THE INTERSECTIONS OF CULTURE, HEALTH, AND SYSTEMS IN CALIFORNIA LATINO COMMUNITIES

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ABSTRACT

The strategies adopted within several low-income California *Latino* communities were explored during evaluations of three larger initiatives designed to strengthen neighborhoods and improve the health and well-being of children and families. A model is proposed which depicts the interrelationships between culture, health, and the larger environmental context, factors which will become more important as political and economic constructs become increasingly globalized. Three interventions, the *promotora* outreach model, a neighborhood resource center, and a parent school-based safety patrol are discussed from the viewpoint of this multi-layered contextual analysis. The lessons learned from these interventions provide insight to practitioners working with diverse ethnic and socio-economic groups migrating across national boundaries.

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The Intersections of Culture, Health, and Systems in California Latino Communities

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INTRODUCTION

Strategies adopted within California *Latino* neighborhoods to improve community health provide important lessons for practitioners shaping health promotion programs, particularly with populations migrating across national boundaries. First, programs serving these *Latino* communities need to be crafted with a global perspective. Patterns of migration between Mexico, Central and South America, the Caribbean, and the United States require health-related community interventions to be culturally grounded in practices from the countries of origin and the United States. Second, a contextual analysis of the economic, political, and social conditions shaping the lives of these group members provides important insight for program developers. Because migration in and out of California is expected to grow, the characteristics of communities will continue to change, and, thus, health promotion strategies will need to remain flexible and receptive to modification. In addition, it is important for community members to understand how public and private systems function to access resources for long-term, sustainable development.

Creating effective health programs by those working in the service delivery and policy arenas, e.g., health and social service providers, coalitions focusing on legislative reform, and grassroots organizers, requires an understanding of the interrelationships of cultural and contextual factors. The analyses presented in this article are based on the authors' experiences over the past five years evaluating community health and economic development initiatives located in multi-ethnic, low-income California communities. The lessons learned from these initiatives may provide insight to practitioners in other countries working with diverse ethnic and socio-economic groups migrating across national boundaries. These factors will become more important as economic and political constructs become increasingly globalized.

A MODEL INTEGRATING CULTURE, HEALTH AND CONTEXT

Developing culturally[1] grounded models built on *Latino* family concerns for health are important for providers, advocates and community members alike. While considerable research has focused on the influence of cultural factors on individual health seeking behaviors and health outcomes, very little has related to the intersection of culture and health with system-wide

[1] Culture, as used in this context, can be viewed from the perspective of symbolic interactionism. That is, it is created over time through social interaction as people validate the past, construct the present and look toward the future. It is because people share perspectives and interact that the continuity of a social group is possible. "The beliefs, values, and prescribed behaviors of a culture are learned through traditions and transmitted from generation to generation" [1].

issue[2] [3, 4]. The community health interventions discussed in this article demonstrate how culture and health issues intersect with larger system-wide factors. Further, each intervention relates to three common factors important to California's *Latino* communities: language as a common symbol, the youthfulness of the population, and the importance of family. These models, a *promotora* health outreach effort, a neighborhood family resource center, and a school-based parent safety patrol, illustrate the strengths and challenges inherent to these types of efforts. The interrelationships between culture, health, and the larger environmental context are depicted in Figure 1, and each of the interventions will be discussed from the viewpoint of this multi-layered contextual analysis.

In this figure, the outer square with the broken line depicts the larger U.S. and cross-border context (the larger political, social, and economic constructs) while the inner square with the solid line represents the system in which the intervention is occurring, such as the publicly funded Medicaid health insurance system (Medi-Cal in California). Circle 1 represents cultural aspects of the community and Circle 2 represents the health issues of the population. The striped area where the circles overlap is the particular health promotion intervention. If this figure is viewed on three planes, then cutting through the striped section blends the imperatives of the *Latino* culture (e.g., the centrality of *la familia*), the health promotion intervention (e.g., children's health insurance), interacting with a particular system (e.g., Medi-Cal), and the larger environmental contexts such as U.S. migration policies and economic conditions in Mexico. Shaping and understanding the outcomes of these interventions while incorporating a contextual analysis with the goals of the health-related program are crucial. Prior to the discussion of the individual programs, the characteristics of California's *Latino* population and their common factors are described.

