

Hispanic-American Culture and Health

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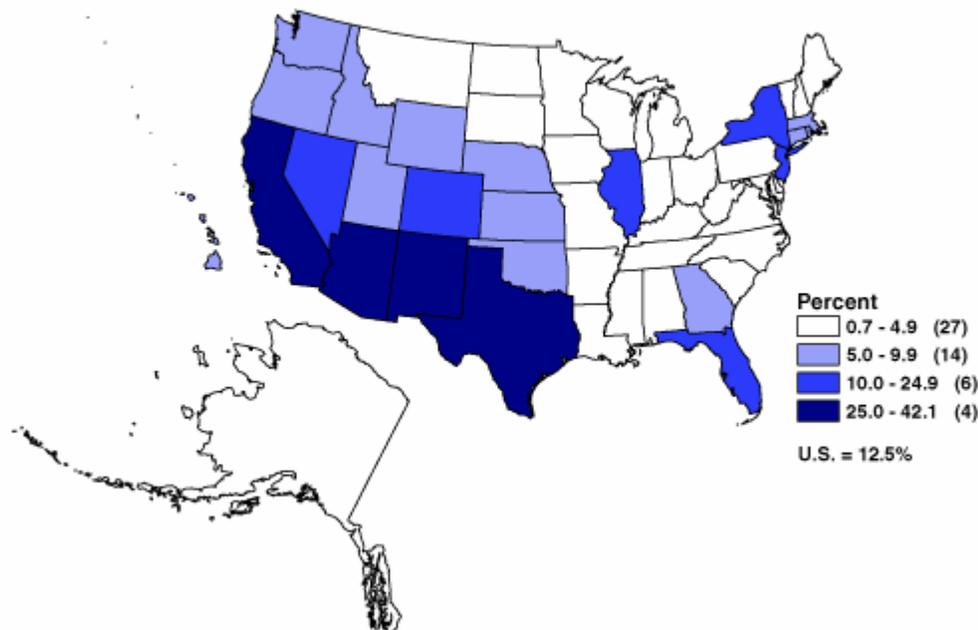
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Introduction

Hispanics with origins from Mexico, Central America, South America, and the Caribbean comprise a significant fraction of the American population and as of 2003 have become the largest minority group in the United States.⁵ There is a need for the healthcare arena to be knowledgeable about this rapidly growing population, and so this chapter intends to serve as a resource for health care professionals and researchers who work with the Hispanic-American community. Its purpose is to provide an understanding of Hispanic-American culture and health status as well as the special circumstances this population faces in the American health care system. While it is impossible to make universal characterizations of a culture and its people, commonalities exist that are distinctive to each culture.

In the USA, Hispanic-American describes persons of Cuban, Mexican, Puerto Rican, and South or Central-American descent regardless of race. Although Brazilians also pertain to the definition of Hispanic considering their descent from ancient Hispania, this population is not included in this chapter since relatively smaller numbers immigrated to the United States. As of the 2000 U.S. Census, Hispanic-Americans represent approximately 13 percent, 37.4 million, of the US population. By the year 2040, the Census Bureau projects that there will be 87.5 million Hispanics making up 22.3 percent of the nation's total population.⁵

Hispanic Population as a Percent of Total Population, 2000
United States



Source: USDC, Bureau of the Census, Census of Population and Housing [2000 SF1]
Prepared by: University Outreach and Extension, Office of Social and Economic Data Analysis - (OSEDA)
Map Generated on 5.02.03

Immigration Waves

Though Hispanic-Americans share many aspects of their heritage, there are many differences among the distinct Hispanic cultures according to their country of origin. The unique immigration waves of each country are partly responsible for the demographic differences amongst Hispanic subgroups.

