The State of Latino **Health** in the District of Columbia

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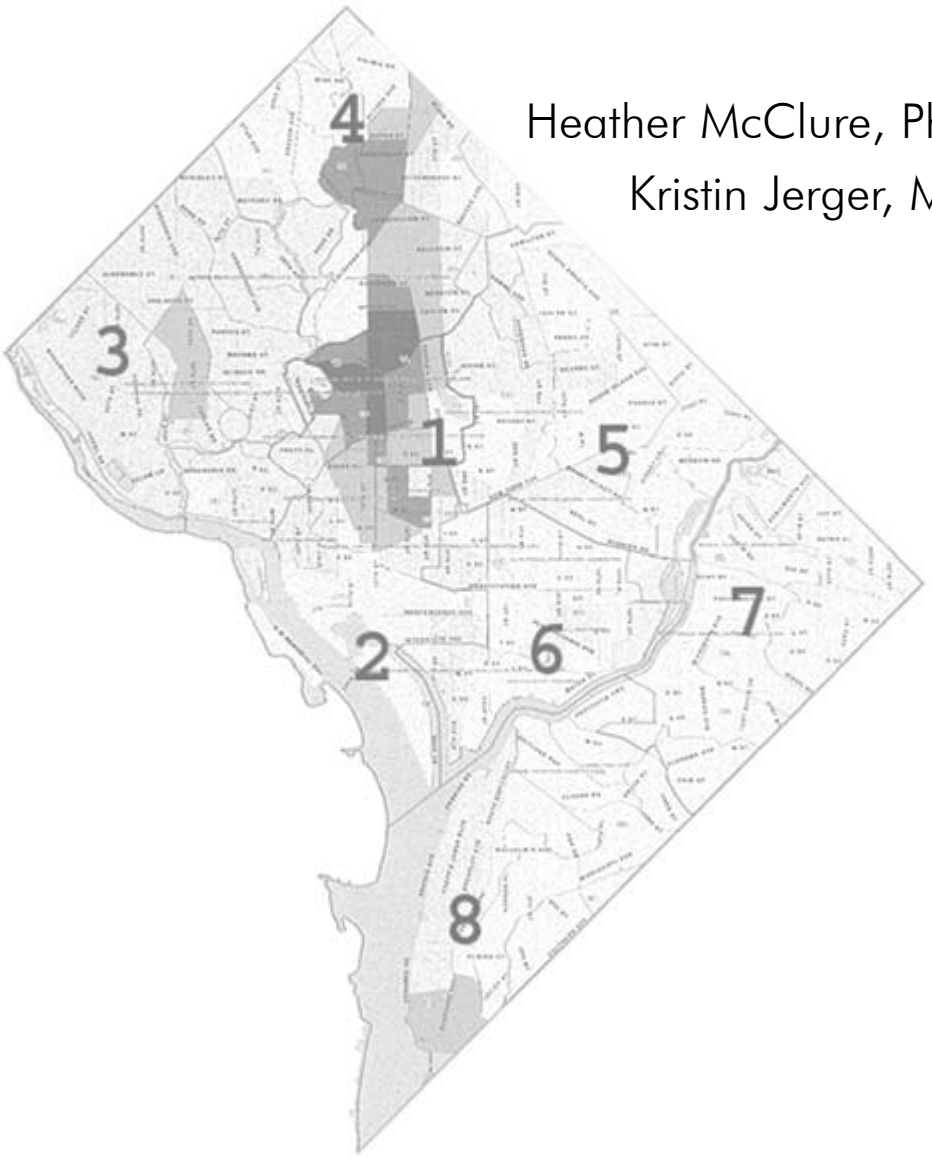

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EXECUTIVE SUMMARY

This report results from the first collaborative and community-based effort to gather and present comprehensive baseline data on D.C. Latinos' health status, knowledge and access to care as an important step toward improving Latino health in the District of Columbia. The study was conducted in 2004 by the Latino Health Care Collaborative (LHCC), which included the Council of Latino Agencies (CLA), the District of Columbia Department of Health's State Center for Health Statistics Administration (SCHSA), the George Washington University's Center for Global Health (GWU) and the community-based clinics of La Clínica del Pueblo, Mary's Center for Maternal and Child Care, and Andromeda. The LHCC is the Latino component of the SCHSA's broader District of Columbia Community Health Assessment Initiative (DC CHAI). The Para Su Salud (To Your Health) program of community workshops, which addressed critical study findings, was developed and pilot tested by the LHCC in 2005. Key areas of concern identified by the study included the following:

ACCESS TO CARE

41.5% of respondents had no form of health insurance
32% of respondents had not seen a doctor in more than two years

Lack of access to care is one of the greatest challenges to D.C. Latinos' health. In addition to impacting an individual's overall quality and years of life, lack of access has a secondary impact on health assessment. Since the phrasing of many standard assessment instruments used to determine disease prevalence rates assumes the respondents have seen a health professional regularly (i.e. "Have you ever been told by a doctor, nurse or other health professional that you have high blood pressure?"), prevalence rates will be underestimated in a population with poor access to health care. As a result, the overall health status of an entire population may be obscured and attempts to provide meaningful and effective health interventions for this population will be impaired.

OBESITY

61% of respondents were overweight or obese

High reported levels of overweight and obesity indicate greater potential risks for chronic disease, including cardiovascular diseases, type 2 diabetes, and breast, kidney, prostate, stomach and colon cancers, along with increased risk of premature death.

GESTATIONAL DIABETES

12% of respondents reported being diagnosed with gestational diabetes

This rate of gestational diabetes is almost nine times the rate of U.S. Latinas, and 17 and 60 times the rates of whites in the U.S. and D.C., respectively, in 2003 (Centers for Disease Control and Prevention). This is a disease that affects both the mother and the child, and so is of particular concern.

BREAST CANCER

3% of respondents reported being diagnosed with breast cancer

This breast cancer rate is substantially higher than those of U.S. Latinas (.6%) or U.S. whites (1.3%). Rates of breast cancer screening also were high, with 80.7 percent of women 40 years and older having a mammogram within the last two years, the highest rate of either U.S. Latinas or whites.

COMMUNITY-BASED HEALTH CLINICS

The health of D.C. Latinos surveyed surpasses that of both Latinos and whites nationwide in specific areas such as screening for HIV/AIDS and breast and cervical cancer, flu shots among Latino seniors, and knowledge about HIV transmission. These successes are even more striking given the barriers to access to care experienced by D.C. Latinos. Survey results indicate that Latino-serving community-based organizations in the District may be filling the gap, especially for Latinos who are uninsured as seven in ten Latinos in the District said they would go to a clinic or health center if they were sick or needed advice about their health -a telling indicator given the relative unpopularity of community clinics among U.S. Latinos (26 percent) and U.S. whites (14.5 percent) (National Center for Health Statistics 2005).

RECOMMENDATIONS

Based upon both the health assessment and health intervention findings reported here, the Council of Latino Agencies recommends the following steps be taken for reducing health disparities between Latinos and whites in the District of Columbia:

1. Future health surveillance of D.C. Latinos will benefit from the use of community-based, linguistically, and culturally appropriate methodologies, such as those involved in this study. In order to obtain accurate prevalence rates within a population with high numbers of uninsured, new questions might be designed relating to risk factors and health conditions that do not rely upon input from a health professional;
2. Existing efforts to conduct bilingual outreach to enroll uninsured D.C. Latinos in health insurance programs should be expanded, and new outreach programs should be established that replicate models with proven success;
3. Current models used by community-based organizations for health education and service delivery-all of which include bilingual health communication as a central component-should be replicated across the District in those sites where D.C. Latinos are accessing health care information and services;
4. Future health education campaigns related to obesity, diabetes, breast cancer, and access to health care among D.C. Latinos should use the Para Su Salud workshop model to increase their impact. A gestational diabetes campaign targeted at pregnant Latinas could be conducted similarly;
5. Increased investment in Latino-serving clinics in general would support and expand their capacity, and could have long-ranging positive effects for D.C. Latinos and for all D.C. residents.

INTRODUCTION

The future health of the nation will be determined to a large extent by how effectively we work with communities to reduce and eliminate health disparities between non-minority and minority populations experiencing disproportionate burdens of disease, disability, and premature death.

~ Guiding Principle for Improving Minority Health (Office of Minority Health 2005)

In the last three decades, the Latino population in our nation's capital has grown in number and complexity. Significant immigrant influxes during the 1980s, as Central Americans left behind countries at war and arrived looking for work and opportunity, accelerated that growth and have made Washington, D.C. one of the most diverse Latino communities in the nation. Latino leaders, community-based health providers, government officials and others have grown increasingly concerned about the poor health of Latino residents compared to white residents in the District of Columbia. [1]Narrowing the gap between Latino and white residents' health relies upon the development of effective culturally-relevant interventions that, in turn, are founded upon accurate health data on the more than 50,000 Latino residents in the District (U.S. Bureau of the Census 2003). Given the projected growth of the D.C. Latino population in future years, this population increase will pose serious problems for D.C. unless there are innovations in health care education and service delivery to meet Latinos' growing needs. This report results from the first collaborative and community-based effort to gather comprehensive baseline data on D.C. Latinos' health status, knowledge and access to care as an important step toward improving Latino health in the District of Columbia.

We need to let our community know that their health is in their hands, not just when they get sick. They need to know and defend their rights (to good health), and teach this to their children.

~ LHCC Key Informant and Health Provider to D.C. Latinos (Rivera 2004)

[1] For the purposes of this report, the definition of "Latino" corresponds exactly to the term "Hispanic" employed by the U.S. Census Bureau. The two terms are regarded by the Census Bureau to be interchangeable and are defined as: "a self-designated classification for people whose origins are from Spain, the Spanish-speaking countries of Central or South America, the Caribbean, or those identifying themselves generally as Spanish, Spanish-American, etc. Origin can be viewed as ancestry, nationality, or country of birth of the person or person's parents or ancestors prior to their arrival in the United States. Spanish/Hispanic/Latino people may be of any race" [U.S. Bureau of the Census (2003). "American Community Survey Summary Tables."]

PROJECT BACKGROUND

Latinos currently number 41.3 million people or 14.1 percent of the total U.S. population, and are the second largest racial/ethnic group in the country (U.S. Bureau of the Census 2005). In future years, the growth of the Latino population promises to increase dramatically. By the year 2050, the U.S. Census projects that the Latino population will grow 188 percent to 102.6 million, nearly one-quarter of the U.S. population (U.S. Bureau of the Census 2005).

Socioeconomic status is generally closely linked to health status. Latinos in the U.S. have lower socioeconomic status than the general population, particularly when compared to non-Hispanic whites. Latinos are approximately three times more likely to live below the poverty line than non-Hispanic whites (22.5 vs. 8.2 percent) and over a quarter of Latino children are poor (28 percent vs. 9.5 percent of non-Hispanic white children) (U.S. Bureau of the Census 2002). The average educational level for this population is lower as well. Over one-quarter (27.7 percent) of U.S. Latinos had less than a ninth grade education in 2002, compared with 4 percent of the non-Hispanic white population (U.S. Bureau of the Census 2002). While 57 percent of Latinos had a high school education or more, the comparable figure for non-Hispanic whites was 88.7 percent (U.S. Bureau of the Census 2002). Though Latinos are the most likely of any racial or ethnic group to seek work, employment options are more limited for Latinos than whites, due in part to lower levels of education and fewer opportunities for children and families in poverty (Pew Hispanic Center 2005). Latino unemployment is higher than that of whites: in 2002, 8.1 percent of Latinos (16 years and older) were unemployed compared with 5.1 percent of whites (CPS). When Latinos are employed, they often labor in private household services (31 percent) or in the construction, agriculture, manufacturing or eating, drinking and lodging service sectors that include low-wage jobs with few or no benefits (Pew Hispanic Center 2005).

With regards to health, Latinos have higher rates of obesity, diabetes, asthma, chronic lower respiratory disease (COPD), HIV/AIDS, and occupational risk than whites (National Centers for Health Statistics 2002; Office of Minority Health 2005). They also have higher incidence and mortality rates from cancers of the stomach, liver, uterine cervix, and gallbladder, associated with exposure to infectious agents and lower rates of screening (O'Brien, Cokkinides et al. 2003). Poor health status is exacerbated by inadequate access to health care, with over one-third of Latino adults lacking medical insurance coverage, the highest rate of any racial or ethnic group (Pew Hispanic Center and Kaiser Family Foundation 2004). In sum, while there is substantial variation among and within subgroups, research has long established a close link between Latino ethnicity and poor health status.

Understanding the cultural and economic dimensions of health care among Latinos is particularly challenging because they are a heterogeneous population, differing not only in terms of country of origin, but also on the basis of duration of residence in the United States; levels of acculturation; and formal education; income, and other measures of socioeconomic status. This heterogeneity, especially evident in Washington, D.C., provided the compelling imperative for this study to determine the health needs of this unique community.

Thus, in the spring of 2002, researchers from the Council of Latino Agencies (CLA) and La Clínica del Pueblo met with the District of Columbia Department of Health's State Center for Health Statistics Administration

(SCHSA) and the George Washington University's Center for Global Health (GWU) to discuss their mutual interest in conducting the first-ever community-based study of the health of D.C.'s Latino residents. CLA and its member agencies that are health care providers to the Washington area Latino population were well aware of the limits of existing data on Latino health. Though clinics had data on their own patient populations, there were little reliable data on Latinos who sought care outside the rich network of Latino community-based clinics in D.C. A month later, CLA, SCHSA and GWU, in collaboration with CLA member agencies and clinics La Clínica del Pueblo, Mary's Center for Maternal and Child Care, and Andromeda, formed the Latino Health Care Collaborative (LHCC), the Latino component of the SCHSA's broader District of Columbia Community Health Assessment Initiative (DC CHAI). A Technical Advisory Board (TAB) of experienced public health professionals from local universities and health organizations was established to guide the work of the partners.

METHODOLOGY

HEALTH ASSESSMENT

Instrument Selection/Design

Key informant interviews were conducted with ten experienced health care providers, policy analysts and researchers of Latino health in D.C. The findings from these interviews helped to direct the selection of survey sections from existing, widely used instruments as well as provide guidance for the Health Intervention developed in the second year of the study. To review input from key informants, please see Executive Summary of Key Informant Report I (Appendix 2) (Rivera 2004). A two-module survey design was selected in order to achieve comparability of results to other populations while gathering data on issues of particular concern for D.C. Latinos.

Module I was administered in all households surveyed and was based primarily on the District's 2002 version of the Behavioral Risk Factor Surveillance Survey (BRFSS), with additional questions on injury and access to health care from the National Health Interview Survey. It included sections designed to solicit information on demographics, access to health care, health knowledge, and health status, with particular emphasis on known priority areas identified through Key Informant interviews. It was designed to be administered in approximately 45 minutes. Module II was designed to respond to clinic partners' requests for information on the health of mothers and children, adolescents, and the elderly. Questions regarding each of these groups were taken from existing instruments available from the Center for Disease Control and Prevention: the Pregnancy Risk Assessment Monitoring System (PRAMS), the Youth Risk Behavior Survey (YRBS), and the National Health Interview Survey's Second Supplement on Aging (NHIS, SOAII). For each household in which Module I was administered, if the household was considered eligible for Module II (had a child, adolescent, or elderly person as a member), one of the appropriate age-group questionnaires was selected randomly and administered to the same person who answered the Module I questions. The questionnaire was written in both English and Spanish and pre-tested in both languages. Respondents were given the option of answering in either language; ultimately, all 819 interviews were conducted in Spanish. Survey questions may be viewed at www.consejo.org.

Selection Criteria and Sampling Design

The quantitative findings presented in this report are based on a stratified, probability-based sample survey of 819 adult, self-identified Latinos living in Washington, D.C., who were at least 21 years old. The survey was conducted by 18 Latino, bilingual data collectors-most of whom were D.C. residents-between February and May of 2004.

With technical assistance from Robert Santos, President/Chief Executive Officer, NuStats, Peter Thomas of the D.C. Department of Health, Wilbur Hadden of the National Center for Health Statistics, and the DHS Office of Planning, a multistage sampling procedure was designed, beginning with the selection of Wards 1, 2, 3, and 4 for the study, because they represented 85.6 percent of D.C. resident Latinos according to the 2000 U.S. Census. The desired sample size was determined to be 750. A multistage sampling methodology provided for the identification of Latino populated wards, census tracts, and census blocks from which there followed the random selection of blocks from those with a minimum of 25 Latino residents and 10 Latino households according to the 2000 Census.

Difficulties encountered in Ward 3 required a revision of this sampling strategy. During a two-week period during which all data collectors worked full-time in Ward 3, they received consent to complete only five surveys. Reasons for this included the following:

- First, the majority of Latinos approached in Ward 3 were not interested in participating in the study. This lack of interest may have been due to the fact that Latinos in this ward have a higher income and social status and, on average, have better access to health care and a better quality of life and, thus, may have had less incentive to participate in the study.

- Second, most of the residences visited were secured buildings (condominiums and apartments). Even after presenting a letter of introduction written by the LHCC Core Partners and receiving phone calls from the Council of Latino Agencies, very few building managers allowed access to data collectors, despite press coverage given the study and support from the Ward 3 City Council Member.

- Finally, because of the region of the city in which Ward 3 lies, the census figures for Ward 3 Latinos were likely to include people who were not long-term residents of the District, being either students or associated with diplomatic missions or international organizations.

At the end of the two-week period and after multiple consultations with the sampling team, it was decided not to include Ward 3 in the study and to distribute samples that were to be taken in it to Wards 1, 2 and 4 in proportion to their respective populations.

Data Collection

A team of 18 bilingual data collectors recruited from the community participated in an intensive three-day training course that covered the purpose of the project, survey logistics, interviewing techniques, the contents of the instrument, correct use of the questionnaires, and quality control. In order to standardize the application of the instrument, monitored out-of-sample practice sessions were conducted both in-house and with Latino members of church congregations in Maryland. Many of the interviewers were health professionals in their countries of origin, and their knowledge and experience proved vital to the speed with which the survey was conducted, as well as the accuracy of responses.

The data collectors were divided into five teams; for each, a team leader was selected based on experience and performance during the training. These individuals were responsible for team oversight, communication with study staff, and quality assurance for completed questionnaires as well as conducting interviews themselves. Cellular phones were obtained for data collectors, and intensive support and communication was provided the study staff, with a 24-hour on-call system put in place to facilitate quick response to concerns raised by data collectors.

Within the selected blocks, interviewers began on the northwest corner and identified every other dwelling unit for screening. In the case of multiple-story buildings, the team worked from top to bottom, and moved clockwise around the block until all dwelling units had been identified and screened. Selected dwelling units were first screened for Latino inhabitants, based on self-identification. The data collector listed all of the people living in the dwelling unit by first name and age, and administered Module I to a randomly selected, eligible adult if written informed consent was obtained. If the household contained a person eligible for the second module, those additional questions were asked of the interviewee as described above. Phone cards with a value of $20 were given to survey participants upon completion. When no one answered the door, up to two call-back attempts to arrange an interview were made; the call-backs were made on week days between 9 AM and 5 PM, week day evenings between 5-8 PM, and weekend days between 10 AM and 8 PM.

An important element of training and fieldwork was quality control, which was addressed by ensuring that interviewers fully understood how to fill out questionnaires and answer sheets and to review them before submitting them to the responsible team leaders. The team leaders reviewed completed questionnaires for missing data or obvious mistakes in administration before submitting them to the LHCC Principal Investigator at the Council of Latino Agencies, who again reviewed the completed questionnaires prior to their submission to the Project Coordinator for data entry at the State Center for Health Statistics Administration (SCHSA). Incorrectly completed surveys were returned to data collectors for completion.

In response to great demand from interviewees, data collectors also gave bilingual information about locations to receive free flu vaccines, as well as a list of affordable and bilingual community clinics.

Data Entry and Analysis

The data entry program and code book were developed by a senior data entry clerk at the Research and Analysis Division of the SCHSA, within which all data storage, data entry, and data quality control were conducted. Informed consent forms attached to the survey answer sheets were detached and stored in a locked cabinet at the SCHSA in a separate file before the answer sheets were made available for data entry. The data clerks were trained by the senior data entry clerk who designed the data entry program, and supervision was provided by the project coordinator/data manager.

Data were entered in a D-BASE program. Daily checks were performed by the project coordinator for quality assurance and verification for accuracy and completeness of a random selection of daily entries. When data entry was complete, all files were merged and exported to Excel and SAS. Descriptive, bivariate, and multivariate analyses were performed using SAS.

HEALTH INTERVENTION: PARA SU SALUD WORKSHOPS

Rationale

As reported in Health Assessment Findings, 61 percent of LHCC survey respondents were overweight or obese (according to the BMI calculated from reported height and weight). Because of the known association of obesity with many costly and devastating chronic diseases, including diabetes, cardiovascular disease, and a number of cancers (World Health Organization 2003; American Cancer Society 2005), the LHCC decided to develop an intervention targeting it. Based on best practices established by previous studies of health interventions in Latino populations (Farquhar, Maccoby et al. 1977; Alcalay, Alvarado et al. 1999), a face-to-face communication strategy was selected and appropriate models were sought. The model found to be most closely aligned with the characteristics of D.C.'s Latino population and the LHCC's program goals was the Por Su Salud Pilot Study, conducted in Chicago (Quinn 1998). After consultation with the Principal Investigator, Mike Quinn, program design and materials from that study provided the foundation from which the LHCC Para Su Salud Workshops were developed, although significant adaptation was required. Adult Latinas were selected as the target audience based on 1) the key role they often play in making nutritional choices for families; and 2) the success of the Por Su Salud study, which targeted women.

