, and local social science researchers. From these efforts, in the fall of 2007, leaders from these groups formed the Latino Health Coalition, including the Children’s Council (local partnership for children), the Farm Worker Health Program at Appalachian Regional Healthcare Systems (ARHS), Community Outreach at ARHS, the Appalachian District Health Department, and the University of North Carolina–Chapel Hill’s Center for International Understanding. Through this program, a group went to Mexico City and Puebla in September of 2007 and 2009 to learn about the differences between the Mexican and American cultural standards of health and health care. From this trip, we determined that little information existed in Appalachia about what services the Latino community most needed or how to disseminate that information.

We decided that the best way to begin providing better services to the Latino community was to develop a community initiative to collect systematic data about the conditions and concerns Latino families face. We knew that we needed to include women’s perspectives because most research on this subject to date focuses on men. We also wanted to publicize our findings to local community agencies to affect change. We found further footing for this project in the community-based research literature, which shares a mission to integrate research, action, and community (Israel et al.
METHODS

We chose a mixed method approach, using quantitative and qualitative methods, following previous researchers working with Latino immigrant populations in the United States. A mixed method approach appeared most appropriate because: 1) it allows the participant and researcher to clearly define the meaning behind each research question; 2) it helps ensure clear translation; and 3) it better suits the communication style of Latinos, which is to develop trust before diving into sensitive topics like immigration (Hayes-Bautista 2002). Also, based on preliminary discussions with the Latino Health Coalition and other Latino community organizations, participating groups wanted a forum in which respondents could fully discuss concerns about the community and public services. For this study, we used a mixture of interview surveys and focus groups to allow participants to fully express themselves, as well as to allow the investigators to fully explain questions and address any concerns. We completed this process in two phases.

The first phase involved a face-to-face survey (see Appendix A; the Spanish version of the questionnaire is available from the authors) that included closed-ended questions concerning demographic information (i.e., gender, age, education level, marital status, income, place of birth, etc). The survey also asked questions about reasons for coming to and staying in the High Country. A team of investigators administered the survey, including two undergraduate students from Appalachian State University and members of the Latino Health Coalition who speak fluent Spanish. The team delivered the surveys in both English and Spanish when needed. After obtaining verbal consent, the survey lasted about 30 to 40 minutes.

The second phase used focus group discussions (see Appendix B; Spanish focus group guide available from authors) conducted by the same team of investigators above. We conducted four different focus groups with at least eight participants in each, including men and women, using English and Spanish as necessary. We digitally recorded focus group sessions for transcription and analysis. The investigators who conducted the focus groups transcribed the recordings. We checked for consistency between focus group facilitators. The focus groups covered more specific topics, such as health care and access issues, Latino community development, and perception of social acceptance and integration into a predominantly White population. After obtaining verbal consent, each focus group lasted about 60 to 90 minutes. The IRB of Appalachian State University approved this research. We ensured confidentiality to all participants to protect their identities because half the sample consisted of undocumented immigrants. We compensated participation with a ten-dollar gift card to a local supermarket.

Sample

We sampled Latino immigrants (documented or undocumented) residing in Avery or Watauga Counties in North Carolina, age 18 years or older. We intentionally sampled nearly equal numbers of Latino men and women. According to the 2006 American Community Survey data only 800 to 1,000 residents of Watauga and Avery Counties combined classified themselves as Hispanic and foreign-born. Coupling these numbers with other obvious problems of isolation and language fluency required us to rely on the networks of Latino community members and service providers (such...
as the Latino Health Coalition) to find the necessary sample. Over half the sample came from respondents’ peers, as well as from attending community functions (e.g., the soccer league). We surveyed 123 individuals—49 Avery County residents and 74 Watauga County residents, with comparable numbers of Latino women and men—65 men and 58 women. Thirty-six people participated in the focus groups, 20 women and 16 men.

Table 1 presents the sample demographics. The sample median age is around 29 to 30 years old, similar to the census median for both counties: 38 years old in Avery and 30 years old in Watauga (US Census 2010a, 2010b). Levels of education, however, differ. Only 9.8 percent of those surveyed completed high school (or equivalent), comparatively lower than Avery and Watauga residents (71% and 82%, respectively). We note, however, that economic issues families face in the early twenty-first century may explain these educational differences. First, poverty disrupts education in Mexico, especially when students must pay for books after grade six. Second, due to the poverty rates, children