Mexican-Americans have one of the more unique patterns of immigration among the Hispanic subgroups. Because the southwestern United States once belonged to Mexico, the annexation of western and southern territories as a result of the Mexican War (1846-1848) generated a large population of Mexican-Americans in the mid-1800s without any migration. Mexican immigration into the US was minimal until the economic conditions in Mexico worsened in the early 1900s. By 1910, the Mexican revolution propelled the country into political and economic turmoil which sparked a tremendous wave of immigration until the 1930s. The onset of the Great Depression then resulted in the involuntary deportation of Mexicans, including US citizens and their American children, and the retention of Mexican-Americans in detention camps that placed a halt in the Mexican immigration wave. The advent of World War II rekindled demand for immigrant labor and promoted the establishment of the Bracero program. This program permitted Mexican day laborers legal entry into the US for work, which Mexicans undertook despite the harsh labor conditions due to the soaring unemployment rates in Mexico. This was accompanied by the renewal of Mexican immigration in the mid-1900s. The persistent focal settlement in the southwestern United States is responsible for the current concentration of the Mexican-American population in the southwestern states.¹⁴

The mid-1900s saw a great influx of Hispanics into the United States not only from Mexico, but also Puerto Rico and Cuba. Puerto Rico has been a US territory since 1898 with its people US citizens as of 1917. Puerto Rico experienced its first great wave into the mainland US in between 1940-1960 with the search for employment as the primary motive for emigration. Most Puerto Ricans settled in East Harlem of New York City during this wave, explaining the current demographic with one third of mainland Puerto Ricans living in New York City.¹⁴

The stimulus for Cuban migration in the late-1950s was primarily political rather than economical. The Cuban revolution positioned the revolutionary Fidel Castro into power in 1959 which brought about dramatic changes to the Cuban societal structure. This stimulated many Cubans to migrate to the US, particularly the middle- and upper-class who were most threatened by the conversion to communism. The majority of Cubans settled in Florida and many established their businesses and practiced their professions in Miami. The US welcomed Cubans as victims of an oppressive regime until 1994. In 1980, there was a wave of Cuban immigration distinct from the initial wave sparked by the revolution. This wave was comprised of “Marielitos”, who were unskilled workers, criminals, and mentally ill people that the Cuban government put aboard boats and sent to Miami. Then in 1994, an influx of Cubans looking for employment initiated which motivated a rapid change in US policy that refused additional refugees from Cuba. Given that the initial large wave of Cubans was comprised of wealthy, well-educated individuals who established a supportive and affluent network in Miami, Cuban-Americans matched the national average of educational achievement in the 1980s.

However, unemployment and poverty rates are appreciably lower for Cuban-Americans than those of other Hispanic origins.¹⁴

The 1970s to early 1990s saw the first large waves of immigration from Central American countries, such as El Salvador and Nicaragua, due to war-torn societies. A large fraction of the influx was comprised of children and teenagers whose parents were killed or lost in the war.¹⁴ Today the total Hispanic population tends to be younger than white non-Hispanic populations, except for Cuban-Americans who have a higher proportion of elderly.⁶

Language

Though Spanish is the language shared by all Hispanics, many dialects exist that are specific to cultural groups. Distinct phrases, pronunciations, and vernacular speech are apparent in dialogue among individuals from different Hispanic origins. For example, in Cuba a bathing suit is called “trusa” while in Puerto Rico it is termed “traje de baño”. Despite the variations in dialect, there is little difficulty in understanding among those using different dialects. The use of English and Spanish language varies among Hispanic-Americans, with approximately 1:2 knowing both English and Spanish, 1:4 knowing Spanish only, and the rest knowing English only. The general trend is monolingual Spanish among recent migrants or older foreign-born Hispanic-Americans, bilingualism among long-standing immigrants and their children, and monolingual English and/or Spanglish (a slang mix of English and Spanish) among third-generation communities and beyond.¹³

Politics

Political views differ among Hispanic groups. Many Cubans and Colombians tend to support conservative political ideologies and commonly align with the Republican Party. Cuban adherence to conservative ideologies follows the impulse for Cuban migration which was anti-Castro and anti-government regulation sentiment. The remaining Hispanic subgroups, including Mexicans, Puerto Ricans, and Dominicans, tend to lean toward the Democratic Party. Considering these populations outweigh in number the conservative groups, the Democratic Party has traditionally maintained greater strength among the Hispanic community.¹³

Traditional Views on Medicine

Folk medicine has a long-standing place in Hispanic-American culture, and is especially common among first-generation Hispanics. Healing through the folk system is practiced by “curanderos” or “santeros.” Curanderos are naturalist healers who use herbs and plants to heal illness. Santeros, on the other hand, use the power of the saints to heal, aid, and counsel individuals. These holistic healers are used widely throughout Hispanic-American culture, without regard to socioeconomic status, and are sought for social, physical, and psychological purposes. The healers do not advertise their services but are well known through informal communication in the Hispanic community network.¹⁰