Development

Key materials developed for the workshops included an educational DVD, the workshop curriculum, and the instruments used to evaluate the workshop impact on participants. Because of the low educational level of the population demonstrated by the LHCC survey (most had less than an eighth grade education), an educational DVD was developed as an audio-visual aid to standardize presentation of factual information and to act as a point of departure for activities and group discussion within the workshop. The initial script for this DVD was drafted to include key information pertaining to the relationship of diet to exercise and the risk of developing chronic diseases such as diabetes, and presented to a focus group of key informants. The script was then edited per the qualitative report generated from this group's feedback and used as the basis for the first version of the DVD. The DVD was then reviewed by focus groups consisting of lay people as well as health promoters (promotoras) and further refined to reflect their input. The workshop curriculum was then developed around the DVD, to be paused after each chapter for discussion and/or activities, and iteratively tested using focus groups in the same manner as the DVD testing. Finally, existing evaluation instruments from the Por Su Salud project described earlier were adapted for use with the newly-developed DVD and curriculum to gather demographic information and to track changes in knowledge and behavior related to program participation. (See Appendix 4, for example of adapted instrument. Copies of the DVD may be obtained by visiting www. consejo.org).

Implementation

For consistency, a single promotora was trained and supervised by the LHCC Project Coordinator to conduct all workshops. Each participant attended an initial workshop in which the DVD was shown (with 8 to 14 participants per workshop) and two additional workshops to refine and support personal diet and exercise goals identified during the initial workshop, to discuss obstacles encountered, and to share any solutions for overcoming these obstacles with other participants. Workshops were held at the Council of Latino Agencies offices (in the Josephine Butler Building) and at Mary's Center. A final graduation celebration for all workshop participants was held at Mary's Center following completion of all pilot workshops. Initial screening for diabetes and support for follow-up medical care were offered at the graduation.

In preparation for clinics' use of the Para Su Salud DVD and workshop curriculum, three training sessions were held at Mary's Center for clinicians, community outreach workers, and social service providers. Written feedback from participants in these training sessions was obtained to determine how these materials might best be used in the context of ongoing clinic programs.

HEALTH ASSESSMENT FINDINGS

The following section presents the findings of the survey conducted by the LHCC in 2004 (n=819, 56% female, 44% male). First, information is presented on the general demographic characteristics of the interviewees with respect to country of origin, education, household income, age, duration of residence in the U.S., and language ability. The next section contains information on access to health care and barriers. The third section focuses on general health status, specific health conditions and other health outcomes.

NATION OF ORIGIN

Figure 1 (below) shows that natives of El Salvador represented more than half of the sample, but that respondents came from many other countries as well. Notably, a total of 12 percent of respondents came from El Salvador's Central American neighbors Guatemala and Honduras. Natives of Mexico, who are around two-thirds of Latinos at the national level, represented another 12 percent, while the two other largest groups at the national level, Cuba and Puerto Rico, were much less represented in the District **(Figure 2)**. There are implications of nation of origin for access to health care and health outcomes (see Discussion for further detail).

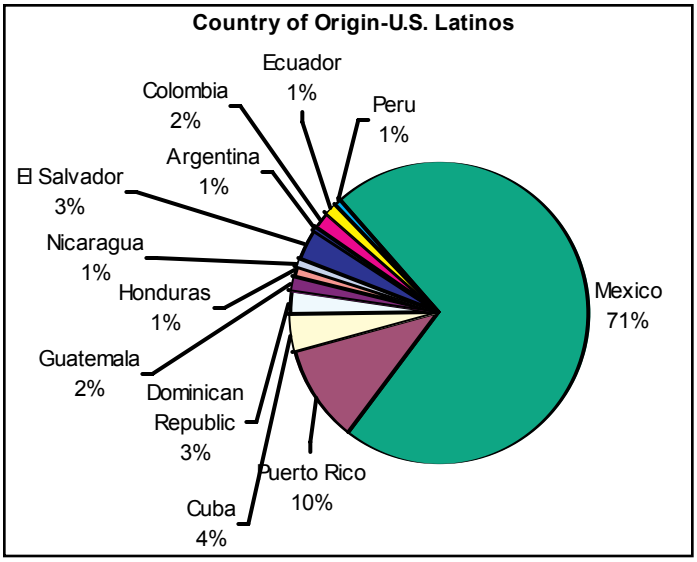


Figure 1
Dept. of Health,
State Center for Health Statistics Administration

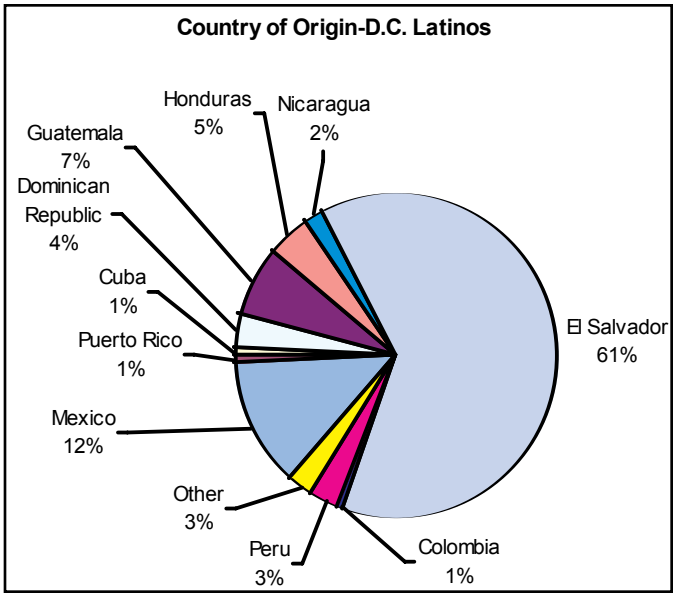


Figure 2
Council of Latino Agencies
(source: U.S. Census, American Community Survey, 2003)

AGE

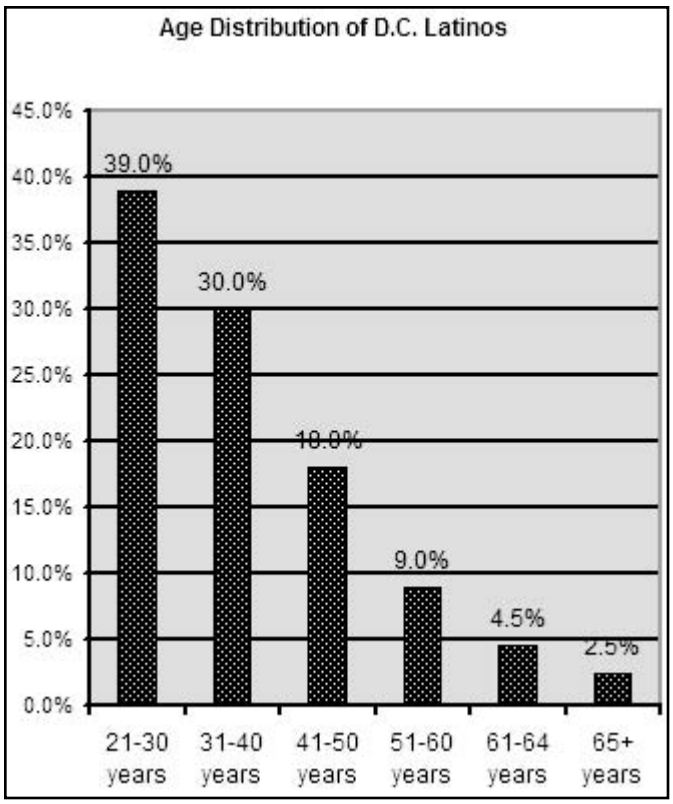
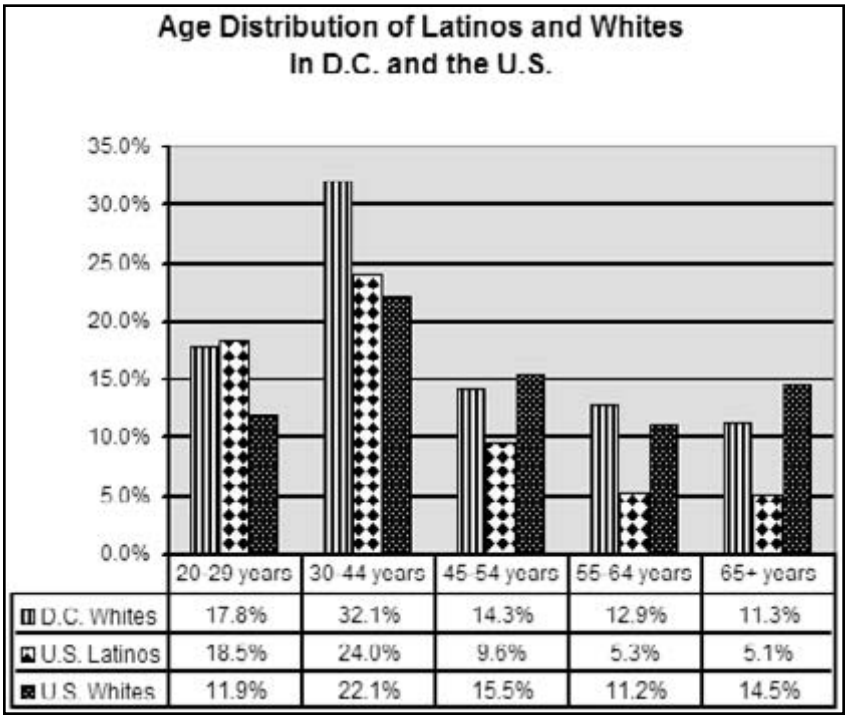


Figure 3
Council of Latino Agencies

On the whole, D.C. Latino respondents were relatively young, with 69 percent of the population aged 40 years or younger, and less than three percent aged 65 years or older **(Figure 3)**. The proportion of 21 to 30 year olds among D.C. Latinos was roughly two to three times higher than among Latinos in the U.S. and whites in D.C. **(Figure 4)**. In contrast, the proportion of D.C. Latinos aged 65 and older was nearly six times lower than that for D.C. whites.



	20-29 years	30-44 years	45-54 years	55-64 years	65+ years
D.C. Whites	17.8%	32.1%	14.3%	12.9%	11.3%
U.S. Latinos	18.5%	24.0%	9.6%	5.3%	5.1%
U.S. Whites	11.9%	22.1%	15.5%	11.2%	14.5%

Figure 4
Council of Latino Agencies
(source: American Community Survey, U.S.Census 2003).

EDUCATION

Overall, the District's Latino community had less formal education than whites and Latinos nationally. Of D.C. Latino residents, 8 percent never attended school and, for just over 50 percent of Latino respondents, the most formal schooling they received was a primary school education **(Figure 5)**. Only one-quarter of D.C. Latino respondents received a high school degree (or GED equivalent) or more education, compared with 59 percent of U.S. Latinos and 99.2 percent of D.C. whites (not shown, see Centers for Disease Control and Prevention, 2003) **(Figure 6)**. These findings have profound implications for the ability of members of this community to access not only high-paying employment, but health care services as well.

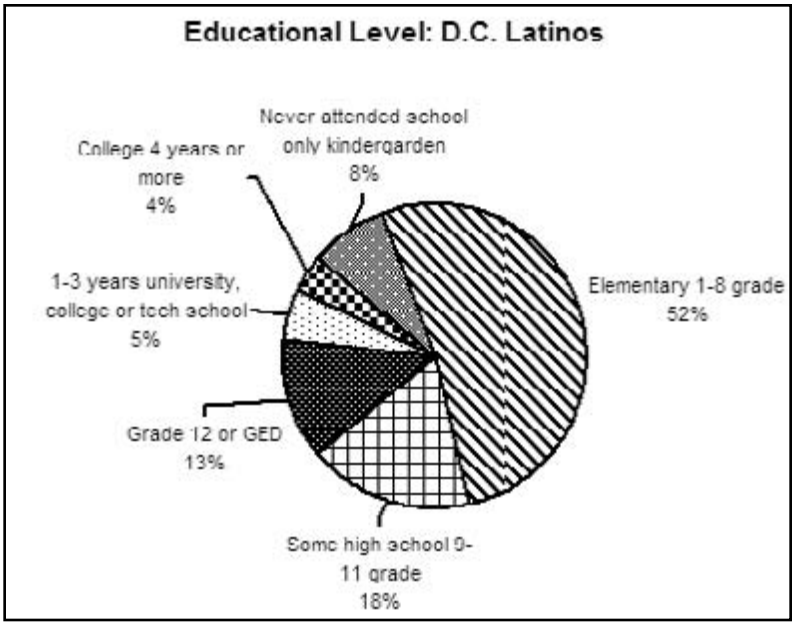


Figure 5
Dept. of Health, State Center for Health Statistics Administration (source: LHCC)

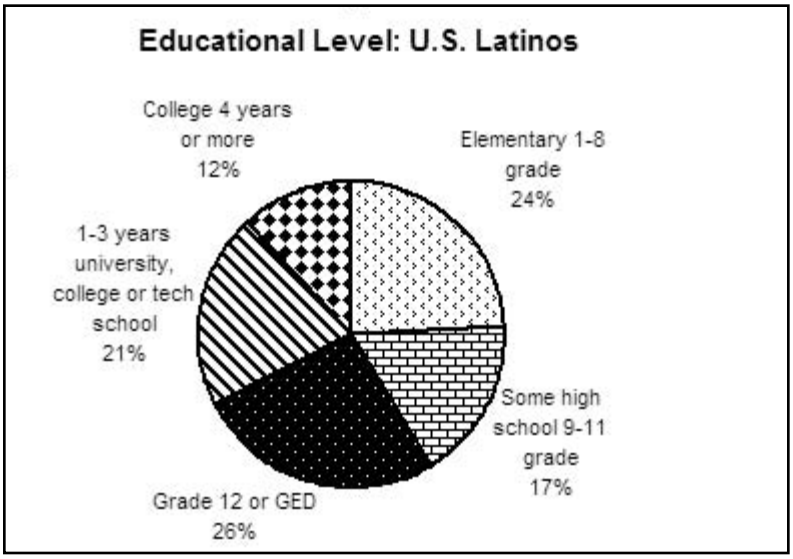
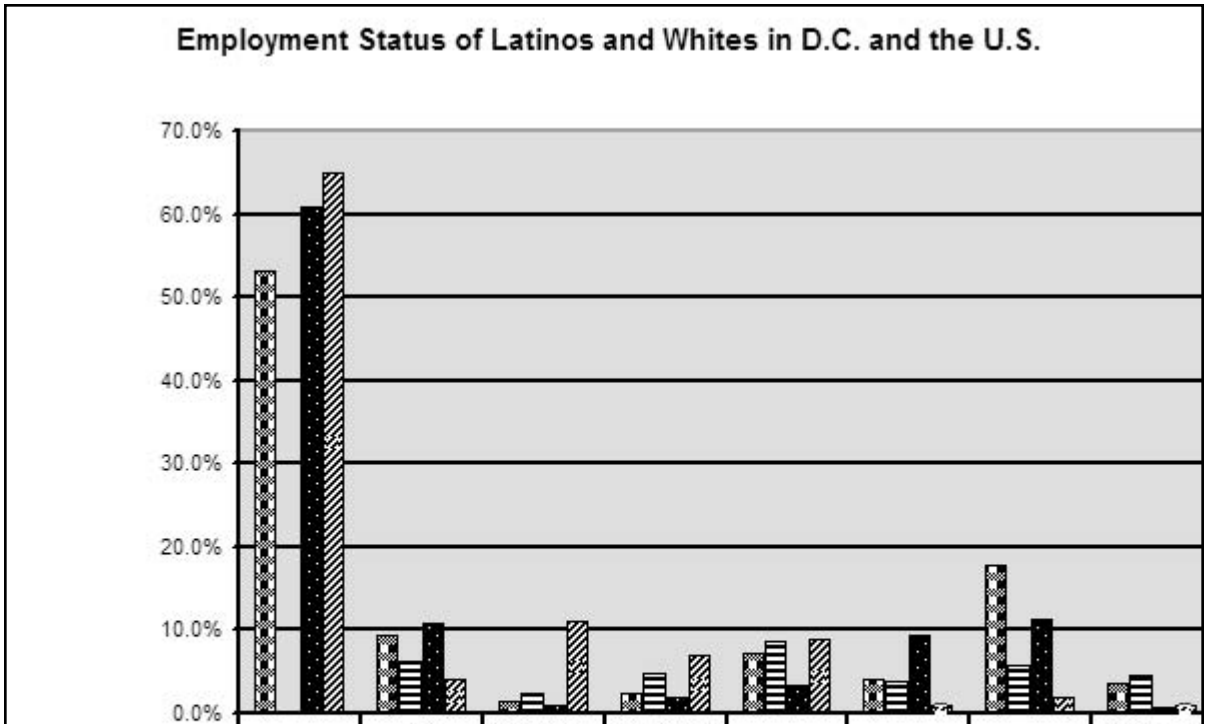


Figure 6
Council of Latino Agencies (source: BRFSS, CDC, 2003)

INCOME

Nearly 70 percent of respondents were employed, with two-thirds employed for wages or salaries, and another four percent self-employed **(Figure 7)**. It is striking that D.C. Latinos of all ages were either "employed" or "unemployed" as opposed to falling into categories such as "student" or "retired." This finding suggests that household incomes perhaps were insufficient to support members who did not contribute financially. D.C. Latinos were employed at a rate comparable to that of D.C. whites (71.7 percent) and higher than that of U.S. whites (62.4 percent), while more D.C. Latinos were out of work (18 percent) compared with D.C. and U.S. whites (2.8 and 3.8 percent respectively).



	Employed	Self employed	No work > 1 yr	No work < 1 yr	Homemaker	Student	Retired	Unable to work
U.S. Whites	53.1%	9.3%	1.4%	2.4%	7.3%	4.1%	17.8%	3.6%
U.S. Latinos	0.0%	6.2%	2.5%	4.7%	8.7%	3.9%	5.7%	4.6%
D.C. Whites	60.8%	10.9%	0.9%	1.9%	3.4%	9.5%	11.3%	0.8%
D.C. Latinos (LHCC)	65.0%	4.0%	11.0%	7.0%	9.0%	1.0%	2.0%	1.0%

Figure 7 Council of Latino Agencies (sources: BRFSS, DC, 2004 except LHCC where noted).

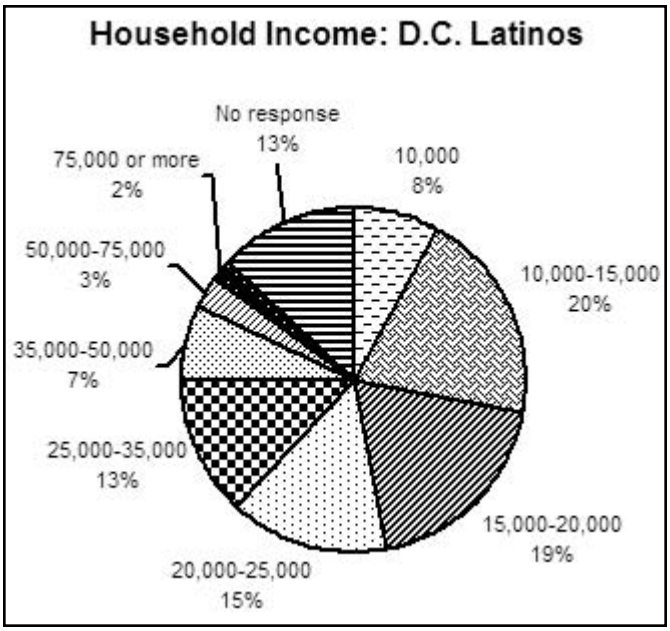
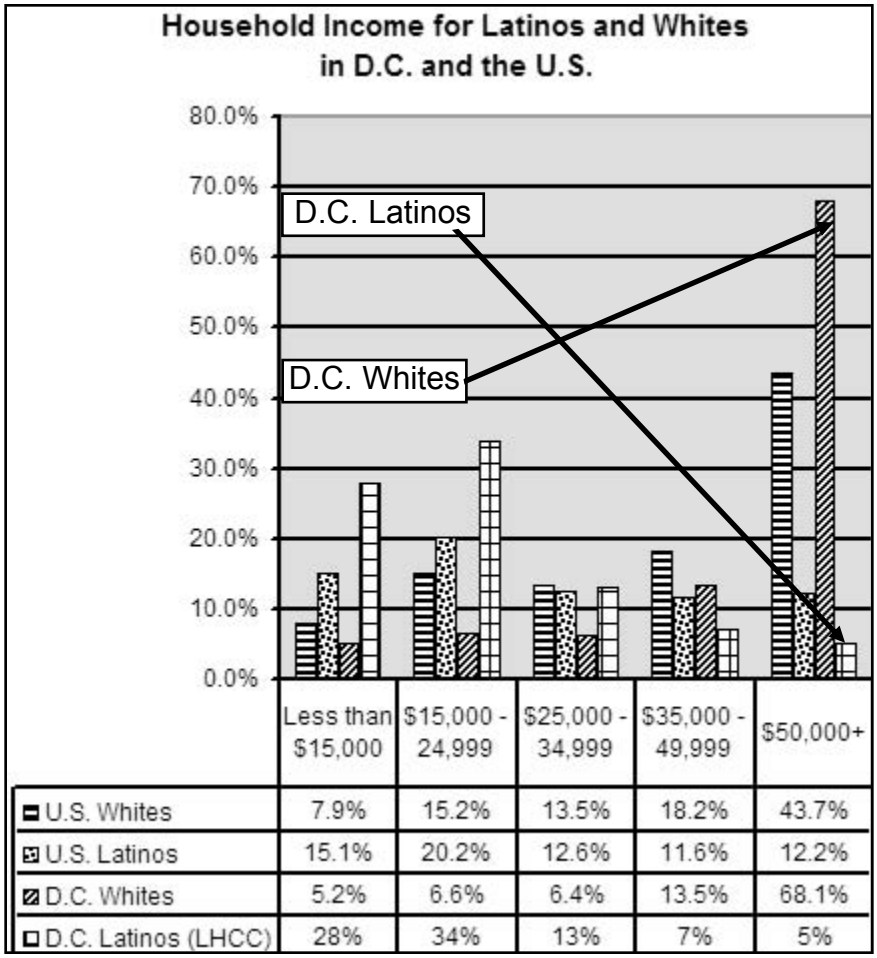


Figure 8
Dept. of Health, State Center for Health Statistics Administration (source: LHCC)

While employed at similar rates, household income levels differed substantially. Within the District, the proportion of Latino households earning under $25,000 was five times greater than that of whites, and the proportion of white households earning $50,000 or more was nearly nine times higher than that of Latinos. **Figure 8** shows that the economic status of a large proportion of the District's Latino community is extremely precarious; nearly two-thirds of respondents reported total household incomes of $25,000 per year or less, while only five percent reported total household incomes of $50,000 or more. In comparison, **Figure 9** shows that 11.8 percent of D.C. white, 23.1 percent of U.S. white and 35.3 percent of U.S. Latino households earned less than $25,000.