<table>
<thead>
<tr>
<th>Social Characteristic</th>
<th>Number</th>
<th>Percent</th>
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<tbody>
<tr>
<td>Male</td>
<td>72</td>
<td>45.3%</td>
</tr>
<tr>
<td>Female</td>
<td>87</td>
<td>54.7%</td>
</tr>
<tr>
<td>Median Age</td>
<td>29.5</td>
<td>X</td>
</tr>
<tr>
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<td>159</td>
<td>100%</td>
</tr>
<tr>
<td>% from Mexico</td>
<td>138</td>
<td>87%</td>
</tr>
<tr>
<td>% Spanish 1st Language</td>
<td>159</td>
<td>100%</td>
</tr>
<tr>
<td>% Only Speak Spanish</td>
<td>103</td>
<td>65%</td>
</tr>
<tr>
<td>Average # of Years in NC</td>
<td>5.2</td>
<td>X</td>
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<tr>
<td>Education Level</td>
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<tr>
<td>6th grade or less</td>
<td>55</td>
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<td>6th–8th grade</td>
<td>51</td>
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<tr>
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<td>31%</td>
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<tr>
<td>Married or Civil Union</td>
<td>110</td>
<td>69%</td>
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<tr>
<td>% Catholic</td>
<td>110</td>
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<tr>
<td>Religion Never Affects Daily Life</td>
<td>76</td>
<td>48%</td>
</tr>
<tr>
<td>Spouse Here</td>
<td>76</td>
<td>48%</td>
</tr>
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<td>Mean # of Children</td>
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<tr>
<td>Child Here</td>
<td>71</td>
<td>45%</td>
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<td>Economic Characteristics</td>
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<tr>
<td>In Labor Force</td>
<td>114</td>
<td>72%</td>
</tr>
<tr>
<td>Working Full Time</td>
<td>65</td>
<td>41%</td>
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<tr>
<td>Median Individual Income</td>
<td>&lt; $10,000</td>
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</tr>
<tr>
<td>Median Household Income</td>
<td>&lt;$20,000</td>
<td>X</td>
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<tr>
<td>Individuals Below Poverty</td>
<td>86</td>
<td>55%</td>
</tr>
<tr>
<td>No Bank Account</td>
<td>107</td>
<td>67%</td>
</tr>
<tr>
<td>Renting</td>
<td>114</td>
<td>72%</td>
</tr>
<tr>
<td>&lt; 4 Rooms</td>
<td>124</td>
<td>78%</td>
</tr>
<tr>
<td>Median # of Occupants</td>
<td>4</td>
<td></td>
</tr>
<tr>
<td>Own a Car</td>
<td>70</td>
<td>44%</td>
</tr>
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</table>
in Mexico tend to work earlier to help support their families than children in the United States. Many of our respondents went to school in Mexico.

Another difference is that 89 percent of those surveyed were married or in a civil union, whereas in Avery and Watauga Counties only around 47 percent and 60 percent are married, respectively. Latinos also reported having at least two more children than most families do in North Carolina (US Census 2010c), and 89 percent reported being Catholic. However, unlike 46 percent of U.S. citizens who suggest that religion affects their daily lives (GSS 2008), only 36 percent of Latinos surveyed indicated such, contrary to assumptions that Latinos are more religious than many U.S. citizens. Minimally, this finding points to religion as not a daily ritual for many Latinos in the High Country.

The economic characteristics of those surveyed are also compelling. First, 64 percent of Latinos surveyed participate in the labor force, which is similar to the overall participation rate in Watauga County (63%) but higher than in Avery County (55%). Nearly half (45%) work full time but almost 81 percent have seasonal or temporary work. In addition, the average individual income for Latino immigrants is equal to, or less than, $10,000 annually and household incomes are equal to, or less than, $20,000 a year. On average, Avery County residents hold incomes higher (at $30,000), with still higher incomes in Watauga County ($32,000). As seen in Table 1, about 55 percent of the Latinos surveyed are below the individual poverty level of $10,830—which is 42 percentage points higher than the individual poverty levels in Avery and Watauga county (15.3% and 17.9%, respectively) (US Census 2010a, 2010b).

FINDINGS

Latino immigrants and Latino citizens in the U.S. face many similar health issues as all Americans, including diabetes and heart disease (Brown and Yu 2002; Hayes-Bautista 2002; Pew Hispanic Center 2002). However, like other poor groups, economic necessity dictates cultural responses to health concerns among Latinos that rely more on spiritual and naturalistic remedies (Hayes-Bautista 2002). Below we present attitudes towards health that emerged from Latino responses to surveys and focus groups. These attitudes highlight the cultural and contextual factors that shape Latinos’ decisions regarding health.

HEALTH WORRY, NOT FOR ME

Not worrying about health is the most prominent theme among Latinos. Only 20 percent of the sample report health as a major concern. Demographics may explain these findings, considering that the median age of 29 precludes this particular sample from experiencing most serious health issues. For instance, one 25-year-old Latino states, “My life, I don’t worry about health. I’m young and I watch what I do to stay in good shape. I have cut off fingers, but I’ve had two put back on . . . in the last two years.” Or, as one other Hispanic man in his late 30s reflects, “When I was young I thought I could do anything physically. Not as much today. It hurts to pick up an 80-pound bag of concrete.” Another 23-year-old Latino states, “I am strong and ready for work now so I better take advantage of it . . . . I just don’t get sick enough to care.” Or as another Latino man stated who was 25 and drank at least three energy drinks every morning before starting work at the Christmas tree farm, “My father has a lot of health issues because he didn’t take care of himself but I don’t see what I’m doing as any worse than him; so, I’ll be fine.”
A few additional social factors probably help explain the “no health worry” trend. First, health issues concern many respondents when they have time and money to address them. So, economic resources complicate seeking health care services and resources. To illustrate this point, three Hispanic men disclose:

Health is important but what you don’t understand is that it is a luxury. Accidents happen but we don’t need to involve the owner or anyone else because they will find someone else to do your job. Go home, drink a beer, and get some rest. That [is] what I do and tell my friends to do.