Treatments by curanderos and santeros include massages, herbs, counseling based on their spiritual capacities (“facultades”), and cleanings (“limpias”) that are performed as baths with a particular mix of plants. Santeros may also prescribe herbs, ointments, lighting of candles for saints, incense, and Florida water made from plants which can all

be purchased in a “botanica”, a spiritual pharmacy that has many storefronts in Hispanic communities. An illness for which curanderos are commonly sought after to heal is “empacho.” “Empacho” describes stomach pains and cramps that are believed to be caused by a ball of food clinging to the stomach. Curanderos treat empacho by performing a strong massage over the stomach. There are accounts of these massages quickly improving the strong stomach pains. However, there has also been testimony of a Hispanic patient attempting to treat acute appendicitis as empacho at home and refraining from hospital care until she was in a critical, life-threatening condition.¹⁰

Hispanic-Americans commonly perceive health as a gift from God regardless of whether they take part in the folk system of healing. Health can be a reward for good behavior, and illness can sometimes be a punishment for wrongdoing. Other potential causes for illness distinctive to Hispanic culture include imbalances between hot and cold, supernatural triggers, and envy.¹⁰

An imbalance between hot and cold is considered a source of illness, with hot and cold not strictly referring to temperature but referring to the cultural classification of a particular substance or illness. “Hot” illnesses should be treated with “cold” remedies, for example penicillin, which is classified as a “hot” medication, should be avoided in treating “hot” symptoms such as diarrhea or rashes. Another view on the role of hot and cold balance in illness is that the cold should be avoided after having an extremely “hot” experience. For example, after doing extensive ironing in the house or toasting coffee beans, a person should avoid stepping directly into the outside cold air in order to avoid becoming sick. A perceived consequence of not following this guideline is “pasma.” “Pasma” describes paralysis of the face or limbs due to a disturbance of the hot-cold balance.¹⁰

A supernatural cause of illness that comes from outside the body is “mal de ojo.” Mal de ojo is caused by excessive admiration. For example, an individual who overly compliments a baby of their beauty can inflict a mal de ojo on the baby that can lead to general malaise, sleeplessness, or even become the cause of severe illness. For this reason, parents may try to protect their babies from mal de ojo by having them wear a special charm made of onyx. Envy, “envidia”, is also considered a cause of illness or bad luck. That is, envy by others of a person’s success can cause the person to become a victim of a misfortunate illness.¹⁰

Not all Hispanic-Americans use the folk system, but health care providers should be aware that patients who seem to have delayed seeking healthcare have most likely counted on curing their illness using the folk process. The folk system is usually used alongside institutionalized medicine and is more likely to be used exclusively in cases of psychiatric disorders, which are often perceived as a doing by evil spirits and forces. If a mental problem is regarded severe enough to deem admission into a psychiatric clinic, then the mental patient is considered a “loco”, who is regarded as a dangerous individual that loses social status.¹⁰

Family Structure

“Familism”, the prioritization of family considerations over individual or community needs, is a strong, almost universal value in the Hispanic community⁷. In Hispanic families, close family members usually go beyond the nuclear family unit⁷. It is common for extended families to live in close proximity to one another, and there is often

strong interdependence among family members for their day-to-day struggles⁷. The prevalence of familism in Hispanic culture is an important factor to consider when weighing significant healthcare decisions with individual patients or Hispanic communities. Traditionally, Hispanic patients will include their family in the decision-making process and weigh their opinions heavily. There are also traditional gender roles in Hispanic families which are most prevalent among early-generation marriages. Machismo is a quality commonly valued by men in the Hispanic family as the essence of manhood⁷. The oldest man in the household holds the greatest power publicly and will often be in charge of making healthcare decisions. Women are expected to adhere to the man's opinion as a form of respect in the public sector. However, it is not unusual for a woman to return to a healthcare provider without her husband if she disagrees with him and would like to exercise her own opinion about her healthcare.

In regards to at-home medicine, Hispanic-Americans usually seek advice from a daughter, mother, grandmother, or neighbor woman since women in Hispanic culture, especially Puerto Rican culture, are considered the primary healers on the family level.¹⁰

Hispanics and Disease in the U.S.