	Less than $15,000	$15,000 - 24,999	$25,000 - 34,999	$35,000 - 49,999	$50,000+
U.S. Whites	7.9%	15.2%	13.5%	18.2%	43.7%
U.S. Latinos	15.1%	20.2%	12.6%	11.6%	12.2%
D.C. Whites	5.2%	6.6%	6.4%	13.5%	68.1%
D.C. Latinos (LHCC)	28%	34%	13%	7%	5%

Figure 9
Council of Latino Agencies (sources: BRFSS, CDC, 2004 except LHCC where noted).

DURATION OF RESIDENCE IN THE U.S. and LANGUAGE ABILITY

	Percent
Born in the United States	0.6
> 0 to < 2 years	12.6
2 to < 5 years	20.6
5 to < 10 years	24.3
> 10 years	41.8

Table 1 Duration of Residence in the U.S.

Finally, as shown in **Table 1** and **Figures 10 and 11** below, duration of residence and language ability, two important indicators that are often used to measure levels or degree of acculturation or assimilation support the perception that the District's Latino community is extremely diverse compared to other parts of the country. The majority of D.C. Latinos (41.8 percent) came to the U.S. more than 10 years ago. However, there were also a number of newer arrivals; the proportion of Latinos who arrived since 1998 was two times greater in the District than for U.S. Latinos in general.

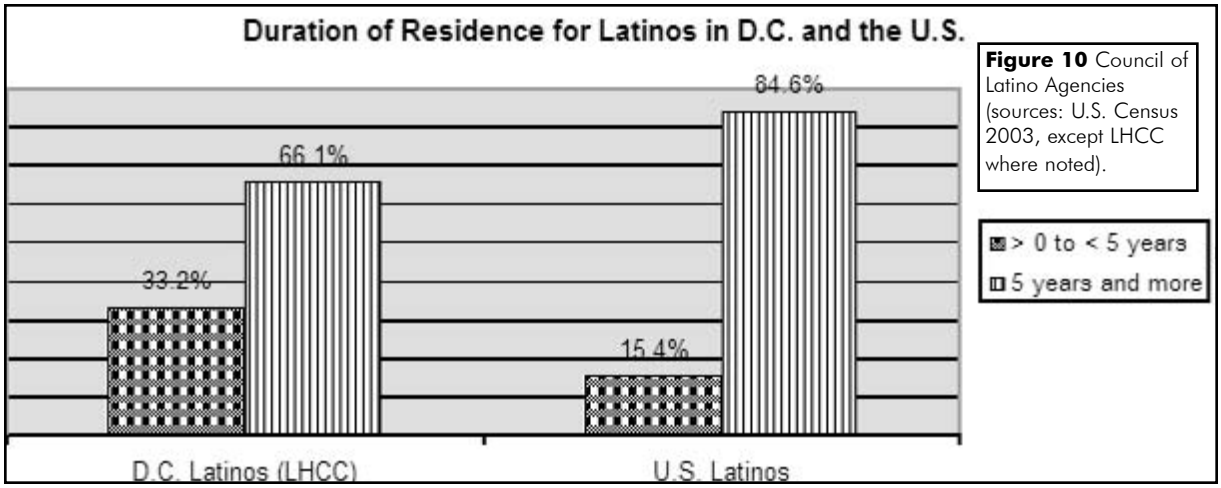


Figure 10 Council of Latino Agencies (sources: U.S. Census 2003, except LHCC where noted).

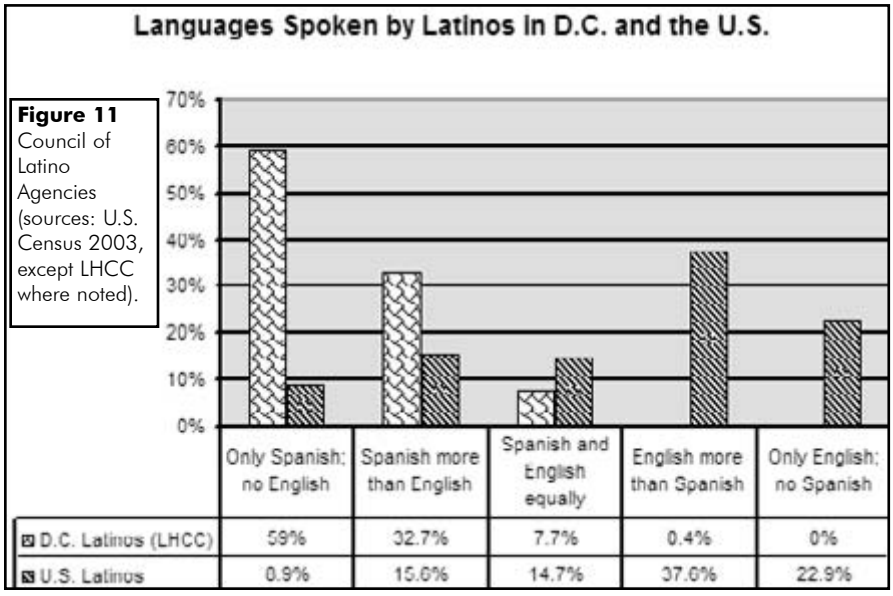


Figure 11 Council of Latino Agencies (sources: U.S. Census 2003, except LHCC where noted).

With regards to language, the majority of D.C. Latinos (59 percent) spoke only Spanish, compared with U.S. Latinos who spoke English and some Spanish (37.6 percent) and only English (22.9 percent, see **Figure 11**). These contrasts may reflect the differences in Latino settlement patterns in the U.S., with the District serving as a relatively recent destination for Latin American immigrants.

While a large proportion of respondents spoke only or principally Spanish, about two-thirds have been living in the United States for five years or more. These findings raise the question of whether language poses a greater barrier to accessing health care in D.C. than for Latinos elsewhere. Although this question was not explicitly asked, other questions asked regarding perceived health care barriers suggest that this may be the case (see section on Health Care Access Barriers). In addition, these data raise important questions related to D.C. Latinos and English language acquisition (see Discussion).

HEALTH CARE UTILIZATION AND BARRIERS

HEALTH CARE COVERAGE

Health services research over the last 25 years has identified numerous consequences of being uninsured on health and economic status. According to The Kaiser Family Foundation, the uninsured receive less preventive care, are diagnosed at more advanced disease stages, and once diagnosed, tend to receive less therapeutic care (drugs and surgical interventions) (Kaiser Family Foundation 2002). In their 2002 report, the Kaiser Family Foundation concluded that increased access to health insurance would lower mortality rates, and increase annual earnings and educational attainment (Kaiser Family Foundation 2002).

Over 41 percent of survey respondents reported that they did not have any kind of health care coverage, including health insurance, prepaid plans such as HMOs, or government plans like Medicare. Though national studies show that the rates of uninsured are highest among Latinos **(Figure 12)**, the uninsured rate for D.C. Latinos was 3.5 times that of U.S. whites, twice that of U.S. Latinos, and nearly nine times that of D.C. whites (Kaiser Family Foundation 2005; Kaiser Family Foundation 2005). More women (67.5 percent) than men (46.2 percent) had health insurance. In contrast, the rate of children who have health insurance appears to be much higher (see Needs Assessment section).

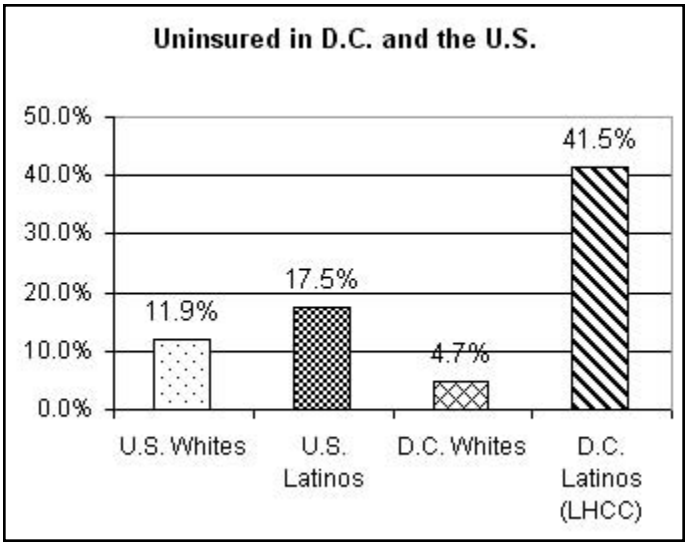


Figure 12
Council of Latino Agencies (sources: BRFSS, CDC 2004, except LHCC where noted)

HEALTH CARE UTILIZATION

As **Table 2** shows, 31.7 percent of respondents did not have any one provider whom they considered as their personal doctor, and about a quarter did not go to a particular clinic.

Table 2. Health Care Utilization

	Yes % (N)	Yes, more than one % (N)	No % (N)	No Response % (N)	Total % (N)
Do you have one person you think of as your personal doctor or health care provider?	53.5 (438)	14.8 (121)	31.5 (258)	0.2 (2)	100 (819)
Is there one particular clinic, health center, doctor's office or other place that you usually go to if you are sick or need advice about your health	67.4 (552)	7.2 (59)	24.8 (203)	0.6 (5)	100 (819)

Dept. of Health, State Center for Health Statistics Administration & Council of Latino Agencies

Over half (53.5 percent) of respondents reported that they had visited a doctor for a routine checkup within the last 12 months (defined as a general physical exam rather than a visit for a specific lesion or illness) and an additional 14.5 percent reported that they had received a routine exam more than a year ago but less than two years ago. Given the variability in access noted above, it is not surprising that nearly a third (31.8 percent) had not had a checkup in more than two years. Compared with other populations **(Table 3)**, the percentage of D.C. Latinos whose last visit to the doctor was more than two years ago was substantially higher, at three to five times the rate of U.S. Latinos or whites, respectively.

Table 3. Frequency of Routine Doctor Visits

	Last 12 months	Between 1 and 2 years	More than 2 years
U.S. Whites	85.6%	7.0%	6.5%
U.S. Latinos	74.5%	9.1%	10.8%
D.C. Whites*	74.8%	14.6%	N/A
D.C. Latinos (LHCC)	53.5%	14.5%	31.8%

source: NHIS 2003a except *BRFSS 2000 and LHCC where noted)

Almost seven in ten Latinos in the District of Columbia indicated that they would go to a clinic or health center if they were sick or needed advice about their health. Going to a doctor's office or HMO (24.8 percent) was their second choice when seeking health care **(Table 4)**. The unusual popularity of health clinics among Latinos in the District-only 26 percent of U.S. Latinos and 14.5 percent of U.S. whites chose health clinics for their care (National Center for Health Statistics 2005)-may indicate the success of Latino-serving community-based health clinics in the District and/or the persistence of barriers Latinos experience when seeking health care elsewhere in D.C.

Table 4. Type of Place Health Care is Sought

	N	%
Doctor's Office or HMO	150	24.8
Clinic or Health Center	416	68.8
Hospital Outpatient Department	24	4.0
Hospital Emergency Room	1	0.2
Urgent Care Center	2	0.33
Other	6	1.0
No Response	223	27.2
TOTAL	819	100

D.C. Department of Health, State Center for Health Statistics Administration

The high percentage of uninsured within D.C.'s Latino population suggests that Latinos disproportionately face barriers to accessing health care in the District. An implication of these barriers for this study is that Latinos in D.C. may receive diagnoses of both acute and chronic illnesses at comparatively lower rates than if they had reliable access to health practitioners, and, if so, the prevalence rates of these diseases reported here (which must be diagnosed by a health professional) may be obscured by poor access to health care.

Barriers

As shown in **Table 5**, the principal barrier to access to health care when it was needed was cost (30.5 percent)- a finding that is consistent with the high proportion of respondents who lack health insurance. This rate was higher than the national average of 26.3 percent of Latinos who, because of cost, were unable to access care when it was needed within the last 12 months (Centers for Disease Control and Prevention 2004).

A second economic barrier that is less recognized is the inability of many people to leave work in order to secure health care services (11.6 percent), reflecting the low occupational status of many respondents-their jobs provided neither health insurance nor time off for health care. The high number of negative responses to these questions indicates that some of the reasons for not accessing health care were not listed in the questionnaire.

Table 5. Reason for Not Accessing Health Care

Reason	%
Cost	30.5
Transportation/Distance	7.6
Lack of Time Off Work	11.6
Family Care/Family Responsibility	6.2

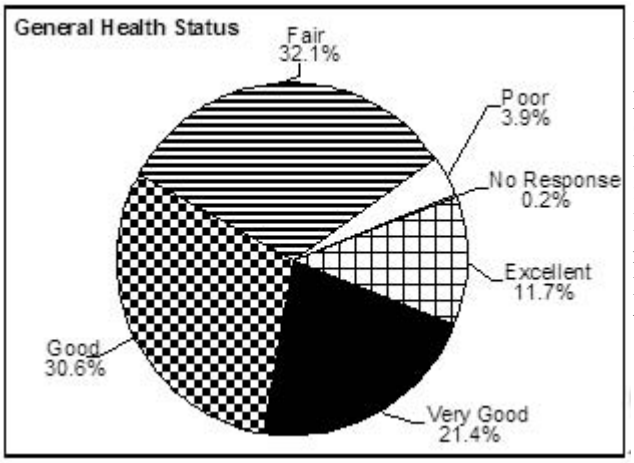
n= 819 Dept. of Health, State Center for Health Statistics Administration

Traditional and Complementary Health Care

In addition, the use of traditional and complementary sources of health care and treatments among a broad range of populations in the U.S., including Latinos, has been widely observed (Centers for Disease Control and Prevention 2004). This is a broad category that covers a wide range of situations and options that are not mutually exclusive. In Latin America, as in the U.S., it is common for people of virtually all socioeconomic levels to use different combinations of "modern" or "Western" medicine in combination with complementary methods such as herbal remedies, and customs specific to Latin America are also practiced by some U.S. Latinos. Among the respondents to this survey, over 36 percent reported using prayer to complement standard health care. In addition, nearly 20 percent reported using herbal medicines, nine percent used chiropractic therapy, two percent saw a spiritual doctor, and over four percent used other therapies.

GENERAL HEALTH STATUS

Perceived health, or how people feel about their physical and mental health, has been recognized as a predictor of illness, mortality and functional disability (District of Columbia Department of Health 2002). In addition, studies show that persons who are in fair or poor health tend to have higher rates of medically attended injury and poisoning episodes than persons who have excellent, very good, or good health (National Center for Health Statistics 2005).



D.C. Latino residents considered themselves significantly less healthy than other groups, with 36 percent evaluating their health as fair or poor **(Figure 13)** compared with 11.1 percent of D.C. residents overall, and 15.1 of the national population in 2004 (Centers for Disease Control and Prevention). As shown in **Figure 14**, this finding reflects a disparity in perceived health status with D.C. Latinos rating their health as poor two to three times more often than whites.

Figure 13
Dept. of Health, State Center for Health Statistics Administration

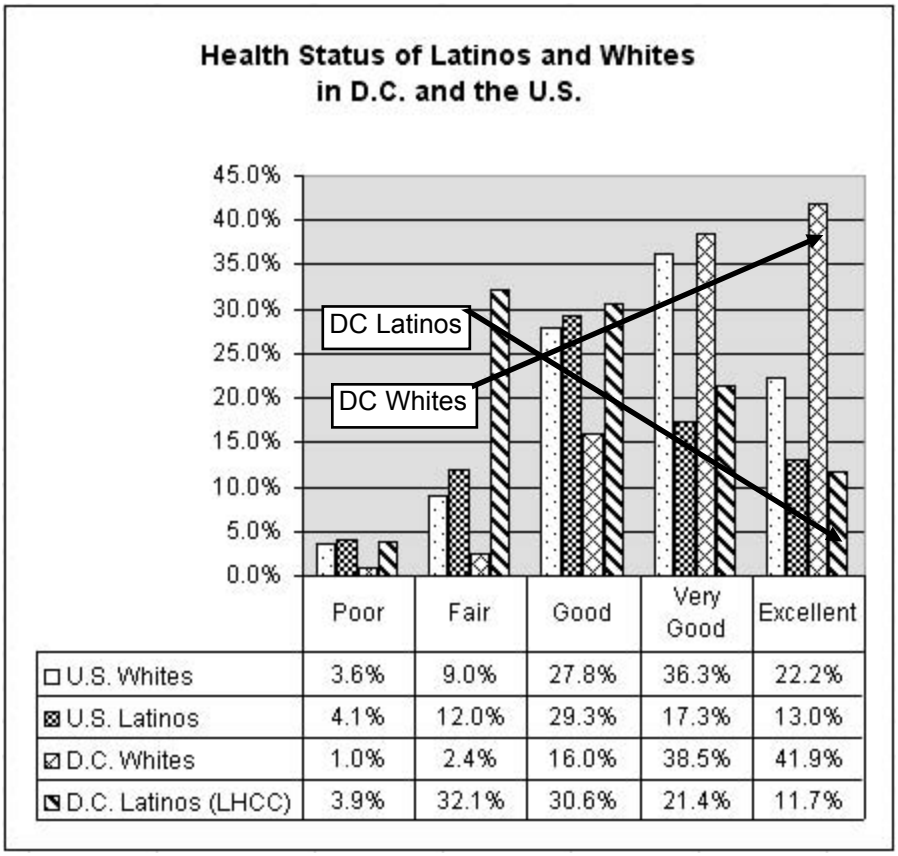


Figure 14
Council of Latino Agencies
(source: BRFSS, CDC 2004 except LHCC where noted)

Despite D.C. Latinos' relatively poor health compared with other groups, **Table 6** (below) shows that 86 percent reported no change in their normal activities in the last thirty days due to bad health, reflecting activity levels comparable to those for healthier-feeling whites (87.2 percent) (National Center for Health Statistics 2005).

Table 6. Perceived Health Status: Number of Days in Month.

Health Status	0 days	1-5 days	6-10 days	11-15 days	16-20 days	21-25 days	26-30 days
Health Not Good	70.6*	14.9	5.4	2.9	0	0.9	3.9
Mental Health Not Good	66.3	18.2	3.9	3.3	1.3	0.4	5.5
Bad Health Prevents Normal Activities	86.0	8.9	2.2	0.5	0	0.1	0.7

*indicates percent; n=819 Dept. of Health, State Center for Health Statistics Administration

In addition, respondents were asked about activity limitations due to disabilities. Nineteen people or 2.3% of interviewees reported that they have a health problem that requires them to use special equipment, such as a special bed or telephone, a cane, or wheelchair, and 3.2% or 26 respondents stated that there was a child or children under 18 years of age whose health required them to use special equipment.

The findings above, when considered alongside data on respondents' incomes, suggest that D.C. Latinos may not miss work or opt out of other critical activities-such as those related to family care that are essential for the workers in the family to continue being productive-because of poor health. These findings reflect national data showing that low-income non-Hispanic white persons (22%) were nearly twice as likely as poor Latinos (12%) to be unable to work (National Center for Health Statistics 2005).

ROUTINE CARE AND PREVENTIVE HEALTH

HIGH BLOOD PRESSURE

Nearly eighty-five percent of respondents reported having blood pressure checked by a health care professional **(Table 7).** Of those 692 respondents whose blood pressure was checked, almost one in five (19.2 percent) reported they were diagnosed with high blood pressure, a lower prevalence than that reported among U.S. whites, though higher than those for both D.C. whites and U.S. Latinos **(Figure 15).**

Table 7. Preventive Health Care Utilization

	% (N)
Ever had blood pressure checked by doctor, nurse or health care provider	84.5 (692/819)
Told by health professional that has high blood pressure	19.2 (133/692)
Currently taking medicine for high blood pressure	60.2 (80/133)

Dept. of Health, State Center for Health Statistics Administration & Council of Latino 'Agencies

Of the 133 respondents with high blood pressure, 60.2 percent or 80 respondents were taking medication, which was slightly higher than the rate for U.S. adults (59 percent) (American Heart Association 2005). In D.C.'s Latino community, more women (21.6 percent) reported being diagnosed with high blood pressure than men (10.4 percent). Increasing age was also associated with a higher risk of high blood pressure (District of Columbia Department of Health 2005). Widows (38.1 percent) followed by divorcees (34.9 percent) and separated persons (24.5 percent) had the highest rate of high blood pressure (District of Columbia Department of Health 2005). Almost 18 percent of people diagnosed with high blood pressure engaged in moderate physical activity, while 13.9 percent engaged in vigorous physical activity. Fifty percent of this same group consumed, on a daily basis, an average of five or more fruits and vegetables.