It costs too much to get medicine or see a doctor. I can’t miss a day of work either because like every other person I know, we need to work to just feed us and keep us warm.

Sure, I want to be healthy to go to work but if I get sick, I understand that there are others waiting for me to get sick so they can get my job. . . . I can’t let my family be done like that. I have to work.

Second, as the men above imply, gender complicates seeking health services. Men risk losing their jobs when missing work. Moreover, it is their “job,” as men, to provide financially for their children. Hispanic women also put their own health after their family. For example, one Latina declares, “Children are first. I have to make sure my sons are healthy and I can’t waste my money on my aches and pains.” Another Latina echoes, “I need to worry about my children and husband [and] make sure they are healthy. . . . I do okay.” A few women with serious health issues put off medical attention because it took either time away from their family, or it cost too much money, as one mother confides:

Health is an important issue and the more time I spend in America, the more that I have become aware of the problems I may have. Recently, I found out that my serious pains I had around my stomach were due to possibly cancer. Well, the costs were too much to get checked out and my youngest son got really sick around the same time. So, I waited to see the doctor to get more tests [I waited] almost two years but it turned out it was just some problems with digestion.

Third, documentation status also complicates seeking health services. One undocumented man in his 40s inform s, “It is [health care] not for me. I don’t think I’m allowed to go in there and get help. I was not born here and when they look at me, I get it.” And another, “No one seems to care if I get sick and die in this country. I know I am breaking the law but don’t you think that humans should be able to be healthy?” An undocumented Hispanic woman reveals:

I had a man, a doctor, tell [me that] I, personally, was ruining America’s system of health because I did not have the right documents, the right culture, to know you have to have insurance and do my part to stay healthy. Health is not about papers.

Finally, some respondents view health as an “American” problem of worrying and even whining too much. As one Latina states:
I think Mexicans think through their health problems. We don’t go to the emergency because we have a cold, we take medicine we already have. We only go if it is necessary and most things aren’t.

Another Hispanic woman comments on Americans’ obsession with health and weight:

We view health differently than you do. Fat is good, it shows you’re healthy. You need to get the flu so you can fight it again. You need the downs to survive the ups.

A Latino working at a Christmas trees farm also points to Americans’ worry with health:

You get sick and Gringos don’t understand that you stop, take care of yourself, and then go on with your life. You don’t need to [be] so dramatic about being sick because you will get better or you will die (laughs loudly)! And, dying, you should not be afraid of when you know you will go to a better place.

The excerpts in this section underscore the focus of migrants on the present—an orientation shaped by economic situations. Second, they also view health and getting treatment for health issues as an expensive luxury. Third, the cultural norm of “family first” dictates women’s and men’s less immediate attention to their own health issues. And, respondents see Americans as overly concerned with the industry of health and health care.

Faith

Faith represents another powerful theme that sways respondents’ views of health. Of the 36 Latinos participating in the focus groups, at least 15 mention God as a necessary component in determining their health and life. Three Latinos, one with cancer, illustrate:

Yes, health is an important issue; however, I am not afraid of it. I have my God watching over me and if I am to get sick, He will take care of me. I do not fear death as it is part of life. . . . I cannot change what is in my body. It will get better if God says it will.

We all feel better when we are one with God. I pray and that is what I was taught to deal with real issues of pain and sorrow. . . . Health is no different. You have to have faith to feel better, whether it is faith in God to help you or just faith in your body to heal itself. . . . What is that they say, time heals all wounds. Well, add faith to it too.

I want to feel better, and I take medicine to deal with my aches and pains. But, I must trust in God to help me with the serious issues because I don’t have the money to do it otherwise.

Using faith to accept health issues occurs frequently among many Latino immigrants in the U.S. (see Hayes-Bautista 2002). However, many other poor Americans deal with health crises similarly by attributing the continuum of health and illness to a force they cannot control (see Rank 2005). As Rank (2005) describes, most poor individuals do not fear illness because they will never have the means (i.e., social or economic capital) to address serious problems like cancer, heart disease, or diabetes. Once disease afflicts the poor, faith, family, and the belief in a better life after death become the primary health care resources. We see this pattern clearly among Hispanic immigrants who reside at the bottom of our economic and social hierarchy. Many do not even seek health care when ill, not wanting to call attention to themselves in our system or wanting to avoid additional discrimination.
Using Health Services

Health care services for Spanish-speaking patients in this rural area are limited. For both counties investigated, there is a hospital, a health department, and several doctors in the main town. In both cases, the main town occupies a central location about 30 minutes away, in good weather, from most people. However, very few facilities offer bilingual staff. The hospital and health department each hire one person to help with translation during regular hours of operation (Latino Health Coalition 2009). The area also benefits from limited public mental health services, an active Farm Worker’s Health Program (see http://www.ncfhp.org/), and two free or reduced-fee clinics (Community Care Clinic and La Clinica)—all with language barriers.

Via focus groups, we asked Latino immigrants what health services they used in the last year. As presented in figure 1, just over half the sample (52%) reported using some sort of public or private health service since moving to the area. Also, about 27 percent report using prenatal services provided by local health departments. A smaller percentage of respondents report using other health services, including mental health (12%), dental (13%), and rescue/emergency services (11%).