LATINOS IN CALIFORNIA

"*Latinos*" is a political term used to designate a heterogeneous Caribbean and Latin American population sharing a historical background and cultural perspectives. In California by 2015, *Latinos* will comprise the largest single ethnic/racial group living in California, representing between 15 and 20 million

[2] In this article, the use of the term "system" is grounded in the work of Foucault who defines the social apparatus as "a system of relations that can be established between a heterogeneous ensemble of elements consisting of institutions, laws, administrative measures, scientific statements, and philosophical propositions . . . a social apparatus is grounded in a particular historical period and responds to an urgent need . . . thus the apparatus has a strategic function which is related to power" [2]. Navigating the system specifically refers to the ability of individuals and groups to interact with U.S. public and private institutions to obtain resources.

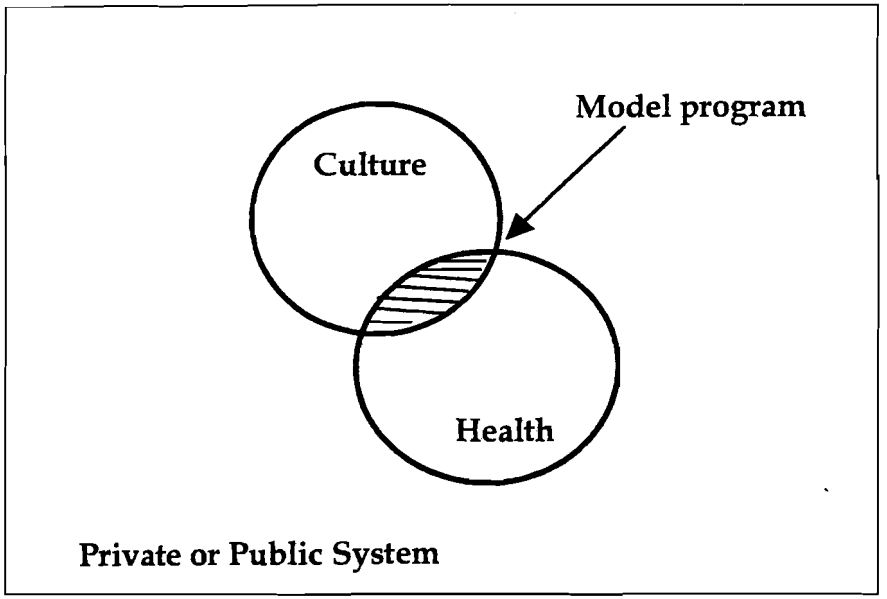

Figure 1. Social, political, and economic landscape.

persons [4]. In California[3], Mexicans comprise the largest *Latino* group. A shared border, agro-business expansion, and a sustained political, economic, and social crisis in Mexico all contribute to the growing representation of Mexicans in California. In the early 1980s, many Central Americans migrated to the United States, primarily from El Salvador and Guatemala [5], and, by 1990, nearly one out of every five *Latinos* was of Central American origin [4].

Previous studies have discussed the complexities in typifying the *Latino* identity [6–8]. First, *Latinos* come from various countries and are the heirs to *mestizaje* or hybrid cultures. In each country, multiple levels of development, wealth, and racial mixtures coexist and media, tourism, migration, and translocal and transnational networks play a major role in the configuration of *Latinos* identity(ies). Second, to define settings as purely urban or rural is difficult because of the multiple, overlapping relationships people establish. Through the use of technology, mass media, and oral histories, urban dimensions are increasingly brought to remote places, thus diminishing the isolation of rural communities. Finally, patterns of settlement and migration are important to understanding and working with *Latino* communities. There are significant differences between

[3] Mexicans represent about 63 percent of the *Latino* population (approximately 14 million people) in the United States. The Hispanic Population in the U.S.: March 1990. Current Population Reports. Series P-20 No. 449. Washington, D.C.: U.S. Bureau of Census, 1991.

Latinos who were born in the United States, other who migrated 20 years ago, and those who recently crossed the border and may follow a pendulum pattern of migration[4]

THREE COMMON FACTORS: LANGUAGE, YOUTHFULNESS, AND FAMILY

In providing a framework for this article, three common factors have been identified which are relevant to a discussion of community health issues within major sectors of the *Latino* population: language as a common symbol, the growing proportion of the population that are children and youth, and the importance of the family.