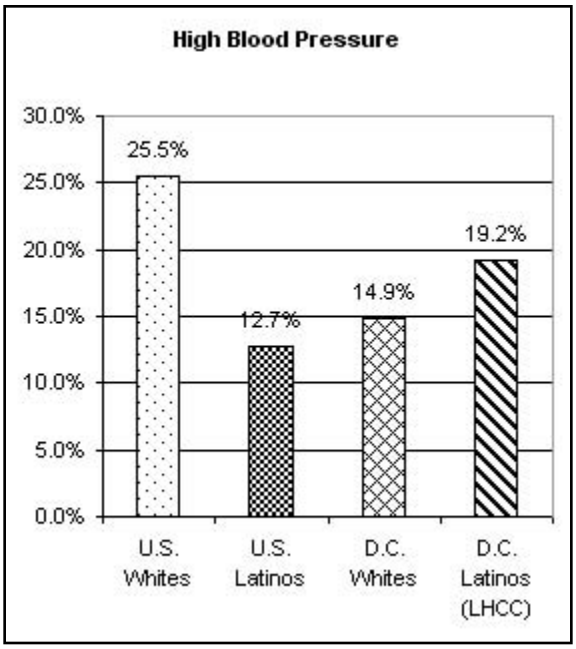
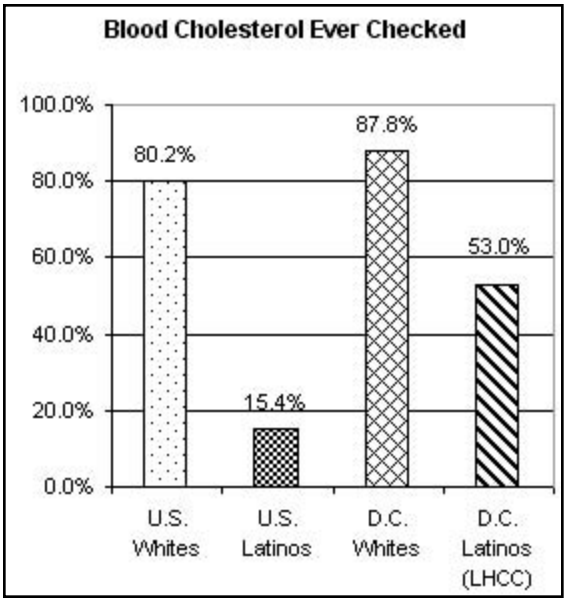


Figure 15
Council of Latino Agencies (sources: BRFSS, CDC 2003 except LHCC where noted)

HIGH BLOOD CHOLESTEROL



Over half of respondents (53 percent or 433 people) had their blood cholesterol checked and 23.6 percent of this group (102 people) were told they had high blood cholesterol. When compared with U.S. Latinos, the proportion of D.C. Latinos who had their blood cholesterol levels screened was nearly 3.5 times higher, though it was lower than that for whites **(Figure 16)**. Of those D.C. Latinos who had their blood cholesterol checked by a health professional, 90 percent did so within the past two years. The prevalence of high blood cholesterol among D.C. Latinos was nearly 1.5 times higher than that of U.S. Latinos and just under that of D.C. whites **(Figure 17).**

Figure 16
Council of Latino Agencies (sources: BRFSS, CDC 2003 (for data on whites), 1997 (for data on U.S. Latinos) except LHCC where noted)

The data show that gender differences are important, since 17.6 percent of females were at risk compared to 8.3 of males diagnosed with high blood cholesterol. Increasing age is also related to a higher risk of high blood cholesterol (District of Columbia Department of Health 2005). Latinos in the District of Columbia who never attended school reportedly had the highest rate of high blood cholesterol (District of Columbia Department of Health 2005). With regards to marital status, widows, divorcees, and separated respondents had higher rates of high blood cholesterol than married persons (District of Columbia Department of Health 2005). Retired persons (30.8 percent) and persons unable to work (33.3 percent) had a higher prevalence of high blood cholesterol than employed persons. Only 12.5 percent who had high blood cholesterol were involved in moderate physical activity and 17.3 percent had health care coverage (District of Columbia Department of Health 2005).

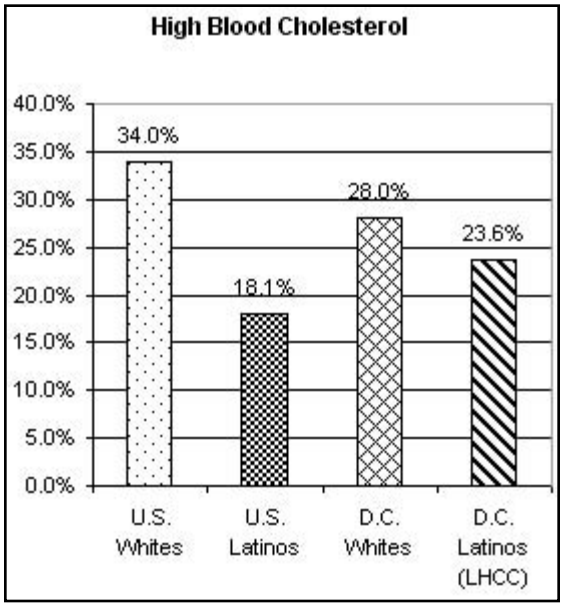


Figure 17
Council of Latino Agencies
(sources: BRFSS, CDC 2003 except LHCC where noted)

OVERWEIGHT AND OBESITY

Since the 1980s, the U.S. population has become more overweight and obese. Obesity and overweight pose a major risk for serious diet-related chronic diseases, including type 2 diabetes, cardiovascular disease, hypertension and stroke, and certain forms of cancer, including cancers of breast, prostate and colon (American Cancer Society 2003; World Health Organization 2003). The health consequences of obesity range from increased risk of premature death to serious chronic conditions that reduce the overall quality of life. In response to this health concern, the D.C. Department of Health in its Healthy People 2010 Plan included as one of its key objectives to increase the proportion of adults who are at a healthy weight to 60 percent, and to reduce the proportion of obese adults to 15 percent (District of Columbia Department of Health 2002).

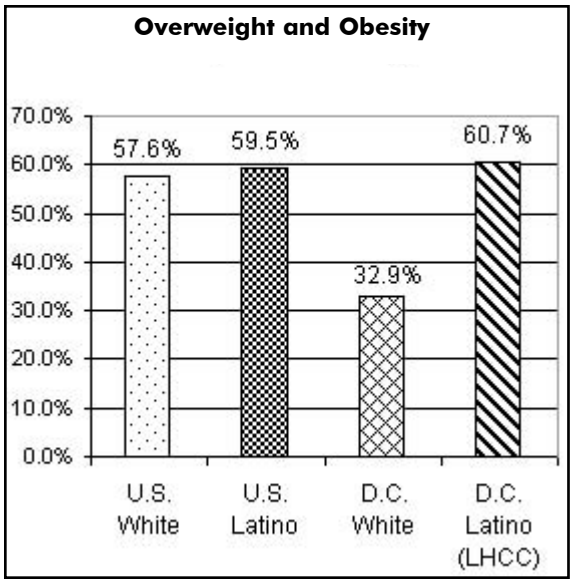


Figure 18
Council of Latino Agencies (sources: BRFSS, CDC 2002 except LHCC where noted)

Nearly 61 percent of D.C. Latino respondents were either overweight or obese as measured by self-reported height and weight, which were used to calculate the body mass index or BMI. (BMI is calculated as weight in kilograms divided by the square of height in meters). Compared with other populations **(Figure 18)**, D.C. Latinos' prevalence was nearly two times that of D.C. whites (32.9 percent), nearly the same as Latinos nationwide (59.5 percent), and slightly higher than U.S. whites (57.6 percent). Of all of these groups, note that only D.C. whites, an affluent and well-educated population when compared with national averages, met the Healthy People objectives described above, with 67.1 percent of D.C. whites reporting that they had a healthy weight.

It is interesting to note **(Table 8)** that being overweight was slightly more prevalent in men (43.7 percent) than women (36.6 percent) while the opposite was true for obesity at 23.4 percent for women compared to 18.2 percent for men.

The risk of being overweight and obese increased from age 20 years until the age of 44, at which point, it decreased. Overweight and obesity increased sharply from ages 20-24 years (37.1 percent) and peaked at the ages of 35-44 (72.9 percent), decreasing between the ages of 45-54 (67.8 percent) and decreasing further by the ages of 55-64 (17.5 percent). Overweight and obesity increased markedly with old age (65+) (59.1 percent) (District of Columbia Department of Health 2005). D.C. Latinos who had an income between $10,000 - < $35,000 and between $50,000-<$75,000 showed a higher occurrence of overweight and obesity than other income brackets. Respondents who never attended school or kindergarten tended to be more overweight and obese than people in other education categories, but were followed very closely by people who had an elementary education (1st to 8th grade) or some high school attainment (9th to 11th grade)(DOH LHCC report) (District of Columbia Department of Health 2005). The risk of being overweight and obese increased with the number of years Latinos lived in the U.S. Latinos who spoke Spanish only (no English) were at greatest risk of being overweight and obese, and this risk decreased for respondents who spoke more English. There was little difference between Latinos who were overweight and obese with health care coverage than those who had no insurance (District of Columbia Department of Health 2005).

Table 8. Body Mass Index (BMI) by Gender

BMI	Female		Male		Total	
	Number	Percent	Number	Percent	Number	Percent
Underweight – BMI < 18.5	56	12.1	21	5.9	77	9.4
Normal – BMI 18.5 – 24.9	129	27.9	115	32.2	244	29.8
Overweight – BMI 25.0 – 29.9	169	36.6	156	43.7	325	39.7
Obese – BMI > 30.0	108	23.4	64	17.9	172	21.0
No response-weight unknown	0	0.0	1	0.3	1	0.1
Total surveyed	462	56.4	357	43.6	819	100.0

D.C. Department of Health, State Center for Health Statistics Administration

It should be noted that data based on self-report consistently show lower prevalence rates than those of studies that involve actual height and weight measures such as the National Health and Nutrition Examination Survey (NHANES) (Mokdad, Serdula et al. 1999; Flegal, Carroll et al. 2002). According to NHANES data for 1999 to 2002, 72.5 percent of Mexican Americans surveyed were overweight or obese, and 32.6 percent were obese (Hedley, Ogden et al. 2004).

WEIGHT CONTROL

Though D.C. Latinos' rate of overweight and obesity is similar to the extremely high levels found in other populations, Latinos in the District were half as likely to use physical activity to maintain or lose weight **(Figure 19).** A related finding was that only one in four respondents (24.8 percent) reported that a health care professional had advised him/her to lose weight and only 6.7 percent had been told to maintain their current weight. In addition, **Table 9** below shows that less than half of the respondents reported consuming fewer calories or less fat to lose weight or to keep from gaining weight.

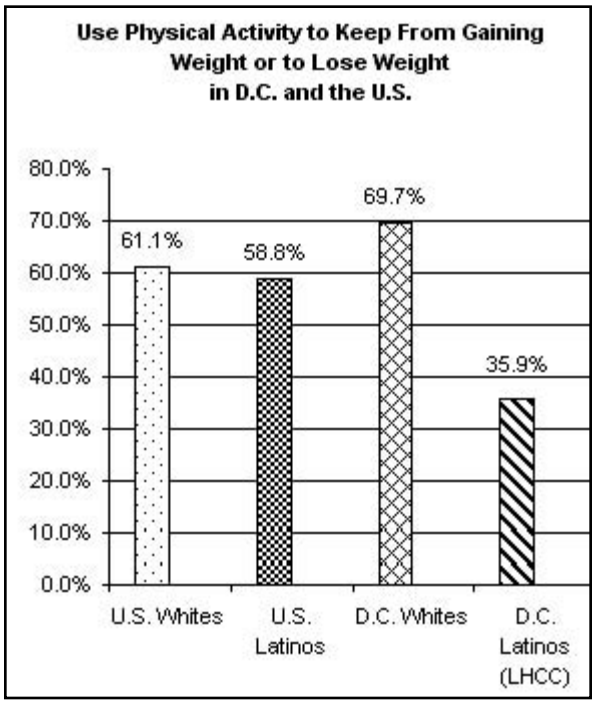


Figure 19
Council of Latino Agencies (sources: BRFSS, CDC 2000 except LHCC where noted)

	%
Currently eating either fewer calories or less fat to: n=790	
• lose weight	40.0
• keep from gaining weight	47.5
Using physical activity to:	
• lose weight	26.2
• keep from gaining weight	30.1

Table 9.
Weight Control Activities
Dept. of Health, State Center for Health Administration

PHYSICAL ACTIVITY

Regular physical activity has been shown to reduce the risk of certain chronic diseases including diabetes, high blood pressure, stroke, coronary artery disease, colon cancer, and osteoporosis (Centers for Disease Control and Prevention 2005). According to the CDC, adults should strive to meet either of the following physical activity recommendations: engage in physical activities of moderate intensity for at least 30 minutes on five or more days of the week, or engage in vigorous physical activity three or more days per week for 20 or more minutes per occasion (Centers for Disease Control and Prevention 2005).

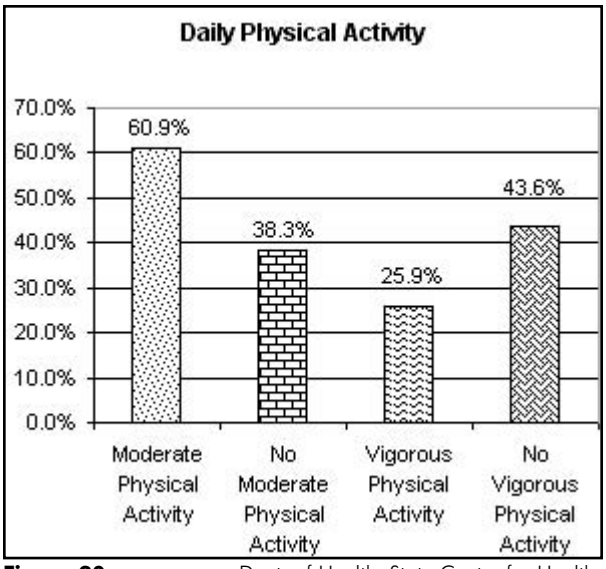


Figure 20 Dept. of Health, State Center for Health Statistics Administration

Nearly four in ten respondents (38.3 percent) reported that they did not regularly engage in moderate physical activity **(Figure 20)**. This rate is between 1.5 and two times higher than those of the U.S. and D.C. populations in general (at 24.4 and 20.9 percent respectively)((Centers for Disease Control and Prevention) for 2002).

Most respondents who were employed or self-employed reported at least moderate physical exercise in the work place; 63.6 percent said that their work involved mostly walking or moving, while another 8 percent engaged in mostly heavy labor or physically demanding work.

NUTRITION

A healthy diet consisting principally of fruits, vegetables, and recommended amounts of protein and carbohydrates also can help to lower risk for major chronic diseases. Table 6 presents data on dietary consumption. A diet rich in fruits and vegetables (recommended levels are five or more servings per day) (Hyson 2002; Centers for Disease Control and Prevention 2005) may be particularly beneficial in warding off risks of cancer and other diseases. As **Figure 21** indicates, D.C. Latinos were doing better at eating daily recommended amounts of fruits and vegetables than other groups, with 52.6 percent not eating enough fruits and vegetables compared with nearly two-thirds of D.C. whites and three-quarters of U.S. Latinos and whites. However, all groups have room for improvement.

Fewer than three in ten respondents (28.7 percent) reported that they are currently taking vitamin pills or supplements.

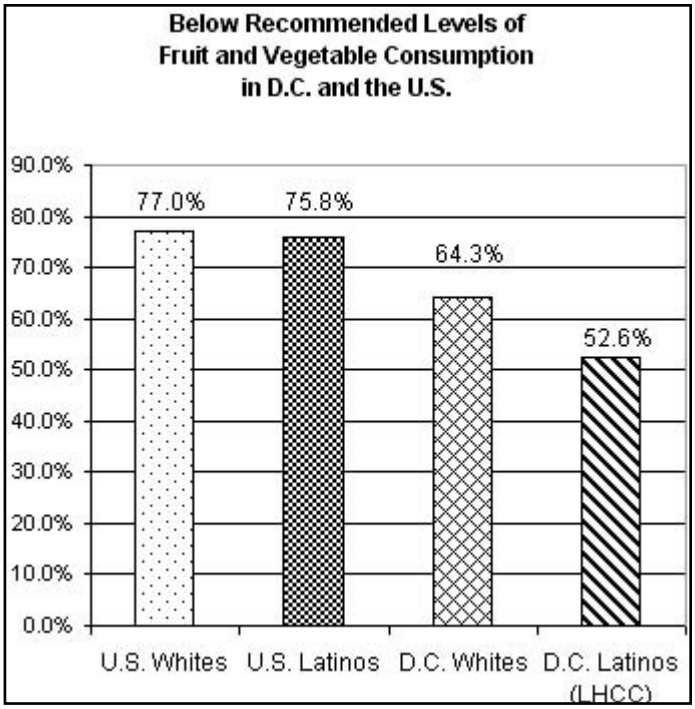


Figure 21 Council of Latino Agencies
(sources: BRFSS, CDC, 2003 except LHCC where noted)

OTHER PREVENTIVE BEHAVIORS

Other important issues related to health behavior included immunizations, tuberculosis control, dental care, and consumption of alcohol and tobacco. Less than one in four respondents reported receiving a flu shot in the preceding 12 months (22.7 percent), which was comparable to U.S. Latinos and lower than the rates for U.S. and D.C. whites (approximately one in three) (Centers for Disease Control and Prevention 2002). Fewer (12.8 percent) reported having ever receiving a pneumococcal (pneumonia) vaccine. Overall vaccination rates were lower than those for other populations, as can be seen in **Figure 22** below.

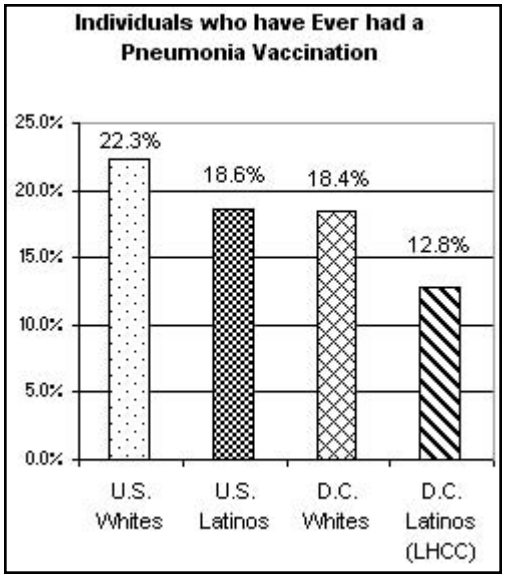


Figure 22
Council of Latino Agencies (sources: BRFSS, CDC 2002 except LHCC where noted)

IMMUNIZATIONS

In contrast to general flu shot vaccine rates, D.C. Latinos aged 65 years and older received the most flu shots (63.6 percent). This rate was significantly higher than that of U.S. Latinos at 54 percent (Centers for Disease Control and Prevention 2003), though lower than that of both D.C. and U.S. whites at just under 71 percent [(Centers for Disease Control and Prevention) for 2004].

TUBERCULOSIS

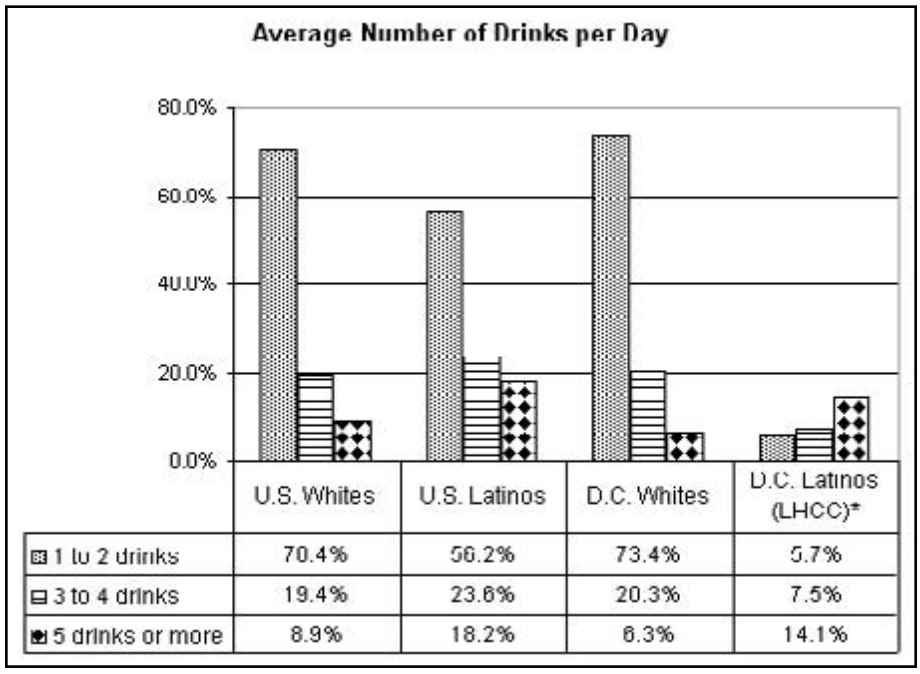
Tuberculosis (TB) is a growing concern both worldwide and in immigrant populations, yet only sixty percent of respondents (59.3 percent) reported having received a skin test or X-ray for TB. Five percent reported having been told by a health care provider that they have TB.