Respondents also identify where they last obtained medical care. Figure 2 points to the most frequently locations as free or reduced-fee clinics (36%), then hospital emergency rooms (25%) and lastly, individual doctors (18%). Only about 12 percent of the respondents went to the Health Department. Other sources of medical care included family members or Hispanic community members with some knowledge about natural remedies.

Clearly, Hispanic immigrants rely on hospitals and clinics for medical attention. As noted during the focus groups, the cost of care in a doctor’s office prohibits visits, and many wait until emer-

Figure 1: Percent of Respondents Who Reported Using Service in the Last Year*

*Respondents checked all services used in the last year.
gency circumstances to seek treatment, hence the high hospital visits. Similarly, Brock (2000) found that many Hispanic H2A workers in the High Country wait to get treatment for upper respiratory illnesses, resulting in emergency room visits for pneumonia.

Over 40 percent of respondents pay for any type of medical care out-of-pocket. About 22 percent depend on charity. However, 18 percent of the respondents use some sort of health insurance to cover costs. In contrast, 82 percent of the respondents in this study do not have insurance, which is 2.5 times greater than the rate reported for a national sample of Latinos in the U.S. (Pew Hispanic Center 2002). Again, cost becomes the prominent issue in deciding which health care services to access. As one Hispanic woman states, “I always ask the doctor or nurse how much it costs to treat anything. I also want to know which option is cheaper so that we can do what we can and not owe people money.”

Use of health services differs significantly between men and women and documented and undocumented. Women are four times more likely to use clinics and doctors and twice as likely to use health departments compared to men surveyed. Conversely, Hispanic men are twice as likely to use hospital services than Hispanic women in the sample. In contrast, Hispanic women are twice as likely to report having some sort of insurance than the Hispanic men in this study.

The focus group discussions help clarify the differences in accessing services between women and men. As one Latino woman suggested, “I take care of the whole family... I’'m the one who has to make sure the children are well and my husband can go to work.” Or as another said in a focus group in Avery County, “I know a lot of the doctors and nurses because kids are always sick and I have to go with them to the doctor.” Another Latino woman in the same group spoke up: “We women are the frontlines of care for our families and the men work; that is the way it is.” Almost half (47%) of the women who answered the survey used the prenatal services available through the health departments and non-profit organizations. Our finding that women access health care resources more often than men reflects the larger social pattern of more women caring for family.

In this sample, undocumented respondents are twice as likely to report using health and prenatal services than documented respondents. However, documented respondents were almost two
times more likely to use dental and mental health services. These differences are due to the high number of women in this sample who are undocumented. As for specific medical agencies used, there are no real differences between documented and undocumented respondents. In short, while about half of Latino immigrants in this sample use local health services, about half do not. Therefore, what barriers exist to accessing health care services?

Barriers to Accessing Health Care

The primary barrier for the respondents in this study is cost. Eighty-two percent of the Latino participants point to cost preventing them from using a health service. The second and third most common problems in accessing health care services are language issues and discrimination. About 75 percent of respondents indicate they could not adequately communicate health concerns to a provider or receive health information from a provider because the medical office lacked Spanish resources. As one Hispanic woman describes, “How do you talk to a doctor or nurse who only speaks English that you have a serious issue like cancer or even a real bad breathing problem?” In the focus groups, respondents also report bringing along their children or peers with better English skills. However, this poses a problem as well because many of the “pseudo-translators” could not understand and translate all the medical information, or the Latino patients found some issues and information embarrassing to share through friends or children. A Latina and a Latino share their experiences below:

I had some problems with my, well, my privates and my daughter had to come with me to talk to the doctor. My daughter is twelve and she was already embarrassed about being the person to talk between me and the doctor. Well, the doctor began to ask me questions through my daughter about whether I was having sex. My daughter turned, started to giggle, and couldn’t ask me until I made her.

I take my friend to help me one time with the hospital. . . . He could not understand what the doctor was saying at all, even though the doctor was trying to speak Spanish. . . . My friend said to me, “I have no idea what he is saying, he is saying something about your heart or gas or something.”

About 32 percent of respondents describe discrimination (or mistreatment), experienced or perceived, when accessing health care in the High Country. Many attribute this mistreatment to people defining them as illegal immigrants. Participants in the focus groups also lack trust in public service providers because of the fear of being deported or mistreated if the individual holds a prejudiced slant towards Latinos. As one Latino man reveals, “I don’t want to go to the doctor because he may find out I’m illegal and there I am. . . . I guess I will deal with a broken leg in my own way before risking being sent away.”

Of the 123 Latino immigrants surveyed, 48 percent tell of mistreatment while receiving or attempting to receive health services. Some participants in the focus groups provide examples of problems at the hospitals, health departments, and physicians’ offices:

I took my daughter to the emergency room and let me tell you, they don’t want you there. When we got there, the lady at the door looked at me; got on the phone, and said, ‘Some Hispanics are here, what do you want me to do?’ I can speak English pretty well but she didn’t even ask me, she just went ahead and made a decision for me. It took over three hours before we saw a doctor.