Hispanic-Americans have a disproportionately high prevalence of conditions and risk factors including but not limited to asthma, chronic obstructive pulmonary disease, HIV/AIDS, diabetes, and obesity. The health profiles are unique to Hispanic groups with different subgroups being disproportionately more affected than other subgroups. For example, Puerto Ricans disproportionately suffer from asthma relative to non-Hispanic whites and other Hispanic subgroups.⁵

Although studies often lack the inclusion of various Hispanic subgroups, present research indicates that Hispanics have a disproportionate prevalence of diabetes comparable to non-Hispanic blacks. The age-adjusted relative risk for diabetes compared to non-Hispanic whites is 1.7 for Mexican-Americans and 1.8 for residents of Puerto Rico, with a relative risk of 1.8 for non-Hispanic blacks.⁶

According to the 2002 Census, heart disease is the leading cause of death for Hispanic-Americans with Hispanic subgroups subject to death rates higher than the national average. The major risk factors associated with CVD morbidity and mortality are hypertension, serum cholesterol levels, and smoking. However, studies have shown that Mexican-Americans have hypertension rates and serum cholesterol levels comparable to Anglos^{2, 11} and smoking rates less than Anglos⁴. On the other hand, the contributing factors to CVD morbidity and mortality, diabetes mellitus, exercise, and obesity, exhibit separate rates with the Hispanic-American population. As mentioned before, Hispanic-Americans are disproportionately affected by diabetes mellitus. Moreover, studies have shown that Cuban, Puerto Rican, and Mexican-Americans have a higher than normal prevalence of being overweight, with Mexican-Americans having the highest prevalence of the three subgroups. Also, a study including Mexican-Americans showed this subgroup engages in less physical activity than Anglos; however this data on other Hispanic subgroups is unavailable.^{2, 11}

Hispanic-Americans are disproportionately affected by HIV/AIDS with this disease afflicting ages 35 – 44 as the third leading cause of death for Hispanic men and fourth leading cause of death for Hispanic women.³ Although the number of HIV/AIDS cases coming from the Hispanic-American community is far below that of non-Hispanic

whites and non-Hispanic blacks³, infection rates have soared in the recent years within the Hispanic-American community to the extent that Hispanics are subject to three times the HIV infection rate for non-Hispanics.¹²

Healthcare Coverage

The Institute of Medicine reports four areas that specifically contribute to health disparities experienced by Hispanic-Americans. These areas are inadequate health coverage, the language barrier, a lack of minority physicians, and healthcare provider biases.¹² Within this multifaceted problem, lack of health coverage is a forefront barrier to healthcare that can make improvements in any other areas contributing to health disparities inconsequential. A lack of health insurance makes healthcare options either inaccessible or unaffordable for many Hispanic-American families.

The Department of Health and Human Services has reported that Hispanics make up the largest group in the US without any health insurance. Hispanic-Americans under age 65 have a 35 percent probability of being uninsured compared to 17.5 percent of the general population under age 65, while 87 percent of uninsured Hispanic-Americans are from working families. These statistics are linked to the low rates of employer-based coverage with 43 percent of working Hispanic-Americans receiving employer-based health insurance compared to 73 percent of Anglos.⁹ Moreover approximately 60 percent of Hispanic families receive an annual income less than 200 percent of the Federal poverty rate, further intensifying the challenge to obtain affordable healthcare.¹²

Of Latino children, 27 percent continue to be uninsured despite the fact most are eligible for the State Children Health Insurance Program (SCHIP). In comparison, 9 percent of white children, 18 percent of black children, and 17 percent of Asian-Pacific Islander children in the US are uninsured. A primary reason for poor Latino children maintaining high un-insurance rates despite SCHIP is the unsuccessful efforts to enroll the Hispanic community in the program. A Kaiser Commission report discovered that only 26 percent of the parents of uninsured Latino children receive information about Medicaid enrollment and almost half of Spanish-speaking parents are unsuccessful in enrolling their children because materials are unavailable in Spanish.¹²

Spanish Medical Translators

Medical translators are often necessary for effective physician communication with Hispanic patients. Latino parents have often referred to language barriers as their greatest obstacle to healthcare access for their children. However, research shows that medical interpreters are often not called when needed, insufficiently trained, or entirely unavailable.¹² The consequence of medical interpretation can best be illustrated in an account shared by Dr. Glenn Flores before the Senate subcommittee on Public Health.