DENTAL CARE

Oral disease, which can be prevented through regular dental visits, is increasingly found to be associated with chronic diseases such as heart and lung disease, diabetes, and stroke (Centers for Disease Control and Prevention 2005). Ten percent of D.C. Latinos had not seen a dentist or visited a clinic in more than two years, and 12.2 percent in more than five years. More than four in ten D.C. Latinos reported that they had seen a dentist or visited a dental clinic for any reason in the past year. More than two-thirds of D.C. Latinos reported having permanent teeth removed because of tooth decay or gum disease, indicating a need for more accessible dental care.

ALCOHOL and TOBACCO

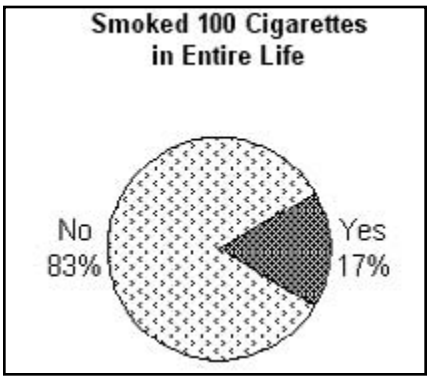
While reported alcohol consumption in the Latino community overall was very low-87 percent report two or fewer drinks in the last 30 days-binge drinking among those who did report drinking was significant, with more than half reporting drinking five or more drinks at a time. The prevalence of binge or heavy drinking (having five or more drinks on one occasion) among D.C. Latinos was 14.1 percent, about two times higher than that of whites in D.C. and the U.S. **(Figure 23)**. This pattern was further confirmed by the finding that 21.8 percent of those who reported drinking alcohol in the past month had five or more drinks in the same day once or twice in the past month, while 15.8 percent had done so three or four times. This rate for heavy drinking among D.C. Latinos, however, was lower than that for U.S. Latinos.



	U.S. Whites	U.S. Latinos	D.C. Whites	D.C. Latinos (LHCC)*
1 to 2 drinks	70.4%	56.2%	73.4%	5.7%
3 to 4 drinks	19.4%	23.6%	20.3%	7.5%
5 drinks or more	8.9%	18.2%	6.3%	14.1%

Figure 23
*Note: the column for D.C. Latinos equals 100% when the 72.7% of respondents who say they have 0 drinks per day are added. Council of Latino Agencies (sources: BRFSS, CDC 2002 except LHCC where noted)

A similar pattern was observed for tobacco consumption. While only 17 percent reported smoking more than 100 cigarettes in their lifetime, of those that reported smoking, 45 percent did so everyday **(Figure 24)**.



Evidence that smoking was an intractable problem for a small proportion of respondents was the finding that 38.5 percent first smoked before the age of 16 (the youngest reported age of initiation of smoking was eight years). It is interesting to note, though, that only 30.9 percent of smokers reported that they had been advised to quit by a health care professional. On the other hand, at least six of ten smokers reported that they refrained from smoking to avoid indoor pollution when inside the home, to protect children from second-hand smoke, and to obey non-smoking policies in the work place.

Figure 24
Dept. of Health, State Center for Health Statistics Administration

CHRONIC DISEASE: KNOWLEDGE AND PRACTICE

CARDIOVASCULAR DISEASE

High reported levels of overweight and obesity indicate greater potential risks for chronic disease, including cardiovascular diseases, among D.C. Latinos. Surprisingly, then, the reported frequency of severe coronary problems was very low. Only 0.8 percent of respondents reported they were told by a health professional that they had a heart attack, compared to 3 percent for D.C. in general [(Centers for Disease Control and Prevention) for 2000]. Similarly, only 1.2 percent of respondents reported they were told by a health care professional that they had a stroke compared with 2.7 percent of all D.C. adults [(Centers for Disease Control and Prevention) for 2000], and 1.8 percent of U.S. Latinos (American Heart Association 2005). The reported prevalence of angina (chest pain or discomfort caused by reduced blood supply to the heart muscle) or coronary heart disease for D.C. Latinos was 1.9 percent, compared with 6.1 percent of U.S. Latinos (American Heart Association 2005). At the same time, 11.2 percent of respondents aged 35 or more reported taking a low-strength aspirin daily or every other day to protect against heart problems, indicating that they were aware of their risk for heart disease and preventing against it.

Table 10. Knowledge and Practice of Cardiovascular Disease

	% (N)
Doing the following to lower risk of developing heart disease	
Eating fewer high fat or high cholesterol foods	52.0 (426)
Eat more fruits and vegetables than before	54.6 (447)
Being more physically active than before	36.5 (299)
Within the past 12 months, a doctor, nurse or other health professional advised you to:	
Eat fewer high fat or high cholesterol foods	42.4 (347)
Eat more fruits and vegetables	44.8 (367)
Be more physically active	39.8 (326)

Dept. of Health, State Center for Health Statistics Administration

These results may be explained in a number of ways. First, lack of access to care may influence screening rates (see Discussion). Second, it could be that some other behaviors are counteracting the risks introduced by being overweight or obese. **Table 10** shows that more than half of respondents were eating components of healthy diets, many without receiving advice from a health care professional in the past 12 months to do so. Nevertheless, as shown in earlier findings, fewer D.C. Latinos were engaged in physical activity than any other group, and only around four in ten reported they were advised by a health care provider to engage in physical activity.

ASTHMA

Among respondents, 6.6 percent reported they had been told by a health care professional that they had asthma, and of those, 32 percent reported that they still have asthma. More women (64.8 percent) report being diagnosed with asthma compared to men (35.2 percent). The highest prevalence of asthma was reported equally in 25-35 year olds and 35-44 year olds (25.9 percent).

D.C. Latinos' asthma rates were substantially lower than those of U.S. Latinos and D.C. and U.S. whites **(Figures 25, 26).** Given the high numbers of uninsured in this sample, this finding raises questions of whether asthma was underreported, especially as District rates for Latinos were two times lower than those for U.S. Latinos. Though people of Puerto Rican origin are known to have the highest rates of asthma among Latinos (Office of Minority Health 2005), and the proportion of D.C. Latinos who are of Puerto Rican ancestry is very small, this discrepancy between U.S. and D.C. Latino asthma levels raises questions for further inquiry (see Discussion).

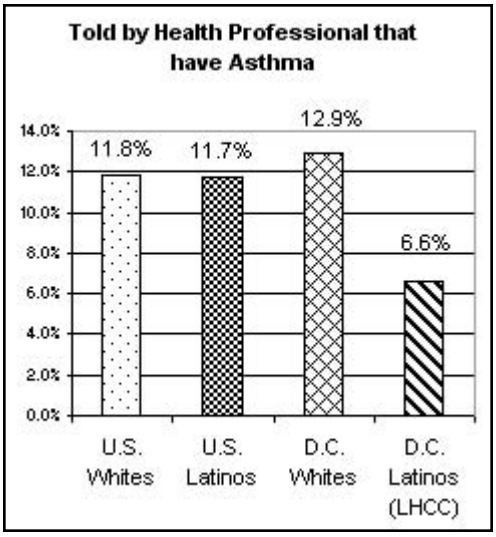


Figure 25
Council of Latino Agencies (sources: BRFSS, CDC 2002 except LHCC where noted)

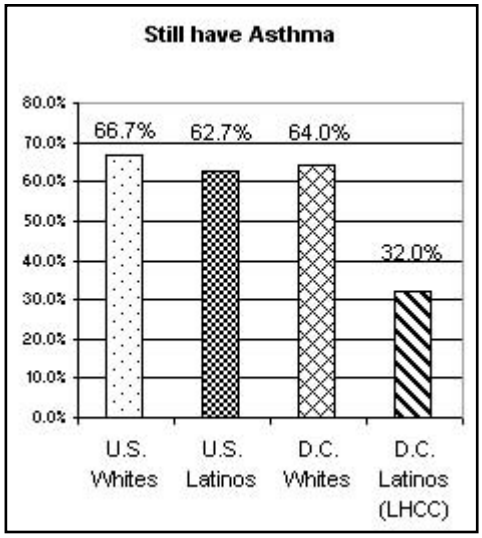


Figure 26
Council of Latino Agencies (sources: BRFSS, CDC 2002 except LHCC where noted)

ARTHRITIS

Nearly 8 percent of respondents reported being diagnosed with arthritis, and 18.3 percent experienced pain or swelling in or around a joint **(see Table 11 below)**. D.C. Latinos' diagnosed rates of arthritis were relatively low compared with those of U.S. Latinos (16.4 percent) and U.S. whites (22.7 percent), an unsurprising finding given the relative youth of this population (National Center for Health Statistics 2005). When the prevalence of arthritis symptoms among D.C. Latinos were compared to other groups, D.C. Latinos' rate of 18.3 percent was lower than those for either U.S. Latinos (20.2 percent) or U.S. whites (28.8 percent), (National Center for Health Statistics 2005).

More women (11.3 percent) than men (3.1 percent) reported being diagnosed with arthritis, with nearly one-quarter of widows (22.7 percent) reporting they have arthritis (District of Columbia Department of Health 2005). As shown in **Table 11**, substantial proportions of respondents with arthritis suffered from symptoms and sought health care for their condition. A smaller proportion, less than three in ten, reported limitations due to arthritis, however, a finding that may reflect the economic and other pressures on this population to remain active, whether at home or at work (see Discussion).

	%
During the past 12 months, had had pain, aching, stillness or swelling in or around a joint	18.3 (150/819)
Symptoms present on most days for at least one month	64.3 (99/151)
Now limited in any way in any activities because of joint symptoms	23.8 (36/151)
Have seen a doctor, nurse or other health professional for these joint symptoms	52.3 (79/151)
Currently being treated by a doctor, nurse or health provider for arthritis	29.5 (43/151)

Table 11. Presence of Arthritis Symptoms
D.C. Department of Health, State Center for Health Statistics Administration

CANCER

Reported levels of breast cancer in female respondents (3.1 percent) were two to five times higher than those of U.S. Latinas and whites **(Figure 27)**. As shown in Figure 28, reported levels of prostate cancer in males (0.6 percent) were low and were less than half the rate for U.S. whites. Nearly 7 percent of women and 4.7 percent of men said they had close blood relatives with breast cancer and prostate cancer (District of Columbia Department of Health 2005). While the Latino population in the District is relatively young on average, and would therefore be likely to have lower prevalence rates of chronic diseases such as cancer than older populations, this high breast cancer prevalence is a cause for concern. This result is especially surprising given barriers to screening and care in general.

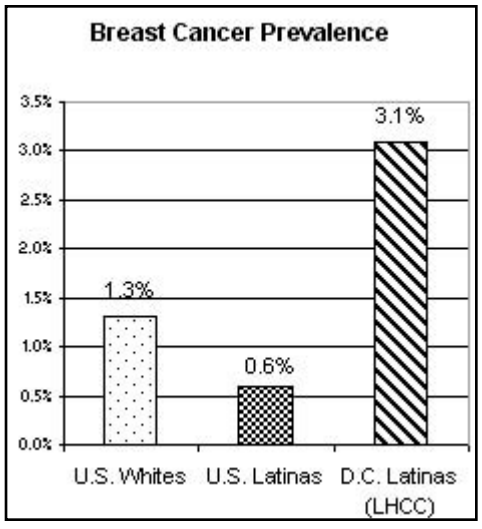


Figure 27
Council of Latino Agencies (sources: NHIS 2005a, CDC 2003 except LHCC where noted)

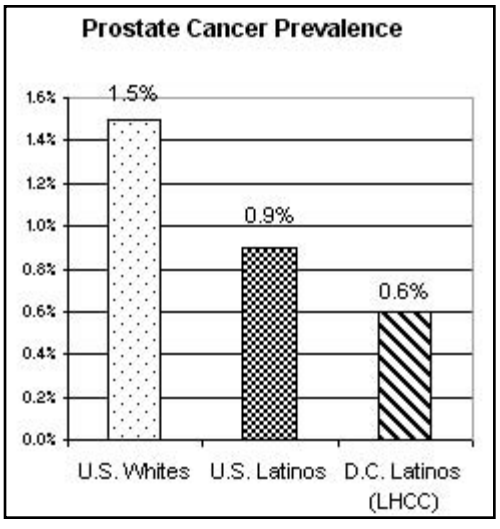


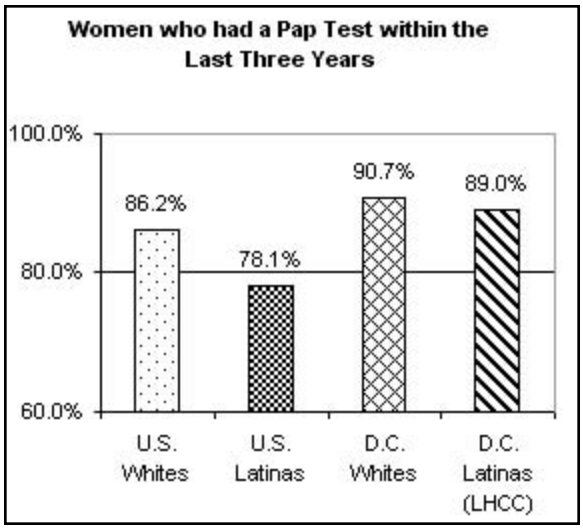
Figure 28
Council of Latino Agencies (sources: NHIS 2005a, CDC 2003 except LHCC where noted)

The results below on cancer-related preventive health care follow the American Cancer Society (ACS) Cancer Detection Guidelines, which can be found in Appendix 2.

	Less than 12 months ago	1 year to less than 2 years	2 years to less than 3 years	3 years to less than 5 years	More than 5 years ago	No Response
Mammogram (women 40 yrs and older; N=183)	63.6*	17.1	9.3	3.6	6.4	N/A
Clinical breast exam (all women; N=462)	70.6	15.4	8.6	1.9	3.0	.5
Pap smear (all women; N=462)	73.6	14.4	7.2	1.4	3.0	.5
Fecal occult blood test (women & men 50 yrs and older; N=129)	72	16	4	0	8	N/A
Sigmoidoscopy or colonoscopy (women & men 50 yrs and older; N=129)	39.5	15.8	21.1	15.8	5.3	2.6
PSA test (men 50 yrs and older; N=50)	40	28	16	8	8	N/A
Digital rectal exam (men 50 yrs and older; N=50)	42.9	28.6	9.5	9.5	9.5	N/A

Table 12. Preventive Cancer Screening * all table values are percentages
Council of Latino Agencies & Dept. of Health, State Center for Health Statistics Administration.

As shown in **Table 12**, of the 462 women in the study, 80.3 percent or 371 had a clinical breast exam, and 89 percent or 411 women were screened for cervical cancer (pap smear) within the last three years, a higher proportion than among either U.S. Latinas or whites, and just slightly below D.C. whites **(Figure 29)**. Of the 183 women in the study aged 40 years or older, 140 had a mammogram with 80.7 percent receiving a mammogram within the last two years, as recommended. As shown in **Figure 30** below, D.C. Latinas' rates of mammogram screening were the highest of any group.



Most women reported that exams were part of routine preventive care (82.1 percent) while 14.1 percent were for diagnostic measures for problems other than cancer. Only 1.4 percent was screened because of a family history of breast cancer, and less than one percent was to monitor existing breast cancer (District of Columbia Department of Health 2005).

Figure 29
Council of Latino Agencies
(sources: CDC, BRFSS 2004 except LHCC where noted; note: BRFSS data is for women 18 years and older)

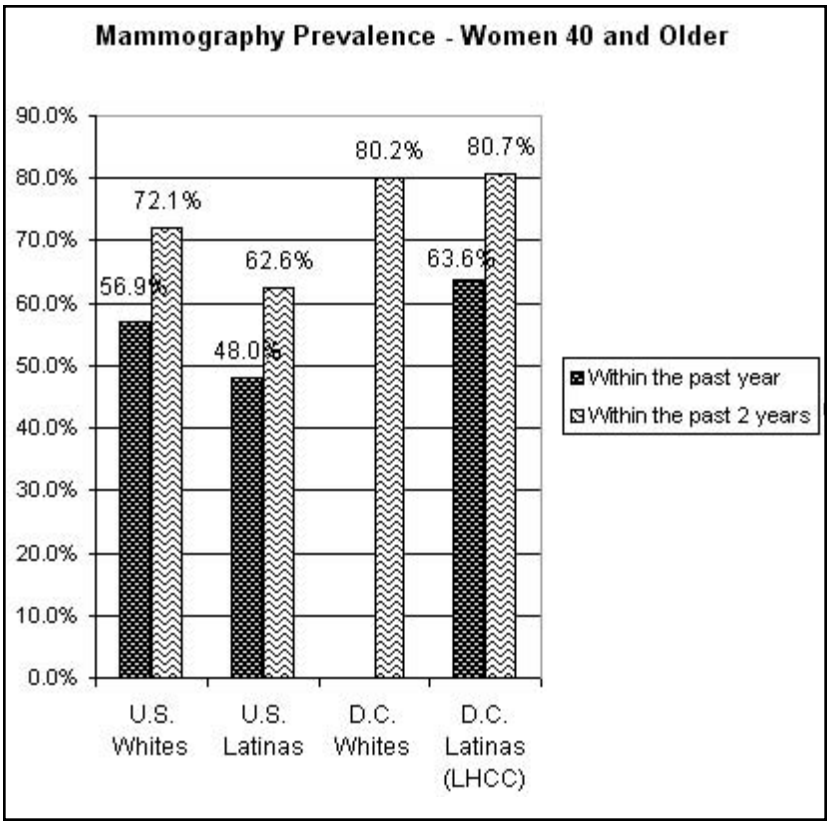


Figure 30
Council of Latino Agencies
(sources: American Cancer Society 2005 except LHCC where noted).

With respect to colorectal cancer, of the 129 respondents (women and men) aged 50 years and older, 29.4 percent or 38 people had a sigmoidoscopy or colonoscopy and 18 percent or 25 people had a blood stool test. Compared with other populations, D.C. Latinos have slightly lower rates than whites of recommended colorectal cancer screening via sigmoidoiscopy or colonoscopy, and substantially lower rates in the use of blood stool home tests than all groups **(Figure 31)**.

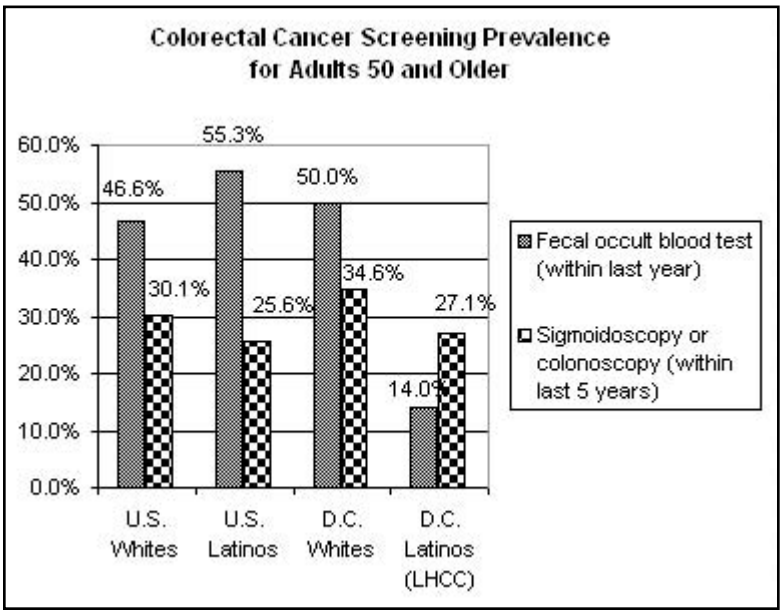


Figure 31
Council of Latino Agencies
(sources: CDC, BRFSS 2002 except LHCC where noted).

Of the 50 men in the study aged 50 years and older, half (25 men) reported having a PSA test and 42 percent (21) had a digital rectal exam. Of those men 50 and older who were screened, 40 percent received a PSA test within the past year, the lowest rate of any group **(Figure 32)**, and 42.9 percent had a digital rectal exam within the last year, a lower rate than whites and comparable to that of U.S. Latinos.

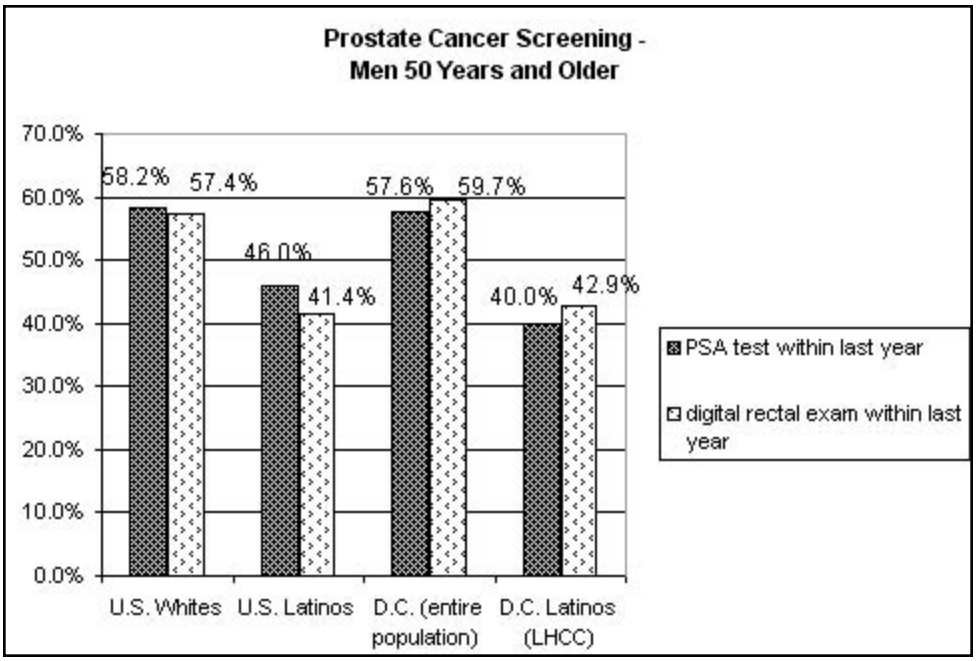


Figure 32
Council of Latino Agencies
(sources: ACS 2003 for U.S. data, ACS 2005 D.C. data except LHCC data where noted)

DIABETES

The prevalence of non-pregnancy related diabetes among respondents was 4.8 percent, with an additional and alarming 12 percent (98 out of 819) of D.C. Latinas reporting gestational diabetes. As **Figure 33** illustrates, D.C. Latinos' rate of diabetes was more than 1.5 times that of D.C. whites, but lower than that of either U.S. Latinos or whites. As seen in **Figure 34** below, the rate of gestational diabetes among Latinas in the District is of great concern as it is almost nine times the rate of U.S. Latinas, and 17 and 60 times the rates of whites in the U.S. and D.C. respectively. Gestational diabetes can lead to the development of type 2 diabetes in the mother, and can result in health problems for the child (see Discussion).