I have three children and they are all different in age. They all get different care. . . . My oldest son seems to always be the last to get served because I think the nurse does not like that he is not a citizen or has papers. She always makes comments, “When are you going back to Mexico?” But, it is a clinic and free, I should not complain.
Another Latina describes her visit to an emergency room late at night, “We went in and they didn’t even want to help us. I felt as though we were not wanted there.” Finally, a Hispanic man conveys his visit to a health department:

I find many of the health people nice but I have some problems with some. . . . I feel that they are rude to me because of who I am, a Mexican. They are rude and get frustrated when I ask too many questions. I have even had them ask me to leave because they did not want to deal with me at that time.

From the above comments we learn that women immigrants and those perceived as illegal are the most likely to face discrimination. This level of discrimination may be a result of recent increases of anti-immigrant sentiment noticed across the American South and particularly in North Carolina (see Lippard and Gallagher 2011; Marrow 2011; Massey 2008; and McClain 2006). As one Latino informs us, “I’m actually an American citizen, but they all look at me as though I’m just another illegal taking services I don’t deserve.” Or, as another, “I get the looks, ‘You don’t belong here,’ ‘We don’t want you here,’ they even do this to my children. Why do people hate my children?”

A Hispanic man recounts:

I am not a tourist and I tell you someone from Florida who deals drugs and destroys this beautiful place gets treated better than me who works hard in this community and follows the rules. We are not tourists. We are here to stay.

This is not a surprise, though, because there were more undocumented immigrants using health services than documented immigrants, and there were more women using these services than men. Thus, it may be that the more Hispanics interact with the public, the more likely they will face discrimination. Overall, discrimination discourages Latino immigrants from wanting to access the health care services available locally. Certainly, the experiences mentioned above negatively impact views of health and health care. Problems concerning language fluency make Latinos even more isolated and less likely to access basic services needed to live healthy lives in the High Country.

**Acculturation Leads to Risky Health Behaviors**

While this study did not focus on identifying risky health behaviors, the subject became a part of conversations in the focus groups. These discussions centered on general health concerns that focus group participants held concerning their families and community as a result of their migration to the area. As some studies suggest (Pew Hispanic Center 2002), Latino immigrant acculturation to American health habits creates both positive and negative outcomes.

For instance, some respondents felt that their change in diet since arriving in the U.S. caused health problems. One Latina from Avery County reports, “I have been more sick since I got here. . . . I know that I am fatter than back home. I eat McDonald’s and cookies and cakes. I don’t walk as much because things are so far apart.” A Latino H2A farm worker recently diagnosed with diabetes states, “I know I have diabetes and if my friends continue to drink about a case of Coke, four or five cans of Monster, and eat two sandwiches to keep them going through the day, they are going to get diabetes too.”

Some of the focus group respondents point out that they also saw more of their Hispanic friends and co-workers using more alcohol and tobacco than back at home. A younger Hispanic man confides:

You come here and you have freedoms you don’t know how to handle. You can buy beer and cigarettes and get really drunk. If I was at home, someone in my town would catch me and say, ‘You stop that!’ I don’t get bothered here because we all do it.
Or, as one Latino shares, “Many men here miss their families and homes and they drink to deal with the depression. It is hard to really understand the distance you feel when you are away from everything you know and love just to earn some money.” One Hispanic woman agrees with the problems of alcohol showing up more now:

Drinking is a big problem. . . . Sure, it was a problem at home but here it is almost like there are no limits—do what you want. And, the men don’t stop drinking because they have nothing else to do unless there is a soccer game or something.

The women in the focus groups point to troubles surrounding the transition to a different culture where women possess different rights and roles. A Latina asserts: “I think there is some tension in Hispanic homes over women wanting to work and do more and the men want them to stay home. I have heard of problems of the cops coming to break up fights.” A Latina from Watauga County speaks to an increase in domestic abuse:

Women have more rights here. I like that, we all do but it does not always work in our houses. This is hard for both women and men from Mexico to get used to and there are disturbances and problems that come up. We work [it] out but I think more and more problems [fights] are happening.

Several Latinas address the specific issue of teenage pregnancy during the focus groups. Although, culturally, a younger Hispanic woman with a child is more accepted among Hispanics than Americans, the situation is different in the U.S. Two Latinas explain:

When I first got pregnant in Mexico, I had my family and a local woman helped me step-by-step with my pregnancy and birth. But, my daughter needs to wait because here, you do not want pregnant young girls. There are also not many women ready to help at the home. I also think that it costs more to have a baby here.

Everything is more expensive here. Girls do not need to have kids here so early because they are more expensive. . . . You also don’t have the same help. I mean you have [name omitted], but she is a stranger and usually family helps you through this process. Besides, here, Americans look down on too many babies, and there is always someone giving my family and girls information about how to prevent teenage pregnancy, so it must be an issue.

In short, some common behaviors are “risky” for immigrant populations because they represent a cultural shift that challenges their community socially and psychologically, leading to further stress and strain, as seen with the comments on domestic violence and teenage pregnancy. The topics of domestic violence and teenage pregnancy in Latino immigrant populations emerge from our project as topics in need of much more full and systematic investigation.