“My story is about a two-year-old Latino girl named Rosa Morales, whose parents brought her to the emergency room for right shoulder pain. X-rays revealed that Rosa had fractured her right collarbone. Rosa’s mother spoke Spanish almost exclusively. When Rosa’s mother was asked what happened, she responded, “Se pego, se pego.” The resident physician interpreted this to mean, “She was hit.” Rosa’s mother then showed the nurse a discharge summary from a previous emergency room visit to another hospital two months prior to the first visit, when Rosa also was diagnosed with a right collarbone fracture after a fall from her bed. Child abuse was suspected by the emergency room staff, and the state Department of Social Services was contacted. A Department of Social Services caseworker came to evaluate Rosa and her 4-year-old brother, Jose.

Without a Spanish interpreter, the caseworker spoke with Rosa's mother, and then asked her to sign over voluntary custody of Rosa and Jose. Rosa and Jose immediately were taken from their mother and placed in Department of Social Services custody. When the Spanish interpreter arrived, Rosa's mother was interviewed again, and she reported that Rosa had fallen from her tricycle and struck ("se pego") her right shoulder. The primary care physician was contacted, and denied any history of abuse or neglect in the family, or having concerns. Rosa's mother regained custody of Rosa and Jose after 48 hours."¹²

In addition to the requirement for medical interpretation by fluent translators, communication in Spanish that is culturally competent is also necessary to avoid adverse medical outcomes. An example of the relevance of culturally competent Spanish is the story of a physician who told a Spanish-speaking patient that she was "positiva" for AIDS. Telling a person that they are positive for a test translates into Spanish that the test came out well and things look positive. When this patient heard "positiva", she understood that everything was okay. She then became pregnant and delivered a baby who contracted AIDS while available preventative measures for vertical transmission were not utilized.¹²

With only a few states granting third-party reimbursement for medical interpreters and only one-fourth of hospitals taking part in the training of their interpreters, the language barrier continues to be a significant obstacle for Hispanic-Americans in the pursuit of adequate healthcare. Moreover, there is a paucity of Latino healthcare providers in the US, with Latinos making up 5 percent of the total physicians, 3 percent of the total dentists, and 2 percent of the total nurses. These statistics make the need for Spanish medical translators all the more significant, along with the apparent need for increased recruitment and training of Latino healthcare providers.¹²

In the absence of medical interpreters and Spanish-speaking healthcare providers, it is common for family members and friends to be pressed into the role of a Spanish medical translator. This creates a dynamic that can significantly hinder the accuracy of communication due to possible underlying biases. However, if no biases exist and the translation is performed impartially, the use of a family member could positively promote the communication between the healthcare professional and patient. Gender differences can also influence the dynamic of translation, and so translators should ideally be the same gender as the patient. Nonetheless, a skilled interpreter would be sensitive to this dynamic and more adept in overcoming the gender barrier during communication. Lastly, the use of children as translators, which is exceedingly common, positions the parent and child in a reverse authority dynamic and for that reason should only be used ultimately as a last resort.⁷

Disparities in Health Care Quality

Reports from the Institute of Medicine have demonstrated that racial and ethnic health disparities persist even when controlled for factors such as access to care. An underlying explanation for this finding is the perpetuation of healthcare provider biases. That is, healthcare providers' perceptions or assumptions about a patient based on their racial or ethnic background alters their provision of care. For example, researchers have found that in children hospitalized for surgical correction of serious limb fractures, whites were on average administered a substantially higher dose of narcotic pain medication at 22 mg/day, compared with blacks at 16 mg/day and Latinos at 13 mg/day. More research is required to better understand what interventions are successful in minimizing

healthcare provider biases and from where such biases originate. However, it is expected that the inclusion of culturally competent training in the education of healthcare providers would provide headway in the reduction of healthcare provider biases.¹²