Risk factors for all types of diabetes include a family history of diabetes, overweight and obesity, a sedentary lifestyle, smoking, being over 40 years of age, and having limited access to health care (National Institute of Diabetes and Digestive and Kidney Diseases (NIDDK) 2005). Although the overall prevalence of reported diabetes is not particularly alarming for this population, LHCC survey results indicate that this is a population at risk due to the presence of a number of these risk factors.

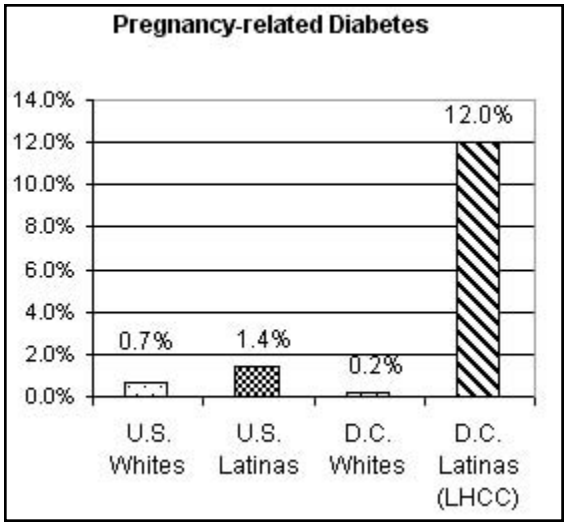


Figure 33
Council of Latino Agencies (sources: CDC, BRFSS 2003 except LHCC where noted)

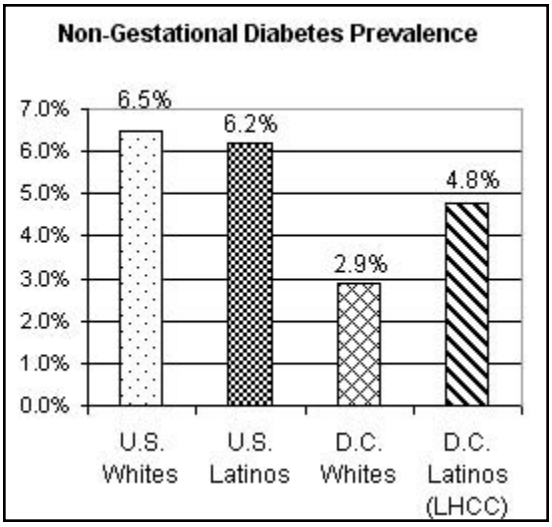


Figure 34
Council of Latino Agencies (sources: CDC, BRFSS 2003 except LHCC where noted)

Table 13 shows that less than two in ten respondents diagnosed with diabetes were taking insulin, and less than half had been taught to manage diabetes. In the D.C. Latino community, rates for diabetes increased with age (District of Columbia Department of Health 2005). The highest rate of diagnosed diabetes was in the 65 years or older age group (33.3 percent). Those who earned between $10,000 and $14,999 (28.5 percent) were more likely to have diabetes, followed by respondents who earned less than $10,000 (25.9 percent). Only 15 percent and 10.5 percent of respondents diagnosed with diabetes engaged in moderate or vigorous physical activities, respectively. Sixty percent of respondents with diagnosed diabetes were born in the United States and 19.6 percent spoke Spanish only (no English).

	%
Now taking insulin	19.4 (6/33)
Now taking diabetes pills	58.1 (18/33)
Ever been taught to manage diabetes	45.5 (15/31)

Table 13.
Treatments for Person Diagnosed with Diabetes
D.C. Department of Health, State Center for Health Statistics Administration

The American Diabetes Association (ADA) recommends that people with diabetes visit their health care provider and have their hemoglobin A1c (the best known indicator of blood glucose stability) checked at least twice a year (ADA 2005). **Figure 35** below shows that, of D.C. Latinos diagnosed with diabetes, 78.4 percent had seen a health professional within the last year, a rate that was lower than that of other groups, and that nearly half of Latino diabetics in the District (39.4 percent) reported not being checked for A1c during this time period. Diabetics who are U.S. Latinos, or D.C. or U.S. whites, are checked for A1c approximately 1.5 times more often than Latinos in D.C. It is possible that barriers to health care access impact the continuity of care received by Latino diabetics in the District (see Discussion).

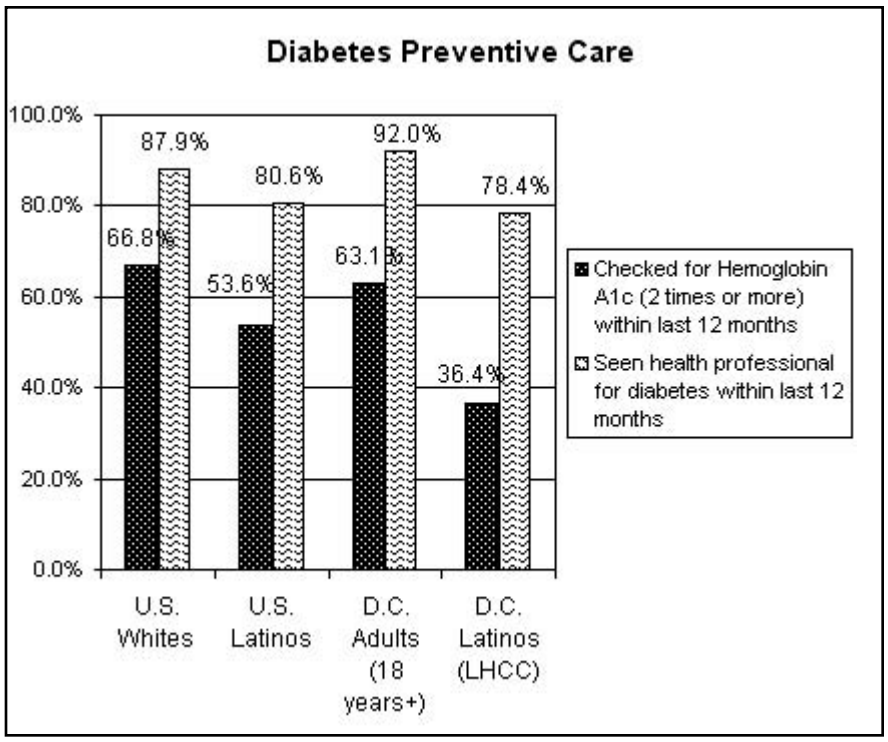


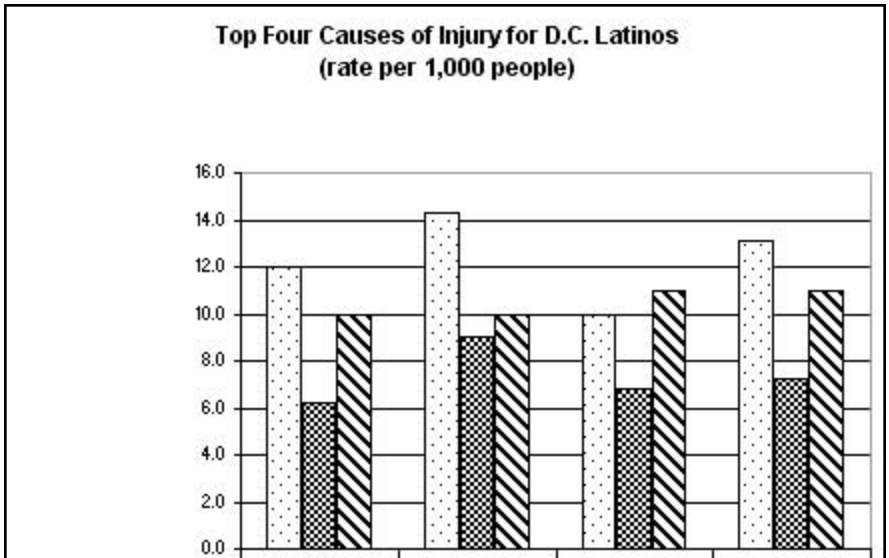
Figure 35

Council of Latino Agencies
(sources: BRFSS, CDC 2001 except LHCC where noted)

INJURIES and ACUTE ILLNESS

Approximately four percent of respondents reported that in the last three months they or someone in their family had been injured or poisoned seriously enough that they sought medical advice or treatment. Of those who were injured, 37.5 percent obtained medical advice just once, 21.9 percent did between two and five times, and 21.9 percent did more than five times in the previous three months, including more than six percent who obtained treatment more than 30 times (an average of once a day). In these instances, 45.5 percent of cases required hospitalization. Overall, the prevalence of injury and poisoning among respondents, at 42 per 1,000 people, was lower that that of either U.S. whites (98.4) or U.S. Latinos (50.9) (National Center for Health Statistics 2005).

Reasons for seeking treatment varied among respondents. Just over one-quarter (25.8 percent or 8 out of 31) of respondents reported seeking medical advice or treatment for an injury due to transportation, including motor vehicle/bicycle/motorcycle, pedestrian/train/boat/airplane. Other reasons were: overexertion or strenuous movements (12.9 percent); struck, stabbed or physically assaulted by another person (12.9 percent); accidentally struck by object or person (12.9 percent); machinery (9.7 percent); fire, burn, or scald related (6.5 percent); falls, poisoning, and cut or pierced (3.2 percent each), and other (9.7 percent). Circumstances surrounding reported injuries or poisonings that required medical intervention varied; most commonly reported were driving or operating a motor vehicle and on the job (29 percent each). Compared with other populations **(Figure 36)**, D.C. Latinos had higher rates of serious injury that were related to operating a motor vehicle. Serious injuries that were transportation-related generally, that occurred on the job, or were due to accident or assault (being stabbed or struck) were higher than the rates for U.S. Latinos but lower than the rates for U.S. whites. Access to care could influence whether, when Latinos are injured, they sought medical advice or treatment (see Discussion).



	Struck by a person or object‡	Transportation*	Operating motor vehicle	On the job
U.S. Whites	12.0	14.3	10.0	13.1
U.S. Latinos	6.2	9.0	6.8	7.2
D.C. Latinos (LHCC)	10.0	10.0	11.0	11.0

Council of Latino Agencies (sources: NHIS 2005b except LHCC where noted)
*Note: this category includes motor vehicle, bicycle, motorcycle, pedestrian, train, boat, or airplane-related injuries.

Figure 36

‡Note: this category combines data for intentional assaults upon a person with accidental injuries due to a person or object.

HIV/AIDS and OTHER SEXUALLY TRANSMITTED DISEASES

The issue of sexually transmitted diseases, including HIV/AIDS, is sensitive within most communities. Nevertheless, 65.4 percent of respondents reported that they had been tested for HIV, a greater proportion than was found among U.S. Latinos or whites **(Figure 37)**. Of those tested, 53.9 percent had been tested within the past year and 22.3 percent between one and two years ago, a frequency of testing that also surpassed those of other groups **(Figure 38)**.

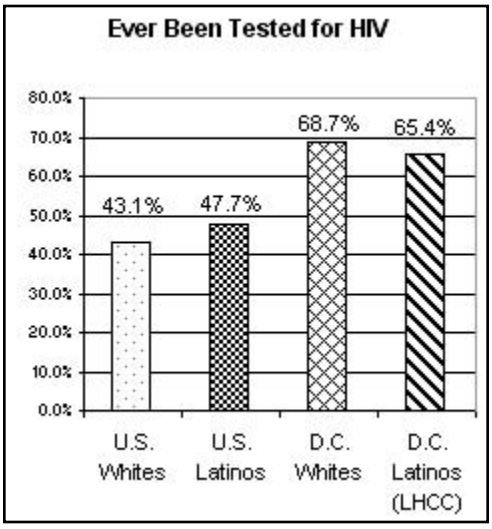


Figure 37 Council of Latino Agencies (sources: BRFSS, CDC 2000 except LHCC where noted)

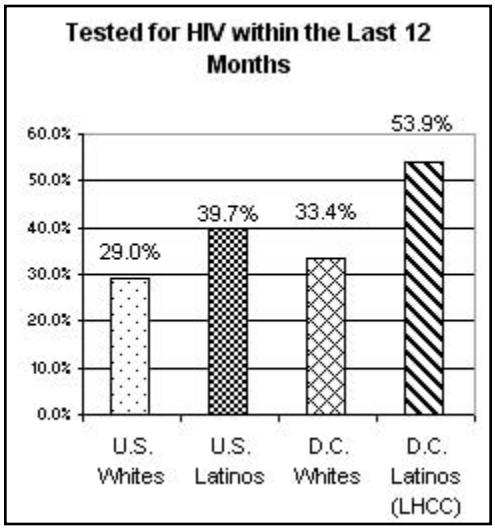


Figure 38 Council of Latino Agencies (sources: BRFSS, CDC 2000 except LHCC where noted)

Of the reasons people gave for being tested for HIV, most were screened as part of routine checkups (43.3 percent) rather than to see if they were infected (19 percent). These high levels of HIV testing suggest that D.C. Latinos were very aware of HIV/AIDS and were taking active steps to inform themselves of their own health status. Only 2.1 percent reported that they had been treated for other sexually transmitted diseases, half of these in health clinics.

Knowledge about HIV/AIDS transmission was tested in the survey by two specific questions. Of all respondents, 59.5 percent correctly stated that a pregnant woman with HIV can get treatment to help reduce the chances that she will pass the virus on to her baby, and 82.3 percent stated that there are medical treatments available to help a person who is infected with HIV to live longer.

Only about one third of all respondents reported using a condom the last time they had sexual intercourse. Regarding sexual behavior in general, 17.2 percent of respondents reported that within the past 12 months, they had more than one sexual partner-compared with 11 percent of adults nationwide-and, of this group, 63.5% used a condom the last time they had sexual intercourse, a comparable rate to that of the U.S. as a whole (Centers for Disease Control and Prevention 2001).

As can be expected, reasons for using condoms varied: to prevent pregnancy (31.5 percent); to prevent diseases like syphilis, gonorrhea, and AIDS (23.4 percent); for both of those reasons (35.4 percent); and for other reasons (2.1. percent). Faith in the effectiveness of condoms varied; 36.4 percent of respondents judged them as "very effective," 43.9 percent as "somewhat effective" and 15 percent as "not at all effective."

COMMUNICATION CHANNELS

Finally, the survey investigated how members of the District's Latino community obtain information about health behaviors and practices. The data presented in **Figure 39** paint a vivid picture: more than three in four respondents reported that they get health information from television. Slightly over a third do so from radio, but only around a quarter from newspapers or from family and friends. In contrast, the Internet remained a little-used medium for health information in this population. This finding suggests that health journalists are effectively serving as public health educators (Schwitzer, Mudur et al. 2005)

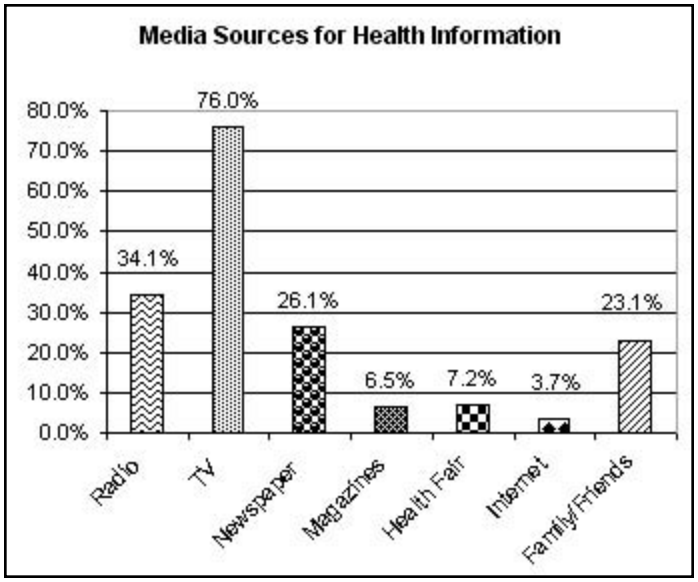


Figure 39 Council of Latino Agencies

NEEDS ASSESSMENT MODULES: MATERNAL/CHILD, YOUTH, AND SENIOR HEALTH

Additional survey modules (Modules IIA-C) were administered to a subset of Module I respondents (as described in Methodology) to identify key needs of children, adolescents, and elderly DC Latino residents. Because of the algorithm used for administration of additional modules, the sample sizes for these modules were much smaller than for Module I, and the sampling strategy reflects a different purpose for asking these questions. In interpreting these results, then, it is important to keep in mind this purpose: to gather information about outstanding community needs in these age groups. Thus, these findings should not be compared to national standards or prevalence rates for specific diseases because the methodology is inappropriate for these purposes. Nevertheless, they are useful in identifying key areas for further study and intervention.

MATERNAL/CHILD HEALTH

Module IIA survey questions involved the health of children (0-5 years) and their mothers during pregnancy and were answered by an adult in the household about a randomly selected child in this age group (n=221, see **Figure 40** for ward distribution). In general, these children seemed to be doing well, with 80 percent weighing 5 pounds or more at birth and most enjoyed very good or excellent health (61 percent).

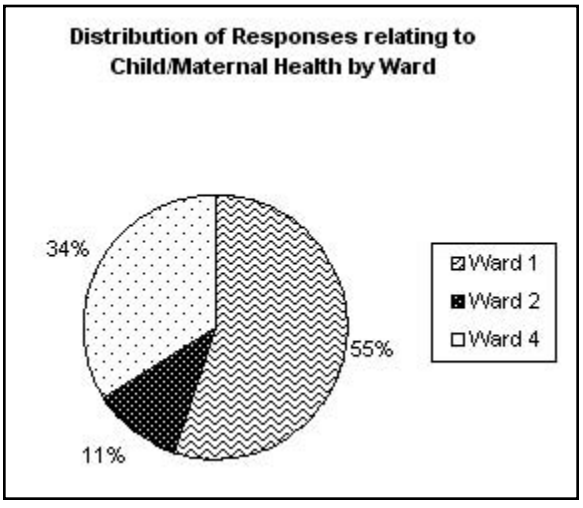


Figure 40 n=221

With regard to health access, this population appeared to be doing much better than their adult counterparts, with 94 percent reported as having some form of health insurance and 95 percent having one or more persons thought of as health providers. The vast majority of these providers were seen in community clinics, with the most commonly visited clinics reported as Upper Cardozo Center (29 percent), Mary's Center (24 percent), and Adams Morgan Clinic (4 percent). For the most part, respondents were happy with the care they received, although some reported difficulty being seen due to long wait times or difficulty getting an appointment (25 percent), presumably due to the high volume of patients seen in these clinics. In contrast, utilization of emergency rooms was reportedly quite low

(7.7 percent reporting two visits in the past year and only 1.8 percent reporting more than that). Only 12 percent reported that their child needed to see a health provider in the past year but did not because they did not like the way they were treated by the health care providers. Rates of immunization are listed in **Table 14** below.

Immunization Type	**% Receiving 1 or more doses**
Diptheria-Tetanus-Pertussis (DTP)	70
Polio	66
Haemophilus influenzae (Hib)	62
Measles-Mumps-Rubella (MMR)	59
Hepatitis B	53
Varicella (chickenpox)	59
Tetanus-diptheria booster (Td)	44

n=221

Table 14. Immunizations
Council of Latino Agencies

With regard to the mother's health (n=169), 86 percent reported getting prenatal care as early as they wanted. Inability to get an appointment and lack of insurance were listed as the leading barriers for the remaining 14 percent. Most were seen in community clinics (36 percent Upper Cardozo Center, 33 percent Mary's Center, 5 percent Adams Morgan Clinic, 2 percent La Clínica del Pueblo), although 5 percent reported returning to their country of origin for prenatal care. Most paid for their prenatal care with health insurance (40 percent) or Medicaid (33 percent), but 19 percent paid out of pocket.

The level of education during prenatal visits was quite high, with more than 84 percent reporting talking with a health care worker about breastfeeding, HIV testing, and using tobacco, alcohol, medications, and illegal drugs during pregancy as well as birth control after pregnancy. Nevertheless, a sizeable number reported that they did not talk about seat belt use (16 percent), physical abuse (19 percent), or screening for birth defects of diseases than run in their family (20 percent).

With regard to health risks encountered during pregnancy, the leading complications reported were diabetes (9 percent), urinary tract infections (9 percent), and physical abuse by anyone (9 percent). More than 87 percent reported not drinking any alcohol either in the three months before getting pregnant or in the last three months of pregnancy, while more than 87 percent reported not smoking at all during these periods.
The majority of respondents (58 percent) reported not feeding their baby anything but breast milk until the child was older than three months.