**DISCUSSION AND CONCLUSIONS**

With the help of 123 survey respondents and 36 focus group participants, this study offers a richer understanding of Hispanics’ health care experiences in the High Country of North Carolina. Economic and social situations primarily shape Latino attitudes about health and health care in the High Country, where accessing health care is seen as a luxury. The American culture of immediately addressing health issues evades Latinos who, as low-wage, sometimes undocumented, workers, exist with limited money and time. Our sample was also largely young, which led to less health worries. Women access
health care more often than men as they care for families. Many in this study, however, expressed that they simply do not access health services because they cannot communicate with or trust non-Hispanic professionals, and many have already experienced discrimination through threats and isolation.

Latinos in this study draw on their spirituality to offset health concerns. Many viewed the issue of health in the context of fate—something that occurs due to natural processes, and in which God or those with power (i.e., medical professionals) will intervene when necessary. Nevertheless, many respondents worry about their health, particularly since arriving in the United States. They observe risky health issues increasing in their community. For instance, weight gain and health problems, like diabetes, caused by the American diet of sugary and fatty fast food. Further, teenage pregnancy among Latino girls and the broader gender roles Latino women adopt in America trouble them. However, again, age and cost are large factors in determining the sorts of health concerns that push these individuals to access service.

Due to some of the problems above, as well as other more common health issues like colds and the flu, half the respondents in this study used some sort of health service in the study area. Many accessed health care through free clinics (36%), a hospital ER (25%), and local doctor’s offices (18%). Some even went to other sources such as family members who practice natural medicine. However, most went to the cheapest and fastest option available—an ER or a clinic. Only 18 percent of respondents carry any sort of health insurance.

The final discoveries in this study concern barriers to health care. Like many other Americans, cost is the primary barrier in accessing health care. Without some sort of insurance and a higher level of income, Hispanics in the High Country find themselves depending heavily on free clinics or emergency services to address almost all their health concerns. Another significant barrier is language; either because many Hispanics in this study could not speak English proficiently enough to communicate with a health professional or there were limited translation/interpretation services available. Issues of rapport and trust, attached to language, pushed many Latinos to travel further to find health care services from a bilingual provider. Discrimination is the third most cited barrier. Many Latinos report negative experiences while using health services, such as being treated as “illegals” or as second-class citizens.

From Research to Action

To address the confounding discrimination and language barriers in health resources, the Latino Health Coalition and the Center for International Understanding at the University of North Carolina created an action plan (Latino Health Coalition 2009). This action plan addresses three goals: (1) to increase awareness about the Latino community and their needs, (2) to strengthen community ties between the Anglo and Latino communities in the area, and (3) to strengthen health services to Spanish-speaking people.

Following the action plan, over 15 presentations about the Latino community and their health needs were conducted with county hospitals, county health departments, and several other non-profit health service organizations. The mental health and hospitals also conducted their own diversity trainings on the Latino community and many have hired at least one new bilingual person. Second, area universities collaborated with Mexican medical schools to establish internships with local health services for third-year medical training requirements. This exchange brings in more bilingual medical students to help with Hispanic patients, as well as increasing exposure of doctors, nurses, and other health professionals to Hispanic culture.

Third, the local office of the North Carolina Farm Worker Health Program and Appalachian Regional Healthcare Systems (the local administrative body of the hospitals) used our findings
concerning Latino health access and economic vulnerabilities to apply for Bureau of Primary Health Care funds to start a new community-migrant health center. If funded, the community-migrant health center will provide two full-time primary care providers and two dental providers for immigrants and the under-insured in Avery and Watauga Counties on a sliding-fee schedule. It would also provide case management and health education to all patients with other barriers and/or chronic health problems and outreach services to farm workers and their families in the region.

Finally, the Latino community organized a group who met with representatives of health, social, and law enforcement services. The group gained information during these meetings on how Latinos may better access existing local services and they provided direct information on the needs of Latinos locally. The group recently stopped meeting due to a surge of immigrant raids and license checks conducted by local, state, and federal law enforcement across the state of North Carolina.

**APPENDIX A: QUESTIONNAIRE**

**Latino Health Coalition Survey**

**Region: A/W**

**Demographic Information**

This section covers information concerning who you are and will be helpful in giving us some idea of the variety of Latinos in North Carolina. Please check or write in the appropriate responses for each question. If you choose an answer that has an arrow (g), then please answer that question as well.

1. **What is your sex?**
   a. ___Male
   b. ___Female

2. **How old are you (specify in years)?** ______

3. **What is your relationship status (please only check one)?**
   a. ___Single
   b. ___Married
   c. ___Civil Union
   d. ___Widowed
   e. ___Divorced
   f. ___Separated
   g. Other (please specify): __________________________

4. **Where was most of your schooling?**
   a. ___United States
   b. ___Country of origin/birth (please specify __________________________)
   c. ___Other (please specify: __________________________)

5. **What is the highest educational level you have attained?**
   a. ___6th grade or less
   b. ___6th through 8th grades
   c. ___High School
   d. ___Associate Degree
   e. ___Bachelor Degree (B.A., B.S.)
   f. ___Graduate/Doctoral Degree (Ph.D., M.D., J.D.)
   g. ___Other: Please specify: __________________________
6. What is your race or ethnicity? ____________________________________________________