Additional Steps Towards Cultural Competency

1. A key step towards cultural competency with Hispanic-Americans is gaining an understanding and acceptance that many Hispanics hold a broad definition of health that simultaneously respects mainstream institutionalized medicine and traditional healing, as well as carries a strong religious component.⁸
2. Hispanics expect their healthcare providers to be warm, friendly, and actively interested in their patient's lives. Sitting closer to Hispanic patients than you would with patients from other cultures, leaning forward when speaking or listening, and giving a comforting pat on the shoulder or other caring gesture can all help indicate interest and care.⁸
3. When communicating with Hispanic patients who are not proficient in English, use a trained medical interpreter to translate if you are not fluent in Spanish. When using an interpreter, have him/her sit to the side while you continue to face your patient.⁸
4. When advising dietary changes, make suggestions fitting to a Hispanic-American diet.
5. Consider including family members in consultations in order to improve patient adherence.⁸ However keep in mind potential gender role dynamics and whether they may influence the consultation.

Additional Resources for the Health Professional

- Cultural competency
 - Kaiser Permanente's *A provider's handbook on culturally competent care: Latino population*.
Kaiser Permanente
National Diversity Department
One Kaiser Plaza, 22 Lakeside
Oakland, CA 94612
510-271-6663 - hotline
510-271-5757 – fax
 - Latin-American food pyramid
<http://latinonutrition.org/LatinPyramid.html>
- Bilingual resources for patients
 - National Diabetes Information Clearinghouse
<http://diabetes.niddk.nih.gov/spanish/indexsp.asp>

- American Heart Association
<http://www.americanheart.org/presenter.jhtml?identifier=3015971>
- Department of Health and Human Services: AIDSInfo
<http://www.aidsinfo.nih.gov/infoSIDA/>
- Clinics in Greater Cleveland that are models of successful outreach to the Hispanic community
 - Thomas F. McCafferty Health Center
<http://www.metrohealth.org/body.cfm?id=750&oTopID=740>
 - Neighborhood Family Practice
<http://www.nfpmedcenter.org/>

References

1. American Diabetes Association. *Total Prevalence of Diabetes & Pre-diabetes*
<http://www.diabetes.org/diabetes-statistics/prevalence.jsp>
2. American Heart Association. *Hispanics and Cardiovascular Disease*
<http://www.americanheart.org/downloadable/heart/1014748201198FS05HIS2WEB.pdf>
3. Center for Disease Control. *HIV/AIDS among Hispanic*. March 8, 2007.
<http://www.cdc.gov/hiv/resources/factsheets/hispanic.htm>
4. Center for Disease Control. *Smoking and Tobacco Use* February 28, 2007.
http://www.cdc.gov/tobacco/data_statistics/tables/adult/table_9.htm
5. Center for Disease Control, Office of Minority Health. *Hispanic or Latino Populations* January 25, 2007/ <http://www.cdc.gov/omh/Populations/HL/hl.htm>
6. Center for Disease Control, Office of Minority Health. *Eliminate Health Disparities in Cardiovascular Disease* January 25, 2006.
<http://www.cdc.gov/omh/AMH/factsheets/cardio.htm>
7. Kemp, Charles. *Mexican & Mexican-Americans: Health Beliefs & Practices* Cambridge University Press. November 2004.
http://www3.baylor.edu/~Charles_Kemp/hispanic_health.htm
8. Management Sciences for Health. The provider's guide to quality & culture: Hispanics/Latinos and cardiovascular disease.
http://erc.msh.org/provider/informatic/HL_CVD_Overview.pdf
9. Smedley et al., eds., *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care* (Washington: National Academies Press, 2002)
10. Spector, R. *Cultural diversity in health & illness* 5th ed. Upper Saddle River, N.J.: Prentice Hall Health, 2005.
11. Torres, S. *Hispanic voices: Hispanic health educators speak out* New York: National League for Nursing Press, 1996.
12. United States. Congress. Senate. Committee on Health, Education, Labor, and Pensions. Subcommittee on Public Health. *Hispanic health: problems with coverage, access, and health disparities* September 23, 2002.
13. Wikipedia. *Hispanic* Wikimedia Foundation, Inc. March 2007.
<http://en.wikipedia.org/wiki/Hispanic>

14. World Book. *Hispanic Americans* WorldBook, Inc. 2007.
<http://www.worldbook.com/wb/Article?id=ar257790&st=history+hispanic+immigration>