YOUTH HEALTH and SAFETY

Module IIB consisted of questions from the Youth Risk Behavior Survey (YRBS), which were designed to be asked of the youth themselves. Because of the design of the LHCC survey, these questions were asked of an adult in the household about a household member between the age of 12 and 20 years (n=98, see **Figure 41** for Ward distribution). It is assumed that these adults did not have as much information about the questions asked as the youth themselves and thus were likely to underestimate the frequency of some risk behaviors. Nevertheless, their responses are useful for identifying clear areas of need as seen by parents and other adults caring for these youths.

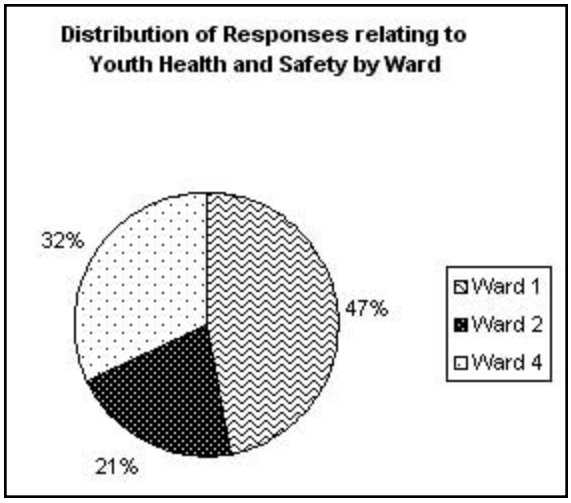


Figure 41 n=98

Overall, the adults surveyed felt the youths were doing well in school (66 percent earning A's and B's) and acting in a safe manner, with 75 percent reported to wear their seat belt all or most of the time, none reported as having carried a weapon in the past month, 85 percent reported as never riding in a vehicle with a driver who had been drinking alcohol, and 95 percent reported as never driving after drinking alcohol themselves. In fact, almost 80 percent were reported as not having had a drink of alcohol in their life, and more than 85 percent have never reportedly used marijuana or cocaine. It was reported that 84 percent have not even smoked tobacco in the past month. With regard to sex, 59 percent were reported as never having had sex, with 85 percent never having been or gotten someone pregnant, and only 7 percent were reported as not having learned about HIV in school.

Although none were reported to have been threatened or injured on school property in the past year, 10 percent had been in a physical fight, 8 percent were reported to have missed school because they felt unsafe at or on the way to or from school in the past month, and 5 percent were reported as having been offered, sold, or given illegal drugs in the past year on school property.

Approximately 20 percent of youths targeted by this survey were reported to describe themselves as either slightly or very overweight and about the same number were reportedly trying to lose weight. Yet, most fell far below recommendations for daily intake of fruits and vegetables (Centers for Disease Control and Prevention 2005) with more than a quarter reportedly eating only three or fewer servings of fruit and 41 percent eating only three or fewer servings of vegetables per week. In addition, a third of respondents reported that the youth in their household had not participated in either moderate or vigorous exercise at all in the past week (another third reported exercise on 1 to 2 days), with more than half watching two or more hours of TV per day.

One of the most striking and concerning findings was that, in the past year, 12 percent of targeted youths were reported to have felt sad or hopeless almost every day for two weeks or more in a row, and 6 percent had reportedly seriously considered suicide.

SENIOR HEALTH

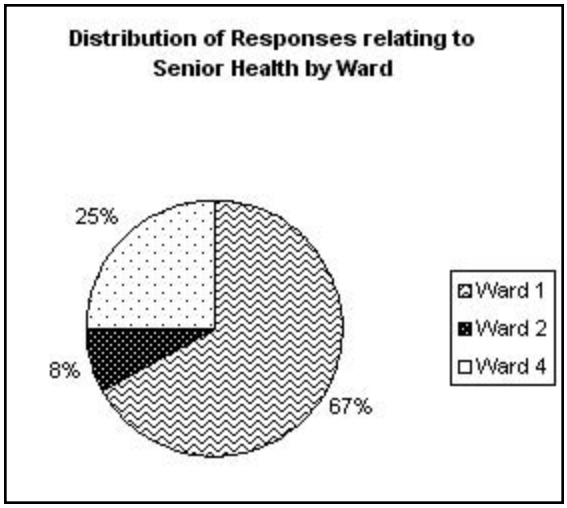


Figure 42 n=24

Because of the small number of respondents for this module (n=24, see **figure 42** for ward distribution), which reflects the smaller population in this age group, only the strongest trends are reported here-those results reported by more than half of the respondents-unless otherwise specified. In general, the sampled population was active and self-reliant despite persistent medical problems, relied very little on social services, and could use more help navigating issues related to health insurance coverage.

Most of the respondents felt the specified elder in their household would rate his/her general health as either fair or poor, with more than half reporting this person to have hypertension. Most were taking between three and five prescription medicines regularly and were administering these medications by themselves (one quarter said they needed more help with this). Surprisingly, none of the subjects had reportedly ever had trouble hearing, blindness, or cancer of any kind. About one-third reportedly had a regular exercise routine, and most did not drink alcohol at all (19 out of 24). With regard to mood, exactly half were reportedly sad or depressed some of the time.

As far as activity level, most leave home every day with most (21 out of 24) using public transportation rather than driving (20 out of 24 did not drive at all.) Their most common social activities were talking on the phone with friends and relatives followed by visiting friends and relatives and attending church-related activities. Very few utilized social services such as senior centers, special transportation for the elderly, in-home support services, or information and referral services. It was not clear if this was because of lack of awareness of available services, difficulty accessing them, or personal preference.

With regard to health care access and utilization of medical services, two-thirds were covered by Medicare and just over half by Medicaid in the month the survey was conducted. Just under one-third reportedly had private insurance. Most felt they had a regular doctor and clinic which they reportedly rated as good or excellent and had seen three to five times in the past three months. One-third were treated at Upper Cardozo Center, with treatment for the rest distributed among eight other community clinics (and one was cared for at Howard University Medical Center). Utilization of emergency services was reportedly very low with the vast majority (22 out of 24) either not visiting an emergency room at all or visiting once in the past year. With regard to filling out insurance forms or benefit applications, most received help from household members, friends, and relatives, but (19 out of 24) reportedly needed more help with these important and often complicated tasks.

HEALTH INTERVENTION FINDINGS

The Para Su Salud pilot workshops were designed to address health risks posed by overweight and obesity (see Methodology) in D.C.'s Latino population. Thirty-six adult, female participants were recruited from the surveyed community and agreed to attend three workshops to learn how to make changes in their diet and exercise/activity levels that would decrease their risk of developing diabetes and other chronic illnesses associated with obesity.

Participants were between 21 and 50 years old. Most were housewives (70%) living in households with an annual income of less than $15,000 who perceived their health at the beginning of the workshops to be "fair" (67%). Out of the 36 participants, half were from El Salvador, with the remaining half in equal numbers from Mexico, Dominican Republic, Guatemala Peru, Honduras, Ecuador and Costa Rica.

The atmosphere of the workshops was harmonious and collaborative. Participants appeared to enjoy learning about cooking and exercise practices from countries other than their own. Although the focus of discussion remained diet and exercise, it became clear that digression into topics of particular interest to group members served a valuable function in maintaining the vibrancy and relevance of workshops to participants' lives. Recurrent topics of interest included parenting bilingual/bicultural children, marital relations, partner abuse, perceptions of physical beauty in their relationships, access to health/exercise facilities, time management, and family pressures.

With regard to specific health problems identified at the beginning of the workshops, 26% had been told by a health care professional that they were overweight, and 19% that they had high blood cholesterol and high blood pressure. Only one participant had been diagnosed with any form of cancer, and it was breast cancer.

As far as access to health care, more than half of the participants (67%) said that if they needed medical attention, they would go to a community clinic and that they had a regular doctor. Of the community clinics listed in the questionnaire, 65% would go to Mary's Center. For health insurance, most (59%) reported having D.C. Alliance, and 29% reported being uninsured.

DIET AND EXERCISE

Data on eating and exercise habits were collected from the participants at each of the three workshops. If a participant missed a workshop these data were gathered by telephone. The same questionnaire was administered each time, at two week intervals, and included questions about intention to change eating and exercise habits as well as about specific physical activities during the previous week and foods eaten the previous day.

With regard to food consumption, participants increased their intake of foods such as whole grain cereal, 2% milk (representing a switch from whole milk), fruit juices, fresh fruits, salads, vegetables (during lunch and dinner) and wheat bread and decreased their intake of unhealthy foods such as sausage or bacon, fried foods, pies/cookies and hot dogs/bologna. However, they showed moderate increases in their intake of some other foods including pastries, butter for vegetables, ground beef, and ice cream **(see Table 15)**.

Yesterday you ate:	First Workshop	Second Workshop	Third Workshop
Cereal	44.4%	55.6%	50.0%
Pastries	19.4	13.9	22.2
Sausage/Bacon	25.0	19.4	11.1
Whole milk	33.3	13.9	13.9
2% milk	44.4	61.1	69.4
1% milk	8.3	13.9	0.0
Fruit juices	*	69.4	72.2
Sodas	*	30.6	13.9
Fresh fruits	66.7	69.4	77.8
Salad	58.3	66.7	75.0
Vegetables @ lunch	33.3	50.0	63.9
Vegetables @ dinner	19.4	38.9	50.0
Butter on veggies	13.9	16.7	25.0
Wheat bread dark	33.3	16.7	50.0
Butter on bread	13.9	8.3	11.1
Fried foods	27.8	33.3	19.4
Hot dogs/Bologna	11.1	13.9	5.6
Hamburgers/ground beef	22.2	11.1	22.2
Pies/cookies	36.1	13.9	25.0
Ice cream	22.2	25.0	47.2
Cream cheese	13.9	16.7	19.4
Mozzarella	33.3	44.4	44.4

Table 15. Food Consumption * Data not collected during the first workshop
DC Department of Health, State Center for Health Statistics Administration

The results for exercise/activity levels were more dramatic. The number of participants reporting exercising nearly doubled from the first to the third administration of the questionnaire (from 44% to 83%). Walking was the activity chosen by most of the participants; 30.6% during the first data collection versus 66.7% during the third data collection. Although the majority of participants reported watching 0-3 hours of television per day, 27% of participants reported watching it 7-10 hours per day at the beginning of the Para Su Salud program. This percentage dropped to 8.4% by the final questionnaire administration **(see Table 16)**.

	First Workshop	Second Workshop	Third Workshop
During the last 7 days, did you exercise? (Yes)	44.4%	63.9%	83.3%
What kind of exercise did you do?	Walked: 30.6 Bicycle: 2.8 Ran: 0.0 Danced: 0.0 Played in park: 0.0	Walked: 47.2 Bicycle: 2.8 Ran: 8.3 Danced: 5.6 Played in park: 0.0	Walked: 66.7 Bicycle: 0 Ran: 2.8 Danced: 8.3 Played in park: 2.8
How many times did you exercise at least 20 consecutive minutes?	0-2 X: 11.2 3-4 X: 11.2 5-7 X: 8.3	0-2 X: 16.7 3-4 X: 22.2 5-7 X: 25.0	0-2 X: 22.3 3-4 X: 36.2 5-7 X: 25.0
How many hours per day do you watch TV?	0-3 hrs: 44.4 4-6 hrs: 11.2 7-9 hrs: 27.8 Don't know: 2.8	0-3 hrs: 66.6 4-6 hrs: 8.4 7-9 hrs: 0 Don't know: 0.0	0-3 hrs: 41.6 4-6 hrs: 16.6 7-10 hrs: 8.4 Don't know: 0.0

Table 16. Exercise and Activity Levels

OVERCOMING BARRIERS

Many barriers to achieving diet and exercise goals reported at the first administration of the questionnaire were overcome or perceived as less formidable obstacles by the third workshop. This change may have been related to the increased levels of motivation reported **(see Table 17).**

The high level of enthusiasm and commitment to change diet and exercise habits of participants in the "Para su Salud" pilot program demonstrated the need for health and nutrition education in our community as well as the need to provide safe spaces and opportunities for discussion, support, and exercise.

	Second Workshop	Third Workshop
What barriers to changing your diet did you encounter?	No problems: 50% Bad health: 2.8 Vacation: 2.8 Too hard: 8.3 Ate out: 2.8 Family opposed: 2.8 No motivation: 2.8	No problems: 63.9% Bad health: 11.1 Vacation: 2.8 Too hard: 0.0 Ate out: 0.0 Family opposed: 0.0 No motivation: 0.0
What barriers to increasing your exercise did you encounter?	No problem: 33.3% Bad health: 8.3 No motivation: 11.2 No time: 16.7 Heat: 0.0	No problem: 63.9% Bad health: 8.3 No motivation: 8.3 No time: 0.0 Heat: 2.8

Table 17. Barriers to Diet and Exercise Goals Encountered

DISCUSSION

LOOKING TO THE FUTURE

The LHCC study revealed a number of areas of concern. These areas serve as a road map for the improvement of Latino health in the District in coming years. D.C. Latinos' most critical health needs should be met with an urgent response as increased population growth over the next decade promises to strain an already overburdened system to the breaking point. By 2015, D.C. Latinos will number at least 62,000 and perhaps as many as 75,000, given adjustments for undercount (U.S. Bureau of the Census 2003). The majority of these future Latinos will arrive as immigrants, not as U.S. newborns, and will likely face the same linguistic, economic and other barriers identified in this study (U.S. Bureau of the Census 2003). This projected growth is the pressing reason for an immediate response; Latinos and all residents of the District will be faced with a growing health crisis unless there are innovations in health care education and service delivery.

This study also uncovered areas in which D.C. Latino health status and knowledge surpassed those of other groups in both the District and nation. These successes are important and instructive; they indicate those areas in which targeted health outreach, education, and early intervention made a positive difference. Expanding upon these successes through increasing resources to support and replicate them could build upon their positive impact for Latinos as well as for other populations in the District.

The Success of Community-Based Research Methodologies

Health assessment tools used in the District, like the Behavioral Risk Factor Surveillance System (BRFSS), historically have been administered by telephone and in English-an assessment technique that limits the number of Latinos that can be reached to only those accessible by telephone and to those Latinos who are proficient in English. Latino participants, especially undocumented immigrants, may be worried about confidentiality, thereby potentially excluding the very families of greatest concern.

Due to these limitations, the data available for DC latinos prior to this study (DC BRFSS 2003) was based on a sample of 87 respondents, mostly english speaking, high income, college educated latinos. Not surprisingly, the findings from this study differed significantly from the DC 2003 BRFSS --indicating double the rate of uninsured, double the rate of obesity and ten times the rate of gestational diabetes. This study's robust results indicate that future health monitoring in the District will be most effective if conducted in partnership with community leaders and residents whose expertise can influence both what is learned about Latino health, as well as how information about Latino health is to be gathered.

Access to Care: Contributors and Consequences

A lack of access to care for Latinos in the District, evident in the 41.5 percent who are uninsured and the 32 percent who have not seen a doctor in more than two years (a rate four to five times higher than that of U.S. whites or Latinos), presents one of the greatest challenges to D.C. Latinos' health. Access to care not only impacts an individual's overall quality and years of life, it also affects the accuracy of public health surveillance; questions to determine prevalence rates-such as those included in this study and most national health interviews-routinely ask whether respondents have received a diagnosis or sought treatment from a health professional. Limited access to care can contribute to limited health knowledge about a disease or the risk of developing a disease. D.C. Latinos had low screening rates for high blood cholesterol, prostate cancer (through PSA testing) and diabetics' A1c level for blood sugar stability; consequently, the rates of high blood cholesterol, prostate cancer, and diabetes may have been underreported in this study. In addition, lack of access to care may also have resulted in underreports in the prevalence of asthma, arthritis, injuries, and severe coronary problems (heart attack, stroke and angina). Finally, preventive health care may also be affected, as shown in the low rates of flu shots among D.C. Latinos in general.

Access to care is frustrated by economic, immigration and linguistic barriers faced by D.C. Latinos. The relative poverty of the D.C. Latino community is striking, with nearly two-thirds of respondents reporting total household incomes of $25,000 per year or less, and 28 percent reporting less than $15,000 per year or less, the highest levels of household poverty of any compared group. Respondents' lack of on-the-job insurance coverage was 83.8 percent and is related to not having enough money to pay for treatment (91 percent). An economic barrier that is less recognized is the inability of many people to leave work in order to secure health care services (11.6 percent), reflecting the low occupational status that many respondents have-their jobs provide neither health insurance nor time off for health care.

As seen in the demographics section, D.C.'s Latino population is diverse as it was formed through a pattern of migration and settlement that is unique to the District. Unlike the Mexican-majority Latino population in the rest of the nation, the 68 percent of D.C. Latinos who are Salvadoran and Guatemalan faced a particular set of legal challenges, which have implications for access to care. Salvadoran and Guatemalan refugees fleeing wars in the 1980s were treated unequally by the former Immigration and Naturalization Service and, as the result of a class action settlement, 200,000 cases-including 13,000 in D.C.-were "frozen" until 1999, leaving most members of this group in legal limbo until the present day. If these cases had been adjudicated earlier, many individuals would likely have become citizens, or would be well on their way. As all members of this

group have worked legally since 1990 (a provision of the settlement), those who are 65 and older and have contributed at least 40 quarters to social security insurance would have become eligible for Medicare once they received permanent residence status.

The impact of this history upon some D.C. Latinos' health is further reflected in this finding: 81.5 percent of respondents reported that immigration-related problems interfered with their ability to maintain good health, as they had difficulties in obtaining legal status in the U.S. despite their long duration of residence (41.8 percent of D.C. Latinos came to the U.S. over 10 years ago). These data suggest that there may have been health consequences of the particular legal challenges faced by District residents of Salvadoran and Guatemalan origin.

The fact that 91.7 percent of D.C. Latinos speak only Spanish or Spanish more than English has implications for health outreach, education and care that is linguistically and thus, culturally, competent. D.C. Latinos who are linguistically isolated may lack valuable health information, as reflected in the 85.9 percent of respondents who say they do not know what to do to prevent diseases or promote their health. Language barriers may also inhibit learning about institutionalized systems, as indicated by the 85.8 percent of respondents who reported they were unable to navigate the health care system, indicating a need for health care system "navigators." In the District, coverage of the uninsured is provided by the Alliance insurance plan of the Department of Health (other insurance plans, such as D.C. Healthy Families, are also available); many of the data presented above illustrate the need for increased outreach efforts in the resident Latino community. The potential of such outreach to increase access to care is great, as has already been shown by Mary Center's Bilingual Health Access Project (BHAP). The effectiveness of Latino-serving community-based clinics in providing language access may be reflected in the response by 68.8 percent of respondents that they would go to a clinic or health center over any other medical site if they were sick or needed advice about their health.

The clear presence of Latinos who are potential candidates for, if not current students of English as a Second Language (ESL) programs raises the question of whether existing programs are receiving the resources they need, and whether more ESL programs are needed. Additional considerations that might impact on Latinos' abilities to learn English and thus, have more skills with which to access health care, may include Latinos' available time to study (which may be determined by low household incomes and the need to work) and the strength of Spanish-speaking networks and neighborhoods in the District that allow non- and limited-English speaking Latinos to access a range of resources (such as Cubans created in South Florida, though on a much smaller scale).

Levels of formal education among D.C. Latinos, 60 percent of whom have an 8th grade education or below, have implications for health communication, whether between providers and patients or through public health campaigns. Given the indicators of clinics' success for Latino health in the District (to be discussed below), health outreach and care that is linguistically and culturally responsive to D.C. Latinos may positively influence health behaviors and health outcomes.

Diseases and Conditions of Concern

D.C. Latinos rate their health as poor two to three times more often than whites, a disparity in perceived health status that reflects the barriers to care experienced by many Latinos in the District. This study identified further disparities between the health of D.C. Latinos and whites (and often U.S. Latinos as well) in the areas of overweight and obesity, gestational diabetes, driving-related injuries, binge drinking, physical exercise, and breast cancer.

Overweight and Obesity

D.C. Latinos' reported rates of overweight and obesity at 61 percent are comparable to those of U.S. Latinos and whites, at 59.5 and 57.6 percent respectively, meaning that D.C. Latinos are not alone in confronting what has been described as an alarming public health trend (Pi-Sunyer 1999; Hedley, Ogden et al. 2004). High reported levels of overweight and obesity indicate greater potential risks for chronic disease, including cardiovascular diseases, type 2 diabetes, and certain forms of cancer, including cancers of breast, prostate and colon, along with increased risk of premature death (World Health Organization 2003; American Cancer Society 2005).

Overweight and obesity in the U.S. have long been associated with poverty and minority status, and recent evidence shows that immigrants' number of years of residence in the United States is associated with higher body mass index beginning after 10 years (Goel, McCarthy et al. 2004).

The status of U.S. Latino health, however, cannot be understood in a vacuum; for example, increasing overweight and obesity represents one of the most important trends in developing countries (Fernald, Gutierrez et al. 2004), and is associated with structural factors such as urbanization and changing diets and lifestyles (Popkin 2001). Specifically, Latin America is experiencing rapid demographic and nutritional transitions, overweight and obesity are on the rise (Filozof, Gonzalez et al. 2001), and associated risk factors, especially cardiovascular disease and cancer, are also increasing. Thus, health status in the Latino community is in part a product of the environment in which immigrants find themselves but, in part, also a product of the lives they led prior to coming to the U.S.

Early intervention with diet and physical activity may represent an opportunity to prevent or to control weight gain, obesity, and obesity-related chronic illnesses (Goel, McCarthy et al. 2004). In addition to increasing physical activity, Latinos in the District might consider reducing sedentary behaviors, such as cutting down on prolonged TV watching, which has been shown to contribute to weight loss (Hu, Li et al. 2003).