7. What is your current employment status?
   a. ___ Working part-time → Current occupation(s)/job(s)? ___________________________
   b. ___ Working full-time → Current occupation(s)/job(s)? ___________________________
   c. ___ Unemployed
   d. ___ Retired

8. What was your occupation before arriving to the United States? _______________________

9. What is your personal annual income?
   a. ___ Less than $10,000 a year
   b. ___ $10,001 to $15,000 a year
   c. ___ $15,001 to $20,000 a year
   d. ___ $20,001 to $30,000 a year
   e. ___ $30,001 to $40,000 a year
   f. ___ More than $40,000 a year

10. How is your job better than the one you had back in your home country?
    ____________________________________________________________________________
    ____________________________________________________________________________

11. How is your job worse than the one you had back in your home country?
    ____________________________________________________________________________
    ____________________________________________________________________________

12. How does your current income compare to the one you had in your country of origin?
   a. ___ Much lower now
   b. ___ Somewhat lower now
   c. ___ Same now as before
   d. ___ Somewhat higher now
   e. ___ Much higher now

13. What is your total household income (household includes yourself and any one else in your household that earns an income)?
   a. ___ Less than $20,000 a year
   b. ___ $20,001 to $30,000 a year
   c. ___ $30,001 to $40,000 a year
   d. ___ $40,001 to $60,000 a year
   e. ___ $60,001 to $80,000 a year
   f. ___ More than $80,000 a year

14. Do you (or your family) rent or own the place you live in?
   1. ___ Rent
   2. ___ Own
   3. ___ Neither, I am temporarily living with someone else
15. Which other individuals live with you? (Please check all that apply)
   a. ___ spouse/romantic partner
   b. ___ children (how many? _____)
   c. ___ parents (how many? _____)
   d. ___ other relatives (how many? _____)
   e. ___ co-workers (how many? _____)
   f. ___ friends (how many? _____)

16. How many rooms do you have in your dwelling (count all rooms except bathrooms)?
   a. ___ 1 to 2
   b. ___ 3 to 4
   c. ___ 5 to 8
   d. ___ 9 or more

17. How many individuals (including yourself) do you support financially? ______

18. What form of transportation do you most often use?
   a. ___ my car
   b. ___ friend’s or relative’s car
   c. ___ bus or other public transportation
   d. ___ bicycle
   e. ___ walk

19. Do you use a checking or savings account here in the United States?
   a. ____ yes
   b. ____ no

20. Do you send money home to family, friends, or others?
   a. ____ yes → 20a. On average, how much do you send in a month? _______
   b. ____ no

21. What is your religion?
   a. ___ Catholic  d. ___ Islamic
   b. ___ Protestant  e. ___ Other (please specify): ________________
   c. ___ Jewish

22. How much does religion affect your day-to-day life?
   a. ___ Never  c. ___ Most of the time
   b. ___ Sometimes  d. ___ Always

23. Where were you born? ____________________________________________

24. Where did you live immediately before coming to North Carolina?
   a. Which country? __________________________
   b. If in the United States, which state? _____________ and city? ________________
25. How long have you been in North Carolina? ______ years and ______ months

26. How long do you plan to stay in North Carolina? ______ (years)

27. What is your main reason for migrating to North Carolina? (Please check one)
   a. ___ Stay with family members
   b. ___ Employment opportunity
   c. ___ Educational opportunity
   d. ___ Climate
   e. ___ Acceptance from local community
   f. ___ Other reason (please specify): _____________________________________________

28. What were some of your other reasons for migrating to North Carolina? (Please check all that apply)
   a. ___ Stay with or rejoin family members
   b. ___ Employment opportunity
   c. ___ Educational opportunity
   d. ___ Climate
   e. ___ Prejudice in previous place of residence
   f. ___ Other ___________________________________________________________________

29. What is your main reason for remaining in North Carolina? (Please check one)
   a. ___ Stay with family members
   b. ___ Employment opportunity
   c. ___ Educational opportunity
   d. ___ Climate
   e. ___ Acceptance from local community
   f. ___ Other reason (please specify): _____________________________________________

30. How often do you feel you face discrimination because you are a Latino?
   a. ___ Never
   b. ___ About once a month
   c. ___ Several times a month
   d. ___ About once a week
   e. ___ Several times a week
   f. ___ Daily
   g. ___ Multiple times per day

31. In which of the following situations do you feel you have faced discrimination because you are Latino? (Check all that apply)
   a. ___ Getting a job
   b. ___ Getting a promotion
   c. ___ Receiving service/entry by a business
   d. ___ Being watched while in a store
   e. ___ Renting an apartment or house
   f. ___ Having landlord maintain apartment/house
   g. ___ Obtaining credit or a loan
   h. ___ Purchasing a house or property
   i. ___ Being treated by police
j. ___ Being treated by the education system (e.g., teacher, school administrator)
k. ___ Being treated by a public service provider (e.g., social worker, employment counselor, health care professional)

32. Have you used the following services during the past year? (check all that apply)
a. ___ general health services   f. ___ prenatal services
b. ___ dental services   g. ___ psychological services
c. ___ banking/loans   h. ___ utilities
d. ___ ESL instruction   i. ___ education (not including ESL)
e. ___ law enforcement services   j. ___ rescue/para-medic services

33. What type of social/public service is the most difficult to obtain in North Carolina? (Please check only one)
a. ___ general health services   e. ___ prenatal services
b. ___ dental services   f. ___ psychological services
c. ___ banking/loans   g. ___ utilities
d. ___ ESL instruction   h. ___ education (not including ESL)
e. ___ law enforcement services   i. ___ rescue/para-medic services

34. What type of social/public service is the least difficult to obtain in North Carolina? (Please check only one)
a. ___ general health services   f. ___ prenatal services
b. ___ dental services   g. ___ psychological services
c. ___ banking/loans   h. ___ utilities
d. ___ ESL instruction   i. ___ education (not including ESL)
e. ___ law enforcement services   j. ___ rescue/para-medic services

35. If you needed medical help, where would you go? _________________________________

36. If you needed medical help, how would you pay?
a. ___ health insurance   d. ___ borrow money
b. ___ out of pocket   e. ___ have no way to pay
c. ___ rely on charity organizations   f. ___ other (please specify): __________

37. Who has been most likely to give you information about health services?
a. ___ friends   b. ___ family   c. ___ public agency   d. ___ other: _________________

38. What goals do you have for yourself and/or your family 5 years from now?
_______________________________________________________________________________
_______________________________________________________________________________
_______________________________________________________________________________
_______________________________________________________________________________
APPENDIX B: FOCUS GROUP GUIDE

Focus Group Schedule

Basic Needs and Community Dynamics

1. What brought you to Boone and the surrounding areas?
   a. What do you think of the locals and the community?
   b. How do the locals treat you?
   c. What kinds of problems have you had adjusting to the lifestyle in this area?
   d. How has the local community changed since you arrived here?

2. What do you do, or whom do you ask when you need help or assistance here?
   a. Do you ever go to the local agencies for help?
   b. Which ones and under what circumstances—can you provide an example?
   c. What do you think is lacking in support for you and your family?
   d. Do you think the community agencies are doing a good job?
   e. Can you name one that has done something to help and how well they helped you?
   f. Who would you go to for support in this area?
   g. Would you use the police? Why? Why not?
   h. How have the schools treated you?

3. What’s it like as far as support from the Latino community?
   a. Why are there not more Latinos in the area?
   b. Who do you see as the leader of your community here and why?
   c. How do you define community?
   d. Is there a sense of community with other Latinos? Why or why not?
   e. How about Non-Latinos? Why or why not?
   f. Since you’ve been here, how has the Latino community changed for you?
   g. What do you think are the problems with organizing the Latino community?
   h. How do you feel about the cooperation among Latino families to help one another?
   i. How is your family important to you?
   j. How has your family changed since you got here or arrived in the United States?
   k. How about the roles as men and women?
   l. Have you had to adjust to more American ways of doing housework, work, or even getting along in your family?
   m. What about your children?
   n. What do you view as their future?
   o. What issues are they facing at school and home?

4. What do you think of your living conditions?
   a. What you think of the housing choices?
   b. What would like to see changed about housing?
   c. Do you have access to the foods you like and the things you like to do?
   d. Where do you go for these things?
   e. How about getting jobs. Do you face any issues?
   f. What would you like to be able to do in a year from now?
   g. What kinds of things do you want to see improve?
h. What do you think about the recent debates concerning “illegal” immigration?

i. Have you heard about the immigrant raids?

j. What do you think about them?

k. Are you afraid about the laws being considered?

l. What about the raids?

5. A significant concern for us is your health. Do you feel that you receive adequate health care?

a. What about medical attention? Where or to whom do you go for medical help?

b. If you don’t go somewhere for medical attention, what do you do?

c. Some people suggest using natural medicines first. Do you use natural medicines first?

d. What do you use and how often?

e. Where do you get your medications?

f. What about your children? Where do they receive treatment?

g. How have you found out about health-related services in the area?

h. I’ve heard some people use more traditional forms of medicine; is this true?

i. What do you see around you?

j. What do you prefer and why?

k. What are your greatest health concerns for yourself?

l. How about for the community?

m. How have these concerns changed since you’ve arrived in North Carolina?

n. What did you do about health care when you were in your home country?

o. What services were available?

p. What kinds of services are missing now that you are here?

q. What improvements would you suggest concerning access to healthcare services?

r. What about health service information?

s. Where do you seek health information now?

t. Where did you get health information in the country you came from?

NOTES

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1. In this report, we use the terms “Hispanic,” and “Latino” interchangeably. While an overwhelming majority of the participants in this study originate from Mexico, some traveled from Central America. Also, many of the respondents use these terms themselves to describe whom they identify with racially and ethnically. Most view themselves as “Mexicans.” We use the term “Latino” to denote a Latino/Hispanic man and “Latina” to denote a Latino/Hispanic woman. However, the terms “Latinos” or “Hispanics” represent the group as a whole. Further, we use “documented” and “undocumented” to note the population’s immigration status. “Documented” suggests that the respondent is either a person who holds a current permanent resident visa or who has been granted permission under a set of specific authorized temporary statuses for longer-term residence and work.
“Undocumented” refers to those individuals who do not hold a current permanent or temporary visa to live or work in the United States.

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