Language as a Common Symbol

Although there are many differences in terms of words stemming from place of origin, class, and education, language is probably the main common symbol among *Latinos* living in California. Hertzler states that "the key and basic symbolism of human beings is language. Language is a culturally constructed and socially established system, in a given society" [9, p. 29]. Every conceptualization of health or illness (experienced, observed, or perceived) is accomplished through language. Eighty percent of *Latino* households are Spanish-speaking [4]. This linguistic homogeneity has contributed to the emergence of numerous Spanish communication networks, including hundreds of newspapers and magazines, several television channels, as well as local and national radio stations.

Youthfulness of the Population

With a median age of 26.2 years, *Latinos* are one of the youngest population groups in the United States. Thirty-two percent of the *Latino* population in the country is children 18 years of age and under. One of every three children in California is *Latino*; and, of every two newborns, one is Latino [4]. Poverty is the primary challenge to the health of many *Latino* children. In 1994, 40 percent of Latino children under six years of age were living in poverty. These are the children whose health status is most likely to be affected by family socio-economic status [10]. For *Latino* adolescents and young adults, many risk behaviors are linked to the complex social and psychobiological factors that

[4] Using Rouse's formulation, the term "migrants" rather than "immigrants" will be used throughout this article. The term immigrants suggests an unidirectional movement, which does not portray the reality of millions of *Latinos* going back and forth between their countries of origin and the United States, as well as between geographical locations within the United States. Instead, the term migrant implies a continuum in the migration process of individuals who spend varying amounts of time in multiple communities across borders, often following seasonal growing patterns and economic cycles [8].

condition their lives. Behaviors associated with drug use, alcohol consumption, smoking, sexual activity, physical inactivity, and lack of entertainment affect not only the individual's health, but also her or his family and social network [11, 12].

The Importance of the Family

Latino families in California tend to be configured in nuclear and interdependent extended kinship structures, with multiple and mobile networks. "Familism" is considered to be one of the most important cultural values of *Latinos* [13]. This term implies an attachment and interdependence of individuals with their nuclear and extended families and strong feelings of loyalty, reciprocity, and solidarity among members [14]. The *Latino* family has been characterized as being highly emotionally and materially supportive of its members [13]. It has been well documented that the *Latino* family, even in highly acculturated circumstances, is perceived by its members as the single most important institution protecting people against external problems [15-17]. High levels of support and trust perceived from the family include *"compadres"* (godparents) and adopted *"tios and tias"* (uncles and aunts) who play an important role in family life. These factors may have direct and indirect relationships to individual, family, and community health.

Strategies for building healthy *Latino* communities require developing interventions that are grounded in these cultural strengths and at the same time take into consideration the challenges of the larger political and economic context. California communities are diversifying rapidly on many dimensions and these changes require flexibility and innovative approaches to crafting health promotion interventions.

CHANGE COMMUNITIES REQUIRE FLEXIBLE APPROACHES

As California's population expands and diversifies, strongholds of strictly homogenous neighborhoods are becoming scarce, and communities that thrive are those able to deal effectively with changing demographic patterns. Communities in which neighbors know each other well, take care of each other's children, and implicitly trust one another rarely exist today. Just as technology has altered modern life, the demands of an advanced industrial society have changed the time and intensity required for work, and thus reduced the time available for family interaction, recreational pursuits, and participation in civic affairs. Over the past decade, the polarization of wealth within the United States has increased significantly [18–21]. The least affluent are required to work longer and harder to meet their basic needs, a fact particularly relevant in low-income migrant communities.

Assets and deficits co-exist in these neighborhoods. For example, the lives of California's migrant farmworkers are shaped by historical racism, current anti-migrant sentiment, and the globalization of capital across the U.S.–Mexico border. While many families have strong ties, spiritual connections, and cohesive cultural practices, they may suffer from the effects of poverty, violence, and chemical dependency. In some California new-migrant communities, neighborhood in- and out-migration reaches 50 percent per year. Yet, existing within these mobile neighborhoods are structures, sometime invisible to outsiders, spoken, unspoken, formal and informal rules, and culture- and gender-specific imperatives. For those developing strategies to build healthy communities, understanding these co-existing micro and macro contexts are important.

METHODOLOGY

Guided by a critical theory social science perspective, the authors' evaluations have utilized constructivist methods extensively described by others [22, 23]. A theory of change approach is utilized along with a variety of qualitative and quantitative measures, e.g., grantee surveys, in-depth interviews, focus groups, and participant observation. The analyses presented in this article are based on the authors' evaluations of three California community initiatives conducted between 1993 and 2000: the Communities 2000 Initiative, the Lifeline Initiative, and the National Economic Development and Law Center's Family Supportive Initiative. The David and Lucile Packard Foundation's Communities 2000 Initiative, a 4-year, $3 million community-building effort, implemented in three California counties, provided small grants to over 100 neighborhood groups. The Initiative focused on building a sense of community, strengthening leadership, and enhancing civic engagement at the grassroots level. Over half the rural neighborhoods were *Latino,* primarily Mexican-American. Lifeline, a 5-year, $3 million San Francisco Foundation Initiative, encouraged systemic change in programs serving low-income children and their families in the greater San Francisco Bay Area. Twenty-two collaboratives were funded, including 157 organizations within all the major ethnic urban communities of the area, including Spanish-speaking organizations serving those of Mexican and Central American origin in urban communities. Finally, the continuing, statewide-focused National Economic Development and Law Center's Family Support Initiative is crafted to assist community-based family support organizations to identify and adopt economic development strategies appropriate for their agencies. This Initiative included agencies from both urban and rural *Latino* communities.

In the following sections three models illustrating the interrelationships between culture, health, and systems in California low-income *Latino* communities are presented: 1) the *promotora* health outreach model; 2) El Centro Familiar: a neighborhood family resources center; and 3) Padres and Madres Para Sante: a school-based parent safety patrol.

A CROSS-BORDER PERSPECTIVE: THE PROMOTORA HEALTH OUTREACH MODEL

For decades, the *promotora* model for community health outreach has been successfully implemented in many Latin American countries [24]. This model, replicated and adapted in the United States, is based on a holistic conception of health, placing personal health within an economic, cultural, and political context. It focuses on a person-to-person approach: home visits or community events are conducted by *promotoras,* who share with their peers similar socio-economic characteristics and cultural norms. It has been well-documented that *Latinos* prefer personal contacts rather than impersonal interaction [25]. Thus, effective clinical interactions are guided by *personalismo,* which means "the trust and rapport that is established with others by developing warm, friendly and personal relationships . . . (these interactions) influence relations between individuals and with the health care system" [3, p. 25]. Among the U.S. *Latino* population, *promotora* projects have been identified as a particularly effective outreach method in rural areas [26].

In a sense, *promotoras* are community health advocates, as well as community health outreach workers (CHOW's). Some are volunteers and others are the paid staff of clinics, public programs, or community-based organizations. However, despite adopting this culturally grounded approach to community outreach, there remain significant system barriers that *promotora* efforts cannot address alone [27, 28]. For example, fear and lack of understanding of the requirements for eligibility to perceive publically funded services and the relationship of these services to U.S. migration policies are widespread in *Latino* communities. As one *promotora* reported, "In our Latino community, the two greatest barriers to enrolling children in Medi-Cal are parents' negative attitudes toward Medi-Cal and their fear that enrolling in Medi-Cal will be considered a 'public charge' and cause them to be deported or denied citizenship" [28, p. 19]. Public charge refers to portions of the U.S. immigration law that forbid those who are dependent on public resources from becoming naturalized citizens.

In addition, the Medi-Cal system is fraught with bureaucratic barriers. For example, to enroll in the publicly-funded Healthy Families, which is a children's health insurance program, children must have legal residential status. Therefore, all the children in one family may not be eligible for health insurance or to receive health services. Providing services to one child and not to another within the same family violates a major cultural value in *Latino* communities, the centrality of *toda la familia.* These kinds of cultural factors have been reported as important issues related to the low enrollment of *Latino* families in California's Healthy Families program [16, 29, 30]. Thus, for effective outreach to enroll families in an insurance program or screen for diabetes, *promotoras* as a single strategy are insufficient. In addition, systems barriers should be identified and public policies advocated to reduce or eliminate them. For example, in the California First Things First Initiative, a California Healthcare Foundation sponsored effort to enroll families in

the Healthy Families, a children's health insurance program, alliances were forged in one county between Spanish-speaking *promotora* outreach workers and staff from the local Department of Social Services. These linkages eventually led to system-level modifications to simplify the paperwork necessary for family enrollment and follow-up [31]. In some communities, *promotoras* operate from neighborhood family resources centers like El Centro Familiar, the second example of a culturally grounded model designed to support the health and well-being of *Latino* families.

CULTURAL PRACTICES INTERSECT ECONOMIC AND POLITICAL REALITIES: THE CASE OF EL CENTRO FAMILIAR

Located in a multi-ethnic, urban, *Latino* community, El Centro Familiar (a pseudonym) has existed for many decades. In recent times, 400-500 families per year were engaged in events and services through El Centro, including participating in traditional community celebrations (Posadas), case management and referral services, and soccer teams for youth. Some of the powerful ways traditional celebrations directly intersected with health promotion activities are illustrated by the flower-making classes and El Centro-sponsored soccer clubs. In Mexico and Central America, women create paper flowers for a variety of purposes including gifts and decorations for special events and holiday celebrations. El Centro had several well-attended flower-making classes where women made flowers, visited with one another, and received information about breast self-exams and diabetes screening. Sometimes health screenings were conducted during the classes. Soccer, a sports activity valued in all Latin American societies, also had good participation by neighborhood youth and parents from the neighborhood.

Despite this culturally grounded format, broader system issues permeated the life of El Centro. One example related to the enormous basic material needs of low-income families, and the other involved the growing anti-migrant sentiment in California. Staff tried to involve volunteers, primarily women, from the neighborhood in organizing events at El Centro. However, as in other communities, competing demands prevented neighbors from participating. Often they were required to hold several jobs and work long hours to meet their basic needs. Case managers expressed frustration regarding the overwhelming level of material needs of families coming to El Centro. For example, it was common for 10 or more people to live in one apartment sublet from an absentee landlord. As gentrification accelerated in this urban community, housing costs escalated exacerbating an already desperate situation for some families. Employment for family members was also problematic where English-speaking abilities, resident documentation status, and job skills presented significant barriers.

The unfolding story of California's Proposition 187 demonstrated the added ingredient of anti-migrant sentiment in the state. A California ballot initiative designed to prevent undocumented residents from receiving any health, education, or social public services was voted on in the November 1994 general election (Proposition 187). Latino communities particularly feared this anti-migrant initiative because many residents were undocumented. While El Centro served a large number of undocumented families, no preparations were made or systematic discussions held with families as Election Day approached. The day after the initiative was passed by a large majority of voters, attendance at El Centro fell to almost zero. This incident illustrates two points. First, El Centro management had become isolated from the issues that most directly affected the community; and second, the Executive Director was afraid to do anything that might be perceived as advocacy by the Internal Revenue Services (IRS). Regarding this second issue, IRS policies limit the amount of advocacy non-profit organizations can conduct and still maintain their non-profit status (501c3). Usually, the IRS does not enforce these regulations unless complaints are received or the issue involved becomes very politicized, such as in the case of migration reform. Although El Centro management feared that any discussion might have been considered advocacy, clearly there was a role to play in providing basic information and education regarding the initiative and the potential implications of its passage, including the basic rights that would continue to exist.

After this incident, El Centro management needed to reflect on their priorities and services to better learn how to adapt as a result of these events. What had been most lacking was a strategic vision that linked the political and economic context with the priorities of El Centro. Management acknowledged that their approach to volunteerism needed to be more realistic; case managers had to prioritize their workloads to match the actual resources of El Centro more appropriately with the needs of the community; and finally, a strategy linking El Centro to public policy advocates was required.

These examples demonstrate that a comprehensive approach to strengthening community health is embedded in a broader context, where variables like migratory status, housing availability, and language proficiency intersect with culturally grounded health concerns. In some instances, the starting point for neighbors is a challenge that already exists in the community, like ensuring children's safety around schools.

SCHOOL-BASED PARENT SAFETY PATROLS LINK PARENTS WITH PUBLIC SYSTEMS: PADRES AND MADRES PARA SANTE

In Padres and Madres Para Sante (a pseudonym), a dozen parents organized within one public elementary school in a neighborhood that was approximately 98 percent of Mexican origin. The majority of these families were first generation

migrants, with limited English-speaking ability, and had very little experience with U.S. public systems. The school is located in a rural suburban community where agro-business has dominated the economy for almost a century, along with discrimination toward people of Mexican origin in housing and employment. Although in recent times this situation has improved, the remnants of these past practices still exist in public and private institutions. In addition, the neighborhood where the school was located experienced a high rate of in- and out-migration, particularly from the Michocan Province of Mexico.

Each morning as parents brought their children to school, they began to discuss their concerns for their children's safety, including cars driving too fast past the school and gang activity in the neighborhood. In time, these parents met with the Principal of the school and with staff from a local non-profit organization involved in community violence prevention to express their concerns. Particularly Ms. Martinez (pseudonym), a Spanish-speaking staff member with a local non-profit organization, was very helpful in assisting the parents in thinking about how they could act on their concerns. Finally, with support from the Principal and Ms. Martinez, the mothers and fathers implemented a school-based parent patrol program. Intersecting with the area's police department, they received training from police officers on pedestrian and school traffic rules. On a volunteer basis, parents ensured that cars stopped within the marked areas to drop children off at the school. Within a year and a half, the parent patrol was functioning well. They had obtained attractive jackets for all the members, with their group's name on the back, with funds provided by a local community foundation.

Leaders from this successful group met with and trained parents from several nearby schools. At one of the other schools, parents attempted a similar effort but were unsuccessful. The basic reason was resistance from the Principal. While this individual espoused interest in parental involvement, he wanted parents involved only in certain activities, e.g., holiday celebrations. Also, his lack of Spanish-language ability presented barriers to communicating effectively with parents. Traditionally in this community, parents had little influence on school policies and some school officials were reluctant to change this balance of power.

The school-based parent safety patrol illustrates how a community effort supporting health and safety can build on the cultural strengths of the *Latino* community, e.g., concern for *la familia,* educating parents about public institutions, and structuring mentoring opportunities and leadership development among parents. At least one of the group leaders was required to speak English to negotiate with the police department trainers and school system officials. As the parents built school to community linkages, they became educated about the functioning of an important U.S. public institution. Though this neighborhood had high in- and out-migration rates, most of the families originated from one area of Mexico and the relationships established with the local school system extended to the next group of arriving families. Presently, parent patrols create

school-wide awareness about traffic and safety issues, build and expand parent involvement, and generate a presence in their community. These visibility factors were cited by parents as an important element in reducing gang activities around their school. For the future, they will continue to build capacity in the neighborhood to use their cultural assets, leadership, and systems knowledge to strengthen their community.

TOWARD THE FUTURE

The above examples demonstrate the importance of linking cultural perspectives and community health strategies to contextual analyses. Further, the growing migration of groups across national borders and the globalization of economic and political constructs, point to the importance of structuring a global perspective into these interventions. Particularly for *Latino* communities in the United States, the recognition of language as a common symbol, the growing proportion of the population who are children and youth, and the importance of the family also should be included in framing interventions.

Recognizing the central importance of language, efforts should be conducted in a linguistically appropriate manner including attending to the nuances of the Spanish language used among different ethnic, socio-economic, age groups, and geographic configuration. The growing proportion of the children and youth in California's *Latino* population implies that health promotion and advocacy strategies should incorporate youth perspectives. This could be achieved by using engaging cultural formats while recognizing that, especially in low-income communities, economic investments in childcare, recreational facilities, and jobs are also needed by youth.

Family is perceived as the most important social institution among the *Latinos*. In this sense, family-focused interventions can impact *Latino* community health and well being positively. Use of *promotoras* is one family-oriented, holistic model that expands beyond direct traditional health-related concerns to assist family members with a wide range of issues including housing and employment. Neighborhood-based family resource centers, offering a comprehensive array of services and cultural celebrations, are another strengths-based approach for supporting *Latino* families. In addition, parental involvement in their children's schools can strengthen the links between children and their parents and public institutions, reinforce positive cultural values, and decrease the later need to focus on anti-social behaviors, e.g., violence prevention.

All of these efforts to involve *Latino* families in improving community health are vibrant and exciting, at the same time their social, economic, and cultural challenges should be recognized. Those having limited English-speaking ability or who are from cultures where business is conducted differently than in the United States, have additional barriers to overcome, whether accessing health care or negotiating with a school principal. Many systems like Medi-Cal (Medicaid in

California) have limited low-income people's access to public resources regardless of their ethnic group. In addition, past and present treatment of *Latinos* in California, including migration restrictions and employment and housing discrimination, speak to concerns that those involved in building healthy communities will be required to address.

Finally, the active involvement of community members in the implementation of health promotion and advocacy efforts is the essence of community health. Migration patterns of *Latinos* in and out of California suggest that the characteristics of communities will continue to change, and thus health promotion strategies should remain flexible. Understanding how public and private systems function and building bridges between them and communities to access resources will remain crucial for creating healthy and sustainable communities.

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