Though D.C. Latinos report they eat more nutritiously than do other groups, it can be important to note that consumption of high numbers of fruit juices and drinks can contribute to overweight and obesity. The Surgeon General and the American Academy of Pediatrics (AAP) have cautioned parents to protect children's health by limiting their intake of fruit juices and drinks (American Academy of Pediatrics 2001; Office of the Surgeon General 2005). Reading labels is important; though "fruit juice" contains 100 percent juice, other products named juice "drink," "beverage" or "cocktail" may contain as little as 10 percent of actual fruit juice, and may contain additional sweeteners or flavors that contain fewer nutritional benefits than fruit juice or whole fruit (American Academy of Pediatrics 2001). The same caution applies to soda and other beverages that contain high amounts of sugar and also have been linked to childhood obesity (Murray, Frankowski et al. 2005)

Gestational Diabetes

Twelve percent of D.C. Latinas in this study reported having gestational diabetes or high blood sugar (glucose) levels during pregnancy. According to the 2003 BRFSS (Centers for Disease Control and Prevention), this rate is almost nine times the rate of U.S. Latinas, and 17 and 60 times the rates of whites in the U.S. and D.C. respectively. It is possible that gestational diabetes is underreported by D.C. Latinas, as studies based on measured results reveal much higher prevalence rates. Most of the information on diabetes in Latinos in the U.S. comes from four large studies: the San Antonio Heart Study, the San Luis Valley Diabetes Study, the Starr County Study, and the Hispanic Health and Nutrition Examination Survey (HHANES). HHANES is the only one of the four studies that included information on Cuban Americans in the Miami area and Puerto Ricans in the New York City area (Stern and Mitchell 1995). According to data on women from these studies, 23.9 percent of Mexican American, 26.1 percent of Puerto Rican, 15.8 percent of Cuban American and 12 percent of non-Hispanic whites have had gestational diabetes (Coustan 1995; National Institute of Diabetes and Digestive and Kidney Diseases (NIDDK) 2005).

According to the American Diabetes Association, gestational diabetes usually goes away after a pregnancy, though once a woman has had gestational diabetes, her chances are 2 in 3 that it will return in future pregnancies (American Diabetes Association 2005). Many women who have gestational diabetes go on to develop type 2 diabetes years later. In addition, babies can be affected; as children, they can be at risk for obesity and, as adults, can be at risk for type 2 diabetes (Hampton 2004). Certain basic lifestyle changes may help prevent diabetes after gestational diabetes, such as increased exercise and good nutrition and the loss of any weight that might contribute to overweight or obesity (for more information, see ***http://www.diabetes.org/gestational-diabetes.jsp)***

Injuries

Compared with other populations, D.C. Latinos have the highest rates of serious injury that are driving-related at 11 percent versus 10 and 6.8 percent for U.S. whites and Latinos respectively. Serious injuries that occur on the job, or are due to accident or assault (being stabbed or struck) are higher than the rate for U.S. Latinos but lower than the rate for U.S. whites. The U.S. Transportation Department's National Highway Traffic Safety Administration (NHTSA) noted that in the United States motor vehicle crashes are the leading cause of death for Latinos between the ages of 1 and 34, and the third leading cause of death for all ages surpassed only by heart disease and cancer (National Highway Traffic Safety Administration 2005). NHTSA also found that Latinos are less likely to wear a seat belt than other racial and ethnic groups. WHO recommendations for addressing road safety include education campaigns that emphasize the importance of observing speed limits and wearing seat belts, discouraging drinking and driving, supporting police enforcement campaigns and launching special campaigns aimed at pedestrians, and at drivers during holidays when large numbers of people are expected to take to the roads (World Health Organization 2004). Finally, the WHO encourages the provision of educational modules on road safety for inclusion within primary and secondary schools at all levels.

Binge Drinking

Though the great majority of D.C. Latinos report not drinking at all, 14.1 percent of D.C. Latinos report binge drinking, a rate that is about two times higher than that of whites in D.C. and the U.S., though lower than that of U.S. Latinos. A 1998 report prepared for the Mayor's Office on Latino Affairs and the D.C. Addiction Prevention and Recovery Administration (APRA) found that drinking is by far the biggest drug abuse problem among the District's Latino residents (George Washington University, Council of Latino Agencies et al. 1998). In that study, researchers identified that Latinos in the District were nearly twice as likely to be problem

drinkers than other District residents. In focus groups, Latino residents stressed that the custom of binge drinking was brought from their countries of origin, where heavy drinking was seen as sociable. According to the 1998 report, this practice creates a cultural context that may condone alcohol abuse and calls for targeted prevention efforts. Excessive drinking, including binge and heavy drinking, has numerous long-term and short-term health effects. Long-term effects include liver cirrhosis, pancreatitis, various cancers, and high blood pressure. Short-term effects can include motor vehicle injuries, falls, domestic violence, rape, and child abuse (Naimi, Brewer et al. 2003).

The high prevalence of binge drinking, when juxtaposed with data on driving-related injuries, raises questions as to whether the two are related. If so, a targeted intervention to reduce motor vehicle injuries might include a component on the dangers of drinking and driving.

Finally, though responses related to injuries in the home were low in this study (when considered along with other factors such as gender, home-based injuries might begin to suggest the prevalence of domestic violence), a qualitative study conducted by the Council of Latino Agencies in 2003 indicated that domestic violence in the D.C. Latino community is a problem (Rivera 2003). Though further research on domestic violence is needed, existing evidence suggests that a preventive health campaign focused on binge drinking that also mentions links to injuries and violence might lower rates of domestic violence as well as motor vehicle-related injuries.

Physical Activity

Targeting physical exercise would be one way to address the high prevalence of gestational diabetes, breast cancer, and overweight and obesity among D.C. Latinos. Though D.C. Latinos' rate of overweight and obesity is similar to the very high levels found in other populations, Latinos in the District are half as likely to use physical activity to maintain or lose weight as other groups, with 35.9 percent of respondents reporting they do not use physical exercise to maintain or lose weight, or do not exercise at all (38.3 percent).
In addition to helping to control weight, physical exercise contributes to healthy bones, muscles, and joints; reduces falls among older adults; helps to relieve the pain of arthritis; reduces symptoms of anxiety and depression; and is associated with fewer hospitalizations, physician visits, and medications (Centers for Disease Control and Prevention 2005). Most studies showing the positive effects of exercise have been done with men. The few studies that have included women have indicated that women may benefit even more than men from being physically fit. Early indications show that physically fit women enjoy even greater reduced rates of death from heart disease than men. Women who do not exercise have twice the chance of dying from heart disease as women who do exercise. Women may live longer than men, but they do not necessarily live better. Elderly women who have not been physically active experience more disability in their daily functioning than women who have been active (American Heart Association 2005).
There are currently few exercise programs available to Latinos in the District, apart from those classes offered through Latino-serving community based centers and health clinics.

Breast Cancer

D.C. Latinas' reported breast cancer rate of 3.1 percent is higher than those among women in any other group. Breast cancer is the most commonly diagnosed cancer among Latinas, despite the fact that Latinas historically have lower utilization cancer screening tests, such as mammography (American Cancer Society 2003). Risk factors for breast cancer include age; changes in hormone levels throughout life, such as age at first menstruation, number of pregnancies, and age at menopause; obesity; and physical activity. Also, women with a mother or sister who have had breast cancer are more likely to develop the disease themselves (American Cancer Society 2005). Protective factors for breast cancer include giving birth to several children and

breastfeeding them for several months, exercising regularly, and eating a diet rich in cruciferous vegetables (or members of the cabbage family) such as kale and turnip greens, cabbage, cauliflower, broccoli, Brussels sprouts (Hyson 2002; American Cancer Society 2005).

As described, respondents in this study reported that rates of breast cancer screening were high, with 80.7 percent of women 40 years and older having a mammogram within the lat two years, the highest rate of any group. Further, the DC DOH's SCHSA reviewed vital records data and found that no Latina died from breast cancer in 2001 or 2002 (District of Columbia Department of Health 2005). Taken together, these findings suggest that Latinas 40 years and older in the District are getting screened often and early. Early detection may be leading to early interventions, with the result that no Latinas are dying of breast cancer. A related statistic adds further support for this interpretation of the data. Of all D.C. Latinas, 80.3 percent are getting clinical breast exams and, of this group, 86 percent of them had an exam within the last two years-an indication that Latinas younger than 40 years old also are practicing healthy preventive behaviors. These high levels of health awareness and healthy behaviors among D.C. Latinas may point to the effectiveness of the outreach, education, screening and care provided by community-based clinics in the District that focus on women's health.

Community-Based Clinics: Improving Latino Health

There are a number of areas where D.C. Latino health appears to be very good, especially when compared with the populations of D.C. and U.S. whites, and Latinos nationwide. These successes are even more striking given the barriers to access to care, and indicate that Latino-serving community-based organizations in the District may be filling the gap, especially for Latinos who are uninsured. This suggestion is further reinforced by the response of seven in ten Latinos who indicated that they would go to a clinic or health center if they are sick or need advice about their health, a telling indicator given the relative unpopularity of community clinics among U.S. Latinos (26 percent) and U.S. whites (14.5 percent) (National Center for Health Statistics 2005). Study findings that point to the critical role community-based clinics are playing in providing effective care to Latinos include high levels of screening for certain diseases, high rates of flu shots among Latino seniors, and knowledge about HIV transmission.

In addition to the high breast cancer screening rates described above, 89 percent of D.C. Latinas were screened for cervical cancer (pap smear) within the last three years, a higher proportion than for either U.S. Latinas or whites, and just slightly below D.C. whites. Finally, nearly two-thirds of respondents (65.4 percent) reported that they had ever been tested for HIV and, of this group, 76.2 percent had been tested within the past two years. All of these rates surpass those of other groups.

The high rates of flu shots among D.C. Latinos aged 65 years and older might offer another indication of the role of D.C.'s community clinics; 63.6 percent received flu shots, a much higher proportion than that among U.S. Latino seniors (54 percent). In the fall before the study began, CLA-through a grant from the Centers for Medicare and Medicaid Services, and in conjunction with member agencies EOFULA, Spanish Catholic Center, La Clínica del Pueblo and Sacred Heart Church-conducted an immunization campaign focused on Latino seniors. Though it is difficult to track change over time in the rate of flu shots among D.C. Latino seniors (as there are few comparative data available), the high immunization rate recorded in this study, when compared with U.S. data, suggests that this community-based flu shot campaign may have contributed to an increase in the numbers of seniors in the D.C. Latino community who were immunized.

The success of Latino-serving community-based organizations in the District may further be indicated by the high levels of awareness about the transmission of HIV-evident in the majority correct responses about questions relating to mother-to-child transmission of HIV and available treatment for people living with HIV. These responses, when considered alongside the high rates of testing, may specifically point to the success of those clinics that conduct HIV/AIDS outreach and education and offer a range of comprehensive services that are culturally, linguistically and economically accessible.

These achievements must finally be viewed with an appreciation for the resource environment in which most Latino-serving community clinics in the District operate. These clinics depend largely on charitable funding, since a lack of insurance and low incomes often prevent Latinos from fully covering the cost of care. When operating revenues are stretched to the limit, as is the case for most clinics that serve Latinos, these community-based providers must limit the number of patients or range of services they offer. It is remarkable, given the resource constraints within which most Latino-serving clinics work, that they have contributed so much to reducing health disparities between Latinos and whites in the District and beyond.

RECOMMENDATIONS

Based upon both the health assessment and health intervention findings reported here, the Council of Latino Agencies recommends the following steps be taken for reducing health disparities between Latinos and whites in the District of Columbia:

1. Future health surveillance of D.C. Latinos will benefit from the use of community-based, linguistically, and culturally appropriate methodologies, such as those involved in this study. In order to obtain accurate prevalence rates within a population with high numbers of uninsured, new questions might be designed relating to risk factors and health conditions that do not rely upon input from a health professional;

2. Existing efforts to conduct bilingual outreach to enroll uninsured D.C. Latinos in health insurance programs should be expanded, and new outreach programs should be established that replicate models with proven success;

3. Current models used by community-based organizations for health education and service delivery-all of which include bilingual health communication as a central component-should be replicated across the District in those sites where D.C. Latinos are accessing health care information and services;

4. Future health education campaigns related to obesity, diabetes, breast cancer, and access to health care among D.C. Latinos should use the Para Su Salud workshop model to increase their impact. A gestational diabetes campaign targeted at pregnant Latinas could be conducted similarly;

5. Increased investment in Latino-serving clinics in general would support and expand their capacity, and could have long-ranging positive effects for D.C. Latinos and for all D.C. residents.

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APPENDIX I

Key Informant Interviews Topline Report: Latino Health Priority Issues at the Community Level

Executive Summary

This topline report presents the results of ten key informant interviews with community-based health and social service practitioners in the District of Columbia. The purpose of the interviews was to gather baseline data that is to be used in developing health messages targeting the District of Columbia's Latino population.
The persons interviewed were:

Davies-Cole, John M.D. Chief of Epidemiology and Health Risk Assessment D.C. Department of Health	Kaplan, Lori Executive Director Latin American Youth Center
Sguigna, Karla M.D. F.A.A.P. Pediatrician, Adams Morgan Satellite Clinic Children's Hospital National Medical Center & Assistant Professor of Pediatrics George Washington University	Melendez, Rosa Case Manager, EOFULA Spanish Senior Center
Galbis, Ricardo M.D. - Psychiatrist Executive Director Andromeda Health Clinic	Ressor, Christine Nurse Practitioner Spanish Catholic Center
Gomez, Maria Executive Director Mary's Center for Maternal & Child Care, Inc.	Romagoza, Juan M.D. Executive Director La Clínica del Pueblo
Huerta, Elmer M.D. M.P.H. Director Cancer Preventorium Washington Hospital Center	Umanzor, Sonia Center Service Coordinator Mary's Center for Maternal & Child Health, Inc.

Summary of Results

What are the health priorities in the District of Columbia Latino Community?

- Preventive education and care.
- Access to healthcare.
- Bilingual and culturally sensitive services.
- Depression and mental health.
- Chronic illnesses, such as obesity, diabetes, heart disease, high blood pressure, and hypertension.
- Substance abuse, youth violence and behavioral problems, dental hygiene, anemia and iron deficiency, STDs, and AIDS.
- Asthma, arthritis, cancer, and hyperlipidemia.

From your experience with Latino patients in the District of Columbia, what do you believe are the most frequent health problems/conditions present in this community?

- Obesity and diabetes.
- Depression in seniors.
- Heart disease, high blood pressure, and hypertension.
- Cancer in general, and cervical and breast cancer in particular.
- Arthritis and asthma.
- STDs and AIDS.
- Substance abuse and depression.
- Teenage pregnancy, behavioral issues, and violence.
- Domestic violence.
- Annual and semi-annual visits to the doctor.
- Occupational health, especially worksite injuries.
- Hyperlipidemia and anemia.

What are unmet needs among these health problems/conditions?

- A public hospital, more clinics, more funding for existing clinics, and more programs.
- Quality services that are bilingual and culturally sensitive.
- A focus on preventative care and education.
- More radio and media programs.
- Education for parents, on issues such as nutrition and obesity, early intervention for substance abuse, and family violence.
- Poverty.
- DC Alliance documentation requirements.
- Good mental health care.

What barriers to care exist for these health problems/conditions?

- Lack of insurance
- Language
- Immigration Status
- Education
- Money
- Access
- Cultural Beliefs

What prevention methods do you recommend to address these frequent health problems/conditions?

- Hold lunches or even a party or dance to promote health.
- Hold health fairs.
- Invite speakers to address different issues, such as mental health.
- Have health workers or promoters provide information to families.
- Utilize the clinics, churches, and schools.
- Utilize the waiting rooms of clinics.
- Develop literacy programs for recent immigrants.
- Use all forms of media.

What communication strategies do you believe are effective in reaching this community?

- Use Radio and TV commercials -- Dr. Huerta's program in particular.
- Create an all health radio station.
- Involve the churches.
- Go general community outreach, through door-to-door canvassing, home visits, and in front of supermarkets, grocery stores, and Laundromats.
- Have health outreach workers become mentors, peers, and role models.
- Sponsor gatherings with guest speakers.
- Develop programs in association with the public schools.
- Develop health fairs.

What specific health messages do you think can be effective in reaching this population?

- Short and to the point.
- Strong and direct.
- Positive and empowering.
- These messages should come from the target group's age group, and be accompanied by information on resources available to them.
- Utilize stories or novellas, placing characters in everyday situations.
- Use TV, radio (specifically Dr. Huerta's program), and newspaper ads.
- Placing messages on buses and the Metro.
- Obtain the support of existing community agencies.

The full Key Informant Report can be found at the Council of Latino Agencies' website: ***www.consejo.org***

Appendix II

Excerpt from the American Cancer Society Cancer Detection Guidelines*

The American Cancer Society (ACS) advises women 40 years and older to have an annual mammogram, and women in their 20s and 30s to have a clinical breast exam every three years. All women should begin cervical cancer screening about three years after they begin having vaginal intercourse, but no later than when they are 21 years old. After the age of 30, if a woman has had three normal Pap test results in a row, she can get screened every two or three years. The ACS recommends that men 50 years and older have an annual prostate-specific antigen (PSA) test and digital rectal exam to screen for both prostate and colorectal cancer. Men at high risk, such as African Americans and men who have a first-degree relative (father, brother, or son) diagnosed with prostate cancer at an early age (younger than age 65), should begin testing at age 45. Beginning at age 50, both men and women at average risk for developing colorectal cancer should have a yearly fecal occult blood test (FOBT) or fecal immunochemical test (FIT), or a flexible sigmoidoscopy every five years.

*Source:http://www.cancer.org

Appendix III

LHCC - Precto "Por Su Salud" Número:_____
Segundo Formulario de Actividad y Dieta

A. Lista de Conductas Alimenticias
Las preguntas a continuación son sobre si usted comió AYER ciertos alimentos.
Solo responda sobre lo que usted comió AYER.
Por favor conteste solamente "SI" ó "NO"

Comió o bebió usted AYER….	**Answer**	
1. Cereal (Caliente o frio)	**SI**	**NO**
2. Si comió cereal, fué de salvado o con pasas, trigo molido, avena, ó fruta y fibra	**SI**	**NO**
3. Repostería como donas, pan dulce ó quequillos	**SI**	**NO**
4. Tocino, salchichón, chorizo u otras carnes de desayuno	**SI**	**NO**
5. Leche, incluyendo la leche en cereal o en chocolate	**SI**	**NO**
6. Si tomó leche, fué:		
entera o regular	**SI**	**NO**
2%	**SI**	**NO**
1% o leche descremada	**SI**	**NO**
7. Jugo de frutas	**SI**	**NO**
8. Sodas o gaseosas como Coca Cola, Sprite, Pepsi, etc.	**SI**	**NO**
9. Fruta fresca	**SI**	**NO**
10. Ensalada verde, como lechuga o espinacas	**SI**	**NO**
11. Verduras (que no sea ensalada) en el almuerzo (medio día)	**SI**	**NO**
12. Verduras (que no sea ensalada) en la cena (en la noche)	**SI**	**NO**
13. Mantequilla, margarina o cream en las verduras cocidas	**SI**	**NO**
14. Pan obscuro como de trigo entero o centeno	**SI**	**NO**
15. Mantequilla o margarina en el pan	**SI**	**NO**
16. Comidas fritas como papas fritas o pollo frito	**SI**	**NO**
17. Hot dog, boloña, u otras carnes frías	**SI**	**NO**
18. Hamburgesa, carne, tacos u otra carne molida	**SI**	**NO**
19. Pastel, pai o galletas	**SI**	**NO**
20. Helados o sorbetes	**SI**	**NO**
21. Queso alto en grasa como el queso de crema	**SI**	**NO**
22. Queso bajo en grasa como Mozzarella o requezón	**SI**	**NO**

B. Lista de Actividades Físicas

Por favor marque una X ó escriba la respuesta de las preguntas a continuación:

1. En los últimos 7 días, ¿Participó usted en alguna actividad ó deporte en la que hízo ejercicio por lo menos 20 minutos—lo suficientemente fuerte para que el latido de su corazón aumente, ó que haga que usted sude? (Esto puede incluír caminar rápido, correr, jugar algún deporte ó pasearse en bicicleta). **SI_____** **NO_____**
2. Si usted hízo ejercicio en la última semana, ¿Qué fué lo que hízo (caminó, corrió, anduvo en bicicleta, etc.)?:_____
3. ¿Cuántas veces hízo ejercicio por lo menos 20 minutos seguidos en la última semana? **_____ veces por semana**
4. ¿Vió usted televisión en estos últimos 7 días?, ¿Cómo cuantas horas al día? **_____ horas por día**

C. Limitaciones

***En las últimas 2 semanas*, ¿Con qué problemas se encontró?:** 1.¿Por qué no pudo cambiar su dieta? 2. ¿Por qué no pudo hacer ejercicio?

D. Plan Individual de Dieta y Ejercicio

***En las próximas 2 semanas*, queremos que usted trate de practicar comer saludablemente y de hacer un poco de ejercicio. Para ésto, tendrá que decirnos que es lo que va a hacer y lo que no va a hacer:**

Cambios en Dieta		
1. Escriba en esta sección que planea cambiar de su dieta en las próximas 2 semanas:	¿Cuántas veces a la semana planea hacer esto?:	Escriba una recompensa ó regalo que usted se daría si lo logra:

Cambios en Ejercicio		
1. Escriba en esta sección que planea cambiar de su dieta en las próximas 2 semanas:	¿Cuántas veces a la semana planea hacer esto?:	Escriba una recompensa ó regalo que usted se daría si lo logra: